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In search of Ariadna's thread

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Summary: *This article was originally presented in Polish at the opening of the 40th Jubilee Conference of Polish Psychiatrists on "Integration in Psychiatry" held in 2001. The author reviews some of the changes that have occurred in psychiatry in recent years, and describes the current developmental tendencies in the field. These tendencies and changes cover an entire spectrum beginning with a favourable manner of perceiving and treating psychiatric patients by professionals in their environment. The article also addresses the strengthening of patients' position and control over their rights, formalised by appropriate legal regulations. Finally, the unfavourable and undesirable conditions, which endanger further advances in psychiatric treatment reforms, are also discussed with some forecast for what the future climate may hold.*

Key words: developmental tendencies in medicine, psychiatric care reform

In this article, I would like to share with you my thoughts and feelings about the actual state and the future of medicine in general, with a particular emphasis on the specialization of psychiatry. These thoughts mostly result from my 58 years of experience in professional practice. Thus – the metaphorical title surrounding the future developments is in some way synonymous with the passing through a labyrinth of challenges and obstacles. In order to find one's way, one needs certain guideposts and clear definition of adequate goals and solutions. It is true that many discussions and publications have already been devoted to these issues, however, there exists a necessity to intensify and deepen the analyses conducted by representatives of different branches of science, with due consideration given to the questions, doubts, reservations, opinions and expectations of the consumers of medical services. I do not consider it necessary to justify the usefulness of discourse assuming equal partnership of participants and aimed at the analysis of global trends in the first half of this century, since its results will most certainly be crucial for specifying and defining future tendencies, chances and challenges to be met by medicine and psychiatry.

The beginning of the new millennium faces two simultaneously occurring developmental tendencies, mostly opposing but at times also mutually reinforcing. One is the tendency toward integration, the other toward fragmentation in the areas of socio-economy, culture, politics and science. Some features of these dynamic processes are particularly noticeable in the dismantling of the former social order in Central

and East European countries and its replacement by what some consider to be "wild capitalism". Integration is fostered by the emergence of one superpower, capable of exerting significant influence on the rest of the world through economic and military means and enforcing globalisation based on revolutionary advancement in computer-assisted information exchange. Great overall progress has been acclaimed in technology with a rapidly increasing power of supranational corporations. As these processes are instrumental in deepening socio-economic inequalities between, for example, the North and the South, many countries witness increasing resistance and protests against policies of monopolizing and hegemonic character and against attempts to limit their sovereignty – all stemming from conflicting political, economic, cultural and national interests. This, in turn, evokes aspirations for new independent states to arise and for nationalistic and separatist tendencies to grow. These are followed by attempts to form regional or even continental-wide alliances and unions assuming, first, unification and standardisation of legislation, technological and trading regulations, and, second, making their structures and judicial regulations uniform, in order to facilitate integrative processes and promote greater equilibrium of power in the world. Many countries differ in terms of scope and speed of these processes, but they also share some features characteristic of changes in particular domains, including culture and science.

We are primarily interested here in the course and directions of future developments in medicine. During their own lifetime, everyone is confronted with suffering, pain, illness, disablement, and death, and therefore expects medicine and professionals practicing it to provide support, assistance, cure and understanding. This results in questions about how and to what extent these expectations will be met, how medicine can deal with fulfilling its humanitarian tasks, and how it will formulate and realise its social functions.

It is possible to predict substantial impact of the following: increased commercialisation of medical services, growing role of cost-efficiency, decreased financing of the public sector by the state and relinquishing some functions of the state in the area of health policy, as well as progressing standardisation of diagnostic, therapeutic, rehabilitative and research methods, accompanied by the growing appeals to the members of the society to change their lifestyles and take responsibility for their own health and well-being. Another set of influential factors includes modifications in scientific paradigms and spectacular achievements in natural sciences, especially biotechnology and psychopharmacology, visible in the production of new vaccines, hormonal preparations, biologic stimulants, drugs influencing cellular, immunological and reproductive processes and also – the general sanitary and hygienic state of the environment. These achievements counterbalance demographic and ecological threats, contributing, at the same time, to the growing role and significance of pharmacological industry and pharmaceutical corporations. Another problem posed by technological progress in diagnostic and therapeutic procedures, reparative and constructive medicine (e.g. transplantations) is the need to introduce changes in the model of education of medical personnel.

Changes in the structure of the morbidity rate of different illnesses are primarily

determined by the following factors: the extension of the average life-span, the increase in the percentage of population over 65 years of age, the growing number of people suffering from chronic systemic diseases and patients requiring continuous care, the emergence of new infectious virus-inflicted diseases, the increase in the number of victims of road and other traffic-related accidents and the victims of military conflicts and natural disasters, and the growth in the number of people addicted to various substances, including pharmacological agents.

