

Ethics briefings

Veronica English, Jessica Gardner, Gillian Romano-Critchley and Ann Sommerville *Medical Ethics*
Department, British Medical Association

Self regulation, law and patient rights

The need to re-establish public confidence in medicine's ability to regulate itself after a series of scandals remains a continuing challenge. In January 2001, the Lord Chief Justice of England and Wales summed up what he perceived as a radical change in public attitudes, noting that medical negligence litigation "was a disaster area" and complaints to the General Medical Council (GMC) were expected to rise to around 4,500 in 2001. Reflecting what he claimed were changing public expectations, he announced the end of the courts' "presumption of beneficence" on the part of doctors. He criticised the judiciary's past deference to medical opinion and claimed that society was shifting its focus from concepts of duties to individuals' enforceable rights. This "move to a rights based society", he said "has fundamentally changed the behaviour of the courts" and by reference to a number of recent major medico-ethical cases, highlighted how the courts rather than doctors appeared increasingly as the ultimate arbiters on questions of medical ethics.

Organ retention

Media attention crystallised around two major issues which exposed flaws in self regulation: the unauthorised retention of organs from deceased patients and the implications of the Shipman case, in which a general practitioner, Harold Shipman was found guilty of murdering 15 of his patients. In May 2000, in his interim report on paediatric practice at Bristol Royal Infirmary, Professor Ian Kennedy drew attention to the fact that organs of deceased children had been retained without their parents' knowledge or consent. It soon became evident that this had been a common practice in other hospitals, both after coroners' postmortem examinations

(which do not require relatives' permission) and so-called "hospital post-mortems" (which do require such authorisation). The report noted that current law was confused and a detailed code of practice was needed to clarify the circumstances in which organs could lawfully be retained from deceased people for research or medical education. This, however, might be insufficient for the restoration of public confidence and specific legislation might be required. In England, the Chief Medical Officer, as part of a national investigation, commissioned an audit of the extent of organ retention. In January 2001, he called a "national summit", involving the public and professionals. This meeting and the public inquiry into organ retention at Alder Hey hospital, contributed to the perception that legislation was probably required to regulate organ retention effectively.

Reform, accountability and the Shipman case

Following the conviction in January 2000 of general practitioner Harold Shipman, for the murder of 15 patients, the Chief Medical Officer commissioned an audit of Shipman's practice from 1974 to 1998. The findings were published in January 2001. Hampered by the fact that Shipman's records were inadequate, allowing fabrication and concealment of his activities, the audit concluded that 236 deaths at home were very suspicious. The evidence took a long time to uncover and the death rate among Shipman's patients was shown to be in excess of that of other practitioners from the earliest years of his career. A high court judge was appointed to expand the inquiry and investigate gaps in the system which allowed murders to go undetected. At the same time, debate within the profession focused on the need for further safeguards for prescribing, storing and destroying drugs, the certification of death and cremation certificates. The case also highlighted the need for

new measures to identify drug misuse by doctors and to review the effectiveness of existing systems of performance management, particularly for doctors (general practitioners and specialists) working in isolation, within the National Health Service and the private sector.

Before the trial, a number of reforms had already been envisaged by government and the GMC to ensure improved monitoring and pre-empt criticisms of self regulation. These included clinical governance, creation of the Commission for Health Improvement, proposals for annual appraisal and a system to address poor performance, and GMC procedures for regular revalidation of all doctors. Following the trial, further measures were established by the government to enable the detection of adverse events. Plans were discussed for new contractual quality standards for single-handed general practitioners. All of these measures were designed to monitor and improve doctors' general performance rather than detect murder. Therefore, the 2001 audit made recommendations specifically intended to address this, including: routine monitoring of death rates; review of general practitioners' medical certificates of cause of death; monitoring of place of death, duration of illness and people present at death; discussion of death rates with general practitioners during annual appraisal and revalidation; assessment of samples of general practitioner records as part of revalidation; effective inspection of general practitioners' controlled drug registers, and research into whether reviewing individual cases would disclose suspicious patterns of medical behaviour.

Arguably, a further implication of the Shipman case and the apparent culture of suspicion of doctors has been at least a temporary diminution of societal interest in euthanasia, physician-assisted suicide and living wills. A UK patient group has published a booklet for people in hospital called *How to Survive*, which perhaps marks these changing attitudes.

