CHAPTER 17

Reading 17.1 **Campbell A.V. (1994). Dependency: the foundational value in medical ethics. In *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press, p 184**

Reading 17.2 **Okasha, A. (2000). Ethics of psychiatric practice: consent, compulsion and confidentiality. *Current Opinion in Psychiatry*, 13: 693–698 (Extract, p 694.)**

Reading 17.3 **May, W.F. (1994). The Virtues in a Professional Setting. Chapter 7 In *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press, (Extract pps. 85–86.)**

Reading 17.4 **Marshall, M. (1994). How should we measure need? Concept and practice in the development of a standardised assessment schedule. *Philosophy, Psychiatry, and Psychology*, 1: 27–36.**

Reading 17.5 **Campbell, P. (1996). What we want from crisis services. Pages 180–183 in *Speaking Our Minds: an anthology*. (J. Read and J. Reynolds). Basingstoke: The Macmillan Press for The Open University (Extract pages 182–183.)**

Reading 17.6 **Butler, Rt. Hon., the Lord. (1975). Chairman, Report of the Committee on Mentally Abnormal Offenders, Cmnd 6244. London: Her Majesty's Stationery Office, (Extract pages 228–229.)**

Reading 17.1 EXERCISE 4

Extract from the start of: Campbell A.V. (1994). Dependency: the foundational value in medical ethics. In *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press, p 184

In this chapter I am seeking to correct a rank order of moral principles which seems to have crept into the literature of medical ethics over the past two decades, almost unobserved. There has developed a presumption in favour of individual self-determination or autonomy, and an implied or explicit criticism of the beneficent approach to the health care relationship as being second best, or justified only in certain strictly demarcated circumstances. Examples of this ordering of principles are not hard to find in the standard works in contemporary medical ethics.[1] A notable counterbalancing of this prevailing view-point has been Pellegrino and Thomasma 's *For the patient's Good:The Restoration of Beneficence in Health Care*.[2] To some extent this chapter can be seen as an elaboration of some aspects of their argument. But my central point is perhaps more controversial than theirs. I want to assert that the fundamental character of human life is one of dependency, and that therefore a medical ethics which seeks to overemphasise the independence of the individual is in danger of being a de-humanising and inadequate account of the therapeutic relationship. I have already stated this fundamental assumption about the dependent nature of human existence in my book, *Moderated Love*. Writing about the wisdom's upon which medical interventions must be based, I described the following features of the 'creatureliness' which constitutes human life:

> To be a creature is to be born of others, to know ourselves through them, to depend upon them and create dependency, to know the pain of losing them and finally to be the instance of that pain to others.[3]

[1] See especially T. Engelhardt (1986) *The Foundations of Bioethics*. New York: Oxford University Press, but several other widely used textbooks, e.g. Veatch's (1981) *A Theory of Medical Ethics*. New York: Basic Books and Beauchamp and Childress's (1983) *Principles of Biomedical Ethics*. Oxford University Press, show a less marked but similar tendency.

[2] Pellegrino, E. D. and Thomasma, D. C. (1988) *For the Patient's Good*. New York: Oxford University Press, 1988.

[3] Campbell, A. V. (1984) *Moderated Love*. London: SPCK, p. 96.

Reading 17.2 EXERCISE 5

Extract from: Okasha, A. (2000). Ethics of psychiatric practice: consent, compulsion and confidentiality. *Current Opinion in Psychiatry*, 13: 693–698 (Extract, p 694.)

Cultural specificity

In eastern cultures, social integration is emphasized more than autonomy; that is, the family, not the individual, is the unit of society. Dependence is more natural and infirmity is less alien in these cultures. When affiliation is more important than achievement, how one appears to others becomes vital, and shame, rather than guilt, becomes a driving force.

In some traditional cultures the collectivity of the community is valued rather than the individuality of its members. Decisions are made not at an individual level but on a familial, tribal or communal level, in the best perceived collective interest.

How can we adhere to our ethical guidelines and at the same time disregard the local values and norms of our target population? How can we practice without showing disrespect or disregard for local values? On the other hand, how can we ensure that respect for the local culture does not become a pretext for bypassing ethical guidelines, to the determent of the patients' rights?

In Mediterranean countries, many people, especially those living in Islamic societies, have an external locus of control and all events are considered to be God's will. Islam is centered on the idea of humans' obligation or duties rather than on any rights they may have. Against that background, consent, autonomy, and decision-making become complex matters [10**]

References

10** Okasha A. The impact of Arab culture on psychiatric ethics: In: Ethics, culture and psychiatry: an International perspective. Okasha A, Arboleda Florez J, Sartorius N (editors). American Psychiatric Press; May 2000.

Reading 17.3 EXERCISE 7

Extract from: May, W.F. (1994). The Virtues in a Professional Setting. Chapter 7 In *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press, (Extract pps. 85–86.)

