

# Medical ethics in the context of the national mental health programme

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## *Introduction*

Medical ethics examines not only violations of individual integrity in clinical practice but also the sanction that available policies and legislation grant to questionable medical practices. The ethical issues in psychiatry are to be examined in the context of the liaisons between the practices of medical and paramedical institutions, our recent national policy on mental health care and the narrowly construed Mental Health Act (1987) currently in effect.

## *National Mental Health Programme*

Current mental health practice in the country is regulated by the National Mental Health Programme (1982) (NMHP). The main objectives of the NMHP are: (i) to ensure availability and accessibility of minimum mental health care for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population; (ii) to encourage application of mental health knowledge in general health care and in social development; (iii) to promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

As such, the NMHP is in tune with the Alma Ata Declaration. More importantly, we must also see it as being in line with the politics of health policies in the emerging (third) world order organised mainly by the WHO, with nation states by-and-large relinquishing their welfare functions to private enterprises or to community practice. The salient features of the community package of the NMHP are: (i) tying up mental health care with the existing general health infrastructure, such as the public health centres and the district hospitals, and training the existing staff, (ii) tying up mental health care with already existing community development programmes and promoting culture friendly cures. Even though the NMHP says nothing specific about the use of purely medical techniques like drug therapy and electroconvulsive therapy, it seems to imply that it favours non-invasive techniques of treatment. The NMHP states: 'There is good evidence to say that about 15-20% of all patients who seek help in general health services both in developed and developing countries, do so for emotional and psychosocial problems. Current medical methods of dealing with these problems by unnecessary

investigations and costly medicines are not only inadequate and ineffective but produce widespread frustration to both the seeker and the provider of these health services'.

The NMHP also has a place for the practitioners of the Indian systems of medicine, who should play their 'distinctive role in the field of health. The agenda of the NMHP is then to humanise mental health practice by articulating the 'proper' mental health principles, that is, the principles of community care.

The NMHP has been proclaimed a historical landmark document in our national health policy. Given the fact that we did not have any document at all until 1982 on mental health policy, this proclamation is excusable. Community care philosophy, which the NMHP embodies, is probably also a more humane alternative for the mentally ill to the highly restrictive and regulative mental hospital services-. However, the NMHP is at best ineffective, and at worst it promotes the dehumanised models of cure that it explicitly rejects.

## *Mental health practice*

Mental health practice, like other types of social practices, can be used as tools of social control, because practitioners implicitly or explicitly resource social stereotypes to evaluate, diagnose and cure. The criteria of cure, such as 'socialisation', 'adjustment', 'becoming socially useful', 'inner happiness' etc., often contain moral assumptions, preferred social values and stereotypes. Broverman et. al.<sup>3</sup> showed that psychiatric practice is informed by 'highly consensual norms' about gender stereotypes. Their study showed that the notions of mental health the professionals used were 'more influenced by the greater social value of masculine stereotypic characteristics than by the lesser valued feminine stereotypic characteristics'. Later studies in the West showed that this trend is probably changing. For example, clinicians are now reported to show positive attitudes towards homosexuals<sup>4</sup>. However, the West has had a long history of feminist and anti-psychiatric dissent and effective social planning altering mainstream consciousness, which we have not had. Until studies are initiated, we can only conjecture about how professionals' attitude would colour their psychiatric evaluations, and consequently, the treatment options for their patients. I have found it useful to go over some of our own psychiatric journals to obtain some insights

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about possible biases in professional practice.<sup>5</sup>

All interpersonal negotiations in social practice must inevitably involve the use of stereotypes, increasing one's vulnerability to social control. Choosing to deal with the system of health is already to accept the possibilities and liabilities of such control. This is even more descriptive of health systems that seek to modify human behaviour. But whether one retains one's dignity within the system depends on the power one has in these negotiations.

The degree of choice one has over what happens to one within the mental health systems arguably reduces with psychotherapy, psychopharmacology, electroconvulsive therapy and psychosurgery, in that order.

One has very little lay information about the changes associated with drug use and other body techniques. Frequently, one experiences irremediable bodily changes, such as tardive dyskinesia, occurring with long term use of neuroleptics or anti-psychotics. The shock of having to deal with a pair of suddenly crippled limbs can be an added trauma to someone already suffering from a severe mental illness. The sense of betrayal one feels at not having been informed before by her doctor of the likely consequences of the drugs she has been using is understandable.

### *Need for studies*

Studies abroad show that the marginalised and the vulnerable (especially women) are **more** likely to be given more prescriptions for psychoactive drugs<sup>6</sup>. We have no comparable studies of psychoactive drug use patterns in our country. Such a study is a dire need. Prescriptions for drugs may have more to do with the stereotypes that the psychiatrist is processing in his dealings with the patient, rather than any 'objective' knowledge about the healing potential of chemicals.

