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Lecture

Psychiatrists and Citizens

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During the last two years, the medical profession in Britain has been participating in a public debate – perhaps in a more exposed way than for some time. Eminent Presidents have been writing letters to *The Times*, and less eminent ones demonstrating in Downing Street. This can all be seen as contributions to the discussion on the state of the National Health Service. But there is, I believe, a wider and in my view a more long-lasting change going on, namely the relationship between the medical profession and the public – the citizens of this country. You may feel that the basic premise is based on a false dichotomy, rather like the sterile debates on community care. Hospitals *are* part of the community. Doctors *are* citizens. Yet there is an implicit or explicit contract, social if not financial, between a country's medical profession and its citizens. As we are in the era of negotiating or inventing or specifying contracts, I wanted to consider this.

The psychiatrist's contract has certain special dimensions, which require our attention. The most obvious one is that psychiatric treatment may involve the loss of a patient's liberty for the purpose of compulsory treatment. The velvet glove of the confidential couch – upholstered and embroidered with our carefully nurtured skills in eliciting, encouraging, and accepting a person's expression of very personal, and often painful information – conceals the iron fist of our powers of compulsory control. This is, undoubtedly, an alarming combination. Without much difficulty it could be made to sound like the inquisition, where a solicitous concern for the state of a person's soul is combined with a well tried range of instruments of torture.

It is not, therefore, surprising that citizens have felt a need to be protected, and for the processes of compulsory care to be regulated. Many countries have appropriate legislation, and supervisory bodies to enforce it, appointed by government. Psychiatrists must serve on these bodies, as they provide a legally recognised framework for their actions and are bound to be theatres of debate and argument, where they will have to explain and argue for regulations which allow them to act so that a citizen receives prompt and effective treatment when this is indicated.

I have publicly declared, in a debate with Larry Gostin over 20 years ago, that compulsory treatment is not a threat but a right: "Every citizen should have the right to be admitted against his or her will, to be treated without loss of dignity, in a first class psychiatric service." Mental health legislation cannot, by itself, produce a first-class psychiatric service. Indeed, the legislation and the service exist in some sort of symbiosis, and reflect each other's standards.

A rather flagrant example of this occurred when the recent Code of Practice (for England and Wales) was published (Department of Health, 1989*a*). A preface was attached to the Code, written by different authors, which stated:

> "Changes to existing practices to conform to the Code can be made without any additional resources, simply by adopting new approaches to discharging responsibilities. Where adopting the recommendations of the Code would have significant resource implications, it is recognised that this can only be done as resources permit."

We protested that this was like saying that 'zebra crossings can be illuminated as resources permit'. But to no avail.

A similar sort of disclaimer is to be found in the widely circulated draft for care programmes:

> "Health authorities are expected to meet any costs arising from the introduction of more systematic procedures from existing resources. Introducing the care programme approach places no new requirements to provide *services* on either health or social service authorities. The introduction of the care programme approach does not place any new requirement on either health or social service authorities to provide the services assessed as necessary in order that a patient can be treated in the community rather than hospital. Social services authorities must judge, in the light of existing resources, augmented by the specific grant, what services they can provide to meet the social care needs of people with mental illness."

At any point where resources may seem to be required to fulfil these plans, a disclaimer is added which puts the responsibility for the allocation of resources firmly on district health and local authorities.

This seems a reasonable approach, if local authorities were allowed some financial latitude. But they are not. Coupled with this devolution downwards

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is a firm central control of the amounts of money for which the local authorities can ask their citizens, to provide the services which they may require. This seems illogical and unjust. This state of affairs is causing anxiety all over Britain, to local authorities of all political persuasions. I understand that the Wandsworth Council (a 'Tory flagship' Council in south-west London) is contemplating a cut of over £4 million to its social services budget for 1991 in order to bring expenditure into line with the government's standard spending assessment and to avoid the dreadful alternative – a rise in the annual community charge by £130 per adult.

