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# An ethical perspective on institutional abuse of older adults

Old age psychiatrists and their teams have a particular responsibility in the identification and prevention of elder abuse and in carefully examining the factors that foster 'the corruption of care' (Wardhaugh & Wilding, 1993).

Elder abuse takes many forms, it is underrecognised and underreported. Abuse is active maltreatment or neglect; it may be intentional or due to ignorance or thoughtlessness. The abuse may be a criminal act, a violation of human rights or a minutely subtle interaction in which the older person feels denigrated. What links the range of behaviours is that they occur in situations in which the victim is dehumanised. The abuser relates through power in the absence of clear thinking. This paper focuses on the role of the doctor, about which previously little has been written, and will deal specifically with the ethics of abuse occurring in the setting of care in residential and nursing homes and hospital wards by those who are in a breach of both a direct obligation to care and an expectation of trust.

The suggestion of the widespread nature of abusive treatment, particularly in hospital wards, may be surprising, however 'there is chilling evidence that elderly people living in care are more likely to be at risk than those who live in the community' (Glendenning, 1997).

## Conflicting loyalties

Working in old age psychiatry, particularly with people with dementia, often presents us with a paradox. At first sight an ethical stance seems easy. *Don't maltreat; if you witness it, report it*. However, the aetiology of abuse is a complex and varied interaction between personal, social and organisational factors. There exists an alarming possibility of behaving as if nothing had happened. Institutions develop their own cultures. Group norms are powerful and we may not always be aware of conflicting loyalties or our human need as doctors to be liked by other team members. This may blind us to unacceptable practices close to home. Taking things at face value is understandable but also represents psychosocial naivety and the possibility of collusion with abusive acts.

As doctors we must recognise that abuse is just as likely to occur in our own workplace as elsewhere, and that we might be guilty of collusion or ignorance. The General Medical Council (1995) is clear that a doctor must make sure that his or her own personal beliefs do not prejudice patient care. Despite a reluctance to examine this aspect of our work, the doctor needs to be trained in the recognition of the influence of his or her personality and values on ethical problems. We unconsciously bring into work negative images of old age as well as a will to do good (Evans, 1998; Garner & Ardern, 1998).

Our training and experience dictate that too close an identification with patients affects our objectivity, but maintaining a clinical detachment could have a detrimental effect on our capacity to empathise with the vulnerable patient. Terry (1998) sees the infantilisation of older people as an emphasis of the split between staff and patients. The 'us and them' in the power hierarchy may result in the inability to think clearly and humanely, which can occur on wards of older people. For Goffman (1961) an institution comprises a basic distinction between managers and the managed. We do not always remember our common humanity. Confused older patients are the most vulnerable to a definition of being 'less than fully persons'. Once so defined 'the way is clear to forms of behaviour and treatment which would be unacceptable to those not so stigmatised' and '. . . the corruption of care is closely connected with the balance of power and powerlessness in organisations' (Wardhaugh & Wilding, 1993).

## Resources or rations

A major medico-political issue is the moral philosophy of resource allocation. Care may not be rationed explicitly but in the face of constant reminders of the finiteness of the budget available to the NHS, clinicians may unwittingly operate an ageist policy. A commonly discussed notion is the quality-adjusted life-year (QALY). In practice, quality of life is assessed by younger staff on behalf of older patients. It is a utilitarian concept that pays heed to neither fairness nor justice.

It is now more acceptable to question the exclusion of people aged over 65 years in pharmaceutical clinical



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trials (Bayer & Tadd, 2000) or why some health or social services screening or facilities are offered to younger adults only. Rationing and discrimination, although different ideas, share a murky border that may compromise the care delivered to older people.

Under the influence of some innovative thinkers (Kitwood, 1990) and the development of old age psychiatry as a separate speciality, the care of patients with dementia has improved in many ways and staff are less likely to be 'sent' to old age wards as a punishment. However, there is still the opportunity for older patients in all settings to be cared for better.

