MBBS

PRE-CLINICAL CPH/PPD/PSAH NOTES

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DISCLAIMER

All information within this document has been written using lecture slides/notes/past paper questions. Information is current from Sem 1 (07/08) onwards. All lectures and notes in this document are the full property of lecturers and staff at St. George's, University of London. This document is not intended as a replacement for revision, instead it is a mere aid for cramming this bland topic. The inspiration to produce this document began one boring day at SGUL Halls of Residence when A201-A206 panicked and began group PPD revision. Some parts of the document are rushed and may need elaboration and there may be a few typos. Good luck!

SEMESTER 1 & 2 – PPD

ETHICS: Long arm of the Law

Common (case) Law – occurs in the courts

Negotiable so can be altered over the years

Follows any previous cases in the same matter by taking similar action (where appropriate)

E.g. Airedale NHS Trust vs. Bland 1993, Consent law

In England currently no one can consent to treatment on behalf of an incompetent adult. Thus, when there is disagreement over treatment of an incompetent adult the Court is asked to make a declaration that the proposed treatment, or treatment withdrawal, is in the patient's best interests. In the case of children the Court may, in some circumstances, give, or withhold, consent to treatment for a child.

Quasi Law – the regulatory body sets out guidelines (GMC guidelines)

Statute Law – where the Queen passes the law & it becomes an Act (cannot be overruled)

Cannot be overruled, unless another Act overrules it

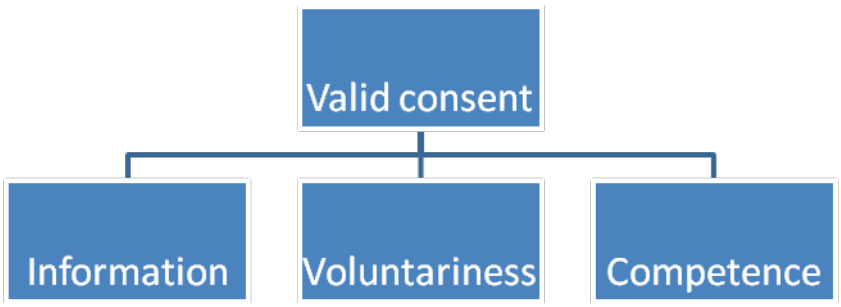
E.g. Mental Capacity Act 2005 – legal framework to make decisions on behalf of those who lack the capacity

ETHICS: Who decides?

Consent

Patient must not be pressured into making a decision either from family or from the doctor. They must be given the opportunity to say 'no'.

Consent means a **voluntary**, **un-coerced** decision made by a **sufficiently competent** or **autonomous person** on the basis of **adequate information and deliberation**, to accept rather than reject some proposed course of action (Gillon 1986)



Importance of consent:

- Legal requirement
- Respect patient autonomy
- Respect for persons
- Establishes relationships of trust with patient
- Benefits patient
    a. Subjectiveness of 'benefit' (e.g., Jehovah' Witness)
    b. More realistic expectations (pt. feels they are in control)
    c. More co-operation (e.g. they will fast before surgery)

Mental Capacity Act 2005 requires the following from a patient when making decisions about treatment:

1. Patient must understand
2. Retain information
3. Weigh up information
4. Communicate their decision

If a patient refuses beneficial treatment, the doctor must assess if the patient is COMPETENT and is giving VALID CONSENT.

COMPETENT ADULTS CAN refuse a life-saving procedure, even if this may appear irrational to the doctors. E.g. woman refusing life-saving treatment even if her foetus dies (surely irrational?) but her decision counts

<u>Exceptions where consent not needed</u>:

- Necessity: Where treatment is best option and patient is NOT COMPETENT to give consent
- Emergency: Dr must act (e.g. ambulance brings patient → hospital in A&E) to prevent harm

<u>Introduction to Ethical Practice</u>

When making **PRA**ctical decisions consider:

- Moral **P**erception – consider ethical dimensions which may not be apparent at first sight
- Moral **R**easoning – The 4 principles:
    - ◊ **Autonomy** – respecting the decision-making capacities of autonomous persons; enabling individuals to make reasoned informed choices (TRUTH/CONSENT/CONFIDENTIALITY)
    - ◊ **Beneficence** – this considers the balancing of benefits of treatment against the risks and costs; HCP should act in a way that benefits the patient
    - ◊ **Non-maleficence** –avoiding the causation of harm; the healthcare professional should not harm the patient. All treatment involves some harm, even if minimal, but the harm should not be disproportionate to the benefits of treatment
    - ◊ **Justice** – distributing benefits, risks and costs fairly; the notion that patients in similar positions should be treated in a similar manner
- Moral **A**ction – actually implementing the ethical practice independently (should do → must do)

ETHICS: Professionalism

Attributes of a HCP:

- Belong to an organisation (NHS)
- Exercise **autonomy** over their work
- Pledge assistance to those in need
- Possess 'esoteric' knowledge – deep knowledge understood by few
- Licensed by state

Duties of HCP:

- **Moral duty** – is it the correct ethical expression? (guilty)
- **Professional duty** – what does the regulatory body say (GMC)? (sacked)
- **Legal duty** – is it within the boundaries of the law? (jailed)

MODELS OF HEALTH & DISABILITY

Consider the bio-psycho-social model when interviewing patients with a chronic illness or a disability as this may be a particularly relevant to their condition/lifestyle.

Also consider patient-orientated care e.g. GP, district nurse, family/carer etc. – Primary Care Team

CONCEPTS OF PSYCHIATRY

Stigma:

Discrimination (Actively carrying out your views on X people)
Ignorance (Having slanted views on X people)
Prejudice (I hate X people)

Mental Illness – abnormalities of behaviour (related to abnormal/distressing experience)

Felt stigma → you feel that people discriminate against you because of your illness
Enacted stigma → when you are actually discriminated due to your illness

Psychosis – Unable to distinguish between reality and fantasy
Neurosis – You can make the distinguish between the reality and fantasy

ETHICS: Children

Minor – A patient below the age of 18

Consent for children

A minor aged 16 – 17 years old with a legal right can consent to medical treatment, and so the parents do not need to be asked (consent for certain procedures is not covered by this).
A minor aged 16 years old may consent to medical treatment provided that they have '*sufficient intelligence and understanding to appreciate the information and advice about treatment and what it involves*' – *Gillick v West Norfolk & Wisbech HA in 1986* (**Gillick/Fraser competency)**

EVIDENCE AND PRACTICE

As a doctor, you may be approached by drug companies who want you to use 'freebies' at the hospital/surgery which promotes their company – be wary of this considering (moral perception)

When carrying out evidence based medicine

Patients **I**nterventions **C**omparisons **O**utcomes	Mother arrives in surgery Monday morning Presents 5 y/o asthmatic son who was wheezy over weekend He was treated with a nebuliser in A&E Mother wants to know if she should buy a nebuliser for home use P – child with acute asthma attack I – does using a nebuliser to treat him work C – what is the difference between nebuliser and spacer device O – nebuliser will increase recovery, improve lung function, keep them out of hospital

To carry out a decision, use the Cochrane Library (database) which has a list of case studies. Research 'nebuliser use in asthmatic children,' and when presented with the results, assess the abstracts of each result to come to a conclusion about the course of treatment.

The **International Statistical Classification of Diseases and Related Health Problems** 10th Revision (**ICD-10**) is a coding of diseases and signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or diseases, as classified by the World Health Organization (WHO).

GMC – a legal body which deals with complaints about doctors **(police)**

Gives doctors general guidance on practising medicine and outlines the duty of a doctor, register the F1 doctors, to ensure the public receive suitable care. Although guidance produced by the GMC creates no legal duty, it does carry weight in law and the Courts have recognised the importance of such guidance.

BMA – group of doctors, philosophers, lawyers, theologians and lay people **(family)**

The BMA has a medical ethics department that answers individual ethical enquiries from doctors, and produces guidelines and books on ethical issues.

PSYCHOLOGY OF MEMORY/LEARNING

Three stages of memory:

Encoding (putting info in memory) → Storage (maintaining info.) → Retrieval (recovering info.)

Atkinson-Shiffrin Model (1968) for the structure of memory
STM: working memory
LTM: requires consolidation

Short Term Memory:

- Need to attend to a stimulus
- Encoding occurs but limited capacity chunks
- Info is active when conscious

Long Term Memory:

- Can last for life
- Requires **consolidation** of info
- Involves the hippocampus in the brain
- Info needs to be retrieved

Retrieval may require cues. At the point of encoding, if you categorise and organise the info to be stored, it is more easily retrieved. Forgetting is when there is a retrieval failure.

Implicit memory (non-declarative/procedural) e.g. motor skills "draw the shape"
Explicit memory (declarative) e.g. verbal skills "describe the shape"

Forgetting is decay, displacement, retrieval failure or interference.
There is different memory for facts (explicit) than skills (implicit). In amnesia motor and perceptual skills are preserved. Semantic knowledge is spared but episodic memory is disrupted. Anterograde: inability to learn new things, whilst retrograde: is inability to remember old memories before the injury.

Classical conditioning
Acquisition → Reinforcement → Extinction → Spontaneous recovery → generalisation

e.g. A loud noise is played at the same time that a rat appears, this process scares a baby. This sequence is carried out in front of the baby several times. Eventually the sound stops playing and the only the rat is shown. The baby makes an association and is still scared with just the rat and not the noise.

Classical conditioning can be intervened by systematic desensitisation. This is quite obvious, and an example can include a gradual exposure. E.g. arachnophobia – you would present small spiders, and as the person becomes more confident you get a larger spider and so on.

Operant Conditioning (operate)
e.g. A bird in a box. When the bird speaks it receives a seed through a chute. When the bird stops speaking and moves in the box, the chute closes. The bird soon realises that it must earn the seed by speaking (type of behaviour exhibited in circus animals).
This type of conditioning can be used in help groups or to modify behaviour, such as Cognitive Behavioural Therapy

STRESS, ILLNESS & COPING

Stress, a distinction needs to be made between:

- **stressors** - external events that may cause stress (e.g. life events, daily hassles, chronic stressors).
- **stress responses** – behavioural, emotional, cognitive, physiological responses to stress
- **strain -** the effect of stress on a person.

Theories to the approaches to Stress:

1. The General Adaptation Syndrome – focuses on the response to stress

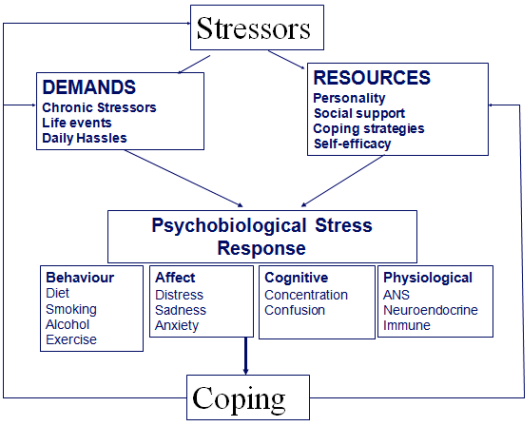
Alarm, the fight or flight response mobilises the body to defend against the stressor.
Resistance, if the stress continues, the body goes into a stage where arousal remains high and the body tries to defend/adapt to the stressor
Exhaustion, where physiological resources are very low, the ability to resist may collapse, and disease or death may result
-ve: stresses of same magnitude (milk gone=no phone battery=ran out of food i.e. all stresses same)
-ve: does not consider cognitive appraisal of a person's response to stressors e.g. Person A knows there is an escaped criminal and Person B does not. They live separately. There is a noise in the garden of both Person A and B. Person A is more alert and scared as they are aware of the existence of an escaped criminal, whereas Person B does not know this information. So, Person B is not alarmed by the noise.

2. Life Change Model / Life Events approach – focuses on stress as a stimulus

Accumulation of life events and continuous adjustment is then thought to have an effect on health. To measure stress, you can count the number of events that have occurred in a period to an individual. Examples of life events are death of a spouse, divorce, marriage, retirement, a new family member, changing jobs, injury or illness etc. Research has found that life events are associated with many illnesses, such as heart disease, cancer and depression. Questionnaires which the patient ticks on a scale and then if the overall rating is high, then this predisposes the person to conditions.
-ve: (milk gone does not = the same stress as no phone battery...I can grade individual stresses)
-ve: you don't know if fighting with family = High BP *or* due to the death in the family = High BP

3. Transactional Model – focuses on stress as an interaction

The demands do not match the resources. Perceived demand of the stressor can be balanced by person's ability to cope. Ability to cope can include coping strategies, changes in personality or support. When perceived demands outweigh perceived resources this results in the psychobiological stress responses. The individual then tries to cope and the results of these efforts may affect the stressor, or the perceived demands and perceived resources.



For example, examinations are stressful for most university students; a student who copes by revising thoroughly will be more confident in their ability to pass so the exams will appear less threatening. In contrast, if a student copes by avoiding thinking about the exams and not revising or preparing for them, then the threat of the exams will increase as they draw nearer.

