"Children are being labelled, stigmatised, and held captive to lifelong medication"
Des Spence, p 206

Will the UK government change our approach to risk?

PERSONAL VIEW **Alys Cole-King, Peter Leppina**

Imagine it is 3 am and your patient is at home, wide awake, and being tormented by suicidal thoughts. What is likely to stop them ending their life and make them seek help: the fact that they have undergone a complex, lengthy risk assessment or a simple "staying safe plan" created with an empathic and trusted practitioner, tailored to their own particular circumstances?

Assessing and managing risk is a major preoccupation in most areas of public policy, including environmental protection, transport, law and order, defence, and of course health. In mental health care the need for carefully considered responses to the risk of suicide was given sharp focus by the December 2008 House of Lords ruling that under the European Convention on Human Rights healthcare providers have a particular duty to protect mentally ill patients who are at risk of suicide from harming themselves.[1] The possibility of being accused of professional misconduct or the fear of litigation if a patient goes on to complete a suicide can be a powerful disincentive for clinicians to acknowledge that a patient is a suicide risk and thus to try to evaluate that risk and identify ways in which it can be mitigated.

Under the heading "Trust health care professionals" the Conservative party's election manifesto envisaged a health service where more decisions are made by frontline professionals using their expert judgment. If the new coalition follows this commitment through, one effect could be to delegate risk taking to frontline professionals. For this to succeed it will be essential to reverse the blame culture if adverse outcomes occur, but this is by no means secured. Furthermore, a clinically driven approach to documentation would help professionals take positive risks for the benefit of patients. Positive empowerment of staff could improve their ability to tolerate the anxiety associated with caring for patients with complex needs and diagnostic uncertainty and provide more person centred care. However, this will require determined and long term commitment to new approaches to risk taking, even in the face of adverse media coverage.

Unscheduled admissions to emergency departments make up many hospital admissions and are not always related to the degree of organic pathology. For instance, patients' decisions to attend emergency departments may be influenced by fear and other psychosocial factors. Patients with medically unexplained symptoms may undergo investigations "just in case," as clinicians fear "missing something" rather than ordering the investigations for genuine clinical reasons. A new approach to risk could enable general practitioners and hospital doctors to enhance their approach to clinical complexity by using their clinical skills for which they are so highly trained. The demand on the NHS currently far outweighs its capacity, and given the current financial climate professionals need to be free to make sensible decisions on the basis of clinical need rather than perception of need in a risk averse culture.

STOCKBYTE/GETTY IMAGES

Lives are not saved by completing suicide risk assessment forms and ticking the box to show that the correct procedure has been followed

Nowhere are attitudes towards risk more important than in how we deal with patients with suicidal thoughts. Every year in the United Kingdom around 5000 people die by suicide. This is twice the number who die on the roads, and suicide is the commonest cause of death among young people. While only 25% of those who die by suicide are known to specialist mental health services, most of the remaining 75% are in contact with frontline services, including primary care. We believe that many clinicians, when dealing with distressed and suicidal patients, are often too fearful to ask about suicidal thoughts in a meaningful way. Many are reluctant to enquire too deeply into a patient's suicidal ideation in case they identify a risk that they then feel unable to "eliminate." The very phrase "risk management" implies that clinicians should be able to reduce and eliminate risk "if only they did it properly" and preferably by following an agreed protocol. We have previously suggested that a more honest approach would be to focus on "risk mitigation,"[2] where rather than an unrealistic preoccupation with eliminating risk clinicians could more usefully consider how the factors that determine an individual's suicide risk can be mitigated.

Most risk assessment tools are based on statistics derived from the area under receiver operating characteristic curves (ROC-AUC scores) to determine their superiority in predicting an event such as suicide above chance. This does not take into account the fact that normal clinical assessments are already slightly better than chance. Moreover, they do not usually convert ROC-AUC scores into effect sizes; but if they did the effect sizes of most assessment tools would be very limited. In other words, even the best tools would be only slightly better than a clinical assessment in predicting an adverse event.

We support the use of evidence based best practice, clinical guidelines, and checklists, but we suggest that these be incorporated into a person centred clinical assessment rather than used as standalone tools. Lives are not saved by completing suicide risk assessment forms and ticking the box to show that the correct procedure has been followed. Rather than simply quantifying and characterising risk, the emphasis should be on identifying patients' needs, reducing their distress, and maximising protective factors. Every assessment is a potential opportunity for intervention.

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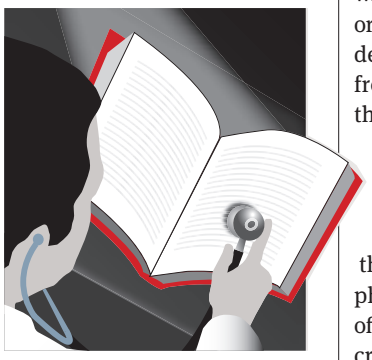
See EDITORIALS, pp 157, 158; RESEARCH, pp 185, 186

Fear of the known

BETWEEN THE LINES
Theodore Dalrymple



Dr Verdo is a realist; he knows that charlatans flourish wherever real doctors have failed

The persistence of charlatanry irritates doctors, who would much prefer to have a monopoly of foolishness as well as of wisdom. How is it that those who strain at the gnats of science so often swallow the camels of superstition?

