President's Message: Egalitarianism, Medical Care, and Mental Health

Throughout the centuries, policy-makers and pressure groups have attempted to impose rules in the face of a recalcitrant reality. Montaigne observed, "Through presumptions they make laws for nature and marvel at the way nature ignores these laws."

So too with health policy where one shibboleth plaguing society is the misuse of the concept of egalitarianism. In our society, that should mean equality of opportunity based on reasonable qualifications and equal protection under the law. Another so-called "egalitarianism," that of professional equivalence, is reflected in the attacks on organized medicine along with the concepts of "freedom of choice" and anti-credentialism — all of which are exemplified in a recent New York Times article.[1]

Medicine is attacked, as usual, for being motivated solely by greed and monopoly. Actually, all groups seeking legal sanction and health care money should be scrutinized for the rationality of their position. The seductive cosmetics of egalitarianism do not justify the creation of more health guilds —particularly when services may be limited, harmful, or wasteful of limited funding from third parties or government.

Freedom of choice is a good principle, if there are legitimate alternatives and knowledgeable selectivity. If laetrile has no effect on cancer, then it is not a legitimate choice, whatever its legal sanction. Similarly, it is no choice if it is not as harmless as the proverbial chicken soup to which it is so often compared (as far as I know, chicken soup, unlike laetrile, does not produce cyanide). The Federal Drug Administration attempts to limit freedom of choice where drugs are inefficacious or unsafe.

So do medical licensing or related acts which limit the activities of those who call themselves healers. Nonetheless, the various states, under political pressures, have authorized health-related services and occasionally reimbursement by a melange of incompatible peoples and self-selected saviors. These include medical doctors, osteopaths, chiropractors, naturopaths, religious auditors, pastoral counselors, social workers, psychologists, massagers and masseurs, marital therapists, family counselors, nurse practitioners, midwives, physician's assistants, indigenous healers, and God-knows-what.

This armada of "healers," all seeking status, money, or professional recognition, ranges from traditional medicine to the theoretically dubious and the overtly quackish. The one thing they cannot have, regardless of the rules of man, is true equality — for they are very, very different.

Hogan, in opposing licensing based on credentials and what he calls "medieval guilds," supports egalitarianism in the mental health marketplace — yet the corollary of "egalitarianism" is the espousal of the lumping phenomenon. All professions and occupations, labeled as equal, are lumped into a mass of therapeutic equivalence. Formal education and training are ridiculed; only "competency," whatever that is, is glorified.

The fraud inherent in the use of the term "mental health professionals" or "mental therapists" has been used to cover the deterioration of government mental health programs, which have become the home of self-perpetuating pressure groups of limited therapeutic utility. As psychiatrists have fled the "egalitarianism" of the public sector into private practice, the poor and the economically strained have remained enmeshed in a worsening two-tier system (public compared to private health delivery). Now those who have brought us the dubious benefits of an egalitarian public mental health system would compound their sins by lowering the private system to that level and undercutting the availability of rational scientific medicine.

Health delivery is not based on a vacuum; it reflects both a theory of disease care and a system to provide it. Some non-physicians believe that emotional disorders are due singly to social, economic, or psychologic factors. Some believe social revolution is the cure for mental illness; one midwest governor thinks jobs are the panacea. One philosopher has solved the problem by declaring that mental illness does not exist; another claims that psychosis is adaptive and conformity is illness. How would the Hogans provide "mental therapy" from disparate groups for the management of schizophrenia, affective disorders, and organic brain syndromes? How would they use "mental therapists" of incongruous backgrounds to deal with these conditions when their tools are professionally inappropriate?

This denigration of the medical profession and the espousal of egalitarianism is typified by a 1978 policy decision of the New Jersey Division of Mental Health and Hospitals.[2] The administrative directive is entitled "The Administration of Psychotropic Medication to Voluntary and Involuntary Patients." Two of the listed objectives were (1) to provide for medical review of the treating physician's medical determination and (2) to utilize the patient's treatment team in formulating clinical care. Various New Jersey statutes state that a mentally ill patient is entitled to medical care in accordance with accepted standards, to participate in planning his own treatment as his condition permits, to refuse medication if a voluntary patient, and to be free from unnecessary or excessive medication or medication used as punishment, for the convenience of the staff, or as a substitute for treatment (sic!). The chief executive officer is authorized to give consent for psychiatric treatment under certain conditions (undoubtedly this was initiated when all executive officers were physicians); now that such administrative positions have been given to laymen, it would seemingly

allow such non-physicians to authorize consent or to refuse consent to medical treatments.