These tendencies will naturally result in the changes and modifications in the organisation of the existing systems of health care and its functions to make them, on one hand, more cost-efficient, and on the other – able to satisfy the basic needs and expectations of the ill and their families. It can partly be achieved by introducing changes in the style and form of services rendered, for example - a broader acceptance of alternative methods of treatment and their practitioners, accompanied by a more tolerant attitude toward them on the part of academic teachers and institutions. Such cooperation, however, is preconditioned by a systematic contact of organizers and providers of medical services with nongovernmental agencies, including those representing patients and their families, the local governments, and public opinion representatives.

The realisation of these postulates may bring the following positive effects:

- First – amelioration of the health state of significant population groups, particularly in the developed countries, and a higher quality of life of some groups of chronic patients;
- Second – elimination of some "old" diseases and better results of treatment of others (AIDS, Ebola, SARS, SHE, Alzheimer), as well as prevention and elimination of some risk factors (smoking, accidents, obesity, unhealthy diets, pollution);
- Third - introduction of more effective and less expensive pharmaceutical products, more efficient technological equipment, progress in reparative, prosthetic and rehabilitative medicine, and, generally, diminishing the suffering, disablement and pain accompanying many degenerative and system diseases;
- Fourth – greater awareness and knowledge of 'biopsychosocial' model of health and pathology and its implementation in medical education and clinical practice;
- Fifth – more consideration given to ethical and moral issues connected with the new possibilities in medical science, which both pose challenges but also offer new chances, due to popularising medical science through discussions at interdisciplinary meetings, in the medical and general public contexts;
- Sixth – easier access to medical services and help in many underdeveloped countries, though frequently accompanied by attempts to limit this accessibility only to some groups of people.

But one can also foresee negative effects, which fall, in my opinion, into three distinct groups:

- Underestimation and disregard for the consumers' expectations as to more partner-oriented changes in the relations between patients and medical personnel, greater understanding of psychological needs of the ill, less object-oriented and more humanitarian approach of the medical staff, directed at the more individual treat-

ment of patients;
- Greater commercialisation of medical services naturally connected with differentiation of access to medical help;
- Hindering creative and innovative thinking and acting of the personnel by promoting and fostering standard procedures, regulated and imposed through rules and regulations, as well as not taking into account the necessary hermeneutic understanding of individual patients and being guided by the analysis based on biopsychosocial integrative model, aimed at counteracting discrimination, manipulation and exclusion.

What is alarming in this respect is the visibly growing tendency to select patients through differentiation of the quality of services accessible to the rich and the poor in rich and poor countries, thus creating a two-class system in medicine. It is particularly noticeable in making accessibility of health services based on such criteria as age, gender, ability to work, ethnic origin, level of education, and social status. These practices may lead, first, to the propagation of neo-Darwinian concepts of utilising new genotechnologies to breed 'better' and degrade 'less valuable' human beings, and, ultimately, to revitalisation of some past but well-remembered theories and their applications not rejected by all psychiatrists, especially German ones.

At this point, I would like to cite my own questions, which were formulated a few years ago, but which still seem valid and relevant:

- Can we be hopeful that technological and socio-economic progress will eliminate at least some of the difficulties and barriers on the way to the emergence of the optimal health care system, based on the ideal health model?
- Is it possible that the progress in microelectronics, the introduction of more efficient and effective computers, robots and automatic equipment will eliminate determinants of ill-health related to work and unemployment, poverty, abuse of drugs and unhealthy life-style?
- What will be the results of ongoing technological progress and advancement in the area of non-invasive procedures?
- Will people become healthier once the following are possible or improved: transplantation of organs; construction of prostheses supporting the damaged motor- sensory, and neuropsychological systems; external piloting and control of behaviour through electrodes and modules implanted in the cerebrum; production of more effective substitutive substances, regulating and stimulating biochemical and immunological processes; achievements in biotechnology: genetic treatment of diseases, cloning, in-vitro fertilisation and reproduction, as well as contraception?
- Is it likely that the considerable progress in the promotion of healthy life-style, diagnostic, therapeutic and rehabilitative procedures, but also acceptance of voluntary and judicially legitimated euthanasia and assisted suicide, will solve most health problems and fulfil the dreams about happiness and high quality of life of individuals and whole societies?
- How far can we intervene in and interfere with nature?
- Can the indirect contact through audiovisual means substitute or replace the direct

face-to-face contact between a patient and a doctor?

One could multiply such questions – some of which seem quite rhetorical – but it is evident that although future discoveries and inventions may have tremendous effects on the developments in medicine, finding answers to these, and many other questions, might be a long, difficult and painful process, accompanied by numerous and dramatic ethical and moral dilemmas.