Psychiatric services will only enjoy the trust and confidence of our citizens if they are seen to be comprehensive, acceptable and effective. A combination of medical and social care is required. If one ingredient is inadequate, the performance of the other will be affected. The current Mental Health Act allows considerable powers for doctors to decide on compulsory care, without recourse to a lawyer. Patients may be admitted to hospital, compulsorily, for periods of three days, or up to six months, on the signatures of two doctors, and either a social worker or a close relative. After admission a person can appeal to a mental health tribunal – usually chaired by a lawyer – but there is no lawyer involved at the point of admission. This arrangement will continue to be debated, not only in Britain but in the European Community. Clearly it is putting a good deal of trust on the doctors, and social workers, and especially on their professional skills and ethics.

The arrangements today in Britain are not dissimilar from those prevailing in the mid-19th century. But towards the end of the century the situation changed – partly because of abuse, but mainly because of the deteriorating state of the overcrowded and understaffed hospitals. They had become gloomy and grim places, staffed by pessimistic doctors. In this setting, the Lunatics Friends Society agitated successfully for legislation which made all admissions dependent upon legal approval. Voluntary treatment did not reappear on the scene, in public hospitals at least, for some 40 years. It is certainly no accident that the recent radical mental health legislation proposed by a United Nations Committee comes from a group chaired by a Greek lawyer. In Greece, at present, there is grave public disquiet about the state of the public mental hospitals.

However, a government's supervisory role of psychiatry carries with it serious dangers. The supervision may lead to control, and psychiatry may become the tool of government. This has happened in the last 60 years, in two European countries – Germany and the USSR – and possibly elsewhere. Both these countries were tyrannies at the time. Citizens had ceased to have any influence on government and protest had become increasingly dangerous.

Nazi Germany provided the most horrifying example. It was a country where psychiatry and psychiatric research were highly developed and internationally respected. Indeed, some of these researchers encouraged the first moves towards 'eugenic measures' – the sterilisation of patients or even of healthy people with family histories of mental illness, including alcoholism. This was soon followed by the systematic extermination of certain categories of patients, especially long-stay patients and the mentally handicapped – including children. We must never forget that the first gas chambers for mass extermination were used not on political opponents, nor on Jews, but on psychiatric patients, on the grounds that they were 'unworthy of life'.

In Russia, the abuse of psychiatry has been based on more traditional grounds, which had been used in the time of the Tsars, for the incarceration of political opponents. Both the offence – any form of political opposition or dissent – and the punishment were products of a totalitarian state. In both Germany and Russia some psychiatrists connived with these measures, but it should be recorded that, in Germany, before these measures were started, a large number of psychiatrists resigned or were dismissed from their posts by the Nazis, and others resisted these measures and protected their patients – often at great personal risk.

We should all pay tribute to our colleagues in Germany who have courageously participated in the rehabilitation of psychiatry in the years since 1945, and in examining the facts and lessons of that appalling episode – and to our brave colleagues in both countries who spoke out against the abuses there, and endured dreadful suffering as a result (Meyer–Lindenberg, this issue, pp. 000–000). The rehabilitation of psychiatry in the USSR is only just beginning.

You may wonder what the relevance of this is to Britain in the 1990s, which is after all, a democracy. The National Health Service (NHS) is to continue and psychiatry has been seen as a 'priority' specialty for many years.

There are three aspects of our contemporary society which should concern us all here – both psychiatrists and citizens. The first is to do with stigma. The mentally ill are still a submerged and stigmatised group. Mental illness is common. Its so called minor forms, which often cause a great deal of distress and disability, make up nearly 20% of a general practitioner's work. A recent survey reported in the press that 85% of the population

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would give money to a children's medical charity, but only 14% to a medical charity for the mentally ill. This situation requires further examination and analysis, beyond the scope of this paper, but I do think that psychiatrists should consider very carefully whether they are contributing, in some way, to this state of affairs. Perhaps because we feel a bit uneasy ourselves, wondering whether we are 'not proper doctors', we resort to trying to disguise psychiatric problems and illnesses as 'just like any other sort of illness'. This is an over simplification with a long history. For instance:

