Correspondence

EDITED BY KIRIAKOS XENITIDIS and COLIN CAMPBELL

Ethical framework in clinical psychiatry

Bloch & Green (2006) provide an excellent overview of the ethical issues that are encountered in clinical psychiatry and the different available frameworks for understanding and resolving them. What is striking, however, is that this discourse is almost entirely without reference to God or religion.

Such pragmatic atheism is, of course, not at all unusual these days. It is a reflection of the impact of the Enlightenment upon our understanding of the way in which public discourse on such matters should be conducted. Indeed, there are even avowedly religious writers (such as Bishop Richard Holloway) who consider that it is unhelpful to bring God into such debates (Holloway, 2000). However, it is still remarkable that an entire article of this kind fails even to mention the matter.

It is remarkable, for example, that the important historical influence of Judaeo–Christian ethical thinking upon the culture in which we live is apparently entirely ignored. It is equally remarkable that the religious pluralism of contemporary Western culture is not addressed.

The omission is remarkable also because religious belief and belonging to a faith community have such important influences upon the ethical thinking of both those who suffer from mental disorders and those who care for them. To imagine that ethical conversation can be had while entirely ignoring such influences makes it feel as though atheism is being imposed upon the debate. The omission is also remarkable because of the validity of at least some of the arguments of Richard Holloway and others with respect to the dangers of bringing God into the conversation. When we feel that we have God 'on our side', human beings can become very intransigent, ungenerous or even unreasoning. The need to understand how and why this is the case is therefore very important.

The omission is also remarkable, however, because it avoids discussion of the possibility of a point of reference for both rule-based and character-based ethics which might actually transcend that of the human parties involved. Again, I recognise that there are those who will deny that such a point of reference exists – but surely the discussion about whether or not it exists, its potential impact and the plurality of views about its existence is rather important.

Declaration of interest

C.C.H.C. is an ordained Anglican priest and a part-time employee of St Antony's Priory, an ecumenical spirituality project in Durham.

Bloch, S. & Green, S. A. (2006) An ethical framework for psychiatry. *British Journal of Psychiatry*, **188**, 7–12.

Holloway, R. (2000) *Godless Morality*. Edinburgh: Canongate.

C. C. H. Cook Department of Theology and Religion, Durham University, Abbey House, Palace Green, Durham DH1 3RS, UK.
Email: c.c.h.cook@durham.ac.uk
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Bloch & Green are to be congratulated for their lucid and helpful paper, which deserves to be read widely. The progression from Kant to the 'ethics of care' seems similar to that from the Old Testament rules/laws/commandments to the New Testament injunction of Christ that people love one another, consonant in turn with the recommendations of other faith traditions about developing wisdom and compassion together.

Bloch & Green's paper resonates with my sense that, as professional caregivers, we do well to acknowledge our own journeys towards personal, moral and spiritual maturity, as described by James Fowler (1981), who draws on both Erik Erikson and Lawrence Kohlberg. Dilemmas such as that described in the vignette offer people opportunities to grow wiser. Grieving losses occasioned by our limitations on the way, we may develop an incremental degree of emotional equanimity, enabling more detached observation and closer engagement.

By staying calm in difficult situations, we foster the trust of others, which is paramount in encouraging people at least to share – and sometimes with relief to relinquish – decision-making and control. Authority comes not only from a professional role and medico-legal powers, but crucially also through a competent, composed and thereby reassuring personal demeanour.

The subjectivity involved should not require an apology. On the contrary, it is essential in allowing us properly and privately to reflect later on our part in what has occurred. This aspect deserves greater emphasis in medical and psychiatric education; for is it not at the heart of why we choose our profession? We want to be good people as well as good doctors, and passing exams is only the half of it.

I disagree, therefore, with the authors' comment, 'Nothing extraordinary is required of [the doctor]'. Consistently selfless devotion to the well-being of others is, sadly, well outside the ordinary these days; but it is exactly what we might choose to ask of ourselves if we are to get the fullest satisfaction from our professional lives. An ethical framework such as Bloch & Green have generously provided is welcome, but they are surely telling us that protocols alone will simply not be enough.

Declaration of interest

L.C. is on the executive committee of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists. He is the author of *Love, Healing and Happiness: Spiritual Wisdom for the Post-Secular Era*, which is to be published in 2006 by John Hunt.

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L. Culliford South Downs Health NHS Trust, Brighton Community Mental Health Centre, 79 Buckingham Road, Brighton BN1 3RJ, UK.
Email: lculliford@southdowns.nhs.uk
doi: 10.1192/bjp.189.1.83a

Medical ethics is in crisis and psychiatry is not exempt. This is so because the pluralism of contemporary democratic society

results in disagreement about what is morally acceptable and because there is no consensus on the best theories and methods for determining this. Bloch & Green (2006) address this problem and suggest a solution by proposing the combination of two established ethical approaches – principlism and care ethics. Their attempt is laudable but the result may be lacking.

