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Psychiatry in the future

The next 15 years: postmodern challenges and opportunities for psychiatry

Psychiatry is a branch of medicine, and medicine has its roots in scientific empiricism. Scientific modernism, a product of the Enlightenment, has come under considerable fire from critics, often labelled as postmodern (Muir Gray, 1999; Bracken & Thomas, 2001; Laugharne, 2002). These criticisms include a portrayal of science as a 'grand narrative' that reduces reality to a material, measurable world, which follows rational rules, and excludes the non-measurable and non-material. The idea of the objective observer is questioned, because all observers have some interest in what is being observed. Also, multiple views of reality are seen as necessary to understand different perspectives, and the idea that scientific knowledge should 'trump' other forms of experience is criticised. This has been described by Bracken in the following way:

'Postmodern thought, culture and ethics involves a coming to terms with the downside of the modernist Enlightenment dream: a world ordered according to the dictates of reason; a world shaped by science, technology and efficiency' (Bracken, 2003).

He goes on to say that these criticisms are not a rejection of Enlightenment values and ideals, but a concern to understand their limitations. Such criticisms have implications for how psychiatry may develop in the next 15 years, and in this article the issues of knowledge, trust, power and choice are addressed.

Knowledge

Scientific evidence is viewed in medicine as the basis of our knowledge. The support of evidence-based medicine has been seen as an advance in knowledge within psychiatry. Indeed, the promotion of an understanding of why certain treatments are advocated has to be a good thing – but is scientific evidence the only source of knowledge, or even the pinnacle of knowledge in medicine? Do we really believe that research evidence is fully objective, or can subjective factors such as the commercial interests of pharmaceutical companies, or academic reputations, influence how evidence is interpreted? Is the judgement of the quality of a piece of evidence free from subjectivity? There are other sources of knowledge, not least the experience of patients, which are not empirical but are being put forward as important determinants of how services should be developed. Let us not fool ourselves: if the medical profession claims that evidence-based medicine should trump other forms of knowledge in determining how services develop, we will be accused of pushing a 'grand narrative' that is tyrannical in nature. We have the knowledge to interpret the evidence, and this puts us in a position of power, so we will be accused

of acting in self-interest. However, if we advocate evidence-based medicine as a vital part of our knowledge, while accepting – and showing – its limitations and welcoming other sources of knowledge, we will be perceived to be more open. User-led research (Faulkner & Thomas, 2002) and qualitative accounts of patient experiences (Faulkner, 2000) are two examples of valuable knowledge that can be included.

Trust

It is often claimed that people are losing trust in institutions. Patients are said to have less trust in the National Health Service (NHS) and in the medical profession. Yet, as Onora O'Neill observed in her Reith Lectures (O'Neill, 2002), in practice people do not behave as if they have lost their trust in doctors. They continue to seek help from the NHS, and demand is not decreasing. She suggests that rather than a loss of trust, there is a culture of suspicion towards health care. The response to this culture of suspicion has been to micromanage the service and to make the NHS more transparent; however, there is little evidence to suggest that these responses are increasing trust, and indeed may be damaging it. Ultimately, she suggests, if our institutions are to rebuild trust, an intelligent accountability needs to include a degree of self-governance, and professionals need to be accountable to the public rather than to regulators or government departments. The implication of this argument is that psychiatrists need to be accountable to patients rather than through the Department of Health, and therefore there needs to be a renewed emphasis on the importance of the therapeutic relationship between clinicians and their patients.

Power

Clinician power has been challenged in recent years, and this challenge is likely to continue. Coulter (2002) describes three points along the spectrum between professional paternalism and patient autonomy. At one extreme, clinicians treat the patient in the way they feel is best. At the other end of the spectrum, patients can choose the treatment for their condition as long as they have adequate information. The middle point is a partnership between patient and clinician, in which the clinician advises the patient according to his or her knowledge, and then they jointly decide the best treatment. Coulter points out that although the research evidence suggests patients want more of a say in the treatment they receive, they do not want a



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consumerist system in which they have total autonomy in health, and the middle way is usually the most favoured option. There are differences in what is wanted according to age, educational status, disease severity and cultural background, and the availability of appropriate information is crucial. Often patients are more conservative than clinicians in their choice of treatment, but demand for clinicians' services can increase when patients are given more autonomy. Giving patients more autonomy is unlikely to lead to a consumerist system because patients want the expertise offered by clinicians; but patients want to be partners in decision-making, not the passive recipients of doctors' benevolence.

Choice

Giving patients 'more choice' is a popular cry in current British politics. The Department of Health has recently completed a consultation exercise on patient choice, including choice in mental health care, details of which can be found on their website (<http://dh.gov.uk>) and the issue is also prominent in the policies of Her Majesty's Opposition. There is a desire for more choice in the UK (Coulter & Magee, 2003) and evidence-based patient choice is 'one of a number of newly emerging templates for medical encounters that advocate evidence-informed choice and shared decision making' (Ford *et al*, 2003). However, there are some important areas of difference between psychiatry and the other medical specialties. The most significant is that although most patients are treated voluntarily, a considerable number are treated against their will. Indeed, the number of patients detained under the Mental Health Act 1983 has increased in the past 10 years (Department of Health, 2001). The danger is that if choice of health care becomes more important, there may be a separation between the care given to voluntary patients – who are less severely ill, more capable of expressing their preferences and more numerous – and that given to detained patients, who are often less capable of expressing their desire for choice. There is a risk of relative neglect of those who are severely mentally ill.

Conclusions

Evidence-based medicine is likely to be challenged over the next 15 years, not because it is invalid but because it is seen as demanding dominance over other forms of knowledge. We as a profession need to support the promotion of research and evidence-based medicine, but also embrace the importance of other forms of knowledge. 'Evidence-based patient choice must embrace a broader definition of [evidence-based medicine] that includes evidence produced outside science' (Ford *et al*, 2003).

In practice, the medical profession retains a great deal of public trust. To keep it, we need to emphasise the importance of the therapeutic relationship between individual clinicians and their patients. The NHS has tended to emphasise systems of care, but patients care very much about the quality of their interaction with clinicians (Ford *et al*, 2003), and we need to refocus on this, especially if patients may be moving towards choosing which clinician they can see. If they can choose their general practitioner, why not their psychiatrist?

Patients want more say in their treatment decisions. The concern that this will lead to an anarchic, consumerist health system is not borne out by research. Patients value and desire the expertise offered by health professionals. They want to have appropriate information on their condition, to be able to discuss the options with their doctor and come to a shared decision. A system that does not allow this to happen will be criticised. In the UK, we have problems with our capacity to allow time to offer this dialogue, but it must be a priority if we are to retain our patients' trust.

With an increased emphasis on patient choice in health care, there is a real danger that patients who are less able to advocate for themselves, who have treatment imposed on them or who are stigmatised by the public will be excluded. Psychiatrists need to be active advocates for their patients who are in this position. In the recent debate over a new Mental Health Act in the UK, psychiatrists and patient groups have united in campaigning for humane and ethical legislation. Psychiatrists have historically been concerned with identifying themselves with the rest of the medical profession in providing scientifically credible treatments. We need to be equally concerned with advocating ethical and equitable treatment for our patients.

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