opinion & debate

Psychiatric Bulletin (2001), **25**, 412–413

MICHAEL BRISTOW

The limits of responsibility

Never mind stigma – it is unlimited liability that is harming the profession†

While attending a rancorous and ill-tempered meeting of the Hackney Community Health Council in 1985 it was brought home to me that psychiatry was different from other branches of medicine. Not in the sense that it was the only one that dealt with intangibles, we all know that X-rays, scans and the like are far less precise than their purveyors let on. But it seemed that the mental health professionals and the groups that represented the clients, relatives and users of the service couldn't agree on a single thing, not even whether people were ill in the first place. It was difficult to imagine, say, the British Diabetic Association and a group of Endocrine Clinic staff knocking verbal lumps out of each other in this way even though diabetes and schizophrenia have a good deal in common.

Sixteen years have passed and matters have improved. Most pressure groups seem to agree that conditions such as schizophrenia and bipolar disorder actually exist and that certain treatments make them better. Psychiatrists have stopped regarding the relatives of those with mental illness as those exacerbating the whole process and have begun to see them as overburdened and important enough to need support in their own right. But reading the flurry of articles on stigma (Salter & Byrne, 2000), especially the response by Howlett (2000) to Persaud (2000), I was taken straight back to the despair I felt in 1985, the feeling that there was still an important matter about which nobody agrees or can even agree terms to discuss.

The matter in question is responsibility. One of the problems with what Howlett rightly describes as the "accelerated and badly implemented" development of community care was that no thought was given by anyone concerned to any possible enlargement of the ambit of professional responsibility. Doctors tend to have a well defined but circumscribed sense of medico-legal responsibility, mainly inculcated during hospital training and generally relating to the consequences of taking or failing or take certain clinical actions when faced with certain clinical conditions. Mental illness practice adds a couple of extra contingencies; the application of the Mental Health Act and the 'duty to warn' exemplified by the Tarasoff case in the US, which particularly affects psychotherapists (Tarasoff *v.* Regents of The University of California, 1976). I do not believe the medico-legal frameworks for nurses and psychologists are essentially any different to ours.

†See pp. 414–415 this issue.

This makes the question of negligence in community care more difficult to deal with when it arises outside the above parameters. Howlett points out that we have shifted more towards the biological in recent years, as an advocate of responsibility he should realise that this is to some degree inevitable. There has been a significant increase in the number of psychotropic drugs available in the past two decades, together with greater understanding of their actions and potential interactions. Not to know about such matters is negligence in its purest form. But misadventures happening to non-compliant individuals days, weeks, months or even years after clinical contact are a far more nebulous matter and I think this is why so few professionals have been 'called to account'. Howlett may see this as 'special protection' that would "not be applied to the rest of the medical profession", but I have never heard the duties of physicians or surgeons to non-compliant patients who avoid follow-up subject to much debate either.

With the exception of individuals with significant mental illness I do not see how a framework of medico-legal responsibility can be applied in the cases of misadventure occurring to non-compliant individuals in the community. I do not think it can always be applied even then, but I think it is legitimate to consider the issue. I certainly do not see how it can ever apply to individuals whose misadventure arises in the context of substance misuse, or lifelong problems of social adjustment. Over 50% of the homicide cases in the National Enquiry bear these traits alone (Department of Health, 1999). I do not see how one (professional) individual can be responsible on a perpetual basis for the conduct of another individual who is living independently and under no duress, merely because the two have had clinical contact in the past. I know of no current moral, religious or common law basis for such responsibility. I know of no other country where it is an expectation. Significantly, because we are increasingly governed by European laws, it does not seem to be an expectation elsewhere in Europe. Even in the litigation-happy US, lawsuits tend to concern the

https://doi.org/10.1192/pb.25.11.412 Published online by Cambridge University Press

more immediate aspects of responsibility already described.

