Rethinking a dilemma in psychiatric practice

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Psychiatry differs from all other medical disciplines in one aspect. Every psychiatric practitioner has to face a particular ethical dilemma in her/his daily professional work. The ethical issue arises in the context of treatment and care of a person afflicted with some mental illness and it arises because the patient's view of and choice regarding his/her own condition and the view and opinion of the professional differ and are contrasting. The conflict arises from difference of opinion between the service user and experiencer of suffering on one hand and the clinician as knowledge-power holder. The conflict will revolve around whether any kind of 'treatment' should be undertaken or not and, if the answer to the first question is yes, which form of treatment is to be undertaken. If we grant (which we often do) that the clinician is the holder of presumably correct understanding of the disease process and available treatments, why should one at all need to take cognizance the patient's choice in the treatment process?

There are two related but different issues involved here. First, why should we at all take cognizance of the patient's sense of autonomy expressing a different viewpoint and choice? The standard answer is that it is a Human Rights issue and the confrontation between human right issues and medical decision often seem to make us, practicing psychiatrists, uncomfortable. Second, there is a need for a theoretical framework to bypass the ethical impasse when we impose physical restraint, forced treatment, surreptitious medication, etc on a patient. We usually take recourse to standard code of medical ethics where beneficence overrides all other tenets of medical ethics which includes autonomy too. In doing so, we also sometimes unwittingly confuse between benefit of the patient with benefit of the family and society at large. Unfortunately, in daily practice, this 'benefit' gets reduced to reducing behaviour that disturbs others.

We also talk about the clinical concept of insight. Lack of insight in the patient presumably justifies clinician's decision to override the patient's choice. But this construct in fact does not give us a strong ethical framework to solve the dilemma because insight can often be reduced to concurrence with the clinician's view and 'lack of insight' to expressing a view different from the clinician's. This leads to circular logic and a 'catch 22' situation for the patient.

In this short article I am trying to formulate a different theoretical stance for medical beneficence that may, to some extent, mitigate the ethical dilemma and help reformulate goal of psychiatric intervention. This should be taken as a preliminary sketch and detailed analysis needs to wait for a future opportunity.

Needless to say, any discussion on this ethical dilemma will be pertinent and meaningful if, and only if, current psychiatric theorisation, including its diagnostic system and intervention methods are based on strong scientific evidence. Any talk on evidence will, in turn, raise the question of solid epistemological validity. We know that this issue is still open for much further discussion and exploration but for the current discussion I am assuming this epistemological and ontological grounding for current psychiatric theory and practice to be reliable enough.

While talking about scientific evidence, as practitioners and applicators of scientific knowledge on other human beings, we must constantly keep in mind that science unavoidably tends to view its subjects of study through a reductionist objectifying lenses. As Martha Nussbaum has shown, objectification has many facets. For any 'scientific' study on human beings, the idea of fungibility as a form of objectification seems unavoidable.

Fungibility is originally a legal term but has in recent days been found useful in discourses in social studies, gender studies and also in some areas in current theories of quantum physics. The term basically means interchangeability of two or more objects in terms of some value. For example, if you lend me a hundred rupee today and tomorrow I return you the money, the 100-rupee note I give you back tomorrow need not be exactly the same 100-rupee note you give me today: I can very well give you another. This is because all 100-rupee notes are financially and legally exactly the same in value --- they are fungible. For Nussbaum, in cases of objectification, the objectifier treats the object as interchangeable (a) with other objects of the same type and/or (b) with objects of other types. This kind of objectification immediately entails another aspect of objectification that Nussbaum discussed --- denial of autonomy. The objectifier treats the object as lacking in autonomy and self-determination --- and this brings us right back to the ethical problem of psychiatric practice we are discussing here.

Here, I shall like to step back and try to understand the idea of choice and its importance in general. The word 'choice' basically brings to my mind the work of Amartya Sen in the field of welfare economics. Amartya Sen makes a paradigm shift in welfare economics when he asserts that the foundation of human development and well being is not resources or goods but freedom. He puts freedom at the core of evaluations of well being of a person. An essential test of individual welfare even within the context of economic development is whether the individual has greater freedom (of choice) today than she did in the past. Though his work primarily pertains to macro-societal sphere there is no logical inconsistency in extrapolating the insights to individual situations because equality, as the starting point to assess well being, clearly indicates the value and importance Sen attributes to each person. We obviously need not go into any details of Capability approach in welfare economics in details here but it is important to note that Capabilities, as conceived by Sen, are related to the capacity of the