> "Two causes contribute powerfully to retard our knowledge of and control over insanity. The first is the prevailing notion of its mysterious origin and nature as if it involved some deep moral stigma or was inseparably bound up with something of horror and altogether beyond the influence of the ordinary laws of animate nature. The second is the popular notion of the cruel treatment of lunatics, and the great aversion thence arising either to have the patients removed to an asylum or even to admit that insanity really exists.
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> Before full justice can be done to the unhappy lunatic, these prejudices must be destroyed, and the wholesome and comforting truth made widely known, that insanity is neither an anomalous visitation of a mysterious Providence, nor an affliction involving any stigma, or incapable of cure. The public must be taught to regard it simply as a disease of the body arising from natural causes, governed by the ordinary laws of the animal economy and, like other diseases, amenable to proper treatment when early attended to; and they must be led to regard asylums as infirmaries for the cure and kind treatment of that disease, and resort to them with the same confidence as they now do to other infirmaries for a fracture or a fever. Insanity, rightly considered, involves no moral stigma any more than consumption or inflammation, and the sooner the atmosphere of mystery and horror is cleared away from it, the happier for the unfortunate sufferers." (Combe, 1850, p. 376)

This was written in 1840, by Andrew Combe, an Edinburgh man. He had a powerful brain theory (phrenology) which has now been replaced by more complex brain theories. His exhortations fell on deaf ears nearly 150 years ago. If we try to sell what Professor Eisenberg has called 'mindless' psychiatry to the public, we do both them and ourselves a disservice. It is all more complicated than that; even though it is equally risky to leave out the brain altogether. But it shuts the door to all sorts of forms of treatment which are important and effective. We should, in my view, abandon the approach of promoting psychiatry as a special form of physical illness. Indeed, on that particular point we would be much better employed in teaching those that practice 'physical' medicine and surgery to behave more like psychiatrists.

My second point is that we seem to be increasingly a success-orientated society. Efficiency and productivity are at a high premium, and the less efficient and productive are of correspondingly lower estimation. They may be seen as failures, or lazy, or deviant in some way which makes them 'unnecessarily dependent'. Because many people are now better off, those that are not must be just not trying hard enough, or are feckless or dishonest, or both. We can certainly become quite punitive to deviants, as witnessed for instance by the disgraceful state of many of our prisons, where three or more men may have to share their single cell with their own excreta. We have also become Scrooge-like with our official benefit system, as witnessed by the social loan system of benefit, and the failure to support young people who have left home, driving them to live and sleep on the streets. We also have a poor record in employing the disabled. Indeed, our quota system for disabled employment is to be dismantled, because it does not appear to be working, but nothing else is being proposed in its place apart from exhortation. Cheap housing for rent is becoming increasingly scarce, as a result of current policies. In our society, the weakest are either going to the wall, or at least being sent off in that direction.

My third concern is the pollution, or debasement, of language. George Orwell's classic essay "Politics and the English Language" (1945) should be on every citizen's reading list – and certainly on the list for anybody working in the health service. Language will, of course, continually change and evolve, but I am referring to the increasing habit of avoiding any arguments by simply making statements and assertions for which there is no foundation. The trick is to continue until the opposition caves in, perhaps from exhaustion. This is the stock in trade of the mountebank and of the advertising and marketing world, and this was the procedure used in writing and launching the White Paper, *Working for Patients* (Department of Health, 1989*b*). This is written like a brochure, lacking any detailed specifications or reasoned arguments. It was, I believe, a grievous and disgraceful offence to the intelligence of all professionals, and especially of managers, working in the NHS.

I have referred elsewhere to the author of this obfuscating optimism as 'Dr Pangloss', as opposed to the erudite, thoughtful Dr Acheson – the Chief Medical Officer – who has managed to insert some good ideas into the White Paper, especially the instructions to health districts to assess and meet the needs of their local populations and put some control on the activities of providers. Just at present Dr Pangloss is giving more instructions to managers

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than to doctors. For instance, health authorities must arrange for every new attender at a hospital to be plugged into the correct contract programme, for billing to the right purchaser – a state of affairs which seems a very long way off, as is the ability to cost a particular treatment.

I feel very sorry for managers, and am not at all surprised that they have resorted to rather poetic metaphors to support them in their existential crises – running with all sorts of balls, in every conceivable direction, over all sorts of playing fields, of every conceivable gradient – and at the same time trying to keep them all in the frame. I was, however, disagreeably surprised to find at a recent meeting of very enlightened managers (enlightened because they were attending a meeting at the Royal College of Psychiatrists), that their ideas of 'outcome' measurement, referring to patient care, included only measures of clinical improvement. The concept of preventing deterioration and maintaining people to function at their current level, or organising a pain-free and dignified death, did not seem to be on their list of 'outcomes'. Such concepts are foreign to the upbeat phrases with which Pangloss-speak is irredeemably polluted.