Dr Verdo, from the town of Marmande in the Lot and Garonne, set out in 1867 to answer this question in his short book *Charlatanry and Charlatans in Medicine: A Psychological Study*. He classified firstly the consumers and then the producers of charlatanry, using his own experience and intuition rather than the methods favoured today. This conduced to brevity, if not necessarily to accuracy.

Dr Verdo says that women are in first place of those susceptible to the lure of charlatans and their wares, for women are "impressionable, changeable and tender, and judge more by imagination and feeling than by logic and good sense." Next come artists and mystic poets, "sensitive souls who are a little mad, and float above the realities of life, searching for unknown shores beyond inhabited regions."

After them are the gamblers, soldiers, sailors, industrialists, and speculators—all those who habitually take risks. Peasants are next, whose ignorance and isolation predisposes to superstition. The least susceptible to charlatanry are doctors, philosophers, physicists, and other scientists who are "used to examining the causes of things, to sound out the secrets of nature, and are always wary of the errors of judgment that could lead them to think the supernatural at work." But even they may fear Fridays and 13 at table.

Dr Verdo divides charlatans into two classes: the public charlatan and the charlatan in private practice. The public charlatan cries his wares to all and sundry, dresses flashily, and claims to have received the secret of his panacea somewhere in the mystic orient. (I have a wonderful French print from the middle of the 19th century of a man addressing a credulous crowd, claiming to have been the king of Persia's physician and who offers his balm to the crowd only because it cured everyone in Persia and there was nothing left for him to do there.)

The charlatan in private practice, by contrast, is a self proclaimed specialist, for example in gout or in "an illness of adventurers that I do not want to name" (and that, in our franker age, was once treated in the "special clinic"). Unlike the public charlatan, who revels in the light of day, the charlatan in private practice is a creature of ill lit rooms, decorated in cheap luxury.

Dr Verdo is a realist; he knows that charlatans flourish wherever real doctors have failed, for example in "cancer, scrofula, phthisis, tetanus, croup, whooping cough, gout, rabies, migraine, sea-sickness, epilepsy, rheumatism, asthma, cholera, etc." This list perhaps explains why a friend of Dr Verdo's, who was a student with him, gave up medicine for economic reasons and took up lucrative charlatanry.

But for Dr Verdo there is a deeper reason why charlatanry and charlatans always flourish. He begins his book with the words, "The inclination to the marvellous is in human nature itself," and he ends his book with the words, "Credulity is one of the attributes that distinguishes man from the animals."

I think this is true because while we fear the unknown we fear the known almost as much, and thus we fly for relief from the one to the other.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

All the Madmen Song by David Bowie

Released 1971 (UK)

"All the Madmen" was inspired by the mental health problems of David Bowie's brother and was released 39 years ago (before Bowie achieved major fame), on the album *The Man Who Sold the World*. It recognises the separation from society of mentally ill people, who are sent to "mansions cold and grey." In a lucid interval, spoken instead of sung, the national shame of mental illness and policies of alienation and institution are questioned with sadness: "Where can the horizon lie / When a nation hides / Its organic minds in a cellar."

Faced with the prospect of discharge, the patient protagonist recognises his comfort in Librium, considers his ability to cope outside, and pushes the risk buttons with, "I can fly, I will scream, I will break my arm / I will do me harm." He adopts a catatonic posture, standing with a foot in his hand, talking to the wall. He is accepting of electric shock treatment. When he asks, "I'm not quite right at all . . . am I?" is this a cryptic taunt that he knows he is putting it on, pushing the psychiatrist to keep his place in the institution? Or, more worryingly, is he questioning his own sanity and certainty?

The patient too separates the mad from the sane and prefers the company of the first, emphasised by the chorus: "I'd rather stay here / With all the madmen / Than perish with the sad men / Roaming free / And I'd rather play here / With all the madmen / For I'm quite content / They're all as sane as me." How apt this is too for today's psychiatrists, blocked from interaction with patients by production line ward rounds, working time directives, ineffective audits, and management meetings, wondering if the organisation they work in is more psychotic than the patients they want to relate to.

Bowie 1971: patient-centred song does modern psychiatry justice

MICHAEL OCHS ARCHIVES/GETTY IMAGES

Unfortunately, thanks to psychiatric intervention (most likely a lobotomy), the patient is unable to maintain a happy status quo: "Day after day / They take some brain away." Along with loss of brain is loss of libido. Now he is simply "not quite right at all," there is no question of "Am I." He still does not want to be set free, but now it is because he is helpless. He has lost control to the institution, which tells him what is real, and he does not object.

