

CLINICAL ETHICS

Everyday ethics in an acute psychiatric unit

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The paper begins with a brief statement about the centrality of autonomy or self governance as a core ethical value in the interaction between health care worker and patient. Then there are three stories describing everyday interactions in an acute psychiatric unit. These are used to help unravel ethical issues relating to patient autonomy. Each story is analysed for its ethical components by describing the protagonists' different perspectives, and their reactions to the events. Attention is also paid to institutional policy. Suggestions are made for small changes in both staff behaviour and institutional procedures. Such changes could enhance rather than diminish patient autonomy.

Within contemporary medical ethics recognition of the principle of self governance or respect for autonomy has altered the nature of interactions between patients and health professionals in all sectors of the health system. Psychiatry is no exception. In recognition of the new emphasis, one of the major theoretical changes instituted in the care of the mentally ill has been one of culture: earlier regimes based on containment have been replaced by systems designed to promote recovery.

Psychiatry has also provided the context for several high profile ethical issues in the application of the principles of respect for autonomy. There are, for example, problems surrounding informed consent for patients with impaired autonomy, issues involving compulsory assessment and treatment, and worries about contraception for those chronically impaired in their competence.

For many patients with a mental disorder, however, there is a more fundamental aspect to autonomy. The very nature of the illness threatens the sense of self. Therefore, since patients suffering from mental illness often lack the capacity for self governance, working towards the restoration of autonomy becomes a core part of treatment and rehabilitation. To take this into account in the delivery of health care services, it is now recognised that: "Relationships, environments, institutional structures, and cultural values can support or detract from the possibilities for self-preservation, a sense of well-being, and the maintenance of self".¹ This goal appears to have required a reorientation of the whole enterprise of caring for the mentally ill.

Where the potential for patient self governance looks to be impaired on a more permanent basis, some have suggested that small forays into decision making in relatively unimportant areas may be all that can reasonably be done. For example, Beauchamp and Childress observed of the chronically ill: "Some patients in mental institutions who are generally unable to care for themselves and have been declared legally incompetent may still be able to make autonomous choices such as stating preferences for meals and making phone calls to acquaintances".² In such situations staff act with respect towards their patients, even though it is unlikely that the interactions between them will ever be of the same quality as those that occur between two autonomous people.

For patients recovering from an acute episode of psychiatric illness, however, the situation is different. For them, the path-

way back to self governance gradually reappears as medication and other treatments begin to be effective in assuaging their illness. In general these first signs of a re-emergence of the capability to act autonomously appear in the context of interactions with other people and, as luck would have it, it is in this very context, the everyday social interchange between staff members and patients, that the capacity for self governance may re-emerge. Although this applies to everyone recovering from a severe illness, for people recovering from an episode of psychiatric illness it is an irreplaceable pathway, and the ability of staff to recognise, respect, and enhance the patient's role in these interactions is likely to comprise a substantial part of the therapeutic environment.

Thus the core of ethical behaviour between staff and patients may reside in the seeming minutiae of small social exchanges. Fine-tuning the relationship between health worker and patient has become a focus of interest. Notwithstanding the comparative value of the "ethically exotic case" Veatch points out that this new sensitivity has shown us that we must now "be aware of the value dimensions of even . . . routine medical choices".³

Teachers of medical ethics have made similar observations. For example, Glick noted that whereas the media usually cover the "Brave New World dilemmas", it is the "prosaic day-to-day interactions with patients which are far more pervasive and important".⁴ Thus, it may be argued, the moral aspect of the task applies not just to the big issues, but to every interaction within the caring framework and both patients and health workers have responsibilities for its legitimacy and authenticity.

Given their importance, how can new understandings of patient autonomy be introduced into the daily exchanges of an acute psychiatric unit? It is not enough to say there should be improved relationships between patients and health workers in these settings—there should be, but exactly which aspect of these relationships is it that needs attention? This is not about being polite, important though that is; it is about acquiring and utilising a deep understanding of the patient's re-emerging needs for self governance.

THE STORIES

Analysis of the following three stories involves an attempt to unravel the subtleties and complexities of ordinary, everyday

interactions between patients and staff in an acute mental health unit. All the patients in these stories had experienced a recent episode of acute mental illness. All the staff members were fully trained and experienced in their respective fields. Neither the motivation of the staff to help, nor the patients to be helped, is at issue here. All were working towards a common goal, namely the patients' recovery from mental illness.

Although fictitious, the stories are grounded in observation of day-to-day events and situations found in acute psychiatric units. The incidents were assessed for typicality by asking representatives of nursing staff, psychiatrists and consumers of acute mental health services to rate each story on a scale from one to five (one being "this would never occur" and five being "this sort of incident is common"). Story one, "Someone to talk to", had a mean rating of 4.6; the other two stories each had a mean rating of 4.0.