### *Electro-convulsive therapy*

The use of ECT or 'shock therapy', as it is often called, has gone up by 20 times in the last twenty years, according to one study done at KEM Hospital, Bombay<sup>7</sup>. Studies show that ECT is what everybody wants, the professionals as well as the 'close relatives' of the mentally ill. Boral, Bagchi and Nandi<sup>8</sup> reported that an overwhelming 70% of relatives of patients favoured ECT treatment, and an equally large 75% of relatives favoured drug treatment, as against 77% of relatives who were doubtful about the efficiency of psychotherapy. Professionals will swear by the humaneness of the treatment and maintain that it has no long term adverse effects<sup>9</sup>. But cognitive deficits have been consistently linked up with ECT use<sup>10</sup>. And even professionals will admit that the administration of ECT in the country is far from humane. Agarwal<sup>11</sup> in an editorial note, wrote that surveys in the West showed 'remarkable deficiencies' in the administration of ECT. Agarwal warns that

'as a developing country, the situation in India is bound to be more disappointing'.<sup>11</sup> Murthy<sup>12</sup> cautions soberingly against the widespread and unconditional use of ECT in the case of depression and suicide.

Even if one grants that the knowledge base we have on ECT justifies its use, the ethical basis of ECT depends upon how closely the practical conditions of administering ECT conforms to certain standards of medical care; whether clear diagnostic criteria are practised (not just prescribed in the treatment manuals) in the use of the treatment; and whether informed consent is obtained, and whether such consent includes information about possible cognitive deficits following ECT. Agarwal, above, in listing the problems about abuse of ECT techniques in the country, notes that the question of patient's consent is rarely looked into by practitioners. The problem, here, as with the prescriptions and use of drugs, is that no information is available.

The NMHP commits itself to non-invasive cures by re-sourcing 'proper' principles of community care. But it does not specify policies for the use of the medical cures. While the policy prescribes in general terms the administrative structure of mental health care through the community, it remains silent on the nature of 'proper' principles and practices. Does the silence on these issues imply a sanction of these widely practised medical cures?

### *Mental health care for all*

The NMHP promises 'availability and accessibility of mental health care for all'. However, it prioritises epilepsy, mental retardation and psychoses. This prioritisation takes away all the promised benefits of the policy. These debilities are what are called 'severe' illnesses. Studies show that severe illnesses in the community is of the order of 1%. The frequency of epilepsy, MR and psychoses is probably less than this. There is however, a whole range of psychological problems (developmental, psycho-social, etc.) which contribute to the other 10 to 15% recorded as morbidity rate in Indian communities. Especially among the vulnerable sections of society, such as the elderly, the women, people in cultural or geographic transition, disaster struck people, the divorced, widowed, etc. morbidity rate of the common mental disorders is very high. Thus NMHP limits itself to only a very small target population by prioritising the severe mental disorders.

More significantly, the use of the medical models- drug therapy or ECT- for cure is almost inevitable in the case of these illness. In treating psychotic disorders, mental retardation or epilepsy, a practitioner is almost never called upon to invent non-invasive techniques or forms of psychotherapy. If drug use or ECT can be justified at all, it is justified all the more easily in the case of these endogenous types of mental disorders than other com-

mon types. So while the NMHP seems to pledge its philosophy on the side of non-invasive and community close techniques, it prioritises illnesses in such a way that the use of medical models of cure is inevitable.

There are of course economic reasons for the studied ineffectiveness of the NMHP to serve community needs. Covertly adopting the medical model ensures that no additional resources are spent on mental health. The very terms of the NMHP state this quite emphatically.

### **NMHP approaches**

The NMHP has been designed to have the following approaches:

- (a) Integration of the mental health care service with the **existing** general health services;
- (b) to utilise the **existing** infra-structure of health services and also to deliver the minimum mental health care services;
- (c) to provide appropriate task oriented training to the **existing** health staff;
- (d) to link mental health services with the **existing** community development programme. (Emphasis added).

The design of the programme is such that we make do with **existing** infrastructure and personnel, ensuring that no extra expenditure is incurred in implementing the mental health programme. The medical practitioners can be 'trained' to address mental health issues also, and also the PHC staffers. Psychotherapy, which works in the more frequent common disorders, requires expert training, institutional and organisational investments. If the state wanted to implement the mental health policy in principle, it would require to spend much more than if it simply linked up mental health with existing health facilities. This attitude to minimise resources spent on mental health care is completely consistent with the recent trends of the diminution of state funding for health care in general<sup>13</sup>.

Thus, while NMHP openly proclaims community care philosophy, it works by prioritisations which will ensure that the medical model will prevail, also ensuring that no additional costs will be expended for mental

health care. By remaining silent on the nature of treatment options to be made available in community care, it does not call into question or debate, the widespread medical models of mental health cure.

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