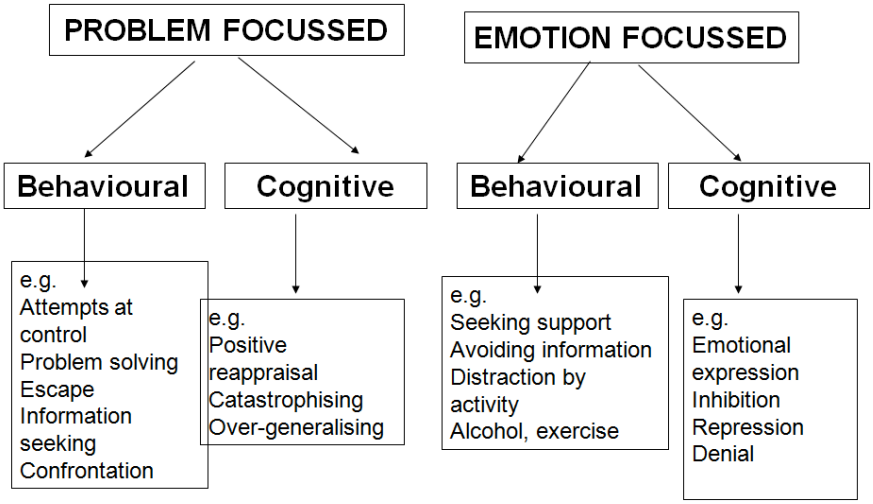
-ve: acute stress cannot cope car crash, but you can deal with a long term relationship

Coping

How individuals cope with health events is very varied and is affected by differences in the type of health event faced, the course, prognosis, and individual differences in resources and coping styles.

Individual differences in coping style are typically divided up into:

- **Problem-focused coping:** coping with the stressor itself.
- **Emotion-focused coping:** coping with the emotional reaction to the stressor.



<u>Acute Health events:</u>

- Predictable acute events – allow some control through allowing time for preparation and the development of effective coping strategies; e.g. elective surgery and childbirth. This type of event is more likely to involve a gradual increase in anxiety towards the event

- Unpredictable acute events – have sudden onset and are controllable; e.g. heart attacks or accidents. **Horowitz' theory of traumatic stress responses** suggests that initial numbing or denial is adaptive in situations where the person is unable to cope with the information or threat of the stressor and becomes overwhelmed. Horowitz proposes that when information remains unprocessed it is 'active' and when ignored or avoided it will intrude on

consciousness in the form of intrusive thoughts, flashbacks, or nightmares. These intrusions encourage the person to process the information in manageable stages.

Chronic Health events:

Moos & Schaefer (1984) proposed a **crisis theory of coping** with chronic illness, which assumes that we need a social and psychological equilibrium.

Social = Psychological → Negative event (diagnosis of chronic illness) → Social ≠ Psychological

In this state of disequilibrium people are susceptible to outside influence and this is a point at which HCPs can make a constructive impact. Equilibrium is usually re-established within a few days.

However, in chronic illness this may be a very tentative equilibrium, which can be shattered at any moment by setbacks or other stressful events.

When faced with the demands of chronic illness, patients have to make large adjustments (Moos & Schaefer). They need to:

- Adjustment to symptoms and incapacities of illness
- Adjustment to treatment procedures and hospital environment
- Developing and maintaining relationships with health care providers
- Preserving a reasonable emotional balance
- Preserving a satisfactory self-image and a sense of competence and mastery
- Sustaining positive relationships with family and friends
- Preparing for an uncertain future.

Chronic illnesses therefore hold considerable difficulties in adjustment and coping and there is some evidence that coping strategies can influence the course and progression of certain diseases. The enormity of these tasks, coupled with the emotional distress brought on by chronic illness means that these patients are at very high risk of depression. For example 20% - 50% of RA patients are severely depressed. Contrast this with postnatal depression, which is much more commonly recognised but only occurs in 12% - 15% of women.

Acute Predictable Event (e.g. elective surgery)
Show a reduced response to stress
Acute Unpredictable Event (e.g. heart-attacks, accidents)
Show a greater response to stress

Type A Behaviour – (Pissed off) – **Hostile/Impatient/competitive** *(learn these exact words)*
Type B Behaviour – (Relaxed) – **Self-evaluative/imaginative/creative** *(learn these exact words)*

INTRODUCTION TO HEALTH PSYCHOLOGY

Psychology (Ψ) is the formal study of normal and abnormal behaviour using systematic measurement and experiment, among representative samples.

Models of health & illness:
Bio(medical) model: Health and illness can be explained purely by disturbances in physiological processes (e.g. resulting from injury or biochemical imbalances)

Bio-psycho-social model: Health and illness affect and are affected by physiological, psychological (e.g. coping mechanisms) and social factors (e.g. social norms).

The most common research designs are:

- RCTs – e.g. effect of stress management training on pain reduction
- Longitudinal surveys (e.g. do higher levels of physical activity in pregnancy prevent the onset of depression)

Main Areas of study

- Health/Clinical Ψ: psychological illness
- Developmental Ψ: psychological development
- Neuropsychology: behaviour and neurology
- Social Ψ: interaction between individuals
- Cognitive Ψ: human information processing
- Occupational Ψ: psychology in the workplace

Health Psychologist are often Clinical Psychologists who specialise in helping individuals who are suffering from psychological consequences of physical illness or who need psychological help with managing a physical illness.

INTELLIGENCE

Intelligence is the general ability to understand and use information
Intelligent Quotient (IQ) is the index of intelligence derived from intelligence tests

Intelligence can be determined by the following:

- poor childhood nutrition
- exposure to environmental toxins (lead)
- exposure to certain drugs in utero (alcohol, cocaine)
- lack of exposure to an intellectually stimulating environment in childhood
- neurological injury or disease
- genetic disorders affecting brain development

LAY HEALTH BELIEFS

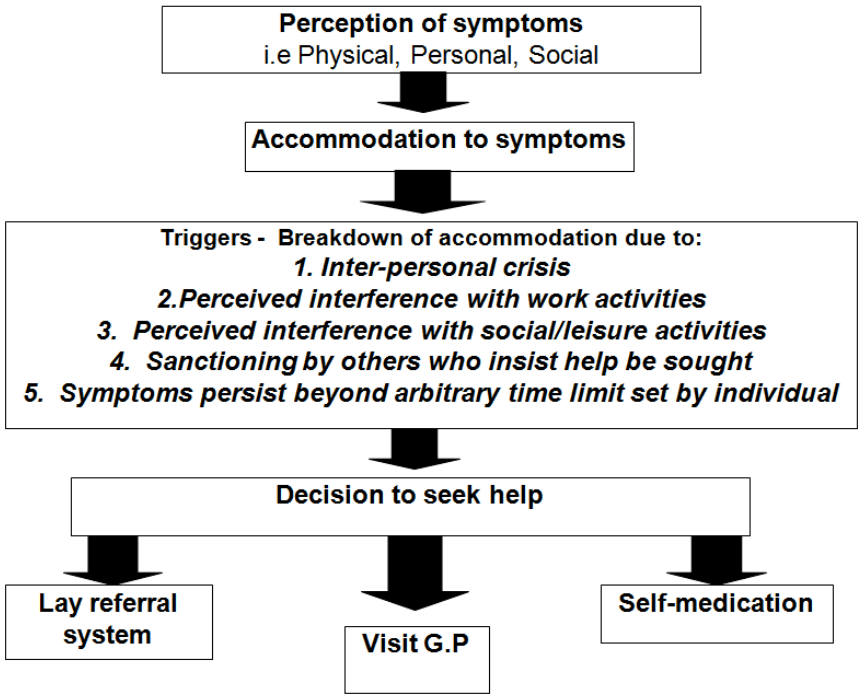
Lay-health beliefs are beliefs which the lay public hold, based on limited knowledge and from information passed on from word-of-mouth and other unreliable sources (Stacey 1988). The *Public Health White Paper – 'saving lives: Our healthier nation'* (1999) was produced by the DoH and described that patients have an active role in implementing lifestyle decisions which affect their health.

Sociological conceptions of lay-health beliefs

1. **Health as functional capacity (Blaxter 1982)**
   i. 'Health is the absence of disease' as well as 'health in disease' (Blaxter 1990).
   ii. Largely a working class conception, but also found in those with chronic ill health, who were less likely to define health in terms of illness.
   iii. Being able to fulfil social and work roles is the main criterion of healthiness
   iv. 'Never having a day's illness' is used as a (positive) moral individual characteristic.
   v. Seeing 'health as coping,' related to this health is the idea of health as 'reserve', as a 'cheerful stoicism', even when physically ill.

2. **Disease as candidacy (Davidson, Davey Smith & Frankel 1994)**
   i. Used in lay health beliefs of relative risk of disease and effectiveness of preventive health behaviours
   ii. Constructed from the appearance of the person and the circumstances surrounding the event
   iii. Can support or challenge biomedical aetiology
   iv. Identification of those 'disease candidates' retrospectively and/or predicatively i.e. "He was fit, skinny and young...He was the last person you would expect to have a heart attack"
   v. This is essentially teleological explanation of illness i.e. "there was a meaning or purpose underlying his/her illness"

Zola (1973) – five decisions which trigger seeking medical care, emphasises importance of lay referral system



People *actively* seek information from both multiple professional and non-professional sources. New technologies may extend and enhance the lay referral system. For example, it has been found that with information sourced from the Internet, people often make a provisional self-diagnosis that could be confirmed by telephone consultation (i.e with a nurse via NHS Direct), and so do not 'have to waste the doctors time'. This last finding demonstrates that in many ways that certain cultural assumptions and values around the sick role continue to prevail. So for example, callers to NHS Direct were found to be eager to preserve their status as 'deserving patients' i.e not to use up resources unnecessarily.

Expert Patients Initiative (DoH 2001) aims to recognise the intimate (and rational) knowledge and experience that patients have of their illness, and encourages patients to take an 'active role in their own care'. This in principle will lead to the development of 'user-led self-management programmes' concerned to increase patient 'self-efficacy' and enable them to take more control of their chronic illness condition.

LOSS, BEREAVEMENT, GRIEF

- Loss is important only if it is something to which we are attached
- The attachment gives us some security
- this may include the security of self esteem

Loss can be applied to things other than just people. Loss is an inevitable part of life, some people cope with it better than others, others find role change very difficult and some experience severe loss of self esteem with role change.

Bereavement: **state of having lost someone or something to which one is emotionally attached**

Grief: **the painful emotions associated with loss: sadness, anger, guilt, shame and anxiety**

Mourning: **psychological processes triggered by loss and process of recovery**

The closer one is with someone, the more vulnerable that person will be if they experience bereavement.

Acute Response to Grief – includes crying, hallucinations, agitation, aimless actions (up to 6 weeks)
Longer Term – social withdrawal, sleep disturbance, depressed mood (last 3 – 12 months)

Stages of grief:

STAGE 1 – numbness, shock, yearning (DISBELIEF)

STAGE 2 – searching, illusions (DENIAL)

STAGE 3 – despair, anger. (ANGER)

STAGE 4 – gradual acceptance. (ACCEPTANCE)

Pathological grief:

- Absent grief – Failure to display symptoms of grief
- Prolonged grief – initially seems normal LIKE NORMAL GRIEVING, continues with disabling severity beyond 'normal' duration, not showing *diminution* in depression or other 'symptoms' of grief 6 months after loss. Loss still centre stage in life 6-9 months on

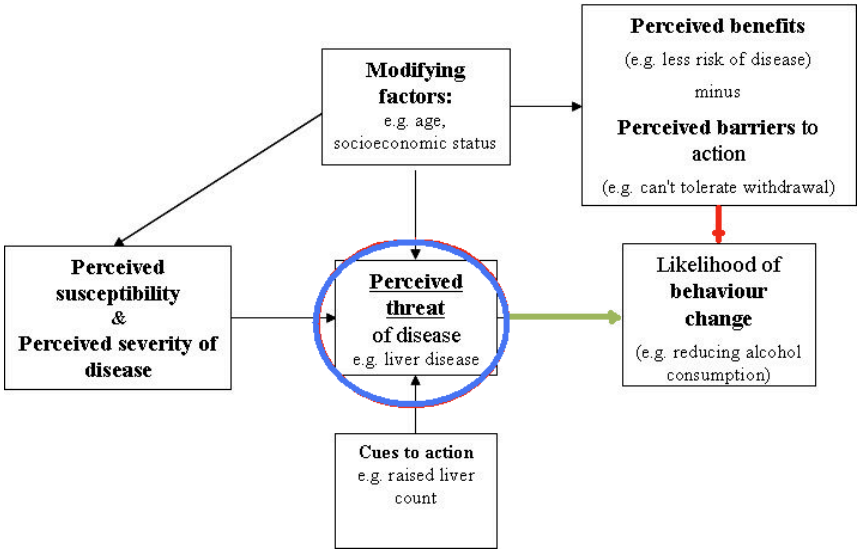
Immune response to bereavement includes HIGH levels of ACTH & Cortisol and reduced levels on Natural Killer (NK) cells.

