

Correspondence

The role of holistic, patient-centred research

I was struck by the article by Dr Crossley and its consideration of the tensions between being 'person centred yet scientific'.¹ We strive to provide patient-centred care within the framework of evidence-based medicine, although we try to ascertain that evidence base using structured, standardised processes.

Other thinking behind the patient-centred approach has been developed by Fulford, expanding arguments surrounding the concept of disease.² In his model of the 'balanced or full-field model of health care' he examines the balance between the objective concept of disease and the subjective concept of illness. In these, he states, there is a tension between the views of the patient (who is subjectively experiencing the feelings and complaints of being ill) and the doctor (who takes the role of the expert in the area of disease, an objective, scientific concept).

If we want to emphasise the subjective experience of patients in our work, then I would like to suggest we increase our exposure to the subjective experience in research.

Categorising original research articles over two decades from the three highest-profile general psychiatric journals, rated by both journal impact factor and the proportion of psychiatrists reading them³ (the *British Journal of Psychiatry*, the *American Journal of Psychiatry* and *Archives of General Psychiatry*) showed that their focus is on objective research, with biological or epidemiological domains accounting for 70% of the articles published ($n = 5710$). When articles were rated using a narrow operational definition of whether their main aim was to study the subjective experience of the patient,⁴ only 2% (156 articles) met the criteria. Variables associated with subjective experience research (perhaps unsurprisingly) included psychosocial research topics (odds ratio (OR) = 10.2; 95% CI 7.4–14.2), and qualitative (OR = 34.6; 95% CI 5.74–208.7) and cross-sectional (OR = 4.2; 95% CI 3.1–5.9) research methodologies. It is likely that journals from other disciplines (such as the social sciences and psychology) would have more articles pertaining to the subjective experience of patients, as would psychiatric journals with explicit aims to publish articles relating to ethics and patient-centred care; however, British psychiatrists are less exposed to these than to the journals investigated.³

There is no reason why a subjective, values-based approach cannot sit alongside the objective, factual approach, and conflicts between values-based practice and evidence-based medicine are unnecessary. To be person-centred we must have a strong understanding of the factual evidence for our interventions, but also understand the patient's unique set of values and experiences. Evidence-based medicine promotes the integration of three key elements: best research evidence, clinical expertise and patient values.⁵ To do this effectively, patient-centred ethos should be applied when taking into account the illness experience, the person and the context in which the illness presents, to find common ground between both the physician's and the patient's perspective.

1 Crossley DR. Holistic psychiatry without the whole self. *Psychiatrist* 2012; **36**: 97–100.

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- 3 Jones T, Hanney S, Buxton M, Burns T. What British psychiatrists read. Questionnaire survey of journal usage among clinicians. *Br J Psychiatry* 2004; **185**: 251–7.
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- 5 Sackett DL, Strauss SE, Scott Richardson W, Rosenberg W, Haynes RB. *Evidence-Based Medicine: How to Practice and Teach EBM* (2nd edn). Churchill Livingstone, 2000.

Caroline S. Cooper, consultant psychiatrist, Pennine Care NHS Foundation Trust, UK, email: caroline.cooper1@nhs.net.

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Holistic psychiatry

David Crossley's paper on the self and holistic care¹ is timely in the context of the heated debate over the place of spirituality and religion in clinical practice. In a commentary on this paper, one of us (C.C.H.C.) raised the difficult matter of challenging unhealthy spiritual/religious beliefs.² In the course of making a point about the difficulties this entails, reference was made to a letter from a previously published correspondence between us,³ suggesting that one possible response might be to argue that 'matters such as religion and spirituality should be excluded from all clinical practice'. This gave the unfortunate impression that the authors of that letter had taken this position. We would collectively like to correct this.

We are agreed that it would be impossible to completely exclude consideration of religion and spirituality from all aspects of clinical practice. Psychopathology often has religious content, and it can be important to understand the role of religion and spirituality in an individual patient's life. We are agreed that it is sometimes appropriate to involve chaplains and other religious advisors in helping people who have mental health problems. We are agreed that psychiatry cannot offer total solutions to mental illness and human unhappiness, and that in practice psychiatry is the application of a flawed science in the context of shared (but sometimes contended) professional values.

However, there are important differences between us as to best practice, and as to the proper approach to spirituality and religion when working with patients. Our fundamental disagreement concerns the extent to which it is appropriate or possible for psychiatrists to offer holistic care to patients, spirituality and religion being one important aspect of this.

C.C.H.C. believes that spirituality should routinely be considered as an important aspect of clinical practice, even where the patient does not directly raise it for discussion, and that a spiritual dimension to treatment renders it more meaningful and possibly more effective. He recognises that this creates real and complex challenges with regard to professional boundaries. However, he believes that the special

expertise offered by psychiatry is at its best when actively engaged with a holistic perspective and that it is in such engagement that it becomes more apparent that psychiatry does not have all the answers. In this way, boundary issues are highlighted and the ensuing debate offers opportunities to reduce confusion and clarify good practice.⁴

R.P. and R.H. believe that the concept of holistic care takes psychiatrists out of a domain where they have special expertise and that 'holism' undermines the important role of other agencies and individuals in helping people with mental illness by implying that psychiatrists have all the answers.⁵ They believe that holistic care invites serious boundary breaches because it creates intrinsic confusion as to appropriate professional behaviour and the limitations of psychiatric expertise.