individual to function. The two important concepts in the capability approach are functionings and capabilities. The functionings of a person refers to the beings and doings of the person that he or she values and has reason to value. Functionings might include being nourished, educated, healthy, having close relationships, riding a bicycle, being employed gainfully, participating in one's community, etc. That is to say that functionings are constitutive of a person's being, and an evaluation of wellbeing has to take the form of an assessment of these constituent elements. Thus functionings are related to various dimensions of human lives; Capabilities refer to the freedom of choice for the individual. The key idea of the capability approach is that social arrangements should aim to expand people's capabilities - their freedom to promote or achieve what they value doing and being. I must emphasise here that health service delivery, obviously including psychiatric services also, is an integral part of social arrangements that Amartya Sen is talking about and, importantly, his idea of choice as a developmental index holds good for health services also. Ability, disability, different ability etc have become, regretfully, often used jargons in health-service discourse, --- when and where informed about human rights issues and UNCRPD. I personally prefer Sen's concept of capability as, instead of keeping the focus and onus on the individual ---- as terms related to ability do ---- the idea of capability embraces both the individual and her/his immediate environment equally within its ambit. Capability represents a person's freedom to achieve well-being and this well-being obviously incorporates physical and mental well-being. According to Sen, capability is the actual ability to achieve various valuable functionings as a part of living. In other words, the "capability of a person reflects the alternative combinations of functionings the person can achieve, and from which he or she can choose one collection. Sen thus establishes that central to the capability approach is the concept of freedom and agency. He states that the assessment of well being should focus on the extent of freedom to choose or, in other words, capabilities of a person. The insight I am trying to derive from Sen's work for

implementation in health sector is that no concept of individual welfare or wellbeing can ignore the basic need for the individual's freedom of choice in every area of life, including issues related to physical and mental health.

I shall now shift to the field of psychology ----- specifically to positive psychology or wellness studies. The insights derived from recent research and theory formation are of prime importance to the work of mental health service implementation. Richard M. Ryan and Edward Deci are the proponents of the theory of Self-determination (SDT). Self-realization or eudaimonia is a central definitional aspect of well being in this theory. SDT conceptualises that well being is a process and not a consequent or end result. Psychological well-being here refers to living an enriched life in a deeply satisfying manner. SDT specifies that there are three basic psychological needs that are universal and cross-developmental, namely those for competence and relatedness and autonomy. Competence refers to the need to feel effective and to have control with respect to one's environment. Autonomy refers to a sense of choice and freedom from external pressure in one's actions, behaviours and thoughts. It is the organismic desire to self-organize experience and behaviour.

Carol Ryff developed an alternative approach to well being as a critique to the researches on Subjective Well-Being which she felt had impoverished theoretical basis. Drawing upon the concepts of well being prevailing since ancient times to modern existential and humanistic psychology, she incorporated in her theory, the ideas of well being given by Aristotle, Abraham Maslow, Carl Rogers and Victor Frankl among others. She proposed that psychological well-being is a complicated structure of positive psychological functioning having different dimensions. Ryff constructed a measure of well-being around six subscales which include-- the feeling of personal growth and continuous development as a human being (personal growth), the individual's belief that life is meaningful and

purposeful (purpose in life), positive evaluation of his or her present life and past history (self-acceptance), establishing and sustaining positive interpersonal relationship (positive relations with others), the capacity of the person to have control of her life and world (environmental mastery) and the ability to make personal decisions (autonomy). It is important to note here that Carol Ryff's alternative approach to understand psychological well being also includes autonomy of choice and self-direction as an essential component of well-being.

Through all this discussion, what I am trying to establish is that an individual needs to feel competent and autonomous in all spheres of life, including medical decisions, to achieve a sense of optimal well-being and happiness. As a patient I need to feel myself as a participant to all the medical interventions being done to my body and mind and not just as a passive recipient of the same, to derive maximum benefit and wellness. Felt coercion and decrement of sense of autonomy will ultimately impair the outcome.

I must here also mention that the four basic tenets of medical ethics, as developed by Beauchamp and Childers, includes the patient's autonomy as the third tenet, first two being beneficence and non-maleficence.

As mental health professionals we know that there are unfortunate situations where a person, through a pathological process, develops temporary impairment of capacity for informed choice. A participatory dialogue between the individual and the clinician becomes difficult or impossible and unilateral decision making by the clinician becomes often unavoidable. That does not mean this judgement of incapacity is left to individual clinician's idiosyncrasy. There are internationally agreed protocols but space does not permit me to discuss those protocols here.

To sum up, what I am proposing here is a paradigm shift in medical training and practice. A clinician needs to be busy with diagnosis, treatment, symptom

removal, arrest of disease process but these are not the goal of treatment. These are just instrumental to achieve the goal ---- restoration and enhancement of the patient's autonomy and competence ---- as much as possible and as soon as possible are the desired goals. If we, as practising psychiatrists, constantly keep this in mind it will hopefully be a major step towards solving the common ethical dilemma of our daily professional activity.

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