

## Focus: current issues in medical ethics

### Medical ethics and child psychiatry

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#### Editor's note

*The authors, both child psychiatrists, discuss some of the ethical problems that arise in their practice, in relation to advice given in the British Medical Association's Handbook of Medical Ethics. They find that the main problems occur when multidisciplinary cooperation is needed. Their concern about confidentiality is shared in the papers by Kenny, Pheby and their commentators, which follow this one.*

Child psychiatrists are doctors and are therefore bound by the ethical code of the medical profession. The non-medical professions with whom we work are in the process of developing ethical codes but doctors have had the longest association with an ethical tradition and it is only in their case that it is clearly backed by the possibility of serious sanctions.

We propose to discuss some common ethical issues in child psychiatric practice, in particular, those which arise for a doctor working with non-medical colleagues and in non-medical settings. *The Handbook of Medical Ethics*, recently published by the British Medical Association (1), has been particularly stimulating in providing guidance in some difficult areas, but also in casting doubt on previously accepted practices.

The Handbook distinguishes three forms of contract between a doctor and patient in which the attitude of the patient, the constraints on the doctor and the relationship between patient and doctor are different. 'It is the duty of the doctor to tell a person with whom he comes into professional contact of the nature of the relationship and in whose interests he (the doctor) is acting.'

The first form is the *therapeutic doctor-patient relationship*. The doctor is acting in the interests of the patient and is responsible to the patient for his actions.

Although most medical work is seen as taking this form, in fact the relationship between a psychiatrist and his patient is often strongly influenced by the interest in the outcome of the diagnosis and form of treatment, by other parties, in particular the family, and more generally 'society'. This point has been

argued, perhaps to the point of absurdity, by Szasz (2) and others, but the 'social' nature of much psychiatry has to be admitted. This is particularly so in child psychiatry, where not only is the 'patient' a minor, but also the referral is frequently not from a medical source.

Secondly, the doctor may act as an *impartial medical examiner* and report to a third party, eg a court or education authority. There may be conflicts of interest in these cases, especially where the doctor has a concurrent therapeutic relationship, and he must be 'scrupulously careful to distinguish between his two roles' and make it clear to the patient which hat he is wearing (1).

Confusion between this role and the previous one is not uncommon, particularly in the child guidance service, where requests for information and opinions on clients from the courts, social services, and the education department are frequent, but in the initial contact with the child and family it may not have been made clear that this was a likely and acceptable outcome. It is clear that a child psychiatrist working in a social service assessment unit will make his opinion available to the social services and the court if necessary, but is a child psychiatrist working in a setting funded by an education department in a similar position?

Thirdly, the doctor may be engaging in *research*. The potential ethical problems of this have been thoroughly debated, and can be monitored by the appropriate ethical committees which have to give permission before research can proceed. As with the other cases the doctor must avoid any harm to the therapeutic relationship or confidentiality. This is discussed in more detail by Graham (3).

#### Confidentiality

'A doctor must preserve secrecy on all he knows'. The Handbook lists five exceptions:

- 1) With the patient's consent.
- 2) Where it is undesirable on medical grounds to seek a patient's consent (eg if it is considered harmful for the patient to know the truth in which case the doctor can give relevant information to a relative or other appropriate person).
- 3) The doctor's overriding duty to society.
- 4) For the purpose of approved medical research.
- 5) If the information is required by due legal process (it may be illegal but ethical to withhold information in these circumstances).

A doctor must be able to justify his decision to disclose information.

The doctor is responsible for the secure storage of medical information which should be used only for the continuing care of the patient unless consent has been obtained. Therefore reports to solicitors, courts, education departments, schools, social services, etc. can be given only with the consent of the patient or his guardian and then only if it is in his interest, *unless* the doctor is in the second form of relationship, and the information has been elicited on that basis (1).

For example, in a recent case, to assess compensation a solicitor asked one of us to see a boy who had symptoms which might have resulted from a road traffic accident. It was agreed with the parents that the effect of the road accident had been to increase parental stress in an already poorly functioning family and thus make it more difficult for *this* boy to cope with the pain and separation because of lack of support.

This argument was accepted by the court who awarded reasonable damages. In this case, revealing confidential medical information about the parents was justifiable in the patient's interests but was ethical only with the parents' informed consent.

In another case, a litigious father subpoenaed the medical reports on a child who had been brought to the clinic by his mother. The mother's consent to disclosure was obtained but in the event the court did not require the reports to be revealed. This particular case highlighted not only the problem of which parent to regard as the 'guardian' when the marriage is still valid but in dispute, but also the technical problem of whose property are the doctor's notes. The latter point is still very much under discussion in hospitals, where the notes are technically the property of the Secretary of State, and appears to be even less clear in a child guidance unit which is administered by an education department or jointly by the NHS and an education department.