So far, this debate has been polarised and somewhat abstract. It would not be helpful to deny our differences, but we share an aspiration to understand the centre of gravity of professional and service user opinion on this matter by reference to tangible dilemmas in real-life practice.

Declaration of interest

C.C.H.C. is Chair of the Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists. The views expressed here are his own and do not necessarily represent those of the Group. He is Director of the Project for Spirituality, Theology and Health at Durham University, and is an Anglican priest. R.P. is an atheist. R.H. is a Buddhist.

- 1 Crossley DR. Holistic psychiatry without the whole self. *Psychiatrist* 2012; **36**: 97–100.
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- 5 Poole R, Higgs R. *Clinical Skills in Psychiatric Treatment*. Cambridge University Press, 2008.

Christopher C. H. Cook, Professorial Research Fellow, Durham University, email: c.c.h.cook@durham.ac.uk; **Rob Poole**, Professor of Mental Health, Glyndwr University, Wrexham; **Robert Higgs**, Consultant Psychiatrist, Mersey Care NHS Trust, Liverpool.

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Hindsight bias and the overestimation of suicide risk in expert testimony

In *Rabone v. Pennine Care NHS Foundation Trust* the Supreme Court examined the duties that the European Convention for the Protection of Human Rights and Fundamental Freedoms might place on hospitals caring for informal psychiatric patients.¹ We have grave concerns about the quality of the expert evidence presented to court in this case.²

Melanie Rabone was 24 when on 4 March 2005 she attempted suicide by tying a pillowcase around her neck and was admitted to hospital diagnosed with 'a severe episode of a recurrent depressive disorder'. By 14 March she 'had shown sufficient signs of recovery' to be allowed overnight leave, and on 18 March she was discharged to accompany her family on a

week-long trip to Egypt. On 11 April she was readmitted voluntarily after tying lamp flex around her neck. By 19 April Ms Rabone had again shown some signs of improvement. She requested leave and, following a meeting with her psychiatrist and mother where she agreed not to self-harm, 2 days' leave was granted. She spent most of the next day with her mother, but in the afternoon said she was going to see a friend. She hanged herself from a tree in a local park sometime after 5 pm.²

The court sought expert evidence as to whether there was a 'real and immediate' risk to the life of Ms Rabone on the day she was granted leave. The expert psychiatrist engaged by the claimants estimated that Ms Rabone's 'immediate risk' of suicide on 19 April was 'of the order of 70%'.² The Trust's expert was more conservative. He expressed the view that 'the risk was approximately 5% on 19 April (after leaving hospital) increasing to 10% on 20 April and 20% on 21 April'.² The written judgments do not record how these figures were arrived at, but it is hard to see how they could have been based on what is actually known about the likelihood of suicide by psychiatric in-patients on approved leave.

The suicide of psychiatric in-patients (including those on approved leave) was the subject of a systematic review and meta-analysis.³ Its results suggest that Ms Rabone's depressed mood and previous suicide attempts would have meant that she was more likely to die by suicide than another in-patient without those features. It is possible, using these empirical data and making an assumption of the base-rate of suicide among all in-patients, to calculate the probability of such a 'high-risk' patient's admission ending in suicide. Such a calculation, even with an extremely pessimistic base-rate assumption, reveals that the likelihood of a 'high-risk' patient dying by suicide while an in-patient is probably no more than 1.2%. Since Ms Rabone's admission lasted 10 days, it is hard to see how a realistic estimation of her risk of suicide on any particular day could have been much beyond one tenth of that – 0.12%. The experts' estimates, the more conservative of which was accepted by the court,¹ were between 40 and 600 times that figure.

We can only speculate as to how the experts arrived at their estimates, however, the most obvious possibility is that they utilised their clinical judgement based on reviews of Ms Rabone's file. Clinical judgement about the likelihood of future events is known to be affected by a range of well-established weaknesses including the failure to consider known risk factors, an inability to consider co-variation between risk factors, underutilisation of base-rate data, and a range of cognitive biases including confirmatory bias supporting an initial hypothesis.⁴ In this case though, the most potent influence was probably the tendency to see events that have already occurred as being more predictable than they were before they took place. This is referred to as hindsight bias and is one of the strongest and most ubiquitous of the cognitive biases.⁵

The Pennine Care NHS Foundation Trust was found to have failed to avoid a 'real and immediate' risk of death by allowing Ms Rabone home on leave when, the court reasoned, her doctors should have refused that leave. The court also reasoned that had she insisted on leaving against advice, her doctors could have, and should have detained her using the coercive treatment provisions in the Mental Health Act 1983. This failure, the court held, amounted to a breach of her human