

Do We Need A Strong Definition of Mental Disease in order to Secure Resources for Psychiatry?

PSİKİYATRİYE AYRILAN KAYNAKLARI GÜVENCE ALTINA ALMAK İÇİN GÜÇLÜ BİR AKIL HASTALIĞI TANIMLAMASINA İHTİYACIMIZ VAR MI?

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Summary

The paper describes two interrelated areas of discourse/debate in which doubts about the disease status of mental illness is expressed, and where these doubts are used in arguments concerning resource allocation.

The first of these discourses is concerned with resource allocation to psychiatric in-patient departments. This debate is compared to the similar discussion concerning resource allocation to neurology, and it is suggested that the different outcomes may be (at least partly) explained by the unwavering ascription of disease status to neurological diseases. This conclusion is further supported by looking at some illnesses on the border between neurology and psychiatry (e.g. Gilles de la Tourette syndrome). The second discourse, analysed in this paper, is the discourse about community psychiatry versus hospital psychiatry. It is suggested that the ideological character of this discourse, and some common side-effects of the move towards community psychiatry (i.e. that resources are lost, despite avowed intentions to the contrary), are made possible by the uncertainty of the status of mental illness.

Based on these analyses it is claimed, that the chances of securing adequate funding for psychiatric care and treatment would increase, if doubts about the 'true disease' status of mental illness could be dispelled.

Some initial comments are made about the prospects of reaching a resolution of this problem, and it is, reluctantly, concluded that the prospects look more promising if one accepts a biological model of psychiatric disease. A final question is then raised in the form of a dilemma: 'What should the philosopher do, if a foreseeable side-effect of seeking the 'truth' about mental illness, is a reduction in the help given to those people who are ill and needs help?'

Key Words: Psychiatry, Mental Illness, Resource Allocation, Concept of Disease

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Özet

Makale, birbiriyle içice iki tartışına konusu olan akıl hastalığının hastalık olarak ortaya çıkış şekline ilişkin şüpheler ve bu şüphelerin kaynak dağıtımında bir sav olarak kullanılma biçimini tanımlamaktadır.

Bu konulardan birincisi psikiyatri kliniklerinde yatan hastalara yapılan kaynak kullanımıyla ilgilidir. Bu tartışma, nöroloji servisinde yatan hastalara yapılan kaynak kullanımı ile kıyaslanmakta, ve farklı sonuçların (en azından kısmen) nörolojik hastalıkların hastalık durumu ile açıklanabileceği öngörülmektedir. Bu iddia Psikiyatri ve Nörolojinin sınırındaki bazı hastalıklara (örneğin Gilles de la Tourette Sendromu) bakılarak desteklenmektedir. Bu makalede ele alınan ikinci konu. toplum psikiyatrisine karşı hastane psikiyatrisi tartışmasıdır. Bu tartışmanın ideolojik özelliği, ve toplum psikiyatrisine yönelmenin bazı etkilerinin psikiyatrik hastalıkların durumundaki belirsizliğe yol açtığı iddia edilmiştir. Bu analizlere dayanarak psikiyatri hastalarının bakım ve tedavisi için ayrılan paranın güvence altına alma şansını artırmanın yolunun akıl hastalıklarının 'gerçek hastalıklar' olduğu yönündeki şüphelerin ortadan kaldırılması ile mümkün olacağı ileri sürülmüştür.

Bu sorunun çözülmesine yönelik olarak bazı yorumlar yapılarak, çekimser olarak da olsa, eğer psikiyatrik hastalıkların biyolojik modelinin kabulü ile bu ihtimalin daha kuvvetli olduğu iddia edilmiştir. Son bir soru da bir ikilem olarak onaya konulmuştur: 'Akıl hastalıkları hakkındaki 'gerçekler'in araştırılmasının muhtemel yan etkisinin, hasta ve yardıma muhtaç insanlara yapılacak yardımın azaltılması olduğu bir durumda bir felsefeci ne yapmalıdır?'

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"Many insurance administrators believe that judgments about medical necessity in mental health care are less precise than similar judgments in other areas of medicine." (1)

The importance of the disease claim

All developed countries are presently engaged in debates about resource allocation to and within the health care system. The purpose of the present paper is to explore the relation between this debate and the discussion about whether mental illness (2) does really have the same firm status as caused by true disease (3) as is usually granted to somatic illness.

That is, the main subject will be the relationship between publicly perceived disease status and effective claims on communal resources (4)

Discussions about disease concepts, especially within psychiatry, is often seen by outsiders as a futile example of 'philosophical nitpicking', with no practical use. The main thesis of this paper is, that this view is seriously mistaken, and that discussions about disease concepts in psychiatry may have profound practical consequences.