In this context, it is most recommendable to make an attempt and discuss the state and prospective developments of psychiatry, in which similar processes take place, with the noticeable differences between psychiatry and other branches of medicine being merely a matter of range, character and pace.

These processes have been dramatically influenced by the impressive progress in science and some turning points of socio-economic and political nature in the past 50 years. The major role may most probably be assigned to the following: better knowledge of biological determinants of pathology, progress in genetics, in psychopharmacology and medical technologies; explicit evidence for the validation and specification of the significance of the brain centres for the functioning and coordination of cognitive, affective and behavioural functions. Additionally, new methods of imaging, by allowing to localise and trace the dynamics of physiological and biochemical processes in the brain, corroborate their importance in mental functioning, thinking, perceiving and feeling, as well in improving adaptive mechanisms. They allow us to verify changes induced by, for example, psychotherapies or traumas. These research methods, by availing themselves of new instruments, increase both our knowledge and possibilities of its application to influence and modify brain functions and personality traits; they confirm that the central nervous system and mental processes and consciousness have decisive significance for the formation and development of a human being, his/her psyche and soma.

One cannot doubt that these neurobiological discoveries contribute to bringing clinical psychiatry closer to other branches of medical science and also to making it more similar. They are also crucial in facilitating integration clinical psychiatry with medicine, in a more holistic approach to a human being and his/her psychophysical unity, and, ultimately, his/her relation and interaction with the social, biophysical, chemical or ecological environment. Its value is undisputable, since research provides evidence that the interaction of genetic and environmental factors is of major importance for the aetiopathogenesis of many mental disorders. Still, many doctors remain convinced that further progress of medicine is strictly related to achievements in biological science and that social sciences and humanities play a secondary role, with a hermeneutic approach being quite insignificant. The model of medical education and training and the resistance to change reinforces the preservation of this reductionist type of thinking.

In the area of postgraduate education, one may observe growing tendencies to apply to it free-market criteria, which results in treating it as a financial investment, the cost of which must be in future reimbursed by the patients.

The problems presented above stimulated an ongoing and heated discussion in

American professional journals on the prospects of psychiatry and the role of psychiatrists and psychologists. Two opposing views are evident:

- Proponents of the first one (Detre, Rush, Liberman) are of the opinion that American psychiatry has been primarily concerned with problems of non-medical nature, fulfilling mainly psychosocial tasks. As psychiatry is being increasingly integrated into the mainstream of medicine, the role of market forces ("managed care" and standardisation) is growing and the function of hospitals is changing, psychiatrists are expected to relinquish some of their clinical functions in order for those to be undertaken by less-paid medical personnel, e.g. psychologists, social workers and advisers, etc. Psychiatrists should become specialized neurologists, which means that there ought to be a new specialisation within neurosciences in order for psychiatry to survive. This specialisation should take into account the character of the population undergoing treatment, the kind of diagnostic tools and treatment methods being applied, as well as social and professional functions, education and skills.
- Representatives of the other view claim that psychiatrists should treat and take care of the ill with complex disorders of chronic character, they ought to base their diagnosis on the verbal interaction with patients, phenomenological descriptions, empathetic interpretation/comprehension of feelings, thoughts and behaviour of the ill, and the application of psychopharmacotherapy.

These are the extreme positions and it seems that most psychiatrists will combine these two models in their clinical practice, particularly in fulfilling the role of the members of interdisciplinary working teams and consultants to other specialists, thus acting as important 'liaison' professionals. The conditions and the character of their work, however, could change considerably if they consciously tried to lower the costs of medical services and followed clearly defined medical procedures and made these the focal point of their activities.

An attempted description of the changes to have taken place in psychiatry in the past 10 years in not an easy task, because it is tempting to treat it one-sidedly, emphasising and exposing either its positive or its negative aspects. Let us begin with a more favourable way of viewing and treating mentally ill patients by their environment. People are becoming – though very slowly – more tolerant of such patients. In many centres and hospitals the conditions and the equipment have been improved, the character of many psychiatric wards is not much different from other wards. There are better possibilities of diagnosis and treatment and bigger accessibility of foreign medical books and journals and international contacts for the medical staff.

There has been an increase in the partnership role and position of patients, and also in the supervision of how their rights, formalised by appropriate legal regulations (i.e. several bills on mental health), are observed. The non-governmental organisations have already become more active, showing more initiative and enterprise, and cooperating with associations of patients and their families. There has also been a relatively dynamic development of community psychiatry, which is not only favourable for the integration of patients with the local communities and emphasises the

socio-cultural factors in treatment and rehabilitation, but, in addition, it counteracts the discrimination and isolation of the patients. The mechanisms used to implement the latter focus on detecting and preventing negative influences of macro- and micro-economic determinants and consequences of such phenomena as bigger prevalence and higher incidence of psychiatric disorders, increasing poverty and unemployment, delinquency, violence, suicides, abuse of alcohol and other intoxicating and addictive substances, eating disorders, unhealthy life-styles, difficulties in coping, growing feeling of apathy, resignation, helplessness and powerlessness.