HEALTH BEHAVIOUR

Health behaviours consist of any behaviour that has an impact on health, whether positive or negative. Several models have been proposed to try and account for health behaviours:

- Health Belief Model (HBM)
- Theory of Reasoned Action (TRA)
- Cognitive Dissonance Theory

Health Belief Model:

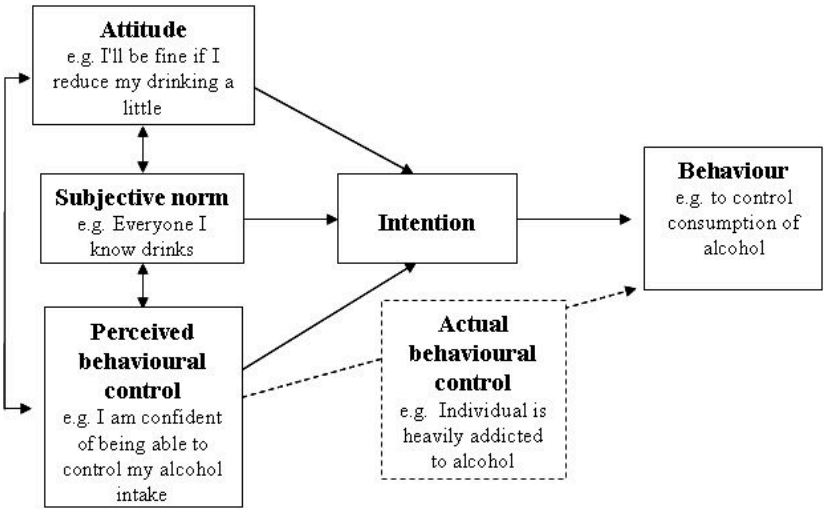


· Does not account for the influences of emotions & habits

· Ignores irrational health behaviour such as a delay in obtaining medical advice following symptoms.

· The influence of social norms is overlooked; for example, the desirability of drinking alcohol if your main social outlook is to visit the pub

Theory of Reasoned Action/Theory of Planned Behaviour:



- People do not always do what they intend, especially when the behaviour involves habits
- People might respond to a situation in the same way as they did in the past
- Anticipatory regret (alcoholic imagines himself worse off in a year, so he stops drinking)
- Moral principle (speed limit determines behaviour that you will not speed on the road)

Cognitive Dissonance Theory:

An example would be someone who is alcohol dependent and who holds the beliefs that 1) drinking excessively is bad for the health and 2) he/she is a heavy drinker. The resulting dissonance might be reduced in several ways:

· Changing one or both cognitions: e.g. convincing yourself that you feel much better when you are drinking, that the benefits outweigh the costs and that you do not drink as heavily as many people that you know.

· Eliminating one or both cognitions: e.g. Convincing yourself that the dangers of drinking are exaggerated.

· Avoiding thinking about the cognitions: e.g. Avoiding discussing your drinking problem.

· Adding a cognition that allows the two conflicting cognitions to be reconciled e.g. 'I will reduce my drinking in the new year' or 'I am addicted and it is out of my control'.

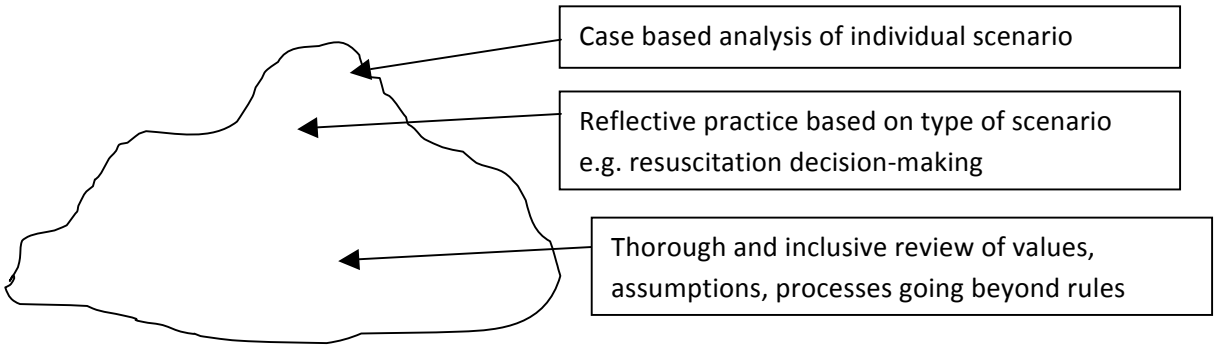
· Changing behaviour e.g. Reducing alcohol intake

SEMESTER 3 – CPH/PPD, PSAH

HOW TO ANALYSE A MEDICAL ETHICS CASE

Ethical analysis of any case is beneficial in the long term for the patient and the healthcare professional i.e. increasing efficiency, teamwork, reputability, morale... Perhaps when a professional is influenced by other colleagues he/she may not respond by the correct means of ethical analysis. Ethical analysis should be incorporated into everyday practice so it is an automatic response rather than a specific task in itself.

The ethical iceberg: decisions and actions are the tip (visible to all), systems and processes leading to action are just below the surface, environment and culture are the deepest part (values and assumptions unnoticeably shape practice).



Given *uncertainty or conflict about values* what decisions or actions are ethically justifiable and why?

Formulate an ethics question based on this scenario:

Baby P was diagnosed in utero trisomy 18 (Edwards Syndrome). His parents tell the NICU team they want 'everything possible' to be done for their son.

INFO:

- The survival rate of Edwards Syndrome is very low. About 95% die *in utero*.
- Of liveborn infants, only 50% live to 2 months, and only 5–10% will survive their first year of life. It is impossible to predict the exact prognosis of an Edwards Syndrome child during pregnancy or the neonatal period.
- The median life span is five to fifteen days. One percent of children born with this syndrome live to age ten, typically in cases of the less severe mosaic Edwards syndrome.

The information given for any decision making case can be subdivided into four categories:

1. Clarifying medical facts
2. Perceived and known patient/family preferences and interests
3. Identifying other parties' preferences and interests
4. Ethico-legal knowledge e.g. relevant codes of practice

The collated information must then be interrogated do determine its quality:

- What is known about the case and how?
- What is uncertain about the case and why?
- What are facts and what are values?
- Does everyone agree about the content of information in the case?

Apply the above to the case of the baby which has been diagnosed.

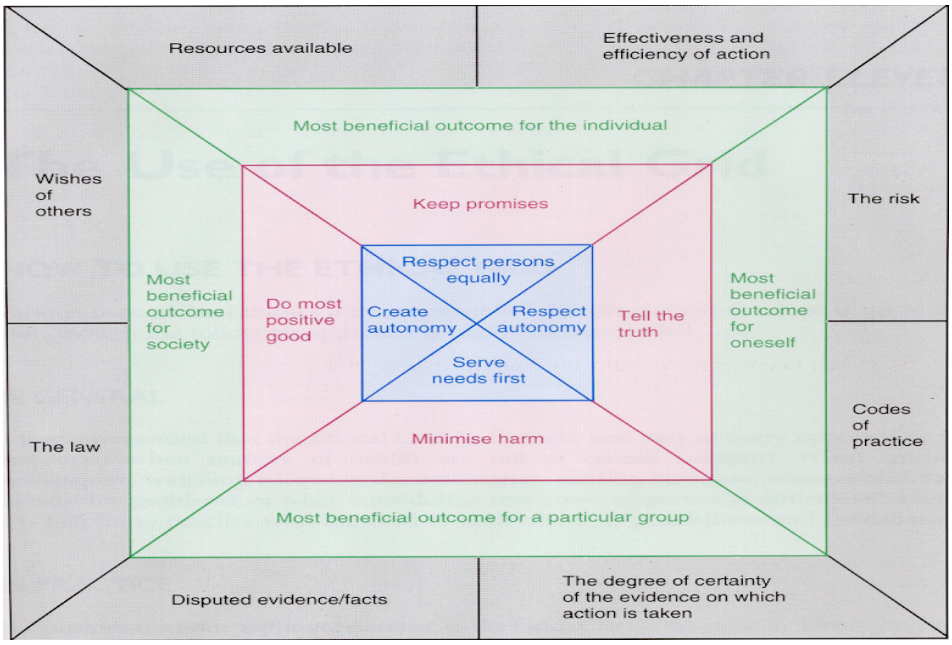
Emotion can influence the work of healthcare professionals, even implicitly. Emotion can change over time. E.g. in Scrubs JD is caring to patients but Dr Cox could not care less. Emotion is significant because it indicates the complexity of decision making to healthcare professionals. Ethics are shaped by emotions as is clinical practice. Awareness of emotion reveals values, differences and hierarchy of priorities. However, *there is no inherent moral worth in an emotion*. Different emotions will reveal different, and sometimes conflicting, values and not all will be positive e.g. embarrassment. Many clinicians recognise the phenomenon whereby emotion is less evident at the end of life as a career progresses.

Berry (2007) wrote of his own experience of a reduced emotional response to patients' deaths. Berry identified some factors which he thought explained why clinicians become emotionally detached in response to patient death:

- Instinct to separate oneself from suffering
- Unease and disappointment at therapeutic 'failure'
- Atrophying effect of perceived hopelessness
- Insincerities in establishing relationships with the patient and/or their families
- Inability to treat a sedated patient with human qualities

There are ethical models, some more relevant than others, which can be used in analysing ethical cases.

Seedhouse Grid



Structured Case Analysis (Bowman) Model

- Summarise the case
- State the moral dilemma(s)
- State the assumptions being made or to be made
- Analyse the case with reference to ethical principles
- Analyse the case with reference to consequences
- Analyse the case with reference to the virtuous healthcare practitioner
- Analyse the case with reference to the law
- Identifiable justifiable ethical solutions and those that are not justifiable
- State preferred approach with explanation

WHISTLE BLOWING AND MEDICAL ETHICS

Errors and mistakes are usually systemic, and they are rarely one-offs or due to poor performance. Errors are made by everybody. It is important to get over the blame culture so that mistakes can be identified are where relevant, be reported to agencies.

Clinical negligence has legal components:

- Must be a *harm*
- Must be a *duty of care*
- There must be a breach of the duty of care which will *cause* the harm

Bolam* v *Friern Barnet Hospital Management committee [1957] 2 All ER 118
Mr Bolam was given electro-convulsive therapy without being told risks, getting restraints or relaxant drugs. He flailed about during the operation and fractured his hip and subsequently sued the hospital. This case is used for assessing the appropriate standard of reasonable care in negligence cases involving skilled professionals (e.g. doctors): the "Bolam test." The professional represents themselves as having more than average skills and abilities even if others differ in opinion.

Bolitho v City of Hackney Health Authority [1996] 7 Med LR 1
This is an important English tort law case, on the standard of care required by medical specialists. A defendant doctor argues that they would not be able to have performed a procedure, while another doctor will conflict this reasoning. It follows the Bolam test for professional negligence, and addresses the interaction with the concept of causation.

Keeping notes and records as a doctor can be brought up in court in order to assess the quality of the doctor. Patient notes must be written appropriately (no humour, legibility, correctly dated etc.) so that if the patient were to access the notes, there would be no problems or complaints. Courts look at notes as a discrete heading in proceedings

If you **sign a prescription** (even on the advice of another) you are legally responsible
Four-fold duty to check:

- **correct patient name** and **drug name**
- **no comparative** or **absolute contraindications**
- **correct dose** and **directions given**
- make provision for **appropriate monitoring** and **follow up**

Health Act 1998, s 18(1) all working in NHS must provide a statutory level of quality
Clinical governance includes responsibility for monitoring clinical performance and ensuring clinical competence

In 1998, the GMC stated that doctors should report underperforming colleagues, but this naturally causes conflicts. It may be that colleagues who are *potentially* underperforming rather than *actually* underperforming that are disclosed. The next issue after identifying a colleague is the person/organisation to disclose this colleague to.

Public Interest Disclosure Act 1998 – Protects 'whistleblowers' from dismissal and victimisation

ACCESS TO HEALTHCARE: THE ETHICS OF DISTRIBUTION

About 15% of taxpayers' money is invested into the NHS. After the 2007 Comprehensive Spending Review, the expenditure for healthcare services was prioritised for: cleaner hospitals, greater GP access and innovation within the NHS. Resources invested to the healthcare are not always financial and also include: time, energy, bed spaces and personnel.

When making a decision there are at least three layers to consider:

Macro – how the overall cake is cut
Midi – how the healthcare budget is allocated
Micro – how clinicians are paid and how much money is spent on individual patients

Questions of allocation of resources involve a range of ethical considerations including fairness, respect for individual autonomy, responding to individual need and benefiting the whole population. Difficult choices have to be made where pressing claims are made upon a limited budget. For example:

- Those who are young and have a longer expected time of survival with treatment?
- Those who are parents with dependent children?
- Treating a greater number of patients rather than fewer patients with a greater need?
- Treatment that prolongs life or treatment that improves the quality of life?
- Established treatments rather than experimental treatments?

Recall the four principles Justice, Beneficence, Non-maleficence and Autonomy.