These three processes: the devaluing of the mentally ill, the rejection of the unsuccessful, and the pollution and debasement of language, relate to experiences in Nazi Germany, for the following reason. The cost of health care will continue to rise, as will the number of people living beyond the age of 75. The pool of people of working age, in Great Britain, and many other countries, will fall, or at best be static. At some point, hard choices will have to be made. Criteria such as 'value for money', or 'quality of life' may well be used. The quality-adjusted life year (QALY) has been developed, but how does one apply QALYs, to a serious mentally handicapped and physically disabled person, who may also be deaf or mute, requiring continued expensive care, or to the large numbers of people suffering from Alzheimer's disease and to their carers, both at home or in hospital? Many people suffering from schizophrenia, or severe depression, lead restricted and painful lives – as do their families. The cheerful world of Dr Pangloss seems far removed from this existence. We are in the world of real news rather than television advertisements. Instead of the reassuring jingle, we are hearing what Wordsworth has called "The still sad music of humanity". Perhaps Dr Pangloss will want to switch it off.

Writers on QALYs have referred to this situation; for instance:

> "The essence of a QALY is that it takes a year of healthy life expectancy to be worth 1, but regards a year of unhealthy life expectancy as worth less than 1. Its precise value is lower the worse the quality of life of the unhealthy person (which is what the 'quality adjusted' bit is all about). If being dead is worth zero, it is, in principle, possible for a QALY to be negative, i.e. for the quality of someone's life to be judged as worse than being dead." (Williams, 1985)

In a recent article on euthanasia in the highly respected *New England Journal of Medicine*, two eminent physicians, one American and one Canadian, have discussed the increasing interest in and practice of euthanasia (Singer & Siegler, 1990). One of the risks, they believe, of allowing euthanasia is what they call 'discriminatory' euthanasia:

> "Patients belonging to vulnerable groups in American society might be subtly coerced into 'requesting' euthanasia. In the United States today, many groups are disempowered, disenfranchised, or otherwise vulnerable: the poor, the elderly, the disabled, members of racial minorities, the physically handicapped, the mentally impaired, alcoholics, drug addicts, and patients with the acquired immunodeficiency syndrome. In a society in which discrimination is common and many citizens do not have access even to basic health care, the legislation of euthanasia would create another powerful tool with which to discriminate against groups whose 'consent' is already susceptible to coercion and whose rights are already in jeopardy."

This is an abyss into which no one wants to look and I do not think for a moment that Dr Pangloss would be advocating 'merciful death' (the term used by the Nazis), along the lines hinted at by the authors of this article. He may be more inclined to take a hint from another American, Dorothy Parker, "No problem is so big that it cannot be avoided". But as a health service becomes overwhelmed, some sort of selective triage might start to operate. And the medical apparatus is not free of moral judgements, as witness the disapproval and anger created by people who take overdoses, or even have terminations of pregnancy, and other groups who have "brought the trouble on themselves".

There are very serious choices to be made for the future, in which citizens must be involved as it will affect their lives as well as their health care. For instance, in Britain we tolerate some 4000 deaths a year on the roads – the equivalent of the Lockerbie air disaster every month – and many more serious injuries, making major demands on the health service, as well as causing great suffering. But we have not introduced random breath tests, nor slower speed limits, and indeed at present are encouraging road transport at the expense of rail. By far the most damaging drugs affecting our health, which put huge

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demands on the health services, are alcohol and tobacco. At least a third of all hospital attendances are either alcohol- or tobacco-related. But pricing policies on both these drugs, which would reduce consumption, remain feeble in the extreme. All these situations – as well as the introduction of extra taxation to provide more funding for the NHS – could be changed or brought about by political action, but our elected representatives believe that their constituents would not tolerate it. Will they feel differently when the stark choices of care, and who should receive care, become more urgent and painful? These choices transcend party politics, but the prospect of having to make them is real enough. The threat to some of our weakest and most defenceless citizens is, I would say, far greater and more urgent than any threat of a nuclear war or of approaching inundation by global warming. It needs to be recognised, so that it can be avoided.