The story ends with the narrator in a state of definite psychopathology, a bilingual clang association: "Zane, Zane, Zane ouvre le chien." The listener can reflect on a reference to Huxley's *Doors of Perception* or on our inmate screaming for the exit door after his treatment.

As with much of Bowie's most thought stimulating work, "All the Madmen" allows more than one interpretation and generates uncertainty—important themes in psychiatry. This patient centred song does modern psychiatry justice by reminding us of the stigma of mental illness and by personalising the patient as he makes his journey through the institution to institutionalisation. It raises the question of how far psychiatry has progressed since the distant time when Bowie had yet to dye his hair orange.

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Bad medicine: medicated minors

FROM THE FRONTLINE
Des Spence

Society is obsessed with protecting children. From the time of conception we offer strict advice to avoid alcohol, cigarettes, and drugs for fear of damaging a child's development. Childhood is a period of chaotic, experimental, challenging, and formative thinking. And despite my years I am still captive to the emotions of my misfit childhood. I would not trade one moment of the misery and happiness of that time, for it is a mental sanctuary from the pressure cooker of adult life.

But nature's developmental mental nursery is under attack from psychiatry and the massive rise in the prescription of psychotropic drugs associated with new childhood conditions such as attention deficit hyperactivity disorder, oppositional defiant disorder, autistic spectrum disorder, bipolar illness, and depression. The reported rates are so high that effectively one in three children has one of these behavioural conditions. Use of stimulant drugs, antidepressants, mood stabilisers, and atypical antipsychotics to control behaviours deemed not to conform to the norm is widespread. This prescribing is supported by "evidence" and reclassifications in the *Diagnostic and Statistical Manual of Mental Disorders* and normalised and validated by us doctors. It is hard to go against the weight of evidence and hard to go against the profession and the often unrealistic expectations of parents. Medicating children is now a billion dollar industry. So should we simply accept these models? Or are doctors blinded by huge financial conflicts of interests that promote these models of childhood psychiatric illness and the intellectual folly that is "early intervention"?

Consider that these definitions of disorders are the product of a small group of "expert opinion," that diagnosis is plagued by self reporting, that specificity is lacking, and that diagnosis is confounded by social factors. Therefore diagnosis is so fraught with overdiagnosis as to be useless. Indeed, many challenge the legitimacy of these definitions altogether, with "disorders" being merely variants of normal childhood behaviour.

Even if we accept the diagnostic definitions, the evidence base for drug treatment comes from small, short, industry funded studies of highly selected populations. We simply don't know whether these drugs are effective in the long term or even safe, in this most formative period of human development. Doctors are aiding and abetting a culture of chemical mental conformity and suppressing diversity by trying to hammer odd shapes into square holes. Behavioural problems in children should be managed by behavioural interventions. Children are being labelled, stigmatised, and held captive to lifelong medication. A medicated childhood is blunt, defies reason, and is just bad medicine.

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Civilisation

THE BIGGER PICTURE
Mary E Black

"You two are the only straight couple in the restaurant," my 13 year old son pointed out cheerfully. We were having a family dinner in Berlin's gay district, where the internet had proffered self catering apartments owned by Marc and his husband. We met their two cute terriers and watched the World Cup finals in a gay smoking bar next door, cheering on Spain with the entire clientele, which numbered only three.

Afterwards we strolled past antique bookshops, courting couples of all persuasions, and a window display of adventurous leopard print underwear. Such a relief after Belgrade, where being openly gay is a serious health risk and where the last and only gay pride event in 2001 landed participants in hospital; hooligans beat them to a pulp. The police were ineffective; perhaps smoke got in their eyes. Smoke filled bars and restaurants are the exception in western Europe but the rule in Serbia.

Our family is travelling extensively at the moment. I leave the library of the London School of Hygiene and Tropical Medicine and head to a smoke free restaurant, passing University College Hospital, where inpatients gather at the entrance to take a drag, their hospital gowns revealing legs mottled red from years of tobacco and alcohol abuse. One elderly man courted fate with an oxygen cylinder on a little trolley as he puffed away. The children are off to Kenya and so are learning about malaria prophylaxis and getting exotic vaccinations. My husband will commute to Azerbaijan, working with a hospital development on an oil pipeline, accompanied by my niece on her gap year before (fingers crossed) her medical school starts. We get to taste stunning Azeri vegetables and discuss how best to reform medical records systems or ban smoking.

Travel is a privilege that ranks second only to being able to read. Through the lens of my profession I learn constantly: I see how different countries apply tobacco control (I am currently enamoured of Australia's plan to have generic tobacco packs), I pore through HIV brochures in cafes, I drop into pharmacies and see what is on the shelf. Direct experience is quite different from reading, and details count. I can test my fixed ideas and see what can be done differently.

I am proud that my children confidently take the minority position in classroom debates and defend the rights of gay people to exist, marry, and adopt children, in large part because they have direct experience of societies and families where this works just fine. There is talk of holding another gay pride march in September. This time the police have offered support. Our family will be there, marching. The price of privilege is to know when civilisation needs to be defended.

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