Justice [distributive] ≡ Equity ≡ Fairness

John Rawls puts forward a concept of a 'veil of ignorance' in his theory of justice. In this theory you are faced with a range of societies to live in. The only catch is that you do not know which position you hold in that society i.e. if you were old, a pregnant woman or a child. Rawls claims that most rational people would choose the society where the people who are most disadvantaged would be as well off as possible, so that if they turned out to be a disadvantaged person, they would have good treatment.

The Human Rights Act 1998 has several acts, which can be linked to allocation of healthcare:

- **Article 2** states that there is a 'right to life'. There is a positive obligation upon the State to ensure that this right is respected. The positive obligation under Article 2 must be interpreted in a way that does not impose an impossible / disproportionate burden on the authorities. Therefore, although the State cannot be expected to fund every treatment, it must act reasonably in allocating resources.

- **Article 8** right to private life

- **Article 12** right to marriage and children

- A refusal to fund medical treatment because of the advanced age of the patient could be a breach of **Article 2** and **Article 14** (prohibition of discrimination). **Article 14** would also be relevant where resources are not allocated for treatment on the grounds of gender.

QALY stands for **Q**uality **A**djusted **L**ife **Y**ear. Let us first consider what the unit of QALY indicate:

1 QALY	=	1 year of perfect health
	=	2 years of half perfect health
	=	4 years of quarter perfect health

When a patient is ill they have a rating of less than one, and any change in their health is reflected as either a rise or fall in the rating.

E.g.

Intervention A prevents certain death and gives two years of healthy life @ £5,000

QALY for Intervention A:

1 QALY = 1 year of perfect health
This treatment offers perfect health for two years
Therefore it is equal to 2 QALYs
So financially Intervention A gives 2 QALYS for £5,000
or 1 QALY for £2,500

Intervention B improves the quality of life significantly (from 0.7 to 0.99) for the last ten years of life @ £10, 000 / 10 years

N.B. – the patient is terminally ill and so cannot reach 1

QALY for intervention B:

Improvement of health (0.99 – 0.7 = 0.29)
10 year extension

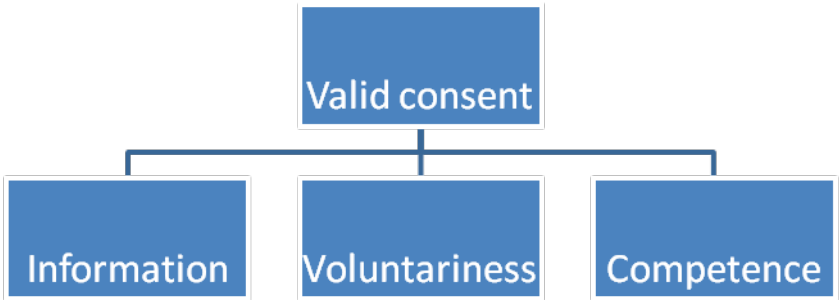
So QALY = 0.29 x 10
= 2.9 QALYs for £10,000 or 1 QALY (10,000/2.9) for £3,450

The general idea is that a high priority health care activity is one where the cost per QALY is as low as it can be. Also cost-effective analysis is important when choosing different methods of treatment.

CONSENT TO TREATMENT

Patient must not be pressured into making a decision either from family or from the doctor. They must be given the opportunity to say 'no'.

Consent means a **voluntary**, **un-coerced** decision made by a **sufficiently competent** or **autonomous person** on the basis of **adequate information and deliberation**, to accept rather than reject some proposed course of action (Gillon 1986)



Importance of consent:

- Legal requirement
- Respect patient autonomy
- Respect for persons
- Establishes relationships of trust with patient
- Benefits patient
    d. Subjectiveness of 'benefit' (e.g. Jehovah' Witness)
    e. More realistic expectations (pt. feels they are in control)
    f. More co-operation (e.g. they will fast before surgery)

Mental Capacity Act 2005 requires the following from a patient when making decisions about treatment:

5. Patient must understand
6. Retain information
7. Weigh up information
8. Communicate their decision

If a patient refuses beneficial treatment, the doctor must assess if the patient is COMPETENT and is giving VALID CONSENT.

COMPETENT ADULTS CAN refuse a life-saving procedure, even if this may appear irrational to the doctors. E.g. woman refusing life-saving treatment even if her foetus dies (surely irrational?) but her decision counts

Exceptions where consent not needed:

- Necessity: Where treatment is best option and patient is NOT COMPETENT to give consent
- Emergency: Dr must act (e.g. ambulance brings patient → hospital in A&E) to prevent harm

RACE & ETHNITICTY IN HEALTH AND ILLNESS

Ethnicity generally relates to some form of distinctive set of cultural characteristics. These can include common geographical and ancestral origins, language and cultural traditions. However, often other shared characteristics such as nationality, migrant status, religion and 'race' are used as substitutes for ethnicity.

There are two implicated concepts of ethnicity in use in the health care context:

- *Ethnic group* is **self-perceived identity and membership of a social group**. This is a conception widely used in survey research including the ethnic monitoring now being carried out within the NHS.

- *Ethnic origin* is **to do with a common ancestry or place of origin**. This conception thus focuses the question of ethnicity back in time and conveys a historical and frequently geographical context.

This approach assumes that ethnic boundaries are fixed and clear, yet in practice such boundaries are frequently fluid and imprecise.

> *Culture* - sets of **beliefs and ideas** that a **social group draws upon** in order **to identify** and **manage** the **problems of their everyday lives**.

Both ethnic and cultural boundaries may be constructed and maintained by social groups themselves. The label of ethnic difference is more usually imposed by the dominant groups in a society, who construct minorities as the 'other'.

`Race' like ethnicity is also a social construction which has no distinct genetic basis. The purpose of ethnic monitoring is to enable the NHS to achieve an equitable provision of services. However, problems emerge when putting both the concepts of race and ethnicity into operation. This process essentially constitutes 'reification' (making an abstract concept concrete or real) of ethnic origin producing a set of categories, for example `Other Asian' or `Other Mixed Background', which are purely artefactual and have no meaning outside the world of health needs planning.

Health professionals need to be sensitive to cultural differences, as well as to the complexities and dynamics of ethnicity. Such knowledge **can provide doctors with essential information** about a patient's beliefs and practices as they pertain to health and health care. Awareness of cultural difference can serve to ***challenge the stereotypes*** that can all too easily slip into a clinical assessment of a patient. Professional cultures and institutional practices in health care can play an important role in reinforcing and constructing norms of patient behaviour. It is usually ***ethnic minorities who are all too often identified as those groups falling outside of these norms – termed 'institutional racism'***.

SOCIAL INEQUALITIES IN HEALTH

The bulk of the inequality witnessed throughout human history results not from biological differences, but from social differences existing between individuals and social groups, and results from the structured social divisions of a particular society at a given time – *social stratification*.

Socio-economic class is used to investigate the effects this stratification may have for different social groups e.g. unequal 'life chances'. The socio-economic model of health adopts the broad position that social inequalities in health reflect differential risk exposure across the lifespan. This relative health risk is primarily associated with an individual's socioeconomic class position (see flowchart in lecture).

Most sociologists argue that the social class divisions of industrialised societies are fundamental to understanding the social and cultural dynamics of these societies. As Milner argues, "*class position...a primary determinant of cultural behaviour, attitudes and lifestyle, irrespective of the general `awareness' of class*" (1999:12).

Social class can be measured in a variety of ways; each method will reflect a different social theoretical position. The most common measure used throughout the 20th century until 2000, was RGOC, based on relative status of occupation.

`Registrar-General`s Occupational Classification' OLD

S/C 1 Professional i.e doctors, lawyers, higher managers

S/C 2 Intermediate non-manual i.e teachers, nurses, middle managers

S/C 3a Junior non-manual i.e secretary, technician

S/C 3b Skilled manual i.e carpenters, electricians etc

S/C 4 Semi-skilled manual i.e postman, farm worker

S/C 5 Unskilled manual i.e hospital porter, cleaner, labourer

The new official social classification measures (NSSEC), used from 2001 onwards, is based on occupation, but this is assessed in relation to skill levels but on employment conditions and relations.

The National Statistics Socio-Economic Classification NEW

1 Higher managerial and professional occupations

[1.1 - Large employers and higher managerial occupations] [1.2 - Higher professional occupations]

2 Lower managerial and professional occupations

3 Intermediate occupations

4 Small employers and own account workers

5 Lower supervisory and technical occupations

6 Semi-routine occupations

7 Routine occupations

8 Never worked and long-termed unemployed

Following World War II, the welfare state was introduced (NHS). This aimed to reduce mortality in the population. It was successful and over the following decades, there was a decrease in the death rate. However, on closer inspection the gap in death rates between upper and lower social classes increased.

The Black Report (1980) examined the association between social class and health, and indicated death the rate of disease incidence (morbidity) and the rate of incidence of death **were not randomly distributed** throughout the population. The report identified a number of types of possible explanation for this finding:

- Artefact – health results are a result of individual behaviour
- Social/Health selection – those with poor health are downwardly mobile
- Behavioural/cultural factors – focus on class differences in health beliefs and behaviour
- Material circumstances – social differences in income, diet, housing and working environment as key determinants of inequalities in health

The report found that it was **primarily material circumstances** that were the main cause of social inequalities in health.

Acheson Report 1998

This showed that since the introduction of the welfare state there was a fall in mortality but the greatest fall in mortality was in upper classes. Thus, some recommended interventions include:

- **Medical Care**
  - at level of morbidity to prevent early death
- **Preventative approaches**
  - to change individual risk
- **In workplace**
  - to improve psychological conditions
- **In social structure**
  - to reduce social and economic inequalities

Public Health Targets

- In the White Paper – *Saving Lives: Our Healthier Nation* (1999), the government committed itself to setting local targets for reducing health inequalities.
- In the *NHS Plan* (2000) national health inequalities targets to '*…narrow the health gap in childhood and throughout life between socio-economic groups and between the most deprived areas and the rest of the country*' (para 13.4).
- In 2001, the DH set out targets for the reduction of health inequalities as follows:
- Starting with children under one year, by 2010 to reduce by at least 10 per cent the gap in mortality between manual groups and the population as a whole.
- Starting with Health Authorities, to reduce by at least 10% the gap between the quintile of the area with the lowest life expectancy at birth and the population as a whole.

PHYSICAL ACTIVITY – Benefits, determinants & interventions

Physical activity is any bodily movement produced by skeletal muscle that results in energy expenditure. E.g. structured exercises (sports) or lifestyle exercises (walking)

Fitness is where an individual possesses a set of attributes that relate to their ability to perform physical activity.

Adults are recommended to do at least 30 minutes of exercise for five days in a week, at a moderate intensity. For children, it is recommended to do at least 60 minutes of exercise every day of the week, at a moderate intensity.

Levels of exercise can be measured either by self-report or objectively. Self-report include exercise diaries and questionnaires. Measuring exercise objectively can include the use of heart rate monitors.

Genetically have evolved from hunter-gathers and so should maintain an active lifestyle. Sedentary lifestyles are a recent thing and can explain the recent obesity epidemic, which are both due to patterns of behaviour.

Exercising is beneficial:

- CVS – reduced risk of CVD, reduced BP, reduced body fat, increased HDL and increased fitness
- Psychological benefits – reduced depression/anxiety and increased self-esteem
- Other benefits – reduced risk of cancer (colon/breast/prostate), increased immune function and increased bone mineral density

There are proposed mechanisms for the psychological benefits of exercise, which include: distraction, thermogenic, opioids and relaxation/stress management.

Being able to perform higher levels of physical activity includes:

- Male
- Non-smoker
- Low BMI
- Being young
- Greater belief/motivation/financial(moral) support for physical activity

Performing physical exercise can occur in several different ways: as an individual (good for flexible hours), group (good for morale), organizational (designated gym time for colleagues at work) or society (PE curriculum),

Several techniques can be put in place to help stay committed to an exercise programme. This can either be a contract at the gym, a personal trainer, a weekly/monthly target or a reward. When setting a goal it must be specific to an exercise (FITT – frequency, intensity, type, time). Also relapse procedures must be in place e.g. “If it rains I won’t jog outdoors, I will jog on the treadmill instead.”

PAIN: THEORY, ASSESSMENT & MANAGEMENT

Pain – primary symptom of injury or pathology and the most common medical complaint. To fully appreciate pain, one must consider psychological processes in addition to physiological process.

Theoretical approaches to pain:

Specificity model – **pain is directly proportional to the amount of tissue damage**. Pain receptors (nociceptors) would fire and pain would be 'felt' in the brain; nociception determining the extent of perceived pain.

Patterning theory – **pain is a result of patterns of neural transmission, as opposed to one pathway that is unique to pain**. Pain was believed to be the result of many inputs.

The Gate control theory (Melzack & Wall) – **allows for the influence of psychological factors via a neural 'gate' mechanism in the spine, which modulates the passage of pain information from the peripheral receptors to the central nervous system**. This theory accounts for why severe pain can be experienced without organic cause.

