Responsibility

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Responsibility is an everyday word and an everyday concept, but for psychiatrists it poses special problems; firstly in relation to the behaviour of patients, especially when this is of an antisocial character, and secondly, even more closely and personally, in relation to our own responsibility in the everyday practice of psychiatry. I wish to discuss particularly the problems posed by situations in which psychiatrists apparently fail in their responsibilities, and I am thus attempting to link our own situation with that of our patients. In both situations, whether a patient has committed an offence or whether a psychiatrist is accused of failing in his job, the assessment largely turns upon deciding whether the lapse can be ascribed in some way to a mental disorder or to a personal 'failure.' To put it bluntly—is he mad or bad? Perhaps regrettably, a factor taken into account in making this decision is not only what *has* happened but what *might* happen as a consequence of this decision; that is, punishment or treatment, especially if one or the other might lead to the most serious long-term consequence, the permanent loss of employment.

When a person has committed an act for which he is responsible, and in which some social process such as the law is also interested, then there are several possible ways of analysing what went on. Firstly, as happens with most minor offences and lapses of behaviour, there is an automatic ascription of responsibility once the facts are established. Secondly, there may be an analysis of the social situation in which the act was carried out, which again can be divided into two separate forms: a description of the administrative network (as sketched out in a job description, for example), or a more thoroughgoing sociological analysis which looks more deeply into the rôles played by the actors in the situation. A third analysis is not concerned with social networks but with an intrapersonal study—for example, the so-called 'mind of the criminal'. Of course, the psychological and the sociological analyses are not mutually exclusive, and how man and his social environment interact has long been better portrayed by playwrights and authors than by heavy-handed social scientists.

These analyses are not just an academic exercise, because society, rightly, requires something to be done about persons who do not live up to required standards, whether at their work or by the commission of a crime. What has to be done in the case of a job is to see that it is done properly; in the case of a crime, to see that it doesn't happen again; and in both situations to try to do something about the person who has failed. It is this last consideration that causes the greatest difficulty, mainly because, as I hinted at the beginning, we tend to be impaled upon the dichotomy of mad or bad. It is becoming increasingly apparent that this dichotomy fits neither the sociological analysis nor the intrapersonal psychological view.

I should like to deal with the latter first of all, and I will begin by stressing yet again that the diagnosis of mental illness, whether in a narrow sense such as 'He has schizophrenia', or more broadly in terms of psychopathology, does not in itself constitute an automatic explanation or exculpation of a failure of responsibility. This was shown some years ago very eloquently and in great detail by one of our new Honorary Fellows, Lady Wootton, in her famous book, 'Social Science and Social Pathology'. This fact is often brought home to those of us who have to see mentally disturbed doctors as patients. The most extreme example I can remember was of a middle-aged physician who throughout his medical career had functioned perfectly well to the satisfaction of his patients and his colleagues, but yet had clearly had florid schizophrenic symptoms from his last year as a medical student. These symptoms only came to light as a result of a trivial driving incident. We should also note that, just as mental illness may not have much influence on professional competence, the vice-versa influence is also hard to establish; namely the effect of conditions of work on mental disorder. I noted this some years ago in an article on Doctors' Mental Health—in fact one of the signs of professional competence is the capacity to carry on with a technical job in spite of illness. Signs of stress and strain, do, of course, occur, but even the precipitation (much less the causation) of frank mental illness by adverse work conditions is hard to prove.

Since categories of mental illness *per se* do not help us in assessing responsibility, does contemporary psychology throw any more light on the situation? Here, as usual, one finds two main approaches which may be broadly described as the behavioural and the psychodynamic, though it is interesting to note that these two fields are now converging with regard to this area in which we are interested today. Psycho-analysts are turning more from exploration in depth and study of disorders of the Id to Ego functions in the here-and-now situation. In psychotherapy there is greater emphasis on challenging patients—setting them goals, tasks, etc. Likewise, contemporary psychology, as is best seen in the influential book of Mischel, is increasingly concerned with behaviour as interaction. The mind is in danger of reverting to the traditional black box, so that introspection and self-reporting are irrelevant. Not even the Ego-ideal has any place in some of the more extreme systems. The implication of these trends is that there may be little sense in trying to talk about somebody as being either a responsible or an *ir*responsible person. Every situation in which he exercises responsibility has to be separately analysed. There is, as it

were, no trait of responsibility and little or no cross-learning from one situation to another. A surgeon may be an extremely responsible doctor in the operating theatre, perhaps less so at the bedside, and a thoroughly dangerous driver when on the road rushing from one hospital to another.