Theorists oriented to principles tend to downgrade prudence because they rely on general rules rather than the concrete insight of the practitioner. Correspondingly, the need for prudence shrinks to the adroit crafting of means to ends or the artful packaging of policies. The virtue of *prudence*, to be sure, deals with fitting means to ends. But, as a virtue, it consists of much more than the 'tactical cunning' to which Machiavelli and the modern world diminish the virtue. The medievalists gave a primary place to the cardinal virtue of prudence on the grounds that Being precedes Goodness. An openness to being underlies both being good and producing the good. The marks of prudence include:

(a) *memoria*—being true to the past (rather than retouching, colouring, or falsifying the past);

(b) *docility*—defined as openness to the present, the ability to be still, to be silent, to listen;

(c) *solertia*—readiness for the unexpected.

This essential openness to the past, present, and future fairly summarises what the distressed subject needs from the practitioner in the helping professions.

Prudence demands much more than a facile packaging of what one has to say. Discretion is a question of metaphysical perception, a sense of what the Stoics called the fitting, a discretion that goes deeper than tact, a feel for behaviour that is congruent with reality.

Other virtues deserve attention in any account of professional education and formation and the terms of persisting professional identity. I will conclude by considering a number of these: perseverance, integrity, justice, benevolence and humility.

Reading 17.4 EXERCISE 7

Two extracts from: Marshall, M. (1994). How should we measure need? Concept and practice in the development of a standardised assessment schedule. *Philosophy, Psychiatry, and Psychology*, 1: 27–36.

Extract 1: pages 29–30

Distortions Arising When the MRC Schedule is Used

The MRC schedule aims to replicate clinical decision making in a "systematic and standardized way." However, the needs it identifies are in some circumstances at variance with those that would be identified clinically. Two examples of the discrepancies that arise are given below. They are derived from my experience using the schedule in hostels for the homeless (Hogg and Marshall 1993).

Example 1: Ratings in the Areas Concerned With Skills and Abilities

The first example concerns the area of functioning "getting and cooking meals." The threshold for a problem in this area is "failure to demonstrate skilled performance at any time during the past year" (Brewin et al. 1987, 975). At step 2 of the MRC schedule, forty-three out of forty-six mentally ill hostel residents in Oxford, England, were rated as having a problem in this area. This high figure reflected the hostels' policy of providing residents with meals but not with cooking facilities. At step 3 of the schedule it was necessary to decide how many of these forty-three residents were to be rated as having an unmet need.

In making this decision, the rater had three options that would allow him or her to remain within the guidelines laid down for users of the schedule. The rater could

- make no need ratings among the forty-three residents, as an "environmental constraint" was present;
- rate all forty-three residents as having a need (for the interventions "assessment" or "remedial training");
- use "clinical judgement" to decide that some of the forty-three residents had a where-as others did not (Brewin and Wing 1988, 10).

All three of these approaches, however, depart from everyday clinical practice:

- Making no rating of need is a departure from clinical practice because often those persons in greatest need will be found in situations in which there are "environmental constraints." Good clinical teams would identify such persons as having needs; if the schedule does not, then it is hardly approximating "the functioning of a well-organised multidisciplinary team" (Brewin and Wing 1988, 2).
- Rating all subjects as having a need is also incompatible with standard clinical practice because most clinical teams know that where-as some residents would find it useful to learn the skill in question, others are glad that the hostel provides meals and do not want to do this for themselves.
- Though the results of using "clinical judgement" to rate need could produce results that were closer to clinical reality than the results of options 1 and 2, above, this approach, as specified in the MRC schedule, still departs from everyday clinical practice. The reason is that in the context of the MRC schedule "clinical judgement" is exercised by a panel of raters who base their judgment on psychiatric rating scales and hospital notes, without having any idea of the patient s opinion. Clinical teams do not operate in this fashion.

The clinical team (which the MRC schedule seeks to emulate) would probably take a different approach altogether. The team would begin by asking hostel residents if they wished to move to more independent accommodations in which they would have to get their own meals. Skills training would be offered to those who wished to move, acknowledged difficulties in getting meals, and said they were willing to learn the skill. The needs thus identified would be close to what most clinicians would consider a need— a patient's lack of a basic life skill that the patient wants to acquire, and that would probably improve his or her quality of life.

Extract 2: pages 30–31

In practice, a problem similar to that in example 1 arose:a panel of raters had to decide to what extent a patient s behavior was upsetting his or her caregivers, guided only by scales of behavior that do not directly elicit the caregivers opinion. Again, rating need in this way is a departure from standard clinical practice. In everyday practice most clinicians would seek the caregivers opinions and base their judgements about need upon those opinions. When we sought caregivers opinions in our study it became clear that only a few of the thirty-eight patients with "socially embarrassing behaviour" were putting the staff under stress. Indeed, in some cases staff members pointed out that such "socially embarrassing behaviour" (such as shouting and swearing) was adaptive in a hostel for the homeless.

References

Brewin, C. R., and J. K. Wing. 1988. *The MRC Needs for Care Assessment manual.* London: Institute of Psychiatry.

Brewin, C. R., J. K. Wing, S. P. Mangen, T. S. Brugha, and B. MacCarthy. 1987. Principles and practice of measuring needs in the long-term mentally ill: The MRC Needs for Care Assessment. *Psychological Medicine,* 17: 971–81.