Story one: Someone to talk to

Ron is bored. He feels restless and would love to go to the gymnasium for a work-out. He has been for a short walk with the occupational therapist this morning but the group walked very slowly. The physiotherapist is busy giving a relaxation class.

Ron's doctor walks past. "Hello doctor, can I go out for a walk?"

"Talk to your nurse, Ron. I'm off to a meeting," answers the doctor.

Ron has no idea who his nurse is today. In the intensive care unit he did. They would introduce themselves each shift. In fact they were always around, never letting you out of their sight.

He walks up to the nursing station. Half a dozen nurses are sitting in the office, laughing and chatting. He knocks on the locked door. The nurses continue chatting. He knocks again and one of the nurses opens the sliding window. "Yes, Ron, what can we do for you?" "Who is my nurse?" asks Ron. "I am your nurse today" explains the nurse at the window. "Can I go out for a walk?" "Let me check your leave status," she says and turns to read the white board. "Oh, you are only permitted escorted leave. I should have asked the doctor to change that this morning. Never mind, you will probably be able to go out tomorrow. Sorry I can't go with you. I have this report to write," she says, indicating the open file in front of her.

Ron walks slowly to the smokers' room. Maybe he'll cadge a cigarette off one of the patients there. He'll get a can of Coke too. The vending machine operator is busy replacing stock. "G'day mate," he says cheerfully. "You wanna drink?" "Yeah," says Ron, "got nothing else to do." "Must be boring in this place. Wanna give me a hand? You look like a strong bloke and I've got to bring the cartons of drink in from the foyer". "Sure, I miss my work-outs at the gym." The two walk off down the corridor together, chatting about their body-building programmes.

Ethical analysis of the stories calls first for increased understanding of both staff and patient perspectives. At the level of personal interaction, Ron experienced dissatisfaction with staff, based on his interior knowledge of what would help restore his normality. His memory of the last few days was

hazy, but his awareness and knowledge of his current needs was clear. He needed to do something physical, and he needed someone to talk to. Since the acute phase of his illness had been controlled, he was experiencing a drive towards re-instating his capacity for self governance.

But Ron was disadvantaged in his quest for activity and social interaction because he was ignorant of the complex organisational details surrounding his care. He was unaware that several doctors had been involved with his admission. He had been told he was assigned a primary nurse and a duty nurse. But he had no way of knowing that neither the nurse who welcomed him on to the ward yesterday, nor the nurse who administered his medication this morning was "his" nurse. He had no idea of the institution's rules and guidelines for the care and safety of patients in an acute psychiatric unit.

Staff knew that Ron had suffered a major depressive episode and had expressed suicidal ideation. He had been given a new antidepressant drug which appeared to be effective. Both nurse and doctor were pleased to see Ron cheerful and taking the initiative. Later, the doctor experienced mild irritation that other members of staff—nurse, occupational therapist or physiotherapist—had not been able to offer Ron a more therapeutic environment. He himself was doing as much as he could in organising the drug trial, monitoring its effects and writing a paper on the results, work which could result in many more patients benefiting from the new drug he had given Ron.

The nurse completed her report-writing but felt anxious that Ron might have decided to go for a walk anyway. She was relieved to see him chatting to the soft drinks vendor and pleased that he had complied with the restrictions placed upon him without causing more difficulty.

Story two: My name is Mr Craig

Thomas Craig sits by himself in the lounge of the acute unit. He finds it impossible to relate to any of the staff or patients around him. He is 63 years old and feels as lonely here amidst the bustle of the unit as he did sitting at home alone. Since the sudden death of his wife 14 months ago it seems there is no one who understands him. Here he is surrounded by people not much older than his grandchildren. When he asked to be taken out of the "young persons' ward" it was explained to him that he was not yet old enough for the psychogeriatric unit. At least he and the staff agreed on one thing.

Most of the time he finds it difficult to communicate with the scruffy, strangely clad patients and staff. Indeed if it were not for their name badges, he could not distinguish one from the other. They are having trouble communicating with him too. For example it is years since anyone has called him Tom. Even his late wife had called him Thomas. Having spent forty years of his life teaching, twenty of them as a principal, he was accustomed to being addressed as Mr Craig or "Sir".

This morning, a nurse looking no older than the pupils he used to teach, and wearing a nose stud which would never have been allowed at his school, dared to call him "Tommy". It was the last straw. His whole world had been turned upside down. His wife had understood the value of good manners, discipline and good grooming, but she was no longer available to commiserate with him. No wonder he felt worthless.