It is perhaps something of a relief to turn from the woolly long words of contemporary psychology to consider what lawyers think about this matter. Last year a very interesting report of the Law Commission—'The Mental Element in Crime'—was published, which has not in my view attracted nearly enough attention. It points out that the state of mind of the defendant may be relevant to four different aspects of crime. The first concerns mental incapacity in general; that is, for example, a child under 10 is entirely exempt from criminal responsibility, and there are some mitigations for children between the ages of 10 and 14. Secondly, the accused may suffer from mental disorder and is therefore considered to come into a separate category. (Would that things were in fact as simple as that!). Thirdly—and this I find a very curious category—the state of the mind has to be considered in relation to the muscular movement resulting in the prohibited act, which may be involuntary in a state that has come to be called 'non-insane automatism' brought about by, for example, drink, drugs or physical injury, or sleep-walking.

The Law Commission's report then concerns itself with the fourth aspect which is, as they say, what state of mind, if any, is required in the accused with regard to the other requirements of the offence in question. Essentially, the three elements which they discuss are described as knowledge, intent and recklessness. Of course, all these three words raise considerable difficulties. Psychiatrists would feel particularly uncomfortable with trying to define intent, though the authors of the report are satisfied with their effort and confine their discussion to its borderlands as they see them. I quote—'Intent means not only when his purpose is to cause that event, but also that either he has no substantial doubt that that event will result from his conduct, or when he foresees that that event will probably result from his conduct.' We should perhaps pay more attention to the procedures such as cross-examination whereby lawyers and jury decide these matters, as I suspect that their methods are probably more reliable than ours in determining something related to the psychological function which we always try to avoid: namely, motivation, will, conation, or whatever word is fashionably applied to that aspect of personality.

Recklessness is another interesting concept, implying a form of behaviour which perhaps cautious psychiatrists tend to think characteristic only of psychopaths and never of themselves. You will note that as regards this aspect of the mind lawyers are considerably more confident that they can see into a man's mind than we are as psychiatrists or psychologists, but at least they share with us some scepticism about the value of introspection and self-reporting.

Sociological analyses of criminal behaviour have, of course, been carried out for many years, and have greatly increased our understanding of the social conditions which give rise to seemingly senseless acts such as vandalism, though the connections are, to my mind, more akin to the understandable 'verstehende' connections in Jaspers' sense than to the casual 'erklärende' connections required by more hard-headed scientists.

The sociological study of psychiatrists' behaviour has long been a happy hunting ground. One has only to think of Stanton and Schwartz and Irving Goffman. More recently, surgeons have come under sociological scrutiny, and I am indebted to one of them for describing surgery as a 'body-contact sport'. Psychiatrists are less gladiatorial and would seem to prefer the analogies of chess or ball games! Bosk, in his recent study of a teaching hospital's surgical practice, is mainly concerned with how failures and errors are dealt with. He divides them into technical errors, the natures of which are fairly obvious in surgery; judgmental errors, that is, failure of the whole treatment programme; and normative errors, which refer to breaches of etiquette, rôle relations and professional behaviour generally, in which he has a sub-category of quasi-normative errors, which refers to breaches of the idiosyncratic behaviour of a particular service and its chief.

In psychiatry such a sub-division is more difficult, as the psychiatrist's personality is his chief technical aid, so that the normative and judgmental errors tend to get confused. Psychiatrists are also less hierarchical, and the doctor-patient relationship is very different. It is interesting, for example, to look at the effects on staff of suicide in a ward or hospital, which is our equivalent to 'death on the table' for the surgeon. In an early paper, Kayton and Freed showed that the different reactions of wards to a suicide depended very largely on the whole structure of the ward, with patients' responses influencing staff as much as vice-versa. They emphasize the importance of full staff-patient meetings as soon as possible after a suicide has occurred in order that the bad feelings thus engendered may be worked through. More recently, Light stressed other defensive reactions, such as the staff claiming that it was going to happen anyway. Perhaps it is simply an effect of the insularity of so many countries' reading of the literature that few of the American authors refer to Isobel Menzie's classical study of the way in which the nursing staff in a general hospital is organized to try to minimize the anxiety and guilt engendered by some nurse-patient relationships, especially in dealing with death. Colin Parkes and others concerned with ward relationships have also stressed the importance of ensuring good communication between members of a caring staff constantly faced with stressful situations. The classical signs of stress in a group (by no means the same as 'overwork', though often so described) are high rates of absenteeism and minor sickness. The medical sociological concept of the

'sick-rôle' is very relevant to our understanding the place of illness in human behaviour at work, though we tend to use it more in relation to family dynamics.