Euthanasia

The Netherlands is likely to be the first country to legalise voluntary euthanasia. For the last two decades, doctors who administer a lethal injection to a patient have not faced prosecution, provided they did so at the patient's request and according to strictly defined safeguards, including the voluntary, considered decision of a patient facing unbearable and untreatable suffering and the agreement of two doctors. New legislation puts immunity from prosecution on a statutory footing, and requires scrutiny of all cases by a lawyer, doctor and ethicist. If the panel is not satisfied that all of the safeguards have been followed, cases will be referred to the Public Prosecution Service and doctors may face imprisonment of up to 12 years. Patients are also required to have a longstanding relationship with the doctor, which effectively prevents foreigners from travelling to the Netherlands to obtain euthanasia.

New evidence of political abuse of psychiatry

From the 1960s to the 1980s, abuse of psychiatry for political ends was systematic in the former Soviet Union and sporadic in Eastern European countries such as Yugoslavia, Czechoslovakia, Hungary and Romania. Political dissidents were incarcerated in special psychiatric hospitals without medical justification for their detention. In 1983, the Soviet psychiatrists' organisation withdrew from the World Psychiatric Association to avoid expulsion for its failure to address such abuse. It was not readmitted until 1989. In comparison with the wealth of literature on past Soviet psychiatric abuse, however, very little has been written about the abuse of psychiatry in China. Evidence now emerging shows that in the 1960s, the Chinese authorities were aware of Soviet political psychiatric abuse and used similar measures to deal with political dissent. In 1970-71, for example, a Chinese author analysing psychiatric cases in one Shanghai centre found that over 70% were "political". According to official accounts, however, the scale of this practice decreased substantially after the cultural revolution.

Nevertheless, since the early 1990s, there have been scattered reports of

Chinese political dissidents being committed indefinitely and involuntarily to special psychiatric hospitals. In 1995, for example, the UN Rapporteur on Torture highlighted allegations of psychiatric abuse involving Chinese dissidents.¹ In 2000, Amnesty International appealed on behalf of the Falun Gong spiritual movement, whose members were incarcerated. Reports indicate that between 100 and 600 members of the group are currently detained in mental institutions and three have died because of mistreatment.²

International standards allow for the detention of mentally ill people who are deemed to be a danger to themselves or others. China, however, uses the concept of "social dangerousness" forcibly to detain dissidents and nonconformists if they are seen as threatening the social order. This contradicts international human rights standards which provide for freedom of expression, freedom of political and religious belief and rights to a fair trial.

China lacks specific legislation on mental health. Since 1985, there have been calls from Chinese psychiatrists for legislation covering compulsory custodial treatment, its scope and patients' rights. Since then, ten versions of a draft mental health law have been debated but there are no indications that legislation is imminent. In early 2000, draft regulations were issued entitled, *Administrative Methods for Psychiatric Judicial Appraisal*. These aim to tighten regulation and introduce some safeguards but make no reference to any statutory rights of the person being evaluated and have no provision for an appeal process. In the meantime, some experts estimate that at least 3000 political detainees have been subject to psychiatric assessment over the past two decades.² The great majority of these individuals were placed in psychiatric custody and subjected to a range of treatment. It is also alleged that the use of psychosurgery, including lobotomy operations, is re-emerging in China for conditions which include anti-government attitudes, "political raving" or "absence of instinct for self-preservation".

Reform of UK mental health legislation

In England and Wales, a White Paper issued in December 2000, described a

new legal framework to replace the Mental Health Act 1983.³ Its aim is to reform when and how non-consensual care can be provided to mentally disordered people in their interests or to ensure public safety. The key changes include: establishment of an independent tribunal to determine longer term use of compulsory powers for treatment and detention; a new patient right to an independent advocate; better safeguards for those who enduring mental incapacity; a Commission for Mental Health; a statutory requirement to develop care plans for each patient, and a duty to disclose information about mentally disordered patients to a range of agencies, including those dealing with health, social services, housing and criminal justice.

As a change to the often criticised current legislation, which only permits compulsory treatment in hospital, new proposals envisage assessment and treatment of patients in the community. This could prevent unnecessary detention. At present, some patients may be left untreated because of a lack of clarity about whether they can be lawfully detained. Current provisions may also restrict unnecessarily the liberty of other patients. The government seeks to create flexibility in the use of compulsory powers. The new framework also includes a broad definition of mental disorder, matched by criteria that set clear limits to the circumstances in which compulsory powers may be used. Diagnosis of a mental disorder alone will not justify the use of compulsory powers.

One effect of the proposed new legislation would be to move away from the narrow concept of "treatability". Under the current system, people with a personality disorder who pose a serious risk cannot be detained because they are not "treatable". The new legislation would more clearly apply to such individuals.

References

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