My Perspective

Where there's a will, there's a way

Do you have a system to inform clients should you be incapable of working because of accident, critical illness or in the case of your unexpected death? **Roslyn Byfield** is concerned it's something too many of us would rather not think about

Have you considered what would happen to your clients and clinical responsibilities if you were suddenly unable to work? Such a consideration may fall between the cracks when we're busy setting up a private practice, and I haven't seen this issue included in private practice trainings. Although crucial in private practice, the question is also relevant to all therapy providers, from the NHS to voluntary sector agencies and EAPs. Are there policies and procedures in place for clients to be informed and supported if their therapist is suddenly incapacitated? We shouldn't assume it's the supervisor's responsibility, unless this has been specifically negotiated with them. And, even if they have agreed to be responsible, procedures are still necessary in order to agree logistics – for example, how would they be informed, and what would be the desired outcomes? Would they just inform clients, or also offer to see them?

I recently attended a networking event at my local Chamber of Commerce, where a local solicitor gave a talk on wills and Powers of Attorney. His opening question was, 'How many of you have a will, with instructions for your business, and a Power of Attorney?' I was the only one who raised my hand (yes, to the first; not yet, to the second), and my own journey through this maze is incomplete. The response was probably not surprising, as most of those present were about half my age, but the speaker had a point: what indeed would happen should their owners be rendered incapable of running the business and there was no clear plan in place for dealing with clients and administrative and financial responsibilities? Without a plan, things could become very messy and confusing for next-of-kin, clients and creditors.

When BACP began revising its *Ethical Framework*, I hoped that, unlike the current version, it would specifically mention or (much better) mandate the need for a system to inform clients, in a sensitive and responsible manner, should we become incapable of working. This incapacity could be due to an accident, protracted illness or death – life events that are uncomfortable to think about, so we may find ourselves avoiding them. Few practitioners I have asked have a clinical will, yet I have heard stories of devastated clients in such instances (eg one trainee arriving at her counsellor's house to find a note pinned to the door, and another not being informed at all), which should bring us up short. It could also be argued that it is an ethical nonsense to pay such attention to the *Ethical Framework* principles but then ignore or sidestep the very thing that's central to caring responsibly for our clients – beneficence. The *Ethical Framework* is just that, though, and will rely on supplementary guidance and *Good Practice in Action Resources* to put the flesh onto the bones. It is encouraging that BACP will soon be producing resources that will explore the issue of clinical wills and I'm pleased to have been asked to comment on the draft. This article, then, can only go so far, as we will need to see and reflect on the final publications. What follows is a description of my personal journey so far towards making a therapeutic will, and should not be read as advice from an 'expert'.

Three-pronged task

When I first entered private practice, there were so many tasks to attend to, not to mention the psychological adjustment to self-employment, that the issue of clinical wills didn't cross my mind. Nor was it covered in two workshops I attended on setting up in private practice. My supervisor reminded me about it at various intervals, and it took some months of consideration before I felt sufficiently embedded in the role to approach a trustworthy friend, with whom I had trained, to suggest a mutual 'clinical executor' arrangement. Fortunately, they agreed, and I did as my supervisor advised, producing a document comprising contact details and a clinical summary for each client, sent via password-protected email. My friend agreed to contact these clients in the event of my incapacity, though we never put anything in writing, and she didn't ask me to do the same for her. I later realised that this list would need updating each time a client left or began. My supervisor revises hers several times a year, meaning that a list may not be 100 per cent complete at the time it is needed.

Making these arrangements was a great relief, until I read, as preparation for this article, one written for *Therapy Today* some time ago,[1] which showed that I had only covered the first of a three-pronged task: clinical, financial and administrative. The second could involve contacting and ensuring deletion of financial agreements, such as direct debits with website hosts, directories, insurance providers and professional bodies. The third could include mailing lists and social media accounts, contacting relevant people regarding any other professional commitments, and dealing with client records and clinical notes. (My supervisor had not mentioned these two categories, which I realised later she may not have thought of, having no website or social media accounts, although she would have records).

I realised that not only would the clinical document need regular updating, but I would also need to address parts two and three, leading to an overarching complication: that of one's personal will. I regularly come across people (including people aged over 60) who have not yet made a will or lasting Power of Attorney (LPA). Having been written more than 10 years ago, my own will needs updating, and I have no LPA. Even if we live with a spouse/partner/friend, we can't assume that they would know what to do in the event of our incapacity to work. And it's even more of a question for those who live alone. When I raised this in a professional social media discussion forum, it resulted in a variety of responses, such as, 'My husband would tell my supervisor.' But unless that supervisor has specifically agreed to take on this role, we can't assume it is their job. And does the partner even know the identity and contact details of the supervisor? It seems, then, very important to establish some link between our personal and clinical wills. If our executor is not someone we are regularly in contact with (a solicitor, for example), there would need to be some way of alerting them, and the clinical executor, that action is needed.

I was taken aback when I raised the issue of clinical wills at a professional networking meeting to find that, although most attendees could appreciate the need, two thought what happened after their death was not their responsibility. My supervisor also told me of an erstwhile supervisee who said if she was really ill she would be 'past caring by then'. Such reactions could be thought to demonstrate a lack of understanding of the need for empathy and planning, and a contradiction of *Ethical Framework* principles. How would you feel if you arrived on your therapist's or supervisor's doorstep, to get no response? I think this could be profoundly destabilising for anyone, since both are roles strongly associated with containment. I can vouch for this, as it happened to me twice in one year. Whatever our level of training, experience and degree of need at that point, it can feel very unsettling, since it will be out of character, and our minds might possibly leap ahead to speculate as to what could have happened. (Both absences I experienced were clarified within a few hours, but such episodes cause a breach of the 'frame', a discontinuity from which it takes time to recover.)