After living on his own for 14 months, Mr Craig now found himself living 24 hours a day with people with whom he

had almost nothing in common. He shared a room with a much younger man. He sat at the dining room table with strangers. Even if he had been well, this situation would have presented great difficulties for him.

He had little knowledge of modern psychiatry. His concept of a nurse still included a smart uniform, efficiency, and respect for patients. He had no faith in any of the staff except the consultant psychiatrist who, although much younger, treated him with dignity, and called him "Mr Craig". Unfortunately he was seeing his psychiatrist only briefly and infrequently.

Nursing staff recognised some of Mr Craig's difficulty, but were not prepared to change their "democratic" style for the sake of one patient. They did think he might be happier with older people, but were told he did not meet the admission criteria for the psychogeriatric unit. There were no alternatives in the rather cramped, utilitarian unit for a more thoughtful allocation of room-mates. Besides, patients generally remained in the acute unit for only a few days or weeks at most.

Story three: Weekend leave

Nancy is sitting in the lounge of the acute unit along with twenty other patients at their "community meeting". Although she has been a patient in the unit nearly two weeks this is the first time Nancy has attended these twice-weekly meetings. Up until today Nancy has been unwilling to leave her room except to go to the toilet or dining room. She feels uncharacteristically vulnerable and is scared of some of the patients who sometimes shout loudly. She thinks those patients who whisper together might be talking about her and she has heard others laughing at her.

Nancy has difficulty concentrating on the meeting. A patient complains that one of the toilets is blocked and the occupational therapist explains the day's programme of activities. Next, the patients leaving at the end of the week are encouraged to say goodbye to the group. Nancy can't wait until she is well enough to be discharged. She misses her partner who has visited her only once and she knows he will not have fed her cat properly.

Suddenly she realises that those who would like weekend leave are being asked to put up their hands. Timidly Nancy raises her arm and is relieved when the charge nurse records her name. Feeling less anxious she spends the rest of the day planning her weekend.

The next day, being Friday, Nancy asks her nurse what time she will be allowed on leave. Her nurse replies that she has been meaning to talk to Nancy since yesterday's community meeting. She is sorry, but her doctor does not think she is well enough to have weekend leave. She can, if she wishes, go out for a couple of hours tomorrow afternoon with her partner.

That night at the meal table Nancy is embarrassed by the inquiry of one of her fellow patients: "I thought you were going out on leave. I saw you asking for it."

Nancy was asked to declare a personal need in a public forum. As a new patient she was not yet fully aware of the interest other patients would take in whether she was granted weekend leave. Ex-patients report feeling acute disappointment and shame when it became known amongst the other patients that their application for leave had been turned down.

From the staff point of view, requests for weekend leave have been incorporated into the weekly meeting for reasons of efficiency as well as a means of assessing a patient's progress. Arranging the leave can be time-consuming because caregivers need to be contacted, medication administered, and limits set. Furthermore, Nancy was unaware of the extent to which granting weekend leave is dependent on the doctors' and nurses' assessment of her recovery. Staff are responsible for ensuring that safety is not compromised when limits on patients' freedom are gradually removed.

DISCUSSION

All the stories illustrate ethical issues at both the interpersonal and the institutional level. At the interpersonal level, each of the patients was acting authentically, either consciously or subconsciously, aware of their therapeutic needs. From time to time during the day, all needed a few minutes of a particular kind of interaction with a health professional. Ron needed interactions that helped him in the task of re-assembling his normal self. Mr Craig needed interactions that acknowledged his background and culture. Nancy needed brief, gentle, reassuring conversations with her health professional on a number of issues, including whether she should apply for weekend leave. All three patients sought help in one of the few ways available to them in an acute psychiatric unit.

Staff members had a different set of pressures to cope with. Administrative and clerical duties claim time and energy. Building and maintaining good relations between staff members is also important. Additional pressures come from attempts to prioritise the various calls on health professionals' time.

The claim that there is insufficient time for interpersonal communication in health care is a common one. Yet in a sense this can be a red herring, since it is more a question of how, rather than how long. A genuine, empathic, respectful interaction with a patient need take no longer than a response that lacks these qualities. It would have taken little time to annotate the notes: "This patient would feel more comfortable being addressed as Mr Craig"; and little time for Nancy's nurse to say a word to her before the community meeting, asking if she felt well enough to go out for a couple of hours on Saturday afternoon. It is likely to be the quality of the interaction that counts, more than the quantity. Talking to Ron certainly would have taken time, but it would not have taken long to recognise his improvement, say something about it, and acknowledge his need. Empathic recognition of his new state could have been helpful even if the opportunity for conversation was not available.