There is no doubt that disease claims are powerful rhetorical tools in the resource allocation debate in general. This is perhaps most clearly exemplified in the ongoing debate about whether or not infertility treatments should be funded by the public. In this debate it has been imperative for the groups representing infertile couples to establish, that infertility is a *bona fide* disease and not just a social condition. These groups have obviously acted on the belief that if they could establish their disease claim, they could also establish their moral and political claim on the public purse (5)

From the pure philosophical point of view it is tempting to claim, that these kinds of arguments depend on a conflation between disease claims and moral claims, and that the moral claims are not generated by the disease status as such but for instance by the suffering caused by the disease, or by the reduction in possibility range etc.. It is, however, important to notice that disease claims do play an important part in public discourse, and that many people seem peculiarly resistant to the logical arguments of the philosophers. The philosopher may well say, that disease status should play no independent role, but it will probably continue to do so behind the back of the philosopher.

Why do neurologists have it so much easier?

In relation to psychiatry a similar phenomenon can be found when one looks at the differences between the resource allocation discussions concerning neurology and the discussions concerning psychiatry.

When the neurologists say that they now have a wonderful new treatment for stroke (i.e. thrombolysis), and that all patients should be offered this treatment, politicians and administrators may well squirm because of the cost, but they do not say 'We know that neurological treatment can relieve suffering, but there is a lot of suffering in our society and we also have to take account of the costs of other social programs' (6)

If, however, psychiatrists make the same claim to possess a new effective treatment, they are likely immediately to see their proposal being put into the balance with other social programs aimed at reducing unemployment, teenage pregnancy etc. etc..

How can we explain this difference?

Neurology and psychiatry are both medical specialties, so the explanation cannot be the power differential between the medical profession and psychologists, social workers or others. Part of the explanation is probably differences in power and position within the medical profession, but this does not seem to be the whole answer.

At least some of the answer must be found in the public perception of the different conditions treated by neurologists and psychiatrists. It is therefore of interest to consider which features of a given condition that are likely to cause its classification as a neurological condition.

There are a range of similarities between the conditions treated by neurologists and the conditions treated by psychiatrists. Both types of conditions are in some way related to brain function, both often impair mental functioning, and both can often be treated by medical means (i.e. using techniques traditionally falling within the scope of medicine i.e. drugs, operations etc.).

But there is also a number of differences. For many neurological conditions it is the case that we know the cause of the condition (or at least a major

factor in its causal network), that we know of some typical pathological lesion associated with the condition (e.g. the plaques in multiple sclerosis or Alzheimers disease), or that we know a convincing pathophysiological correlate of the condition (e.g. the EEG changes occurring during the various epileptic seizures). The reverse is true concerning most psychiatric conditions. We may have some evidence of genetic influences in causation or of correlations between conditions and transmitter and/or receptor imbalances in the brain, but the evidence is only rarely as hard and fast as in the case of neurological conditions.

The importance of these differences can be further illuminated by considering the case of Gilles de la Tourette syndrome, a condition characterised by motor and vocal tics and in some cases coprolalia. It has for a long time been recognised that this condition was on the borderline between psychiatry and neurology (7) and in different places both neurologists and psychiatrists have been involved in the treatment. However, recent findings suggesting a strong genetic component in the causation have moved Tourette syndrome towards being a definite neurological disease. In the abstract of a recent review we thus read:

"Gilles de la Tourette syndrome is a neurological disorder characterised by the presence of motor and vocal tics." (8)

And this assertion is happily combined with the following statements about treatment:

"Treatment of Tourette syndrome involves education and counselling of the patient and family. Medications such as neuroleptics, serotonin-uptake inhibitors, and stimulants are available to treat the manifestations of Tourette syndrome and need to be individualized for each patient" (8)

It is clearly not the case that the neurologists are any more successful in treating Tourette syndrome than the psychiatrists or neuropsychiatrists were previously (as evidenced by the incongruous list of different treatment modalities), but the mere fact that we now know a little more about the genetic/neural etiology of the disorder has moved it from psychiatry to neurology. It is now commonly classified as a disorder of the basal ganglia, and no longer as a neurobehavioural syndrome.

But the same features which makes a given condition a neurological condition, also brings it closer to the central members of the class of bodily diseases, and thereby consolidates its claim to be accepted as a 'real disease' in public discourse.

It will therefore be the case that neurological conditions on average are more disease-like than psychiatric diseases, and that they are therefore more likely to be seen as belonging to the sphere of medical suffering, and not to the more general sphere of social or personal suffering.

But this is obviously an effect of applying a disease concept that makes diseases involving bodily malfunction central members of the general class of diseases.

Because this disease concept is the one which is mainly operative in the public discourse, neurological diseases and neurologists have an easier time attracting resources than their psychiatric counterparts.