One of the reasons this matter is important is because it is currently very difficult to recruit consultant general adult psychiatrists, especially in the inner-city, despite the golden opportunity to be, in Howlett's terms, "overpaid in one's early 30s". In a few years general adult psychiatry has gone from being the most popular branch of psychiatry to one of the least. Trainees freely admit that a major factor is the atmosphere of blame and the unlimited sense of liability that currently pertains and makes taking a job in areas of high morbidity seem about as attractive as a 20-year-long game of Russian roulette. Howlett may not see the decline in psychiatrists' numbers as any great loss, but I would caution him against too much enthusiasm for the alternatives. While forensic psychotherapists may claim to be able to 'treat' personality disorder, as far as I know most of the research applies to small numbers of individuals under lock and key and none of it involves large-scale trials. I have yet to hear of any that applies to individuals after release, which is the critical time. Anyway, no psychotherapist will be prepared to take 'responsibility' for his or her client's actions – the whole idea of psychotherapy is that the individual participating in it is at a certain level of maturity and competence, otherwise therapy is not possible. For that matter no other professional group will be prepared to take the kind of blanket responsibility that psychiatrists are expected to take and if they attempt to they will run into the difficulties in recruitment and retention that we are currently facing.

The notion that taking some of our 'cherished powers' away and giving them to a tribunal who will clarify our responsibilities is simply not the case. Some of my inner-city colleagues may breathe a sigh of relief that a tribunal may catch some of the flak usually directed at them. I am unaware, however, of any mechanism in the drafts of the new Mental Health Act that would make these new tribunals any more liable for their decisions than mental health tribunals currently are. The real issue – the limits of responsibility towards those not actually suffering from a defined severe mental illness – will continue to be fudged.

Graham Greene, in his novel *Our Man In Havana*, has his protagonist enquire of a policeman why he tortured some people rather than others. Because, replied the policeman succinctly, they come from the torturable classes and expect no different. There is a real danger that general adult psychiatrists are being sucked into the 'blameable classes', in other words blamed simply because we can be, very much as our colleagues in social work tend to get routinely blamed whenever anything happens to a child on the protection register. The effect of a couple of decades of routine blaming on social workers' morale, recruitment and current practices – which I would contend are dominated by bureaucratic back-covering to an alarming degree – should be studied closely by those who want to introduce the same 'clarified responsibilities' for us.

I think medico-legal responsibility can stretch so far 'into the community', but no further. If Howlett thinks differently I challenge him to say why and how and on what ethical basis. If he agrees with me he should say so. I think there is no single subject more important than the limits of responsibility and I can think of few more important contributors to the debate than The Zito Trust. Some agreement on the limits of responsibility might help us all feel we are on the same side. It would also help us concentrate on improving the aspects for which we do agree responsibility and possibly even to improve consultant recruitment.

If the issue continues to be fudged or if we are definitively made responsible for anything that happens to anyone who comes through our door then I think the only 'steep learning curves' that Howlett will witness among psychiatrists will be learning more elaborate and time-costly ways of covering our backs, learning the route to the European Court, if unfortunate enough to be sacked for failing to prevent the unpreventable and lastly, of course, learning to avoid or quit careers in NHS community psychiatry.

Finally, a word about stigma – that was where this whole group of articles started. I would contend that one of the worst stigmas for a person with schizophrenia is to be considered to have the same proclivities to violence as an individual with antisocial personality disorder. Yet in failing to demand any limits on responsibility and tolerating the erosion of diagnostic categories in such areas as the new Mental Health Act and the function of assertive outreach as laid down in the national plan, we are colluding with this stigma. We are also giving the more perceptive of the general public one more good reason for stigmatising us.

References

DEPARTMENT OF HEALTH (1999) *Safer Services: The National Confidential Enquiry into Suicide and Homicide by People with Mental Illness*. London: Department of Health.

GREENE, G. (1958) *Our Man in Havana*. London: Heinemann.

HOWLETT, M. (2000) Commentary: on the back foot – psychiatry and community care. *Psychiatric Bulletin*, **24**, 287–288.

PERSAUD, R. (2000) Psychiatrists suffer from stigma too. *Psychiatric Bulletin*, **24**, 284–285.

SALTER, M. & BYRNE, P. (2000) The stigma of mental illness: how you can use the media to reduce it. *Psychiatric Bulletin*, **24**, 281–283.

TARASOFF, v. Regents of the University of California (1976) 551 D20 334.

Michael Bristow Consultant Psychiatrist, South West London and St George's Mental Health NHS Trust, Locality 4 CMHT, Cheam Resource Centre, 669–671 London Road, North Cheam, Surrey SM3 9DL

https://doi.org/10.1192/pb.25.11.412 Published online by Cambridge University Press