Let us, however, now continue with the problems that arise from a doctor manifestly not coping with his job. As I said early on, one of the difficulties in discussing responsibility arises from the fact that the consequences of deciding whether a person is mad or bad may seem too dichotomous. In extreme cases it can result in the person losing his liberty, either by due processes of law sending him to prison, or by combined medical and legal action committing him to hospital. Punishment or treatment, or both within one or other of those contexts, often seems inappropriate for the manifestly incompetent doctor, and indeed very often for the delinquent or criminal. The decision—mad or bad—also, as I have suggested, rests on criteria which may be irrelevant to our contemporary understanding of what is actually going on in the deviant situation. Mental illness is a category which in itself explains neither a professional failure nor a crime, and only occasionally does it indicate the appropriate corrective action. Similarly, the procedures in prison seem neither to cure nor prevent, though their short-term value—of removing a man from society—is undoubtedly useful.

We seem to be trying to move slowly forward to treatment or management of a situation based upon our understanding of what went wrong in a here-and-now social situation, and within the personality of the actor mainly involved.

The concept of deviance from an accepted norm, for which the appropriate corrective treatment in the broadest psycho-social sense can be prescribed, is what appears in part to lie behind the General Medical Council's new procedure for dealing with sick doctors. They refer to anxieties about fitness to practise by reason of physical or mental conditions unspecified, but the Council's paper shows only too well how aware they are of their equivocal position between Medicine and Law—when they try to set up a mechanism for management which is somewhat different from these two traditional professions who have very different ideas about procedures. For example, a doctor treating a patient need not, in fact may not or cannot, disclose all the information on which he bases his decision for that treatment; whereas the law, rightly and in accord with a deeply felt natural sense of justice, requires an accused to know all the grounds of the charges made against him. Considerable disquiet has been shown in a number of quarters about the secrecy of the evidence of a doctor's incompetence, and neither the GMC nor I see as yet an entirely satisfactory solution to this problem. The proposed procedure is that the confidential reports on a sick doctor are shown to that doctor's lawyers (and medical advisers) who will decide what in those reports it is proper to disclose to him. Those representing his interests are thus in full possession of the facts and can act accordingly.

As regards delinquency, the attempt to find a middle ground between madness and badness by the use of the probation service, community homes and a generally 'new look' has unfortunately been singularly unsuccessful. It highlights very strongly our inadequate knowledge of the proper processes of re-education; the use or misuse of inadequately trained staff; and the tendency—perhaps more obvious in education than medicine—to rush into a new treatment without proper evaluation.

Deep in the heart of everyone, but especially the delinquent population, is some sense of natural justice as being equated with a quantum of punishment for every quantum of crime. Many people are surprisingly critical of the indeterminate sentence, for example. One cannot help feeling that although this attitude is reinforced by current social forces, its psychological origins must go far back into childhood development.

Why do failures occur in doctors' professional work? It is not usually due to lack of intelligence, or of technical knowledge. Nor, to use the Law Commission report's words, is it usually from intent—recklessness in a broad sense may be relevant. Sometimes it would appear to be a lack of experience and training, usually in management skills; but most often, in psychiatry at any rate, it would seem to be a personality problem only occasionally classifiable into mad or bad. Quite often, in older consultants, it may simply result from a loss of interest, though why this should occur should be an urgent cause for inquiry.

Sometimes this is the result of increasing frustration with working conditions. To use another fashionable piece of psychological jargon, a consultant, like any leader, needs an internal locus of control so that he does not feel driven by external forces. For this he needs to be able to foresee the future and have some personal control over it. Patients are unpredictable enough without adding what seems to be arbitrary interference by outside bodies and agencies, official and unofficial. It is also more difficult to maintain the necessary *esprit de corps* of a team or teams when they do not have a common place of work, like a hospital, in which they meet frequently informally as well as formally.

It is, however, too superficial just to deplore working conditions without recognizing the consultant's own contribution to the situation. An old adage says a man is married to his work, and there is certainly a degree of 'assortative mating' in that not only are psychiatrists self-selected for our profession by certain personality qualities, but within our specialty further selection may occur. Although some consultants may seem to be in difficulties by being square pegs in round holes, others fit in or collude unconsciously only too well with an unsatisfactory situation and simply make it worse.