How would you feel if you arrived on your therapist's or supervisor's doorstep, to get no response?

Some steps to consider

I'm aware I still have work to do regarding my own clinical will but it has helped enormously to understand more about what's involved, and to have done at least some of the work. To truly demonstrate client care and adherence to the *Ethical Framework*, and to avoid bringing the profession into disrepute, I believe there needs to be a clear policy in organisations and in private practice, rather than leaving it to chance or an ostrich-like belief that it 'won't happen to me'. I look forward to the forthcoming BACP *Good Practice in Action Resources*, which I hope will further open up this issue to debate and help us get to grips with a potentially uncomfortable, yet unavoidable, responsibility. In the meantime, I would like to suggest the following steps:

- Think about whom you could trust to take on this responsibility for you, perhaps on a reciprocal basis. (It's obviously important to choose someone you consider reliable.)
- Consider how administrative and financial responsibilities, eg direct debits/insurance renewals, might be dealt with. It could be that your executor is prepared to deal with clients but not the other areas as well. This could include destroying clinical records and notes in the event of your death. The issue of dealing with clinical notes and records is complex and has been covered by BACP in a number of information sheets (now archived).[2,3] As there may be different rules applying to the records of a deceased therapist, I hope this will be clarified in the forthcoming *Good Practice in Action Resources*.
- Your executor will need to know how to access all these items. If they agree, compile a list of the organisations you have arrangements with, eg web host, insurer, directories etc, with their contact details, and send it to them. If they *don't* agree, think about how these other tasks could be carried out – is it something you need to include in your personal will?
- Once you've agreed the necessary actions with someone, send them a password-protected email (text the password, so it arrives via a different channel of communication), attaching a document comprising a short summary of the work with each client and their contact details. If appropriate, send them the details of the necessary financial and administrative tasks and contact details.
- If this is a reciprocal arrangement, make sure you keep their information somewhere safe yet accessible, so you can find the contact details quickly, if you need to.
- Reflect on your personal will and LPA, if you have one, and what links may be needed between these and your clinical will. If you don't have a partner or family member available and willing, consider asking a trusted friend to contact

your clinical executor if any mishap prevents you from working, and let your executor know who this is. Also, let your supervisor know what arrangements you have come to. Remember to update your list each time a client leaves or begins work with you. Think about how best to put this in writing (Sally Depenser's article contains a suggested format for clinical wills).

How do other professional bodies approach the issue?

In the context of BACP's collaboration with the British Psychoanalytic Council (BPC) and UK Council for Psychotherapy (UKCP),[4] it's useful to note that these two professional bodies mandate, or partially mandate, such a procedure, and regularly check that members have a system in place. If BACP decided to make this mandatory, and in my view it is a major omission not to, a check could be incorporated into the annual re-registration/accreditation process.

Clause 12 of the BPC *Code of Ethics*[5] states: 'Registrants must limit their work, or refrain from practice, when their physical or psychological health is seriously impaired, or if in doubt about their ability to perform competently, must seek appropriate advice.' On the question of having a clinical will and executor(s), Clause 20 states: 'Registrants must nominate two colleagues to hold a list of their patients and supervisees in confidence, in the event of death or an inability to work. The names of these nominees must be lodged with the constituent societies.'

Section 9.2 of UKCP's *Ethical Principles and Code of Professional Conduct*[6] states: 'The psychotherapist accepts a responsibility to take appropriate action should their ability to meet their obligations to their clients be compromised by their physical or mental health.' And section 9.3 continues: 'The psychotherapist commits to carefully consider how, in the event of their sudden unavailability, this can be most appropriately communicated to their clients. This will also include careful consideration of how a client might be informed of a psychotherapist's death or illness and where appropriate supported to deal with such a situation.'

I received the following clarification from UKCP as to whether or not clinical wills are mandatory: 'This isn't a UKCP requirement, so we would advise members to check their UKCP organisation or modality college for more information. Some colleges expect their members to make suitable arrangements. Some of our organisations advise their members in private practice to appoint an executor to take responsibility for destroying client records in a confidential way after the death of the therapist. It is generally regarded as best practice to make provision for the management of patients/clients in the event of sudden illness or other emergency which may make the therapist incapable of response, or their death.

'The Humanistic and Integrative Psychotherapy College of UKCP states: "We recognise it as our professional responsibility to ensure that arrangements are in place for sudden, long-term or permanent absence from work, so that clients' needs can be provided for. And the Council for Psychoanalysis and Jungian Analysis College of UKCP requires all individual members to provide details of "professional will arrangements in place".'

In my view, the BPC code is more accessible and digestible than BACP's *Ethical Framework*, which, I consider, is dependent on supplementary guidance and resources to make it workable. I'm concerned that the separation of the *Ethical Framework* and *Good Practice in Action Resources* could result in important material not being read and acted upon by members. But we must work with what we have and give it a chance to 'bed in'. It seems to me that key milestones in the journey towards making an effective clinical will are overcoming our discomfort around considering our own incapacity and death, and, as Despenser suggests, 'Acknowledging the curious feeling that by writing it all down I have somehow tempted fate.'[1] I look forward to seeing the draft resource on clinical wills later this year and engaging in further debate as the new framework implementation date draws nearer.

References

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Your thoughts please

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