## Treatment issues

Ageist assumptions lead to therapeutic nihilism; 20% of residents of homes are receiving antidepressants, although 40% are likely to have depression (Audit Commission, 2000). Conversely, refusal to accept the defeat inferred from some prognoses may induce therapeutic mania and heroic treatments (Main, 1957). In addition, there is widespread prescribing of antipsychotic medication in long-stay settings (McGrath & Jackson, 1996). It is possible to understand the identification of the nursing staff with the helplessness of the patient. The nurses may in turn lodge their feelings of helplessness with the prescribing doctor, who is made to feel that something (anything) must be done. Rather than developing imaginative psychosocial or behavioural ways of managing troubled and troublesome patients, a prescription is written for a major tranquilliser and all parties are momentarily calmed.

## Capacity and consent

Contrary to the stereotype of old age, a minority of older people have a dementia illness. For those who do, this will limit their capacity for choice but will not destroy it altogether. Autonomy may be retained for some types of decision but is lost for others. Psychiatrists need to be skilled in maximising capacity so that patients have as much autonomy as possible in decision-making and to be skilled in the difficult task of communicating with patients who have confusional states and in recognising that the needs and wishes of patients and their families do not always coincide. Even patients with significant impairment are able to make simple choices about their lives and environment. It is too easy for doctors to influence the decision-making to the benefit of the organisation (e.g. quickly emptying a hospital bed without proper time, listening and consideration being given to the older patient's wishes or needs).

## Understand or condemn

*Primum non nocere* – above all, do no harm. This part of the hypocratic tradition must not be mistaken for inaction. We have a moral obligation, not only personally, to avoid causing harm but also to protect patients from harm while in our care. Part of that protection is an understanding of how harm may be caused. Understanding is neither condoning nor excusing. It is an appreciation of the human factors and emotions that may be associated with abuse, and will decrease the likelihood of abuse actually occurring. Much abuse is unthinking. Most of the people referred to the UK Central Council for Nursing, Midwifery and Health Visiting following allegations of maltreatment do not realise that what they are doing constitutes abuse (*Nursing Times*, 24 February 1999).

Doctors can encourage and model self-criticism. They can, with clarity and caution, overturn misplaced political correctness that puts a taboo on saying anything negative about people. In spite of professional ideals, ordinary human feelings are inevitable (Main, 1957). Sharing the idea with colleagues that Mr X makes me feel frustrated and angry is not the same as behaving angrily with Mr X. Providing a forum for the discussion and understanding of work-related problems and feelings can prevent them being acted out and may address mindlessness and detachment (Terry, 1997). Winnicott's seminal paper (1949) 'Hate in the countertransference' gives permission to face unacceptable negative feelings about patients rather than using defences of denial and projection. The capacity to tolerate hate 'without doing anything about it' depends on being completely aware of hate. Staff need the freedom to recognise negative as well as positive feelings, particularly as the patients being cared for may be irritating, repetitive, resistive to care, aggressive, ungrateful, demanding or physically disgusting. Consciously to ignore these descriptions, which all staff will recognise in some of their patients, is to increase the likelihood of unthinking mistreatment. However, the freedom to recognise and discuss mixed feelings also requires the understanding that this is not an invitation to denigrate patients.

When abuse is suspected this must be reported. The doctor's primary responsibility is to ensure the safety and well-being of the patient. There is a paucity of research about the management and care of victims of ill treatment.

The older victim is often still the object rather than the subject of our attentions, even when we are trying to protect. The lack of research into the effect of abuse on the person is an indication of how far we have yet to travel in order to improve the living conditions of many of society's most alienated citizens. Our attitudes may change with improved advocacy and improved efforts to understand and communicate with older patients.

## Training

Under- and postgraduate medical training in the care of the elderly must be improved in the recognition of non-accidental injury; assessment of competence and decision-making capacity; moral, ethical and legal issues in the care of the older patient; and communicating with patients who have cognitive impairment. Particular situations have been shown to have an increased



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likelihood of generating abuse. Doctors need to be able to understand and contribute to the management of the aggressive patient, the demanding patient or the one no-one likes, and to appreciate the importance of appropriate sexuality in continuing care settings and the management of conflict between staff and patients.