Multidimensional model of pain
Four component of pain:

- **Nociception/detection** (the neural detection of noxious stimuli)
- **Sensation/experience of pain** (e.g. throbbing, stabbing)
- **Emotional response** to that sensation (e.g. fear, tension)
- **Behavioural response** (e.g. limping, grimacing)

- *Pain threshold* – **level at which a stimulus is regarded as painful**. This appears to be relatively stable across people and cultures, although tension and anxiety can affect it.
- *Pain tolerance* – **the intensity or duration of pain that a person finds unendurable**. Typically measured as the length of time a person is prepared to keep their hand in a bucket of ice and water. Pain tolerance is highly influenced by culture, context, and psychological state.

Measuring pain
Pain can be measured either by self-report, by observing pain behaviours or by measuring physiological values. Pain varies along a number of dimensions, including intensity, duration and time course, rate of change and frequency. Response to pain is affected by the events which lead to the pain and the sensation of pain will be variable between different conditions.

Self-report measures are the most widely used measures of pain.

- *Simple measures* e.g. simple severity scale (1 to 10)
- *Multidimensional measures* e.g. McGill Pain Questionnaire which has 20 questions which identify all components of extent of pain
- *Computerised measures* e.g. use of visual animations to measure different pain sensations, such as a picture of a needle piercing skin. Individuals move the needlepoint to indicate the intensity of their piercing sensations. Useful if there is a language barrier.

Self report measures are not always useful as they are subject to bias/inaccurate recall and the patient may not include the whole range of pain/emotional response associated with the pain.

Observing the patient when required to carry out a task such as, walking in a line. The number of pain behaviours is recorded directly or rated overall by an observer. What constitutes pain behaviour has to be carefully defined; for example, there are:

- *Verbal behaviours* (moans, crying out, sighing, grunting etc.),
- *Physical actions* (limping, rubbing the injury, etc.) and
- *Postural indications* (not walking upright etc.)

The presence of the observer can change the type or frequency of pain behaviour displayed. Different observers may define behaviour in a different way (how strong does someone have to exhale for a breath to become a sigh?). Different conditions will have different behaviours (someone with broken legs will be unable to walk). Reliability between observers must therefore be considered.

Physiological measures tend to have more reliability than the previous two methods of measurement. Several measures include:

- EMG (muscle tension
- EEG (brain activity)
- Heart Rate
- Skin conductance
- Neuroendocrine measures (e.g. hormone levels)

These measures are influenced by other psychological and physical factors, such as mood, stress, diet and exercise. For example, increased muscle tension is related to anxiety, which in turn is strongly related to reported pain. Therefore muscle tension could reflect pain or anxiety, making interpretation difficult.

Psychological interventions can be applied to dealing with pain, such as behavioural or cognitive approaches (this is in the Psychological Interventions lecture).

INFORMAL CARERS

The Department of Health has reported that there were an estimated 1.72 million clients receiving services that were provided, purchased, or supported by CSSRs (Councils with Social Service Responsibilities) during 2004/5. Of these, 85% of clients received community-based (hospitals/nurseries) services following assessment, and the remaining 15% received residential-based services following assessment (care homes).

Care provided *in* the community is carried out by the statutory community services and care *by* the community, usually by immediate family, is known as **informal care**.

Community Care Act 1990 – introduced 'who provides informal care'
To help priority groups such as the dependent elderly, people with physical and learning disabilities, people with long-term mental health problems, **live as independently as possible**, either in their own homes or in residential care.

Under this act, LA social services departments (SSDs) have the role of `commissioners' meaning they must both provide services and purchases other services. SSDs and PCTs produce an annual care plan once having assessed the needs of the local area. The assessment is based upon the resources available and the needs of the patient. The Community Care Act also instructs that **a patient in need of community care must not be discharged until that resource becomes available**. This can however causes problems with regards to the number of free beds available.

The 2001 census found that there were 5.2 million unpaid carers of which the majority were female, who worked the following:

- 19 hours a week (68%)
- 20 to 49 hours a week (11%)
- 50 hours+ a week (21%)

Informal care spares the national health budget (£57 bn!), although its toll on the carer can be very great. Despite receiving a carer's allowance, the majority of carers were reported in a survey to be financially worse off. Another survey showed that the health of carers deteriorates over time which as opposed to someone not providing informal care. Carers looking after family members with mental health problems can be stigmatised as being responsible for contributing to the problem.

Assumptions underpinning State Policy

- Relationship between state and family i.e. introduction of the Community Care Act
- Changing role of family i.e. from extended family (Asians) → nuclear family (modern) so state welfare system provides care
- Role of women i.e. cannot assume that women will look after dependent, as they have equal opportunities and rights
- Culture i.e. cannot assume care will be readily provided to Asians, even if they know other Asians. Asian husbands are not providing sufficient support for their wives when looking after dependent-child. Even if you are Asian in the UK, does not necessarily mean that you will get informal care readily.

Carers (Recognition and Services) Act 1996

This legislation entitled carers, providing over 20 hours a week (32% see above), to an assessment of their needs.

In February 1999, the Labour government published its national strategy for Carers entitled *Caring about Carers*.

Carers and Disabled Children Act 2000

This was aimed at formally strengthening the rights of carers of disabled children to having an assessment of their needs as carers. Local councils were given more power to directly support carers and there was also a voucher scheme introduced to offer carers short breaks.

Carers (Equal Opportunities) Act 2004 (came into power in 2005)

Building on existing legislation that LA must inform *all* carers that they are entitled to assessment of their needs. This act placed emphasis on assessing the carers leisure interests during assessment and in developing a better relationship between the council and the health service.

PSYCHOLOGY OF PERCEPTION & MISPERCEPTION (include McGurk effect and Simon & Levin)

Perception and sensation refer to two different processes in psychology.

Sensation = process of detecting the presence of stimuli by sensory organs
Perception = recognition and interpretation of stimulus

It is through perception that we develop knowledge and understanding of the world.

Two major theories of perception:

- **Bottom-up** theory (proposed by Gregory) – recognition and interpretation of stimuli is a direct process that is determined by the information presented to the sensory organs. This basic information is then used to build a meaningful representation of the scene **i.e.** square is perceived as a square because it presents itself with four sides of equal length set at right angles to each other, by matching these features with stored information, perception can be used to objectively identify squares in our environment

- **Top-down** theory (proposed by Gibson) – simple sensory information is insufficient in explaining recognition and interpretation of stimuli. This theory argues that recognition and interpretation is an active process by our knowledge and expectation of the world **i.e.** looking at an optical illusion and spotting the image hidden, in future you will always notice the hidden image

Various methods have been devised in order to study perception. The key methods can be defined as the *behavioural* approach and the *physiological* approach. We will consider the behavioural approach, which focuses on the relationship between the physical properties of stimuli and our perceptual response to them. The two most widely used behavioural techniques are the phenomenological approach and the psychophysical method.

- Phenomenological method – this provides a useful way in which to obtain descriptive information. i.e. – say what you see

- Psychophysical method – this enables us to establish quantitative relationship between a stimulus and perception. Absolute thresholds: the minimum intensity required for the senses to perceive stimulation, at least half of the time

  Vision: a candle viewed from 30 miles on a dark, clear night
  Hearing: A watch ticking from about 20 feet away in a quiet room
  Taste: 1 teaspoon of sugar dissolved in 2 gallons of water
  Smell: 1 drop of perfume diffused around a small house
  Touch: The pressure of the wing of a fly falling on your cheek from about 0.4”

Visual perception and perceptual organization – despite the vast amount of sensory information that is present in our environment we are able to achieve a stable representation of our visual world. This suggests that our perception is highly organized. Some of the ways in which we do this are through grouping, perceptual constancies, depth cues, pattern perception and motion perception. Our perception is not always accurate, however, as the effect of visual illusions demonstrates.

http://www.faculty.ucr.edu/~rosenblu/VSMcGurk.html

Factors affecting perception (PEMPPAD)

Given that perception is to a large extent our *interpretation* of sensory stimuli it is unsurprising that we experience stimuli in different ways. Research has identified various factors that influence our perceptions.

1. Personality – people with different personalities show a tendency to behave differently in different situations. It also appears that some aspects of personality can have an effect on perception (e.g. introverts have more sensitive visual perception and are better at perceptual tasks that require sustained attention than extroverts.)

2. Emotion

Depression – people suffering from depression show a tendency to interpret ambiguous information negatively and report pain as being worse than people who are not depressed.
Anxiety – people suffering from anxiety show enhanced perception for threatening information.

3. Motivation

People are often likely to perceive information as relating to their needs. (e.g. Therefore, sometimes patients may overestimate the benefits of a particular treatment).

4. Perceptual set

Context, expectations and past experience all effect our interpretation of the perceptual information that we receive. We are prone to seeing what we expect to see and hearing what we expect to hear (e.g. If we are trying to stop smoking everywhere we look we will notice stimuli connected with smoking).

5. Physiological – perceptual abilities can be severely affected by injury or disease. For example:

Agnosia – individuals with this disorder are able to see accurately, but have an inability to make sense of visual information.
Fluent aphasia – results in production of fluent speech in the absence of the ability to comprehend words.

6. Attention: The vast majority of sights, sounds, etc., pass us by without becoming part of our conscious awareness. On the whole, in order for us to receive information we must pay attention to that which is most pertinent (e.g. clinicians must learn to discriminate the most vital information when making a diagnosis) **Simons and Levin scenarios**

7. Demographic

Age – perceptual processing changes with ages. Older people are less able to ignore irrelevant information and selectively attend to specified information than younger people.

Gender – males have better visual acuity in daylight conditions, while females' vision adapts more quickly to the dark.

Culture – individuals from cultures who take part in ceremonies that involve hanging from steel hooks embedded in their backs report feeling no pain. Less spectacularly, individuals from Western cultures appear to be more susceptible to visual illusions.

PSYCHOLOGICAL INTERVENTIONS

Behavioural Techniques – based on learning (e.g. classical and operant conditioning):

- ✓ Systematic desensitisation – based upon classical conditioning e.g. introducing spiders
- ✓ Relaxation – e.g. massage or meditation
- ✓ Biofeedback – e.g. an increase or decrease in BP
- ✓ Operant Conditioning – uses positive and negative reinforcement to change behaviour

Cognitive Techniques – focus on altering maladaptive cognitions and/or providing adaptive cognitions e.g. Rational Emotive Therapy (RET)

Rational Emotive Therapy (RET)

A – Identify **A**ctivating event
B – Identifying **B**eliefs and thoughts in response to **A**
C – Identify the emotional and behavioural **C**onsequences of **B**
D – **D**ispute the irrational beliefs
E – **E**ffect of therapy is to restructure the belief system to acknowledge rational and discard irrational beliefs

E.g. coping with pain – Distraction from pain, relabeling pain, distancing oneself from pain, changing the context

Cognitive Behavioural Therapy (CBT) – to improve self-mastery and reduce emotional distress

Cognitive and behavioural techniques are combined under CBT, usually lasting for 20 sessions.

Identifying maladaptive strategies →removing them →Teaching positive strategies for coping/managing

There are three stages:

1. Educational stage
2. Skills acquisition
3. Maintenance phase

CBT can be applied to chronic illnesses, pain and disabilities

Counselling – providing a supportive environment to help people through difficult periods

Stress Management

Encompasses both CBT and counselling techniques, and these are usually tailored to the individual's needs. There are three stages in stress management:

1. Understanding cause of stress
2. Developing appropriate skills/behaviours to cope
3. Developing appropriate attitudes and beliefs to cope

Stress management can be for one or all of the following targets:

- Changing the external cause of stress
- Changing the individual's response to stress
- Providing long/short term solutions
- Preventive or palliative

Stress management can be used to anticipate stress, to help people with ongoing stress (relaxation), or as interventions following a critical event (critical incident debriefing).
Critical incident Stress Debriefing (CISD) – designed for emergency services workers to cope with acute traumatic/stressful events e.g. meeting someone else who experienced the trauma (normalise). Structured educational and supportive group who meet up to work through the following:

1) Introduction – establish ground rules
2) Facts – examine factual accounts from victims
3) Thoughts and sensory perceptions
4) Emotional reactions
5) Normalisation/anticipatory guidance
6) Future planning and coping
7) Disengagement

Brief Intervention (FRAMES) – used to treat problems e.g. alcohol intake
Feedback about personal health
Stress personal **R**esponsibility for making change
Advice to reduce the problem or its manifestations
Provide a **M**enu of alternative strategies for changing maladaptive behaviour patterns
Empathetic interviewing style
Promote **S**elf-efficacy; this leaves the patient enhanced feeling able to cope with their agreed goals

PATIENT ADHERENCE & SATISFACTION

Satisfaction – the difference between perception of actual services vs expectations or ideals (Campbell & Einspahr 2001)
Adherence – extent to which patients follow the advice of the clinician (Sacket & Haynes 1976)
Non-adherence – the point below which the desired therapeutic effect is unlikely (Gordis 1976)

Factors affecting patient satisfaction:

