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Is psychiatry torn in different ethical directions?

SUMMARY

Psychiatry is the only specialty that uses legislation which is torn between utilitarian and rights-focused approaches. Although on the

one hand this improves the opportunity for good outcome, on the other it reduces autonomous decision-making. Because psychiatry is the only medical

speciality in this situation, this may cause stigmatisation and an inappropriate expectation on psychiatry to fulfil some kind of social policing role.

Psychiatry is the only medical specialty that uses legislation (Human Rights Act 1998, Mental Health Act 2007, Mental Capacity Act 2005) which is torn between utilitarian and rights-focused approaches. On the one hand, this improves the opportunity for good outcome, but on the other it reduces autonomous decision-making. Because psychiatry is the only medical specialty in that situation, this may cause stigmatisation and inappropriate expectations on psychiatry to fulfil some kind of social policing role. This paper discusses the way in which psychiatry and medicine are different (because psychiatry is torn into two different ethical directions) and the way in which they are similar, because both psychiatric and medical professionals will have to make capacity assessments on the very people whose best interest they make decisions on.

The three Acts

In 2007 the new Mental Health Act for England and Wales received Royal Assent and is likely to be implemented by the end of 2008 (House of Commons, 2007). After almost 10 years of controversy about the new legislation the law that was finally passed contains a number of amendments to the 1983 Act, namely the introduction of community treatment orders, a broader definition of mental illness and a widening of professionals who can take responsibility for the detention process including tribunals (Department of Health, 2007a). Although the 2007 Act makes some rights-focused provisions, on the whole it is much more utilitarian than the 1983 Act. This, although politically legitimate, is ethically questionable (Lepping, 2007). It is particularly interesting that the 2007 Mental Health Act makes no mention of capacity as a cornerstone of detention. In fact, it specifically maintains the 1983 Act's premise that capacity is not a necessary criterion when a decision on detention is made. This means in effect that it

is possible to detain a person who has full capacity to make decisions as long as they meet criteria for detention under the Act. This is in stark contrast with the Human Rights Act (House of Commons, 1998) and the Mental Capacity Act 2005 (England and Wales) (House of Commons, 2005), which are two rights-focused pieces of legislation centred on protecting autonomy (from the state) and autonomous decision-making in people who have capacity to do so.

The Human Rights Act 1998 focuses on the relationship between the citizen and the state or bodies of the state such as the National Health Service (NHS). It outlines essentially what the state is not allowed to do to the citizen although most rights in the Act are either qualified or passive rather than active and absolute. The Mental Capacity Act 2005 describes the importance of autonomous decision-making even if the decision is deemed eccentric or unwise by health professionals (Department of Health, 2007b). It gives the individual various ways in which he or she can influence and even regulate medical, social and financial decision-making in case he or she loses capacity at a later date. This includes legally binding advanced refusals as well as appointing a person with a lasting power of attorney or writing a non-legally binding advance statement to inform best interest decisions. Provisions are made for those who are un-befriended to facilitate decision-making in their best interest.

Autonomy v. outcome

It is clear that the Human Rights Act 1998 and the Mental Capacity Act 2005 are designed to protect the autonomy of the capable individual, while the Mental Health Act 2007 allows detention in case of mental illness or suspected mental illness even when the individual has maintained capacity to make decisions. Beauchamp & Childress (2001) point out society's legitimate interest in



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good clinical outcome including striving to prevent harmful decisions made by individuals. This utilitarian approach needs to be balanced with the individual's right to make autonomous decisions. It is therefore interesting that recent legislation on these issues has taken us clearly into a more rights-focused arena with the exception of mental health where we seem to be moving towards a more utilitarian approach. This is likely to increase stigmatisation of people with mental illness because it assumes that the capable individual with mental illness is more likely to make eccentric or unwise decisions that may lead to poor outcome than an individual without mental illness. In fact, there is a distinct lack of evidence that this is actually the case. Although all psychiatrists are aware of individuals with chronic mental health problems who make decisions that are likely to lead to a deterioration of their health, this is also the case in most physical illnesses, such as diabetes, chronic obstructive pulmonary disease, ischemic heart disease and many more, where individuals continue to pursue a harmful lifestyle and are non-adherent despite clear negative effects on their health. However, no legislation allows the detention and treatment of those individuals, while the legislation specifically allows the detention of individuals with mental illness.