Suggesting changes to policy

All the interactions took place within an institutional setting where there was a legal requirement for staff to follow procedures and policies. Efficient day-to-day running of an acute psychiatric unit requires that all staff know, and work within, the stipulated framework. But these glimpses into patient experience suggest that policy decisions influence the extent to which patient autonomy is respected. If so, then perhaps committees should spend a little time thinking about the ethical implications of their decisions. For example, in story number two, the question of how to address patients had already been seen as sufficiently important to require a policy decision but the rigid application of a well-intentioned policy appears to have been determined on the grounds of "efficiency" rather than on a consideration of respect for patient autonomy. Could not health workers take the opportunity in their introductory conversations with patients to ascertain how they would like to be addressed? And given the emotional costs to patients, should the policy of assigning all patients to wards on the basis of their chronological age remain unquestioned?

Story three, “Weekend leave”, raises doubts about a policy that requires patients to request leave in public. Ethicists might ask a range of questions. Who benefits most from this policy? Does it discriminate unjustly on the grounds of individual differences in personality? Is there a failure of respect for patient autonomy when staff fail to engage a patient individually on matters involving their illness and treatment? How can patients be made aware of, and prepared for, hospital routines? Given their importance, how could more opportunities for therapeutic interactions between staff and patients be woven into the day-to-day routines of the unit? It is in such details as these that policy decisions relate to the ethical care of patients in acute psychiatric units.

Suggesting changes in interpersonal interaction

Analysis of day-to-day interaction has generated a need for more practical guidelines for staff. Although most health care workers are now trained in communication skills, it could be that the underlying principles need revisiting. Happily, good sense is available from a variety of sources. First, Toombs has argued the moral necessity of asking patients: “How is it for you?” as the only way to cut through to the immediacy of the patient’s experience.⁵ Representing many medical theorists, Zinn has suggested that empathy is the appropriate tool for bridging the profound difference in experiences between health worker and patient.⁶

Then there is Veatch’s notion of “true partnership” whereby “two persons of widely different backgrounds, find a point of mutual interest in which each can give to the other while retaining substantial autonomy”.⁷ Acknowledging the differences between patient and health professional—differences in ability, knowledge and power, Veatch rejects the idea of physician and patient as equals. He opts instead for mutuality of respect. Interactions characterised by such mutuality have within them the potential for true healing.

Seedhouse has offered a practical solution to the problem of insufficient time to consider the consequences of routine staff behaviours. Acknowledging that many medical interventions result in temporary diminution (physical or mental) of patient autonomy, he suggests that health workers ask themselves a key question: “Will these diminishings have the effect of increasing the autonomy of the patient in future?”⁸ Simply by asking this question, a busy staff member in an acute psychiatric unit might be helped to decide on the spot, whether a particular course of action had within it the possibility of leading to enhanced patient autonomy.

Using this question as a yardstick, one might ask whether preventing Ron from taking the initiative in the restoration of his mental health increased the possibility of his coping more adequately in the future. One could argue that if this were typical of all the interactions he was involved in during his stay in the unit, his experience there would not empower him to take over responsibility for his own health.

The same measure might find that hospital policy and the failure of the staff to form a therapeutic relationship with Mr Craig did not increase the likelihood that he would become

more autonomous. Mr Craig’s feeling of being trapped in an alien and inhospitable environment probably hindered the re-emergence of his sense of self and may even have damaged his potential for renewed self governance.

Leaving Nancy to request weekend leave in public without telling her in advance what to expect, was unlikely to promote her recovery. Her experience of disempowerment on the unit probably did nothing to increase her autonomy or her decision making skills.

In each story it appears that the patient’s autonomy was undermined rather than enhanced, in spite of the conscientious efforts of well-trained staff. Thus, it could be argued, there needs to be more consideration given to bridging the gap between the subjective “lived experience” of the person with the mental illness and the health professional’s world of work with all its accumulated array of routines, motivations, and moralities. Increasing awareness of, and respect for, patient autonomy in everyday interactions may help address this issue. Small adjustments in staff behaviour or in an institution’s procedures could result in the promotion of healing rather than hurtful interactions.

In the same way as the physical ability for self care gradually reappears in a patient who has had major surgery, so the ability for self governance gradually returns to patients receiving medication or other therapies for the treatment of an episode of serious mental illness. In recognition of the therapeutic effects of being independent, health care workers in surgical settings encourage patients to do as much for themselves as possible before offering assistance. Similarly, for psychiatric patients, the first signs of a return to autonomy may be valued as early indicators of the effectiveness of treatment. There are therefore therapeutic as well as ethical reasons why nurses and other health professionals in psychiatric units might want to enhance their patients’ efforts to regain self governance.

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