Another sphere of recent activity has been the attempted reform of the health-care system and its services, including psychiatric ones. Some supporters of these reforms deemed them necessary because of the urgent need to improve the quality and accessibility of services and claimed that health expenditures grow many times faster than the incomes and that their further increase threatens the state budget. The means to solve this problem, in many countries undergoing transformation, was not to increase, but even decrease, the part of the gross national product allocated for health services.

Several factors have been conducive for this situation to have emerged: limiting the role of the state in the functioning of the public sector, introduction and propagation of free-market mechanisms in health care, increase in the technical demands and allocation efficiency, general adoption of cost-efficiency strategies and implementing them through diminishing costs and increasing profits. Resorting to these strategies on a wide scale, determined by the supply of medical services, must have and has a negative effect on accessibility, quality, and integration of health care.

Other areas of conflict are connected with the lack of satisfaction of the medical staff with the pay level and with enforcing the standard procedures, which quite often lead to violation of ethical rules. There is also a general feeling that the administrative staff and insurance agencies neglect the activities, roles, interests and prestige of particular medical groups – the attitude readily arising when the choice of the treatment method is decided on the basis of "less for more" rule, i.e. excessive emphasis of economic factors.

It should also be mentioned that this situation is made even more difficult by the role played at present by pharmaceutical companies, which, in an effort to enlarge their net profits, increase the prices, and whose activities may not be free from corruptive elements. High prices of medications more and more frequently prevent some patients from buying them, especially when the burden of covering the costs is on them by means of, for example, decreasing the real level of financing by the state budget or promoting privatisation in the form of enlarging the private sector and further commercialisation, leading to larger amounts of money drawn directly from pocket to pocket.

The control of local authorities over the funds and the position of insurance agencies, managed not infrequently by non-competent officials, as monopolists in the role of a third payer, lead to grave errors in establishing the scope of services to be rendered and contracting them. This endangers the health and general living conditions of patients. It is particularly evident in case of chronic psychiatric patients, because this policy results in the reduction of the number of available bed-places, overcrowding of psychiatric hospitals and the shortage of personnel.

By taking charge over some establishments by social care, some positive tendency is marked here by ensuring a considerable number of bed-places for the chronically ill. This, however, is often accompanied by closing down psychiatric health centres and open day clinics, worsening of the quality of out-patients' services due to reductions in time limits of treatment, staff quantity, difficulties in applying psycho-social methods, like psychotherapy, in treatment, and rehabilitation of acute and chronic mental disorders.

Prevention of both relapses and excessive hospitalisation becomes harder, because it appears to be pure fiction to ensure in practice the continuity of care by relinquishing the regional and sector-related responsibilities and adopting a deceptive procedure of 'money following the patients'.

The development of community psychiatry is threatened by low funding and the present situation on the job market, particularly in case of the work establishments for the handicapped, the number of which is systematically decreasing.

These phenomena become a barrier and a threat to the further advances in psychiatric reforms and some of its achievements. It seems that the evaluation and anxiety presented above are shared by numerous psychiatrists and psychologists in many parts of our country and voiced at national conferences. Here, I would like to quote the editor-in-chief of "Nowinki Psychiatryczne", T. Jaroszewski, M.D.:

"The work in clinics and hospitals undergoes changes, health centres crash, private practices multiply, the procedures of training and specializing have changed. We have to cope with new classification, documentation, rules, regulations, standards and Pharmacopeia. It is as though we are on a volcano. Things change all the time and information is hardly available. Its basic source is non-professional papers. And in our journals, full of scientific knowledge, there is dead silence in this respect. There is also silence, with hardly any discussion, at the general meetings of delegates of the Polish Psychiatric Association, which convene every three years - there are only reports and hurried elections of board members. Are there no problems? It seems that without active involvement the entire psychiatric community in the discussion and in appropriate activities, the threats posed to psychiatry may continue to increase and that our community will be partly held responsible for this development."

And still two more quotes. The first one, of the former Polish Minister of Health, G. Opala – "Medicine becomes a business". The second, of the present German President, Johannes Rau, from 1998 – "The progress of medicine cannot cause social regress, it should not enlarge social inequality. […] Health cannot become the privilege of the affluent in our society or the privilege of the countries more affluent than the third world. It is the task far exceeding the scope of medical science".

I am convinced that we, psychiatrists, will do whatever we can for this truth to reach other politicians and societies, because it is one of the most important implications to make the Ariadna's thread stronger.