## Policy

A number of recent initiatives from the NHS (e.g. clinical governance), and more widely from the Department of Health (2000, 2001), may prompt the development of policies to end the abusive practices that have been recognised. However, effective change is more likely when demonstrated and led by senior staff with an understanding of themselves and their own reactions, an understanding of staff at all levels and the personal and professional difficulties they face and an imaginative understanding of what it must be like for the older person to live in one of the homes or wards to which they are subjected. In this doctors have a major role.

## Conclusion

Older people should not be seen only as potential victims. However, patients in institutions are vulnerable through mental incapacity, physical frailty and dependency. They are the most likely to fall prey to dehumanising attitudes. Institutional abuse of older people is common, insidious and a serious indictment of the caring professions, including medicine. Aetiological factors are multiple, complex and deep-rooted but individual responsibilities are clear. Old age psychiatrists' daily work brings them into intimate contact with the difficulties inherent in caring for disabled and dependent older people and the ambivalent feelings that this evokes. They are in a position to understand and influence the institutions with which they are in contact, and have a duty to do so. Since the enquiry into the death of Stephen Lawrence (Macpherson, 1999), institutions are being invited to examine individual and collective racism. Old age psychiatrists have a responsibility to take the lead in prompting an examination of ageism and the capacity for abuse in the homes and wards where they work. 'Patients must be able to trust doctors with their lives and well-being' (General Medical Council, 1995).

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## References

AUDIT COMMISSION (2000) *Forget me Not: Mental Health Services for Older People*. London: Audit Commission.

BAYER, A. & TADD, W. (2000) Unjustified exclusion of olderly people from studies submitted to research ethics committee for approval: descriptive study. *British Medical Journal*, **321**, 992–993.

DEPARTMENT OF HEALTH (2000) *No Secrets*. London: Department of Health.

— (2001) *National Service Framework for Older People*. London: Department of Health.

EVANS, S. (1998) Beyond the mirror: a group analytic exploration of late life and depression. *Aging and Mental Health*, **2**, 94–99.

GARNER, J. & ARDERN, M. (1998) Reflections on old age. *Aging and Mental Health*, **2**, 92–93.

GENERAL MEDICAL COUNCIL (1995) *Duties of a Doctor*. London: General Medical Council.

GLENDENNING, S. (1997) The mistreatment and neglect of elderly people in residential centres: research outcomes in the mistreatment of elderly people. In *The Mistreatment of Elderly People* (2nd edn) (eds P. Decalmer & S. Glendenning), pp. 151–162. Newbury Park, CA: Sage Publications.

GOFFMAN, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Doubleday.

KITWOOD, T. (1990) The dialectics of dementia: with particular reference to Alzheimer's disease. *Ageing in Society*, **10**, 177–196.

McGRATH, A. M. & JACKSON, G. A. (1996) Survey of neuroleptic prescribing in residents of nursing homes in Glasgow. *British Medical Journal*, **312**, 611–612.

MACPHERSON, W. (1999) *The Stephen Lawrence Enquiry*. London: HMSO.

MAIN, T. F. (1957) The ailment. *Medical Psychology*, **30**(129), 0–145.

ROYAL COLLEGE OF PSYCHIATRISTS (2000) *Institutional Abuse of Older Adults*. Council Report CR84. London: Royal College of Psychiatrists.

TERRY, P. (1997) *Counselling the Elderly and their Carers*. Basingstoke: Macmillan.

— (1998) Who will care for older people? A case study of working with destructiveness and despair in long stay care. *Journal of Social Work Practice*, **12**(2), 209–216.

WARDHAUGH, J. & WILDING, P. (1993) Towards an explanation of the corruption of care. *Critical Social Policy*, **37**(13), 4–31.

WINNICOTT, D. (1949) Hate in the countertransference. *International Journal of Psychoanalysis*, **30**, 69–74.

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# Practical and legal aspects of withholding patients' mail

There are a number of different clinical circumstances in which the issue of incoming and outgoing mail to or from a patient in a psychiatric hospital, whether detained or not, may present particular difficulties. Under current mental health legislation there is provision for post to be stopped or inspected on clinical and legal grounds (Jones, 1999), but these are fairly limited and concern only outgoing mail in specific circumstances, other than for patients detained in special hospitals (Mental Health Act (MHA) 1983). The issue of patients' mail may lead to



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