A few years ago an interesting paper was published by a psychiatrist—Torre—who had been for some years a consultant for various agencies in the United States government and international organizations. He thus had unusual opportunities to observe what his article is entitled—'Psychiatric Disability in High Office'. He makes a number

of points which are, I think, relevant to the exposed position of consultants. For example, the importance of the job frequently interferes with the leader's receiving prompt and adequate medical care. I am thinking here particularly of single-handed hospitals and private practice where there may be no adequate deputy. It may also be difficult for colleagues, especially junior colleagues, to be able to draw attention to manifest illness, medical or psychiatric, in a consultant who may hide behind the sacred cow of consultant responsibility far too long. Torre points out that there are special difficulties if a leader has a certain charismatic quality—when he becomes irrational his followers are usually the last to recognize it. At times it may be important to conceal from the public the fact of illness in senior executives. Lastly, of course, and this is more applicable to political than professional situations, the illness or deviancy may be inextricably mixed up with the rôle the leader plays in society. The isolation of the man at the top, psychologically and socially, is often inadequately recognized. Let us never forget the bereaved Queen Victoria's cry, 'There's no-one to call me 'Vicki' now!'

Torre also points out what is particularly clear in the case of psychiatrists; namely, the difficulty in deciding how to assess fitness for continuing employment. Even in the case of mentally ill persons generally there are problems. A recent working party of the National Advisory Council on the Employment of Disabled People points out the paucity of studies on the assessment of their employability. Most psychiatrists interested in rehabilitation can only proceed intuitively and pragmatically with a series of more or less sheltered work situations for their patients till their maximum effectiveness is reached. The present unsatisfactory state is shown by a recent publication of MIND which gives examples of discrimination at work against former mental patients, something of which every psychiatrist has had experience. The College has recently set up a committee to look at this very difficult question with special reference to the advice often asked by (and sometimes unwisely given to) patients and employers. It may well be that the expertise built up by those experienced in administration and management is more relevant to assessing competence to practise than our psychiatric type of interview which is largely geared to elucidating psychopathology.

A simple analysis of the stresses of the work situation cannot be a substitute in the end for a judgment on a man's personality. This is, of course, not a new theme. One has to look no further back than Dostoievsky to find a devastating exposé of the thinness of the purely social approach to crime. From a still wider perspective, our ways of trying to get away from the rigidity of the legalistic approach to crime and punishment for personal failure have one of their main roots (at least as far as our Western society is concerned) in the Gospels. The effective and imaginative flexibility of forgiveness and healing by a charismatic leader is all too soon routinized into a professional élite—medical, legal or priestly—dispensing justice which has to be done in secret if it is not to become intolerably repressive; and we have had enough of public confessions in recent years in many countries to realize how cynically they can be manipulated (not to mention the dubious value of some public inquiries into the behaviour of hospital staff). Existential responsibility means that a man *has* to stand the consequences of his actions; the moral judgment passed is essential if the seriousness of his office is to be properly emphasized.

Yet we clearly have much bigger responsibility for each other than we perhaps admit at the present time. The College's concern with medical audit should be seen not as a sort of police action to check up on what people are doing, but as essentially preventive, so that a consultant can feel he has the support of his colleagues if he is showing signs of stress and disturbance, and some amelioration of the situation can be made long before a crisis occurs. Another College initiative has been taken with the Association of Anaesthetists to bring quick and confidential psychiatric help to anaesthetists with psychological problems impairing their work capacity.

We need more study of the personality requirements of leaders in medicine, and especially psychiatry, in view of its changing rôle in society. Listening to trainees I get the impression that we may be training them to expect too much direct doctor-patient contact for treatment in their consultant work, whereas they need to use administrative skills more and more. Their exercise is no longer as attractive as it was when the Medical Superintendent was like a Governor-General—only just below God and apparently with direct access to Him. There thus needs to be more training in leadership. Finally, more room for manoeuvre for re-employment of persons not functioning in their particular niche might solve some problems. There are all too few sideways moves in the Health Service at the present time.

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SECTION FOR THE PSYCHIATRY OF OLD AGE

A day conference on 'Developments in Training and Research' will be held on 4 February, 1980, at the Royal Society of Medicine, Wimpole Street, London W1. Further information is available from Mrs G. Lloyd, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1. Telephone: 01-235-2351.