Perhaps the most important flaw is that care ethics is riddled with problems (Rudnick, 2001) that may not be adequately resolved by combining care ethics and principlism. For instance, care ethics encourages an overly paternalistic approach by practitioners, which is illustrated by the parent–child model of physician–patient interaction, as presented by many care ethics proponents. In addition, care ethics may be philosophically redundant, as it may be reducible to more veteran ethical approaches such as virtue ethics and casuistry (case-based ethics), which are also notoriously problematic.

If care ethics is not satisfactory as part of an ethical framework for psychiatry, what could be a better alternative? A promising and relatively novel approach is dialogical ethics, which may need to be combined with justice or fairness considerations (Rudnick, 2002). This approach accepts moral pluralism but utilises sound procedures and processes of dialogue among all parties involved to address ethical problems satisfactorily. Dialogical ethics may be well suited to highlighting and addressing some of the more special problems of psychiatric ethics. For instance, dialogue with patients may sometimes pose special challenges in psychiatry, as it requires particular communication skills and cognitive abilities that may sometimes be deficient in people with mental illness. This deficiency could be addressed by remediation and accommodation strategies, as well as by substitute decision-making (which would also be required to engage in dialogue to address the given ethical problem). Be that as it may, a reconsideration of the ethical framework of psychiatry is needed.

Bloch, S. & Green, S. A. (2006) An ethical framework for psychiatry. *British Journal of Psychiatry*, **188**, 7–12.

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A. Rudnick Department of Psychiatry and Philosophy, University of Western Ontario, and Regional Mental Health Care, 850 Highbury Avenue, London, Ontario N6A 4HI, Canada.
Email: arudnic2@uwo.ca
doi: 10.1192/bjp.189.1.83b

I found the philosophical discussions of Bloch & Green (2006) interesting, without necessarily revealing anything new. However, I was deeply concerned by the case used as an illustration. It appeared to reflect a rather paternalistic, single-professional, single-agency approach to child protection. Clinically this perspective can lead to serious mistakes. As named doctor for child protection for the Leicestershire Partnership NHS Trust I train other staff to seek advice from me and from the named nurse. There was no mention by Bloch & Green of statutory duties of care to the child. The fundamental principle of paramountcy was not mentioned. It was identified that with a mother with psychosis there was a significant risk of harm to the young child. Once this is identified, the children's social services department should be notified (Department of Health, 1999), and should take the lead role in carrying out Section 47 child protection enquiries. All agencies have a duty to assist in collating and sharing all relevant information, to update on the situation and assist in monitoring the child and providing additional support. Reder *et al* (1993) give many examples where information is known to one or two individuals in single agencies who fail to share it, resulting in the omission of any child protection plan. If anything seriously untoward were to happen to the baby, a thorough case review would be undertaken by the area child protection committee/local safeguarding board and a doctor could potentially be found negligent for failing to carry out child protection procedures. I wonder whether this highlights the need for many doctors to update their child protection training?

Bloch, S. & Green, S. A. (2006) An ethical framework for psychiatry. *British Journal of Psychiatry*, **188**, 7–12.

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J. Bruce Brandon Mental Health Unit, Leicester General Hospital, Gwendolen Road, Leicester LE5 4PW, UK.
Email: Janet.Bruce@leicspost.nhs.uk
doi: 10.1192/bjp.189.1.84

Job satisfaction of mental health social workers

Evans *et al* (2006) address major issues concerning mental health social workers, who are an important part of the multidisciplinary team. Although a remarkable paper, I would like to raise a few points regarding the methodology.

First, a single-item rating scale was used to measure job satisfaction, which I consider a multidimensional construct. It can be influenced by a variety of factors and should have been measured using scales such as the Job Descriptive Index (JDI; Balzer *et al*, 1997) or the Warr–Cook–Wall scale (Warr *et al*, 1979). The JDI assesses the amount of work in the job, current pay, opportunities for promotion, supervision and co-workers. The Warr–Cook–Wall questionnaire covers overall job satisfaction and satisfaction with nine aspects of work, each rated on a seven-point Likert scale with higher scores representing greater satisfaction.

Second, there is no mention of the reliability or validity of scales used to measure burnout and job satisfaction. In addition, the adjusted response rate is only 49% and the profile of non-responders is not included to clarify responder bias. Moreover, stepwise multiple regression would have been more useful than linear regression to investigate the relationship between several independent variables and a dependent variable.

Notwithstanding these limitations, this paper should be an eye-opener to employers regarding the needs of mental health social workers.

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N. Kader MerseyCare NHS Trust, Park Lodge Hospital, Orphan Drive, Liverpool L6 7UN, UK.
Email: nishakeem@gmail.com
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Authors' reply: We agree that job satisfaction is a multidimensional construct, and we measured several features of