Hogg, L., and M. Marshall. 1993. Can we measure need? Using the MRC Needs for Care Assessment in hostels for the homeless. *Psychological Medicine,* 22: 1027–34.

Reading 17.5 EXERCISE 8

Extract from: Campbell, P. (1996). What we want from crisis services. Pages 180–183 in *Speaking Our Minds: an anthology*. (J. Read and J. Reynolds). Basingstoke: The Macmillan Press for The Open University (Extract pages 182–183.)

. . . Although in the last ten years the demand for twenty-four hour services has gradually gained acceptance, the demand for non-medical provision has stayed very much at the margins. This may be partly due to the refusal of psychiatrists to consider approaches challenging their reliance on medication. (It is interesting how the medical establishment's clarion cry of 'Anti-psychiatry' so quickly paralyses the faculty of rational consideration.) But is also due to a failure to define more carefully what people mean by non-medical services. Does this mean absolutely no use of medication? Does it mean not using medication as the standard first resort? Does it mean having medical and complementary approaches? Does it mean having staff teams that are not led by psychiatrists? Does it mean an open employment of the expertise of local users/survivors?

At the moment, debate on these questions does not seem to be very open and it is not easy to discover what progress has been made in different localities. Although there is evidence from other countries that it is possible to support people through crises without using neuroleptics (Mosher and Burti, 1994; Podvoll, 1990), our NHS system seems reluctant to innovate. As it stands, using the expertise of survivors and not using medication appear to be the most likely elements to be dropped from new crisis services.

I conclude on a personal note. My first crisis admission was not a medical event. For me, it was a moral event, a moral failure. All my subsequent admissions have contained shadows of that first failure. None of the important implications have been medical ones. In my view, the crucial questions about mental health crisis services are to do not with locations and technology but with understandings.

References

Mosher, L. and Burti, L. (1994) *Community Mental Health—A Practical Guide*, Norton, London.

Podvoll, E. M. (1990), *Seduction of Madness—A Revolutionary Approach to Recovery at Home*, Century, London.

Reading 17.6 EXERCISE 15

Extract from: Butler, Rt. Hon., the Lord. (1975). Chairman, Report of the Committee on Mentally Abnormal Offenders, Cmnd 6244. London: Her Majesty's Stationery Office, (Extract pages 228–229.)

The psychotic person, unlike the neurotic, tends to confuse his morbid subjective experiences and fantasies with external reality. There is an impairment of those mental functions upon which insight and understanding depend and an inability to adapt to the ordinary demands of the social environment. This can come about because intellectual capacities are seriously reduced (the group of organic psychoses); because alteration of mood is lasting and profound (the group of manic and depressive psychoses); or because thinking is disordered or perceptions are distorted (the groups of schizophrenic and paranoid psychoses).

18.34 We have considered whether to equate the definition of severe mental illness with the concept of psychosis, but there are two objections. On the one hand there are mild or incipient forms of psychosis, which, while clear enough to enable the clinician to make a diagnosis, would not be regarded as being evidence of severe mental illness in the terms in which we have described it. On the other hand the concept of psychosis, as a general category to embrace all those mental illnesses for which physical causation is already known or is expected to be discovered in the future, may not survive as a medical classificatory term. It is therefore necessary to identify the abnormal mental phenomena which occur in the various mental illnesses and which when present would be regarded by common consent as being evidence of severity. A definition of severe mental illness derived in this way must be comprehensive but also, as far as possible, economical.

18.35 We propose the following definition:

"A mental illness is severe when it has one or more of the following characteristics:—

(a) Lasting impairment of intellectual functions shown by failure of memory, orientation, comprehension and learning capacity.

(b) Lasting alteration of mood of such degree as to give rise to delusional appraisal of the patient's situation, his past or his future, or that of others, or to lack of any appraisal.

(c) Delusional beliefs, persecutory, jealous or grandiose.

(d) Abnormal perceptions associated with delusional misinterpretation of events.

(e) Thinking so disordered as to prevent reasonable appraisal of the patient s situation or reasonable communication with others."

Further explanation of the above sections of the definition is given in Appendix 10.

18.36 We are of the opinion that these tests draw the line of criminal responsibility at a place and in a way to which medical witnesses can testify. But it has to be borne in mind that the mental conditions included in our definitions are of such severity that the causative links between the offence and the defendant's mental condition can safely be presumed; and it is necessary that such a mental condition, which is of itself to carry freedom from criminal responsibility, should be both justifiable to the public and also strictly defined. It is essential to exclude mild or incipient forms of psychosis; it is not a question of severe mental illness suffered to a slight degree. Moreover, the adoption of this definition necessarily turns over the test of criminal responsibility to medical opinion. But doctors are often, and understandably, mainly concerned for the welfare of the patient (in this case the offender), and may forget or even ignore the duty owed to the public in the enforcement of the criminal law. Stretching of the test because it is thought that criminal sanctions or the "stigma" of conviction may be antitherapeutic must be guarded against.