There are clearly two aspects to this:

1. Current legislation on capacity is inconsistent and tries to combine good outcome with the need to protect autonomous decision-making.
2. Mental illness is the one aspect of medicine where this dilemma is most clearly defined in legislation, because psychiatry is the only medical specialty in which legislation itself causes an ethical conflict.

Our medical colleagues are slowly starting to realise that the Mental Capacity Act 2005 demands of them to assess capacity. Although they have done this informally for decades they have thus far always looked towards psychiatry to do formal capacity assessments. This has now changed to the point where any decision maker needs to assess capacity, including nurses, social workers and carers. The ethical problem with this lies in the fact that the person who assesses capacity is usually the same person who decides what is best for the incapable patient, thus introducing an obvious conflict of interest. This ethical problem will be shared by medical, surgical and psychiatric health professionals and has only been addressed in the Mental Capacity Act through the deprivation of liberty safeguards. These safeguards separate the assessor from the best interest decision maker, but they will only cover a very small minority of patients.

It is perfectly legitimate to argue that society has an interest in good outcome. What is stigmatising and discriminating, however, is the fact that these provisions are reserved only for people with mental illness. It also increases psychiatry's role of social policing being the only medical specialty with the possibility of looking at good outcome as a primary contributor to a decision on detention, whereas other medical specialties only need to consider the patient's capacity to make decisions. In order to avoid being drawn into a social policing role (Royal College of Psychiatrists, 2007) psychiatry needs to contribute to a national debate about the role of medicine, and psychiatry in particular, as well as the definition of good outcome.

Medicine faces similar problems to psychiatry when it comes to the ethical dilemma of having the same person as assessor of capacity and decision maker, but it is not yet torn between two different ethical routes by legislation. However, medicine deals with many chronic diseases and often undesirable lifestyle choices, and a frank discussion about how far we want to take utilitarianism and good outcome is needed more than ever at this point in time.

Declaration of interest

None.

References

- BEAUCHAMP, T. & CHILDRESS, J. (2001) *Principles of Biomedical Ethics* (5th edn). Oxford University Press.
- DEPARTMENT OF HEALTH (2007a) *Mental Health Act 2007*. Department of Health (http://www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en_1).
- DEPARTMENT OF HEALTH (2007b) *Mental Capacity Act 2005 (England and Wales)*. Department of Health (http://www.dh.gov.uk/en/Policyandguidance/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityAct2005/DH_064735).
- HOUSE OF COMMONS (1998) *Human Rights Act* (http://www.opsi.gov.uk/acts/acts1998/ukpga_19980042_en_1).
- HOUSE OF COMMONS (2005) *Mental Capacity Act* (http://www.opsi.gov.uk/acts/acts2005/pdf/ukpga_20050009_en.pdf).
- HOUSE OF COMMONS (2007) *Mental Health Bill (Bill 76)* (http://www.opsi.gov.uk/acts/acts2007/pdf/ukpga_20070012_en.pdf).
- LEPPING, P. (2007) Ethical analysis of the new proposed mental health legislation in England and Wales. *Philosophy, Ethics and Humanities in Medicine*, **2**, 5.
- ROYAL COLLEGE OF PSYCHIATRISTS (2007) *Mental Health Bill Newsletter*. Royal College of Psychiatrists (<http://www.rcpsych.ac.uk/pressparliament/aboutourparliamentarywork/legislationandresponses/2007/mhbnewsletter0307.aspx>).

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