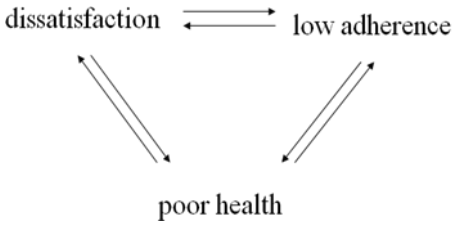
- Interpersonal skills of HCP (communication skills, patient centred approach)
- Technical quality (accuracy of diagnosis)
- Accessibility (distance from patient's home)
- Availability (waiting lists, choice of provider)
- Cost
- Physical environment (cleanliness, condition of room, quality of food)
- Continuity
- Health outcome
- Demographics

Measuring satisfaction:

- Surveys
- Interviews
- Questionnaires
- Focus groups
- Anecdotal evidence

The reason patients do not adhere to treatment is usually down to the following:

1. The health beliefs of the patient
2. The characteristics of the treatment regime
3. Communication between the healthcare provider and the patient

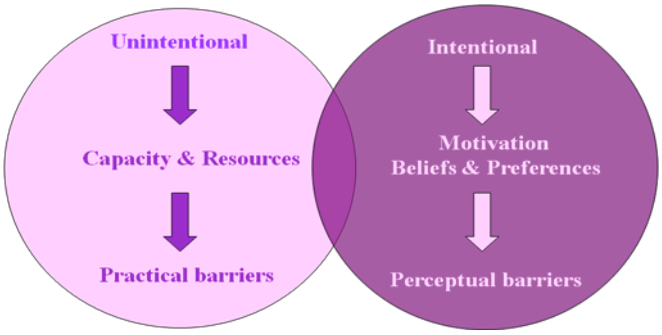


Consequences of dissatisfaction:

- Changing GP or hospital
- OTC medication with Prescribed medication
- Using unorthodox treatment
- Poor health status
- Low adherence to treatment (lack of compliance)

Measuring adherence:

- Self report
- Prescription refills
- Pill counts
- Physiological measure
- Health outcome
- Mechanical device
- Direct observation



Adherence can be increased by:

- Improving doctor-patient communication
- Providing CBT counselling
- Tailoring information to the patient
- Patient-centred approach
- Simplify treatment regimes

SOCIOLOGY OF MENTAL ILLNESS

Social causation: stressful 'life events' model

- Positive position which assumes that mental illness is an objective 'social-fact' and accepts as legitimate diagnoses e.g. schizophrenia
- Explains causes of mental illness epidemiologically (social construct)
- Identifies 'vulnerable' social groups who experience increased stress to be particularly at risk
- Negative correlation between social support and illness
- Stresses associated with poverty (e.g. no materialistic + no friends) pushes already vulnerable people towards psychosis

Social reaction (labelling theory and social stigma)

- When an individual does not conform to social norms and this behaviour is categorised as 'deviance'
- Mental illness is a clinical iceberg where many manifest symptoms of deviance, but very few are diagnosed as mentally ill. The more visible the symptoms the greater chance of being labelled as having a mental health problem
- This labelling process is dependent on what is acceptable in that society, and the only person who can label the individual is the psychiatrist
- Once the individual is labelled by the psychiatrist, they are stripped of their old identity and are given a new one which they internalise (master status)
- Stigmatisation of the individual then follows as a 'psychiatric patient'

Social constructionism

- Everyday knowledge is socially constructed by individuals and is directed towards practical problems, hence a 'social fact' is established through social interaction and interpretation
- Queries potential assumptions underpinning what is 'abnormal' or 'normal' in society
- Queries construction of psychiatric knowledge base underpinning diagnostic categories

SEMESTER 4 – PPD, AID, Growth, Repro

Ethico-Legal Issues and Gender

Pre-1970 gender on birth certificate could be altered, however due to *Corbett vs Corbett* case, static definition of gender required (chromosomes and genital anatomy). Therefore, post 1970 birth certificate unchangeable.

Gender Recognition Act 2004 – allows official registration of gender different from that on original birth certificate. There are five minimum requirements:

1. Must be 18 years old
2. Must have a diagnosis of gender dysfunction
3. Must have lived in the gender for 2 years
4. Declaration of marital status
5. Declaration that you live as new gender till death

Ethics of Elderly Care

Medical technology has the ability to prolong life but not necessarily prolong mental health, subsequently; the care of patients is dependent on the social service. The autonomy of the elderly patients is reduced due to organic conditions, cognitive impairment and socio-economic factors.

Q: What would you legally do when an older patient, requiring institutional care, resists admission?

A: Consult the National Assistance Act 1948 – allows compulsory removal from the homes of people

1. Not mentally ill (but suffer from grave chronic disease)
2. Old
3. Infirm or physically incapacitated
4. Living in insanitary conditions
5. Not receiving care and attention

REMOVAL BASED ON BEST INTEREST OF THE ELDERLY PATIENT OR TO PREVENT INJURY/NUISANCE TO OTHERS. Eviction cannot occur without notice by a doctor to a magistrate's court given 7 days notice unless in a medical emergency removal is permitted for up to 3weeks. Alternatively, the Mental Health Act 1983 can be used in a person refusing to go to hospital. However, can we label an elderly patient who is confused as being mentally ill?

An elderly patient's capacity can be assessed by the Mental Capacity Act 2005, but the capacity may be fluctuating for an elderly patient. They must be able to UNDERSTAND the information, RETAIN the information, WEIGH UP the information and COMMUNICATE their decision. Remember, just because they have a mental condition it does not mean that they lack capacity and don't have a right to express their opinions.

To assess the quality of life of the patient, it is effective to elicit a good social history to find out about PADLs and DADLs. Do not assume that elderly patients do not enjoy their life, just because they have a mental health condition.

Elderly people are vulnerable and should be treated paternistically (benevolent yet forceful). Unless patient is clearly compromised they should be involved with medical decisions.

Communicating Risk

The goal in decision making is to select health services that increase the chances of valued health outcomes and that minimise the chances of undesired consequences according to the best available scientific evidence.

You must be able to communicate risks in various contexts:

Timing: Acute illness vs. chronic illness
Seriousness: Screening vs. treatment
Consequences of intervention: beneficial consequences vs. harmful consequences

The patient must be central in decision making processes and the exchange of information between doctor and patient is central to good decision making. Also, the information must be tailored to suit the patient and no assumptions should be made about the level of the understanding of the patient.

Population Interventions – flour-folate story

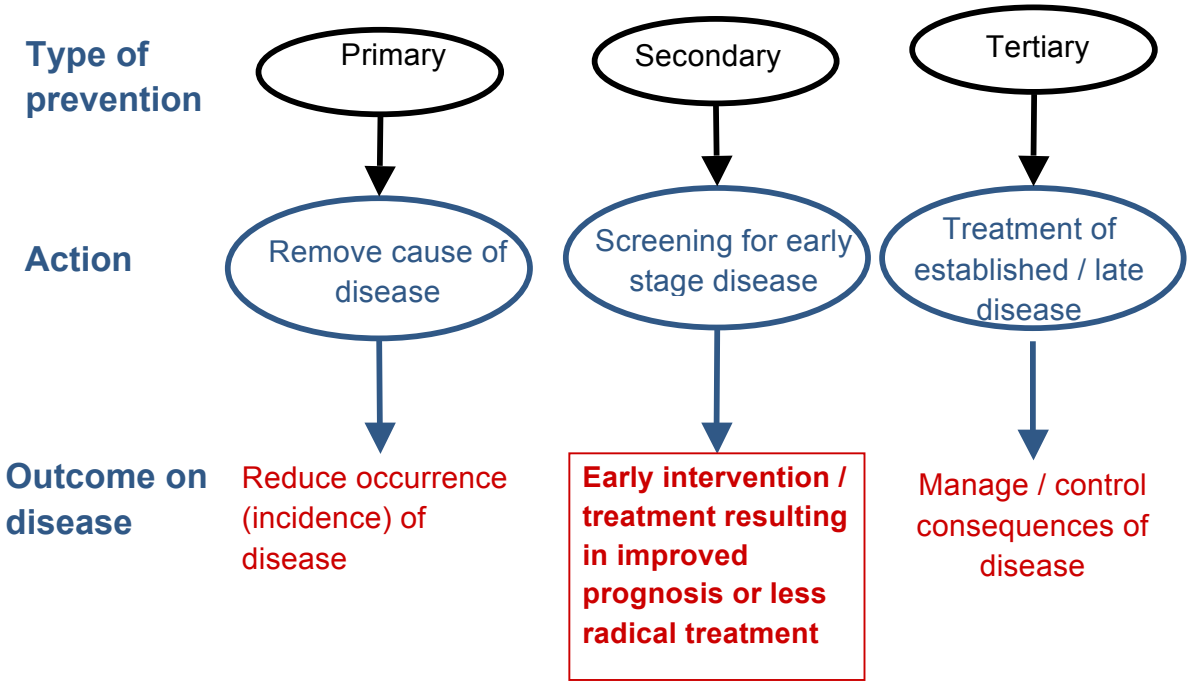
Pregnant women are encouraged to supplement folic acid before conception occurs. The first clinical trial to prove this (1992) showed that there is a significant reduction in risk of developing Neural tube Defects in people who supplement folate.

Professional Boundaries

The GMC has many guidelines in place; here is a summary of those which demonstrate professional boundaries.

- **Doctors should not treat themselves or their families**
- **Confidentiality –** Patients have a right to expect that information about them will be held in confidence by their doctors. You must treat information about patients as confidential, including after a patient has died.
- **Whistle blowing –** You must protect patients from risk of harm posed by another colleague's conduct, performance or health.
- **Integrity –** you must not use your professional position to establish or pursue a sexual or improper emotional relationship with a patient or someone close to them.
- **Personal health** – must be registered with a GP outside of your family, have appropriate vaccinations and must consult a qualified colleague if you suspect you have a serious illness.
- **Probity** – must act with beneficence, and you must not allow any of your personal interests alter a course of treatment (e.g. if you are receiving gifts from a drug company it does not mean that you will advertise that drug), but if you do then you must make the patient aware of this involvement

Screening and secondary prevention



Screening is the systematic application of a test or enquiry to identify individuals at sufficient risk of a disorder to benefit from further investigation or direct preventive action, among persons who have not sought medical attention on account of symptoms of that disorder

It is often not desirable or necessary to perform diagnostic test on everyone as it may be COSTLY, HARMFUL OR UNETHICAL.

Screening tests are usually compared with the gold standard (reference standard). Performance can be summarized by 3 main measures:

- Detection rate **DR** (sensitivity)
- False positive rate **FPR** (1-specificity)
- Odds of being affected given a positive result **OAPR** (or as a probability ➔ positive predictive value)

		Gold standard /diagnostic test		
		Affected (diseased)	Unaffected (healthy)	
Screening test result	Positive	TP	FP	
	Negative	FN	TN	

i.e.

If person has the disease and are screened with a positive screen result = TRUE POSITIVE

If person has the disease and are screened with a negative screen result = FALSE NEGATIVE

If person does not have disease but screen result says positive = FALSE POSITIVE

If person does not have disease and screen result says negative = TRUE NEGATIVE

So:

		Gold standard /diagnostic test		
		Affected	Unaffected	TOTAL
Screening test result	Positive	a	b	a+b
	Negative	c	d	c+d
TOTAL		a +c	b+d	a+b+c+d

DR = $\frac{a}{a+c}$ It's the proportion of **affected** individuals (i.e. with disease) that have a screen positive test result

FPR = $\frac{b}{b+d}$ It's the proportion of **unaffected** individuals (i.e. healthy individuals) that have a screen positive test result

Detection rate (DR): Probability (or chance) that a people with the disease are test positive on screening test

False Positive Rate (FPR): Probability (or chance) that a people without the disease are test positive on screening test

OAPR is a:b

Among those who have positive test results (i.e. top line of table) – what is the ratio of the number of affected individuals to the number of unaffected individuals

Screening test result		Cancer	No cancer
CA 125 result	>35U/L	53	23
	<35U/L	52	300
TOTAL		105	323

OAPR = 53:23

Alternatively we could express it as a proportion (or probability) instead of odds…….**POSITIVE PREDICTIVE VALUE (PPV)**

$$PPV = \frac{\text{Number of affected individuals screen positive results}}{\text{Total number of people with screen positive results}}$$

PPV = 53/(53+23) = 53/76 = 0.70 ➔ 70%

Interpretation of OAPR and PPV:

Out of 76 cases referred to oncologist because of screen positive results…

53 had ovarian cancer, 23 didn't have cancer

OR

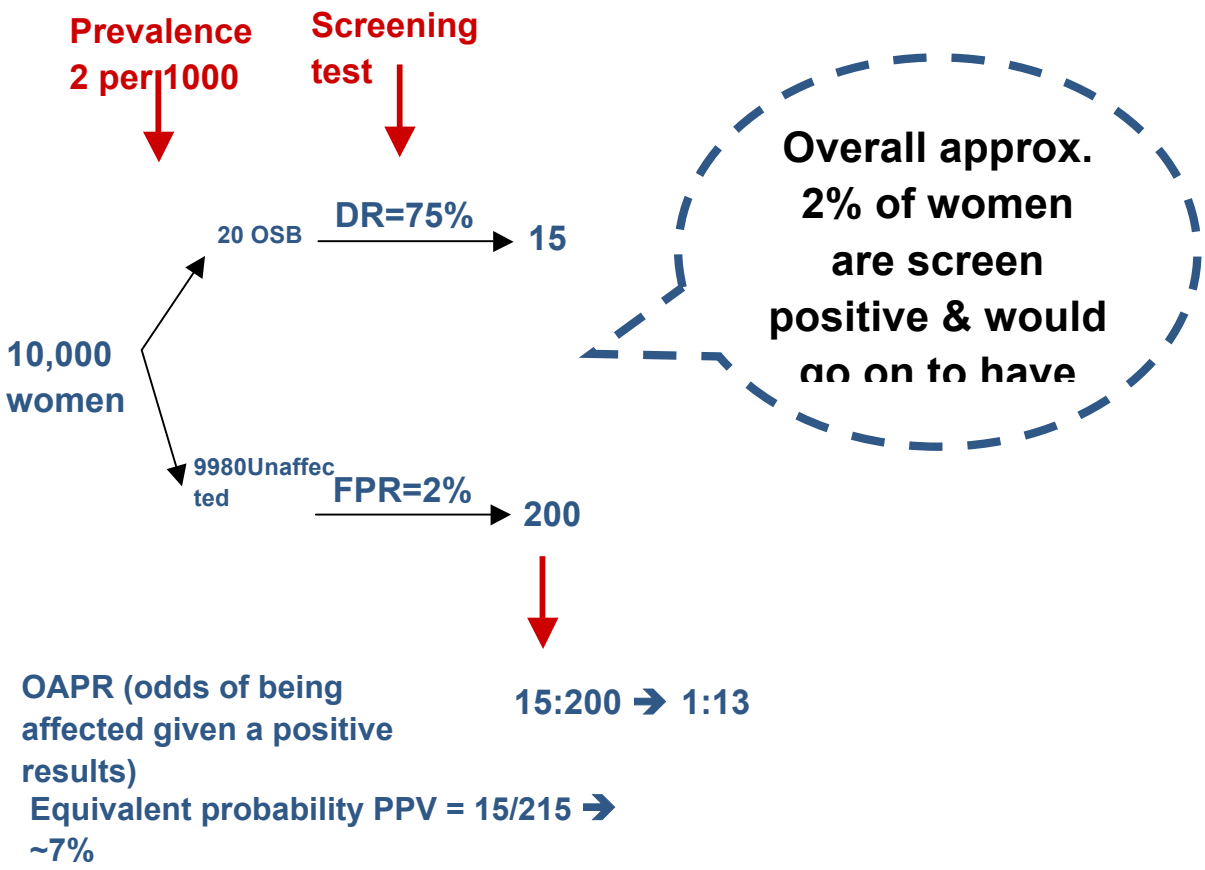
- 70% of referrals have ovarian cancer
- Two ways of expressing same concept

Example: **Antenatal screening for open spina bifida (OSB)**

DR = 75% (75% of pregnancies with OSB have positive screening test results)

FPR = 2% (2% of unaffected pregnancies have positive screening test results)

How would this screening test perform if we were to screen 10,000 women?



Requirement for a worthwhile screening programme

Disorder	**Well defined medically**
Prevalence	**Known & of public health importance** **– should we screen for extremely rare diseases however devastating they might be to health?**
Natural History	**Possible to identify early disease from healthy**
Treatment	**Effective treatment is available** **There is no point screening if no treatment exists**

	risks of early treatment both physical and psychological should be less than the benefits
Test	**It should be simple, safe, easily implemented, acceptable**
Test Performance	**The expected performance of the screening test must be known**
Ethical	**The test & procedures after a positive screening test result should be acceptable to both screener & individual** **adequate health provision for the extra clinical workload resulting from the screening**
Access	**All people who could benefit should have access to the test**
Financial	**Cost-effective** **Early detection & treatment vs. late diagnosis & treatment** **Costs should be balanced against:-** **(i) risks - hazards associated diagnostic test, interventions / treatment** **(ii) benefits - reduction in morbidity or mortality**

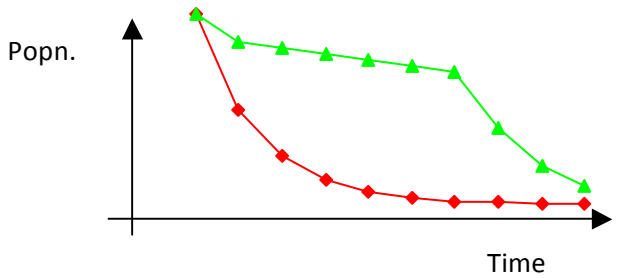
Ageing, Impairment and Disability (AID)

INTRO TO AGEING & DISEASE

Death rates and infant mortality rates have declined in the last 50 years since the establishment of the NHS. The 80+ age group has increased drastically in population also, and is set to continue rising.

Survival Curves – represent population survival with age

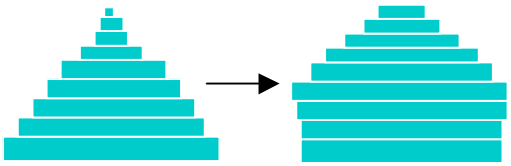
Normally a survival curve begins at 100 and declines with time. However, survival curves can be increased by addressing the needs of the ageing population; called SQUARING THE RECTANGLE thereby increasing life expectancy.



Rectangularisation in the UK is due to:

1. Decreased infant mortality
2. Improvements in public health
3. Improved diets – ABOLITION OF 1842 Corn Laws allowed cheap food to be imported from America
4. Increased standard of living
5. Improvements in sanitation

Population pyramids are also used to represent the population in the UK and have now developed an inverted appearance due to an increasing number of older people in the population.



There is an exponential relationship between age and the prevalence of disability/chronic disabling diseases.

There are scenarios for longer life and the implication on health:

1 yr gained = 1 yr of additional woe

1 yr gained = <1 yr of additional woe

1 yr gained = No additional woe

1 yr gained = < woe despite life gained (Fries: 'Compression of Morbidity' theory)

Data shows that about 3 yrs prior to death is the time when there is greatest usage of hospital resources. This is not only in old people, but also in younger people!

AGEING – process of generalised impairment of function resulting in the loss of adaptive response to stress, and a growing risk of age related disease.

Now, we must be able to identify the difference between the ageing process and a disease (otherwise one may mask the other). Thus Strehler has made concepts to define an ageing process, and all must be fulfilled.

Strehler's Concepts of Ageing

- **Deleterious** – should be eventually harmful to the organism e.g. loss of heaing/vision
- **Intrinsic** – restriceted to changes of endogenous origin e.g. hair loss
- **Progresive** – all changes continue progressively with time e.g. greying hair turns white
- **Universal** – identifiable in all members of a species (and may affect some to a different extent) e.g. collagen cross links, loss of calcium from bones

Thus the disease can be treated based on these four concepts and so can be differentiated from ageing.

THEORIES OF AGEING

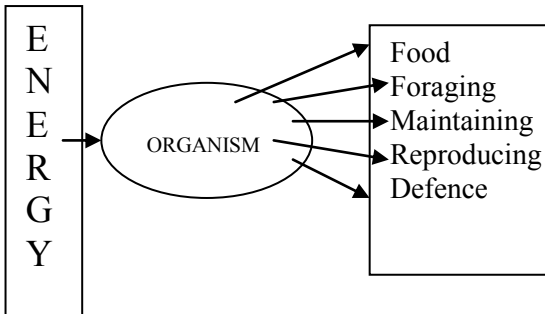
Some theories believe ageing occurs as a product of evolution i.e.

Mutation accumulation – gene not expressed until after specie has reproduced and passed that gene on, cannot stop gene from being passed on

Antagonistic Pleiotropic gene – gene has an early effect, so is kept…but has an adverse effect later on, contributing to ageing

Disposable Soma Theory

This theory views the organism as a machine that transfers free energy for several options.



Amount of energy that is given to a particular option depends on the ecological niche that the specie has evolved to fit into. E.g. humans invest more energy for maintenance, while mice may invest more energy towards reproduction. This results ins species specific longetivity.

There are theories based in bodily systems: Neuroendocrine – functional decrease in neurones/hormones central to ageing and Immune – changes in immune system responsible for ageing.

Cellular Level Theories

- HAYFLICK PHENOMENON – first discovered in fibroblast. When grown in culture they underwent a set number of cell divisions. More divisions were achieved from younger cells. This has been achieved in other cell types. *Hela-cells derived from cancerous breat tissue escape the Hayflick phenomena because they have unlimited divisions.
- CROSS LINK FORMATION – There are fewer collagen cross links in older cells
- HEAT SHOCK PROTEIN – Hsp produced at times of cell stress, e.g. surgery, disassemble damaged proteins and bring in new ones. Fewer Hsp in oldies, so smaller cosmetic scarring but decreased ability to cope with stress leads to ageing

Genetic Theories

- GERONTOGENES, LONGETIVITY ASSURANCE GENES – **Gerontogene** is a gene that in some way contributes to ageing faster. **Longetivity assurance genes** are genes which make the individual live longer.

- TELOMERES – Telomeres are the ends of chromosomes, which have repeating short sequences of DNA bases. This stabilises the chromosome during cell division. However, each time the cell divides the telomere gets shorter until it gets to a critical length where no further divisions can occur – explains Hayflick Phenomena. *Germ cells/tumour cells produce telomerase which prevents shortening.

Genomic Stability

- Error Catastrophe – errors occurring in transcription/translation lead to abnormal proteins which may be important for cellular processes, e.g. DNA repair, and accumulation of these errors may result in ageing. DNA repair declines with age

- Free-Radical theory – free radicals produced from reactions within cells damage cellular DNA. Some enzymes protect cell damage, e.g. superoxide dismutase, and so protection prevents ageing

- Mitochondrial theory – Mitochondrial DNA damage, due to O_2-radicals leads to ageing. Possibly the mitochondrial DNA has no protein coat.

PSYCHOLOGY OF AGEING

BIO-PSYCHOLOGICAL APPROACH – the ageing brain determines any psychological changes that occur with age.

There appears to be a decline in intellect with old age and for tasks requiring rapid processing speed. This decline is considered to be abnormal if it begins early on, rather than later in old age.

Bernice Neugartern's Model (Adjustment)

Events occurring during life require some degree of adjustment, and the more predictable the event…the less likely it is to demand individual adjustment. The reverse is true if unexpected, which may cause destabilisation.

i.e. Experiences in life effect adjustment e.g. Kids growing up during Depression adjusted better when they became old and had less money. Kids growing up during war are more likely to suffer anxiety disorders when older

Socioemotional Selectivity Theory – Carstensen *et. al* (2003)

Knowledge of how long you have left in life leads to diverting motivation away from trying to gain knowledge, and putting it towards emotional satisfaction.

Theory of Third Age – Peter Ladlett (1989)

This theory views later-life as a time of self fulfilment, where one can follow their own projects and plan their lives.

Erikson's Theory – Psychosocial

This theory argues that at each stage of life we face a particular type of psychosocial crisis, whose resolution helps establish an emergent trait or 'virtue' that then serves us well in addressing challenges in later life i.e. learning from experience

Key adult 'qualities' are:

- Sense of identity (being someone)
- Capacity for intimacy (having someone)
- Experience of generativity (helping someone)
- Acquisition of integrity (taking responsibility)

ELDER ABUSE

It is a criminal offence to wilfully neglect a vulnerable adult who lacks capacity (2007). In order to safeguard any vulnerable persons, you should speak out and ensure that human rights are being addressed.

"ABUSE is a violation of an individual's human and civil rights by any other person/persons...All persons have the right to live their lives free from violence and abuse."

Who is a "vulnerable" individual?

- A person of 18 years old, or over, who requires hospital/community care by reason of mental or other disability, age or illness

AND

- Who is unable to care for themselves or unable to protect themselves against significant harm/exploitation

This description typically refers to the elderly and very frail who suffer mental illnesses.

The act of neglect and abuse can be carried out by anyone, but it can often be by the primary carer.

Types of abuse:

- PHYSICAL – slapping, biting, punching etc.
- SEXUAL – rape, assault, sexual acts without consent etc.
- PSYCHOLOGICAL – emotional abuse, isolation etc.
- FINANCIAL – theft, fraud, withholding benefits etc.
- DISCRIMINATORY – racist, sexist or abuse based on impairment
- NEGLECT or acts of omission – ignoring medical/physical needs
- INSTITUTIONAL – poor professional practice, poor nursing care etc.

Signs of abuse include: unexplained injuries, bruising on scalp, burns with irregular distribution etc.

Not only this, the body language of the individual may be suggestive of abuse.