### Refusal to see and treat

The BMA makes it clear that a doctor can refuse to see a patient except in emergency, and except where he is the only source of medical advice. Although there is no elaboration in the handbook, the question arises of the ethical position of a consultant child psychiatrist, or indeed any other consultant, refusing his services, when he is the only source of specialist advice. Indeed most child psychiatrists practise single-handed in situations where there is a district or area commitment so that he or she is effectively the *only* source of child psychiatric advice. We suggest that if a patient is referred by a doctor, the consultant ethically cannot refuse to see such a patient without at least arranging for an adequate alternative service to be given which is acceptable to the patient or his guardian and the

referring doctor. Ethically he can refuse referrals from non-medical sources though, and he would also have the responsibility to draw to his employer's notice the length of his waiting list if it were growing unacceptably long. Indeed the BMA makes it clear that we should be accepting referrals from non-medical sources only in exceptional circumstances and in this its advice conflicts with that of the Underwood Committee (4) who advocated direct parent access to child psychiatric services on the grounds that general practitioners might withhold referral unreasonably because of poor training in child psychiatry. Perhaps things are better now and certainly GPs must be kept informed of our contacts with their patients.

The doctor is entitled to decline to provide any treatment which he believes to be wrong but there is a distinction drawn between treatments to which he has a conscientious objection and treatments he believes to be detrimental to the patient's best interests. He must not allow his decision as to what is in the patient's best interests to be influenced by his own personal beliefs. This arises for us particularly over treatment issues where personal beliefs about drug and behavioural treatments on the one hand and psychotherapy on the other colour the advice and treatment a patient may receive from us. In the absence of sound research findings, personal conviction used to be the only guide but this is probably no longer justifiable in the present state of our knowledge and will become even less so. To withhold drug treatment from adolescents and adults with recurrent severe depressive disorders or schizophrenia when the evidence of their ability to relieve these disorders is incontrovertible is now unethical. As Eisenberg says, 'The use of drugs is not in contradiction to, nor a substitute for, respectful listening and judicious confrontations of psychic conflicts. The psychopharmacologist must be no less sensitive to personal and family dynamics than the psychotherapist if he is to be fully effective; . . .' Equally, to withhold effective psychotherapy or behaviour therapy, where it has been shown to be more effective than other treatments or no treatment, is also unethical.

### Consent

Consent to treatment is vested in the parent or guardian of a minor up to eighteen years. There are special problems about 16-18 year olds who can themselves 'consent to treatment'. The question is can they refuse treatment if in the opinion of their parents it is necessary to preserve their life or health? These issues come up occasionally in our practice, *eg* in the case of attempted suicide and in young people refusing treatment because of un-sound mind (6). Even younger people may refuse treatment *eg* in termination of pregnancy, and it might constitute an assault to impose treatment

(even with parental consent) unless it were clearly life-saving. On occasions it is necessary to remove guardianship from a parent who unreasonably withholds consent for treatment and make the child a ward of court, institute care proceedings or take a place of safety order. In practice these issues rarely arise in child psychiatric practice but may do so in paediatric practice.

Sometimes, however, it is clear that a child's development is being seriously 'avoidably impaired or neglected', but social work colleagues may say that the alternative to staying with these parents is so much worse that they are not prepared to institute care proceedings. What ethical responsibility does one have to press for alternative placement, once one's therapeutic skills with a family are exhausted?

Psychiatric assessment and treatment cannot of course be statutorily required by schools and education authorities, but sometimes referral to a child guidance unit, especially from non-medical agencies, overlooks the importance of consent: for instance, referral with no or minimal prior discussion with the parents is not infrequent. Of course such a family frequently makes its wishes known by failing to attend – and failed first appointments are very common. However, coercion to attend is sometimes implicit, and sometimes even overt; *eg* a child is suspended from school 'pending assessment'.

### **Compulsory treatment and labelling as maladjusted**

Formal certification of children is rarely necessary, but in our experience has sometimes been necessary for a failure in the system rather than for medical reasons, *eg* a fourteen year old boy in a manic state who had burned down his parents' house was unable to be admitted (partly because it was Christmas Eve), either to the psychiatric adolescent unit or to a social services children's home. Finally the local mental hospital admitted the child but only did so when he was sent on an Order under the Mental Health Act, though he and his parents were willing for voluntary treatment. It should be noted here that the 'compulsory' element applied to the hospital rather than the patient.