What would happen if we tried to change disease concept, or to persuade the participants in the discourse that some other disease concept was more appropriate?

Community psychiatry and money

One place to look at the effects of applying different disease concepts would be within psychiatry itself.

Within the area of psychiatry disease claims also play a role in resource allocation decisions. In health care systems built on health insurance it is often a necessary condition for reimbursement that a procedure is deemed to be 'Medically Necessary' (1), and this is often spelled out in terms of the procedure being an efficient treatment of a disease state. In public health care systems the relationship between disease claim and resource allocation is more complicated, but it never the less plays an important role.

One of the discourses where this phenomenon is exemplified is in the discourse concerned with the move from institutionalised to community psychiatry. Many countries in Europe have introduced community psychiatry and there has often been a concomitant debate concerned with the ideological rationale behind the introduction (9)

In most cases the authorities have initially promised that the introduction of community psychiatry and the closure of psychiatric in-patient departments would not lead to any reduction in the net resources devoted to psychiatry, but in most cases this promise has not been kept. In-patient departments have been closed, but only part of the resources have been transferred to the new community centres, and the rest has been diverted to other uses (10).

Part of this development has probably been caused by the temporal coincidence between the introduction of community psychiatry and a prolonged economic recession in many European countries, but other parts of medicine have been able to maintain or increase their share of the available public funds in the same period, so the economic conditions cannot be the whole explanation.

If we look at the discourse about community psychiatry we find another possible explanation for this unfortunate chain of events.

The basic ideological claim behind community psychiatry is, that it is better for psychiatric patients to be treated in the community than to be treated in a hospital. This claim was in the initial phases of the development often not backed by any empirical evidence, but only by reference to the social isolation of psychiatric patients in the old treatment regime or to other postulated unfortunate effects of institutionalised psychiatry. The community psychiatric movement did not embrace the anti-psychiatric stance of Szasz and Laing (11), but it was initially driven more by ideology than by science (12), and some have even claimed that present scientific knowledge calls for a return to institutional psychiatry (13).

I think that this reliance on ideology instead of science (14) and the emphasis on a non-biomedical / psycho-social model of mental illness, has laid community psychiatry open to the charge, that it is just another way to treat social problems. Other claimants to the same resources could and did advance arguments like the following:

If the clients really have a mental disease then they should be treated for their disease (i.e. treated in the medical sense), and when the disease is treat-

ed they can return to society without any specific-social programs,

or

If the clients don't have a disease, why should we then spend more on them, than on other people with similar social problems?

Because of the reliance on a psycho-social model of psychiatric illness the proponents of community psychiatry have been ill equipped to counter such claims directly in the public debate (where a more biomedical conception is prevalent); and they have therefore often fallen back to the position that what we are really doing is not treating disease, but giving some people a worthwhile life. This position seems unassailable, but it renounces the claim to specific medical resources.

Finding the right **disease** concept for mental **illness**

Sabin and Daniels propose the following classification of medical necessity in the context of mental illness (1);

Equal Opportunity for	Target of Clinical Action	Ultimate Goal of Health Care
1. Normal Function	Medically defined deviation	Decrease impact of disease or disability
2. Personal Capability	Chosen constraint of personal capability	Enhance personal capability
3. Welfare	Unchosen constraint of potential for happiness	Enhance potential for happiness

Within this classification the number of suffering persons treated increases as one moves downwards to more and more expansive definitions, and the same is true of the costs. Unfortunately the public acceptance of the costs decreases as one moves downwards in classification and thereby the possibility to make effective claims to public resources, as exemplified above.

There can be no doubt that public support is strongest for interventions aimed at treating conditions in category 1, and that it would therefore be optimal, from a resource allocation point of view, if common psychiatric conditions could be brought into this group.

It is possible to map some of the classical conceptions of mental illness unto this classification, with the most strictly biomedical conceptions coin-

ciding with Sabins' and Daniels' category 1, the common psycho-social conceptions coinciding with category 2, and the consequentialist rejection of disease concepts in favour of pure welfare maximisation and the most expansive community psychiatric conceptions coinciding with category 3.

If we try to use the scheme as a general categorisation of illness states and categorize different condition-treatment pairs, the categorisation immediately reveals an interesting discrepancy between mental and bodily illness. Most of the bodily conditions presently treated within the health care systems in Western Europe would fall into category 1, some in category 2, and very few in category 3, but most of the mental conditions would at first sight fall in category 2 or 3, because no clear and incontrovertible malfunction is found.

Is there any way to force more mental illness into category 1, and thereby make it incontrovertibly medically necessary?