Mental Capacity Act 2005

Key principles:

- A presumption of capacity – every adult has the right to make decision
- The right for individuals – to be supported to make their own decisions
- Individuals must maintain that right – even if decision appears to be unwise/eccentric
- Best interests – always in clients best interests
- Least restrictive intervention

An individual's ability to make decisions might be affected by the 'TWO STAGE TEST'

- An impairment/disturbance in the functioning of the person's mind/brain
- If so, does that affect the person's ability to make a decision at that particular time

If that test is used to assess capacity, it MUST be recorded in the notes. Lack of capacity for one decision does not mean that all decisions can be taken.

Safeguarding Vulnerable Groups Act 2006 (comes into force Autumn 2009)

If there is any evidence that an individual poses a 'significant risk' they will be placed on a vetting/barring list. Once listed, the individual will not be able to work in regulate activities set out n the Act. This will be in addition to CRB checks.
e.g. a paedophile will not be allowed to work in schools

EMOTIONAL AND COGNITIVE DEVELOPMENT (Growth)

AGE	Psychoanalytic	Cognitive (Piaget)	Moral (Kohlberg)	Psychosocial (Erikson)
0-1	Oral Stage	Sensorimotor.	Level 1 Preconventional morality. • Stage 1 • Stage 2	Trust Vs Mistrust
1-2	Anal Stage			Autonomy Vs Doubt
2-3		Preoperational.		Initiative Vs Guilt
3-5	Phallic (Oedipal)			
5-7	Latency			Industry Vs Inferiority
7-10		Concrete Operational.		
10-12			Level 2 Conventional morality • Stage 3 • Stage 4	
12-13	Puberty	Formal Operational.		Identity Vs Confusion
13-16			Level 3 Postconventional morality • Stage 5 • Stage 6 (achieved in <10% of adults)	
16-20				Intimacy Vs Isolation
20+	Adult Sexual Development			
Middle Adulthood				Generativity Vs Self Absorption
Ageing Years				Integrity Vs Despair

Cognitive (Piaget) – i.e. thinking is basic and becomes more advanced with age

Sensorimotor

- Differentiates self from object "oh look i'm not that pencil case lying there"
- Recognises self as agent of action and acts intentionally "move hand therefore will reach"
- Develops object permanence "the ball will still exist even if i'm not aware of it"

Preoperational

- Thinking is egocentric "my doll will see exactly as I do from my point of view"
- Uses language, represents objects using images "it was like a circle"
- Objects classified by a single feature "That is a square"
- Achieves conservation of numbers

Concrete operational

- Can think logically about events "I woke up, got ready then went out"
- Achieves conservation of mass (7 yrs) and weight (9 yrs)
- Objects classified by many features "That is a blue square with a dark background"

Formal operational

- Can think logically about abstract ideas
- Can make hypotheses, think about the future and has a philosophical approach to ideas

Moral (Kohlberg) – this development can be modelled showing an approach to a dilemma

"Should a dying man steal a drug he can't afford to prevent his wife dying?"

LEVEL 1 – PRE-CONVENTIONAL MORALITY

Stage 1. Punishment and Obedience Orientation. Obedience to rules to avoid punishment; *right* is the avoidance of physical damage to persons or property.

- *Heinz should steal the drug. If he lets his wife die, he'd get into trouble.*
- *Heinz shouldn't steal the drug. He'd get caught and sent to prison.*

Stage 2. Reward Orientation / Instrumental Relativism. Conform to obtain rewards; acting in one's own interests and needs and letting others do the same; *right* is what's 'fair'.

- *Heinz should steal the drug. His wife needs to live and he needs her companionship*
- *Heinz shouldn't steal the drug. He might get caught and sent to prison, and his wife would probably die before he got out, so it wouldn't do him any good*

LEVEL 2 – CONVENTIONAL MORALITY

Stage 3. Good-boy / good-girl Orientation. Conforms to avoid disapproval and meet expectations of others. 'Being good' is important and involves having good motives and showing concern.

- *Heinz should steal the drug. Society expects a loving husband to help his wife regardless of the consequences.*
- *Heinz shouldn't steal the drug. He'll bring dishonour on his family and they'll be ashamed of him.*

Stage 4. Authority Orientation. Upholds laws and social rules to avoid censure of the authorities and feelings of guilt about not 'doing one's duty.'; Laws are upheld except when they conflict with other social duties; *right* is also contributing to society.

- *Heinz should steal the drug. If people like the druggist are allowed to get away with being greedy and selfish, society would eventually break down.*
- *Heinz shouldn't steal the drug. If people are allowed to take the law into their own hands, regardless of how justified the act might be, social order would soon break down.*

LEVEL 3 – POST-CONVENTIONAL MORALITY (this represents philosophical ideas)

Stage 5. Social Contract Orientation. Actions guided by principles commonly agreed by one's group on as essential to public welfare (relative values); Some non-relative values, such as life and liberty, must be upheld in any society, regardless of majority opinion.

- *Heinz should steal the drug. The law isn't set up to deal with circumstances in which obeying it would cost a human life.*
- *Heinz shouldn't steal the drug. Although he couldn't be blamed for if he did steal it, even such extreme circumstances don't justify Heinz taking the law into his own hands. The ends don't always justify the means.*

Stage 6. Ethical principle Orientation. Actions guided by self-chosen ethical principles. Laws and social principles usually valid because they are based on these principles. When laws violate these principles one acts in accordance with the principles, which are the universal underpinning of justice.

- *Heinz should steal the drug. When a choice is made between disobeying a law and saving a life, one must act in accordance with the higher principle of preserving and respecting life.*
- *Heinz shouldn't steal the drug. He must consider other people who need it just as much as his wife. By stealing the drug, he'd be acting in accordance with his own particular feelings with utter disregard for the values of the lives of others.*

Social development and attachment (Lorenz, Harlow & Bowlby)

(Lorenz) IMPRINTING – Specialised form of early learning during critical period where there is an innate predisposition to acquire specific info. Characterised by irreversibility and life-long retention
e.g. baby geese innately follow their mum!

(Harlow) Hard mother vs. Soft mother – Rhesus monkey studies

Young monkeys were isolated from mothers and put in an artificial environment with either a rough metal mother which provided food or a soft clothed mother which did not provide food. The monkeys preferred the soft mother even with the lack of food!

When returned to a normal habitat the specimens showed impaired behavioural and social skills. Thus, it is important to have some intimate care in young age, and appropriate interaction to allow development.

(Bowlby) Attachment theory

An affectionate bond results from maternal reinforcement. The effect of this is to bring the individual close to the care giver and maintain them – important in early childhood and infancy.

Attachment behaviour is triggered by fears and threats.

The role of the caregiver:

- Be available and responsive
- Intervene judiciously
- Provide a secure base
- Encourage exploration from base

If there is acute separation from the caregiver it results in PROTEST → DESPAIR → DETACHMENT

If the caregiver always fulfils the needs of the child it has several implications. The child feels that are competent and valued – the reverse is also true if never fulfilled.

The "good enough" mother means a caregiver who is able to fulfil demands in most cases but not all the time – this way the individual is encouraged to make develop.

Stages of attachment:

- **First few months**. Infant orientates without discrimination.
- **5-7 months**. Infant preferentially orientates and signals to discriminated persons.
- **7-9 months**. Infant maintains proximity to a discriminated figure by locomotion and signals, and protests if they leave (separation protest). This stage sees the onset of attachment and also the onset of 'stranger anxiety'.
- **9-24/36 months**. Formation of a goal directed partnership between child and caregiver. Until this point caregiver a resource for the child, but now the child begins to accommodate to caregivers needs.
- **School age**. Lessening of attachment behaviour. Relationship less based on proximity maintenance, but on more abstract considerations such as affection, approval and trust.

Psychosocial Development (Erikson)

Each stage of life has a dominant theme or task, which can have a positive or negative outcome. Tension builds up as a 'psychological crisis', which must be resolved. Crisis resolution represents achievement of a developmental task that allows the next stage of growth

E.g. trust vs mistrust – the favourable is trusting new faces as an infant

Normal Development milestones:

Motor development

• Lifts head	2-3 months
• Reaching	4-6 months
• Sits alone	7-10 months
• Walks	10-16 months
• Goes up stairs	20-26 months
• Skips	4-4.5 years
• Rides a bike	5-6 years

Language development

• Vocalising	2-3 months
• Laughs	2-4 months
• Babbling	6 months
• Waves 'bye-bye'	9-12 months
• One word with meaning	9-14 months
• Shakes head for 'no'	12-16 months
• 'I', 'you', 'me'	2-2.5 years
• 5 word sentences	2-3 years
• Grammar development, with overgeneralised rules	2-3 years

Toileting

• Dry by day	2-5 years
• Dry by night	2-6 years

Sexual development

• Awareness of own sex 'boy/girl'	80% by 2 years
• Identification of sex of others	80% by 3 years
• Sex differences evident in play	3-4 years
• Emotional / sexual orientation	Evident from early adolescence.

SOCIAL CONSTRUCTION OF GENDER (Repro)

Biological sex is the way in which the sex of an individual is determined on the basis of biological differences (external genitalia). **Gender refers to the social and cultural perceptions associated with sex differences, socially constructed as 'masculine' and 'feminine'.** I.e. gender classed as male so you are masculine. N.B. – this method of identification can be quite flawed in patients with atypical sexualities

Examples of gendering practises:

- When children are born they are ascribed a gender identity by their parents, which is based upon the external genitalia of the child. This gender identity is then reinforced by choosing an appropriate name for the child and by buying appropriate clothing. Once the gender of the child is socially ascribed, they are treated differently from the children ascribed to the other gender. The child then responds to this different treatment by feeling and behaving differently. As soon as the child begins to talk, they begin to refer to themselves as members of their gender.
- Parenting – there are different expectations for mothers than for fathers
- Work roles – these have been traditionally been gendered

Why is gendering consistently done from birth in virtually all societies and cultures?
Gender as a social institution is one of the major ways in which the division of labour in human societies is organised – in this case through ascribed membership of gender as a social category. The alternative would be choosing people for social tasks based upon their skills, motivations & talents.

'Gendered' social practises are responsible for shaping men and women's bodies in certain ways, to reinforce images of masculinity or femininity. One example would be the encouragement of boys (but not girls) to undertake strenuous physical exercise, which will have a long term effect on the bodies of both men and women – the result of which can result in negation or *transcendence* of biology (challenging the idea that biology is fixed). Surveys have shown that after the age of 3, boys carry out a greater mean number of hours of exercise each week compared to girls.

In many ways the production of 'women' and 'men' as separate and unequal social categories, operates by converting average differences into absolute differences, when in fact large numbers of women are actually physically stronger than many men.

Socially constructed conceptualisations of masculinity and femininity which become embodied in such social practices can become fuelled by the individuals themselves. For example, if a woman takes up strenuous exercise after her teenage years, her body may not have developed as much as a man's and so her body is restricted in the amount of exercise it can participate in – this renders the female as weaker compared to the male.

Annandale and Hunt's (1990) research into gender differences in health status utilises the *Bem Sex Role Inventory* (BSRI) measure, which does not assume that biological sex and gender. There are 60 questions in the BSRI; for each the individual grades themselves. The BSRI is based on gender stereotypes, so what it actually measures is how well the individual fits into their traditional sex role. i.e. you are a man and score highly masculine in the test, thus you have a traditionally masculine personality

In a study by Lawlor, Ebrahim and Davey Smith (2001) which examined trends in sex differences in mortality from coronary heart disease, it was concluded that the fact that men have much higher rates of heart disease than women may be nothing to do with biological sex, but something to do with gender. The study suggested that it was gender differences in dietary habits which may be responsible for why death rates from heart disease differ so significantly between men and women.

PSYCHOSEXUAL DEVLEOPMENT (Repro)

Normal psychosexual development occurs in the first three months of foetal development. Y chromosome leads to development of testes and secretion of foetal androgens – the absence of which results in feminisation.

Sex – Defined by the gonads or potential gonads, either phenotypically or genotypically

Gender Identity – An early awareness of belonging to one of two categories of human beings

Gender identity is shaped by actions of parents and environment e.g. blue dress, Barbie dolls etc.
Gender identity emerges by the age of 2-3 where boys play with boys (and girls with girls) and by age 3most children will correctly answer "Are you going to be a mummy or a daddy?"

Gender Role – outward manifestations of personality that reflect the gender identity (masculinity or feminity) e.g. boys choose male toys and are aggressive with peers

Atypical development:

Gender identity disorder (transexualism) where the individual feels more comfortable as the other gender.

Transvestism is purely cross-dressing as a sexual fetish without any confusion of gender.

Genital abnormalities affecter gender identity/role:

Micropenis
This actually does not affect the individual's perception of gender identity/role

Botched circumcision

Eunuch transvestites in India (Hijra/Khusra)
Castrated males (showing no sexual drive) function as male prostitutes

Gender orientation:

- Heterosexuality

In UK, first sexual experience 13 (boys) and 14 (girls) and 17 full on sex (for both). More prevalent in more relaxed society.

- Homosexuality

Boys: common in childhood (20%) but very small proportion go on to show this in adulthood (3%)
Girls: Only 10% of pre-adolescent girls show this, and by adulthood a mere 2% exhibit lesbianism

Excessive masturbation is the sign of neglect or sexual abuse.