A more common set of problems arises when a child is classified as maladjusted, or more correctly, assessed as being able to benefit from the kind of special education provided in schools for the maladjusted. A number of ethical difficulties arise from this procedure, particularly when the needs of the individual child have to be evaluated in conjunction with those of his teachers and his classmates, and economic factors may also have to be considered. Indeed there is no way in which the classification of 'maladjusted' can be made objective as the very concept implies a misfitting of the child with his environment, rather than illness in the child. The classification of 'maladjusted' apart from

its inherent stigma can damage the interests of a child in a number of ways: *eg* other efforts to meet a child's needs within the ordinary school system are not made and informal or formal suspensions take place. The waiting period for placement may be a year or more and part-time home tuition may be the only provision; meanwhile the child not infrequently loses faith in the clinic and becomes increasingly alienated and socially disturbed. Unfortunately even if placement in a maladjusted school occurs, the psychiatrist may have no say as to which particular school is chosen. Apart from particular schools having characteristics which may or may not suit individual children, it is also possible for a special school to become severely dysfunctional. In such cases it is often difficult for an education department to intervene quickly and the parents of disturbed children are rarely articulate enough for their complaints to be convincing.

### **Relationships with other professions**

Consultants in child psychiatry, perhaps more so than consultants in any other branch of medicine, work in close contact with non-medical professionals, in the acceptance of referrals, and in arrangements for management and treatment. For instance, in the Inner London Education Authority child guidance units the majority of referrals are from 'educational sources' *ie* schools, educational welfare service or educational psychologists. In hospital departments of child psychiatry medical referrals are more common.

The BMA handbook discusses the problems of confidentiality and sharing of responsibility particularly with other professions allied to medicine, and comments that it is much more satisfactory when these other professions hold similar ethical standards with adequate sanctions. This applies to nurses and 'the professions supplementary to medicine' but does not apply to social workers who are not compelled to register with a disciplinary body. This is not seen by the BMA as causing any particular difficulty when the personnel are known, but in fact social workers both in hospital and community clinics are now responsible to external social service departments and in some areas are required to give identifiable information which is put on a central computer.

Even more prevalent than computerisation however, is photocopying. This means that reports and replies to referral agencies may be very widely circulated, for instance to all the members of a case conference thus providing situations where confidential information may be disclosed unnecessarily and psychiatric assessments misunderstood.

The ethical issues which arise from working in a multi-disciplinary team are not much discussed in the handbook except that 'a doctor who delegates treatment or other procedures must be satisfied that

the person to whom they are delegated is competent to carry them out', and that the doctor 'must retain ultimate responsibility for the patient's overall management'. These views have been developed, of course, from hospital practice, and indeed the position with regard to professionals who are not 'health' employees might well be different. Certainly, in child psychiatry, the right of doctors to the leadership of child guidance teams has been considerably questioned, with the implication that they may therefore no longer be able to control case notes confidentiality or oversee treatment (7).

### Practice in non-medical settings

Many of the ethical difficulties for child psychiatrists arise particularly because of the nature of their work in child guidance clinics, many of which are funded, through historical accident, by education departments, rather than by the health service. The psychiatrist often seems to occupy an ambiguous position between that of providing diagnostic and therapeutic services for children and families and of being an agent of the schools. If a school cannot cope with some children there may be a tendency to label them as having psychiatric problems with the implication that ordinary teachers cannot be expected to deal with them. Obviously the first approach is to treat the child and family when possible, and support the school in dealing with the difficulties, but sometimes it is clear that it is removal rather than help which is being sought.

For example, a school was asked to provide extra support for an immature fifteen-year-old girl. She was forcibly taken, without explanation, to an off-site unit and not allowed to continue her examination courses. Because of her resistance to this manoeuvre, the school staff said she should be in hospital.

At other times the psychiatrist's role is one of covering up deficiencies in the educational system and defusing the anger and fear of parents and children which may perhaps be justified, eg a tough small ten year old was frightened of returning to a school where he had been dragged into a lift and beaten up. Transfer was eventually arranged, to another ordinary school, but similar children are often sent to 'delicate' schools. The assessment that

psychiatric treatment was not necessary was strongly disputed by the referring agent.

### Conclusion

Obviously this has not been an exhaustive list of the types of ethical problem that particularly face child psychiatrists, but we hope that sufficient instances have been raised to indicate the general areas of difficulty. The BMA handbook, while not considering child psychiatry in particular, is extremely helpful in showing how problems similar to our own occur in other branches of medicine and how best to deal with them. Many of our concerns over confidentiality, consent and confusion as to whose agent a child psychiatrist is seem to arise from the undefined but close working relationships that we have with non-medical professionals who are responsible to agencies outside the health service. The ethical implications of this position, especially when the medical leadership of the multi-disciplinary team is questioned, are beginning to emerge. It is perhaps time to re-affirm and clarify our position as doctors and autonomous clinicians, who should be primarily responsible to patients and their own general practitioners. The issue at present is whether this is possible in settings such as child guidance units which are not administered by the health service or whether the trend for child psychiatrists to leave such settings will increase.

### References

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