If we allow ourselves to assume a simple monism with identity between mental states and brain states (e.g. see Reznick (15)), it is obviously fairly easy to show, that mental illness and physical illness are of one and the same kind, because there can be no real separation between the two. A 'diseased mental state' must be caused by a 'diseased brain state'.

From a resource allocation point of view it would therefore be felicitous, if Reznick's view of mental illness was correct, but there are good reasons to believe that his simple monism cannot adequately describe the relation between mental states and brain states (16) If we reject Reznick-type simple monist arguments we encounter a problem. On many of the more complex materialist theories about the mind-brain problem it is also possible to show that mental illness is caused by (or followed by) changes in brain states which should count as disease. The arguments are, however, typically rather complicated and hard to explain to outsiders (i.e. to all but the specialists in philosophy of mind). They are therefore unlikely to have any impact in the public discourse.

It may, therefore, be the case that the only psychiatric conditions which can claim category 1 status in the public discourse are the ones where there is either 1. a significant biological correlate, or 2.

the mental disturbance is very pronounced (e.g. the psychoses). This is only a narrow range of the conditions falling within the broader category of mental illness, and it may be tempting to try a combination approach between a narrow biomedical conception and a more expansive psycho-social, so that the conditions encompassed by the psycho-social conception can 'share in the lustre' of the 'real diseases' in category 1.

This may, however, be a dangerous strategy because a too generous acceptance of a psycho-social concept of mental disease may lead to a reduction in public support for mental health services, as Sabin and Daniels have argued in a subsequent letter:

"We believe that Dr. Ford is correct in his conclusion that a fully satisfactory account of "medical necessity" will incorporate systematic evaluation of functional impairment. Many efforts are being made to develop practical, reliable, and valid ways of doing this. We fear, however, that his definition of "clinical necessity" may create a level of eligibility for services that will jeopardize support for mental health insurance coverage. If that happened - and it has in the past - a humanely intended effort to broaden the range of those who might receive mental health services would lead to an actual narrowing in the real world." (17)

The health care philosopher therefore seems to be left between the Scylla of a narrow biological model of mental disease which ensures public acceptance of the costs of psychiatry, but which leaves many of those suffering without treatment, and the Charybdis of a broader psycho-social model which ensures that all those suffering from mental illness can legitimately claim treatment, but which erodes public support for the whole enterprise. He is poised between them, and cannot embrace either out of fear that it will lead to an unwarranted reduction in the mental health services offered to people in need.

Is there a solution to this dilemma?

Probably not in the philosophical sense. If philosophy is the search for truth, then we are forced, on pain of inconsistency, to embrace the disease concept which is generated by our analysis, no matter what side effects it may have. We are therefore left with the dilemma stated in the abstract:

'What should the philosopher do, if a foreseeable side-effect of seeking the 'truth' about mental illness, is a reduction in the help given to those people who are ill and needs help?'

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2. I try to use the standard distinction between disease and illness, i.e. disease is the bodily condition whereas illness also incorporates the subjective experiences
3. Throughout the paper I will presume, that there is some class of phenomena normally called disease in Western European societies, and that certain changes in the human body are central members of this class (e.g. plague, rheumatoid arthritis, ileus etc. etc.).
4. Throughout the paper I will accept two basic assumptions about mental illness, a. mental illness exists and causes suffering in some persons, and b. there are psychiatric treatment modalities which can, at least, alleviate the suffering caused by mental illness.
5. The idea being that something like the following argument holds: If A is a disease then the public should pay for the treatment of persons afflicted with A. A is a disease. Therefore: The public should pay for the treatment of persons afflicted with A. Establishing the first premise on philosophical grounds is difficult, but as an empirical generalisation about public policy it holds in many Western European countries.
6. Some politicians might instead say: "The people getting stroke are usually elderly, and treating them do not give good value for money", but I will leave this against argument out of the discussion.
7. Often placed in the nebulous area of "neuropsychiatry".
8. Suchowersky O. Gilles de la Tourette syndrome. *Canadian Journal of Neurological Sciences* 1994; 21(1): 48-52.
9. I am here mainly concerned with the public discourse and not with the discourse within the psychiatric profession.
10. Reisby N. Distriktpsykiatrien - fungerer den?. *Ugeskr Laeger* 1995; 157(19): 2697.
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14. Science itself often contains an implicit ideology, but there is, at least in principle, no insurmountable problems preventing the scientific investigation of the claims of community psychiatry.
15. Reznek L. *The Philosophical Defence of Psychiatry*. Routledge: London, 1991.
16. A full discussion of this point would lead into the maze called Philosophy of Mind, and I will allow myself to leave this out of the present paper.
17. Sabin JE, Daniels N. Reply to letter, *Hastings Center Report* 1995; 25(2): 2.