Satisfactory psychiatric services can only be achieved by a joint enterprise between psychiatrists and other professionals on the one hand, and the citizens on the other.

To ensure success, psychiatrists need to be in the market place and I would hope that this will be more like the Greek *agora*, which contained market, politics and philosophy, than 'the market' of currency dealing or pure economics – not that economics is ever pure. Psychiatrists need to exchange ideas with all sorts of people and be prepared to argue their own particular views – which are, I am glad to say, by no means uniform. We need to raise the level of discourse to something more sophisticated than what often passes at present. For instance, we need to get away from psychiatrists being seen as peddlers of pills with some electricity to back them up – the so-called 'medical model', and advocates being regarded suspiciously by psychiatrists as 'all Citroens and sandals'. Equally we must be careful that our own contributions are sensible and properly supported by evidence. Sometimes psychiatrists seem to occupy either an omnipotent stance or an impotent one, with nothing much in between. A more important difficulty is our natural sensitivity to what we feel to be unjust criticism or to wilful misunderstanding or misrepresentation. Nevertheless, the cure or treatment of agoraphobia is exposure *in vivo*, and we have to go through with it.

We can take heart that we have many friends and allies 'out there', and that it is possible to make the middle course an interesting one – one of the many achievements of Professor Anthony Clare. We must remember that the Press needs good-quality information and treat their sources with respect, if only for their own sakes, to preserve them for future occasions. This whole approach involves a certain combination of confidence and modesty. Above all we must not employ Dr Pangloss to package our message into a few small short slogans or a mass of soothing verbiage.

Secondly, we need citizens to help us actively in our enterprise, and by citizens I mean both other professionals as well as so-called 'laymen'. Our relationship with other professionals is full of interesting pitfalls. There will, of course, be 'turf wars' and arguments, but in principle I hope we will follow the pattern of modern football where the general purpose is abundantly clear and there is a good deal of overlap as to who does what and where, and we cover for each other. There is so much work to be done in our field that nobody is going to be cut out.

In addition, we must make the best possible use of the immense fund of goodwill and voluntary action that exists for psychiatric work of all sorts. My own personal experience with the Samaritans Organisation, for instance, has given me great respect for what can be done by people who would be called 'non-professionals' but in fact have careful training and direction. In all this we must not forget that we learn most from our own patients and must listen to their views about what they see as important for their care.

Thirdly, we must, as psychiatrists, make sure that we are properly trained and remain so. We will be expected to take a lead. People will want us to do so and indeed we must do so. In particular, we must be sure that we remain well informed and do not get stuck at the level at which we first emerged from our training. Training needs to be seen as a lifetime experience.

The value of psychiatrists has been abundantly recognised by the high demand for them at present, and by the response of the Department of Health's Joint Planning Advisory Committee in creating a considerable number of new senior registrar posts. We carry a further advantage. We do not, as a rule, bring in our wake a large train of expensive equipment or staff, such as pathologists, anaesthetists or X-ray machines. Some of our finest exemplars, such as Professor Michael Rutter, FRS, and Professor George Brown, a Member of the British Academy, have all done their major work by using interviews, the basic equipment of the psychiatrist. Like Turner's palette, this looks pretty ordinary, but the high technology is in our heads, in our mental equipment. That is where it must remain and we must be sure that any built-in obsolescence is minimised. Psychiatry remains, proudly, a clinical and social science. As its

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practitioners, we are mobile and can go out to meet our citizens wherever they may be – in palaces or in packing cases, in prisons or in pebble-dash suburbia. We must take advantage of this freedom and we must earn our right to exercise it.

In addition, we must maintain our political freedom. At this point it is often the custom to quote "The price of freedom is eternal vigilance", but this is a Panglossian corruption. Freedom cannot be bought. The original statement by John Curran, a well known Dublin Liberal lawyer, was made 200 years ago. "The condition upon which God hath given liberty to man is eternal vigilance; which condition if he break, servitude is at once the consequences of his crime, and the punishment of his guilt." This applies as much to our clinical freedom as to our political freedom. We have to remain vigilant, both as psychiatrists and as citizens.

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