The anti-medical nature of the directive is reflected in its language which states that medication is necessary if the patient is incapable, without medication, of participating in any treatment plan available at the hospital that will give him a realistic opportunity of improving his condition. In other words, acording to this philosophy, medical treatment is not treatment but a means of participating in treatment.

Physicians may administer psychotropic medication in an emergency to prevent death or "serious consequences to a patient" if they certify that it is so needed and the chief executive officer authorizes consent. If it is impossible to comply with the procedure without jeopardizing the life of the patient, the medication may be administered on a physician's order alone. Taken literally, this would seem to indicate that a non-voluntary patient who is assaultive to a sickly bedridden patient but refuses treatment would not be treatable without permission of a lay person (as in this example the patient's own life would not be jeopardized).

If a patient refuses to take psychotropic medication that has been prescribed, the physician "shall speak to the patient and attempt to explain" his reasons for prescribing the medication, the benefits and risks, and the advantages and disadvantages of alternative courses of action. If the patient still refuses to take medication and the physician still believes that medication is necessary, the physician should tell the patient that the matter will be discussed at a meeting of the patient's treatment team. If the patient's clinical condition permits, the physician should invite the patient to attend the meeting of the treatment team. The physician should also suggest that the patient discuss the matter with a person of his own choosing, such as a relative or friend.

If after a team meeting the physician believes that medication is necessary and the patient still refuses to take the prescribed medication and if the patient has been adjudged incompetent and if there is a consensus by the team, then the patient's guardian shall be contacted for consent. If the guardian refuses or neglects to provide a denial or consent, then the chief executive officer may consent to the administration of the medication.

If there is disagreement between the team and the physician in regard to medication, the medical director (or his designee) shall examine the patient and review the record. If he agrees with the physician, then the same procedure as to the guardian and chief executive officer follows.

If the patient has not been adjudicated incompetent, then the medical director (or his designee) must conduct a review of the involuntary patient, and if he agrees with the need for medication, the medication may be administered. Voluntary patients may not be treated.

The medical director is authorized to retain an independent psychiatric consultant to evaluate the need for medication, particularly where there is disagreement between the treating physician and the team.

While the overall plan obviously is cumbersome and even bizarre, the point to be made here is that team members (apparently psychologists, social workers, nurses, aides, technicians, occupational therapists, etc.) are allowed to vote on the use of the medication, an act for which they have no qualifications and which clearly constitutes a decision as to medical practice (and therefore is the practice of medicine).

While not directly dealing with the issue of egalitarianism, the court in *Davis v. Watkins* and *Davis v. Balsom* (the Lima State Hospital case in Ohio) recognized what it called the Mental Health Professional, also called Qualified Mental Health Professional or QMHP. These have become known colloquially as Quimps. The use of the expression, Quimp, tends to blur the differences between the various professional and occupational groups. Parenthetically, the court has also applied due process standards to "increases" in medication, a policy which raises numerous potential difficulties, as law personnel have moved into the medical decision-making process.

Nonetheless, psychiatry is and will continue to be a medical specialty with a body of knowledge and systems of therapeutic and diagnostic techniques, steadily changing, helpful at times, not at others. Psychiatrists will continue to treat patients, not clients, and cannot, by the rules of nature, be lumped together with other groups with which they are not equal, but simply different, very different.

Hogan has criticized the clarification of psychiatry as a medical specialty in a recent Virginia ruling.[3] There the judge ruled:

"In the treatment of nervous and mental disorders, psychiatrists are capable of providing a full range of psychiatric treatments, not just psychotherapy. In addition, as medical doctors, psychiatrists may render medical treatment and diagnosis. It is undisputed that clinical psychologists are not qualified to diagnose nervous and mental disorders and to decide from what source these disorders stem."

One of the beauties of scientific medicine is its use of multiple modalities in a coordinated fashion. Unidimensional healing systems cannot rise above their origins. Fiat or law cannot change the nature of disease or how it may reasonably be altered; the medical model will survive because of its merit and workability. The biases of those who fragment knowledge in furtherance of partisan causes one hopes must ultimately fail. In any event,the presumptions of irrational social policy will, as they did in Galileo's day, give way inevitably to the rules of nature.

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References

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2. Administrative Bulletin 78-3, Division of Mental Health and Hospitals, State of New Jersey, March 1, 1978
3. *Virginia Academy of Clinical Psychologists et al. v. Blue Shield of Virginia, et al.* (U.S. Dist. Ct., East Virg., April 9, 1979)