

Euthanasia: a problem for psychiatrists

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Abstract

This paper discusses the ethics of euthanasia. Situations are described in which the normal duty to sustain life is overridden by other duties towards the patient; but these situations are contrasted with euthanasia properly so called. Arguments for euthanasia are considered, and a refutation of those arguments is offered. The case against euthanasia is reinforced by an appeal to the possible harmful consequences of a policy under which it is allowed. Particular implications for psychiatry are advocated.

Keywords: *Euthanasia, suicide, duty to sustain life, duty of care, ethics.*

Why should psychiatrists concern themselves with the question of euthanasia? There are two reasons. First, the question can be expected to be pressed increasingly by those who seek to have euthanasia legalised and accepted as a proper medical option; and psychiatrists, along with other members of the medical profession, need to be involved in working out what answer ought to be given by the profession as a whole. Secondly, psychiatrists could also have a more specific interest in the issue: some proposals for legislation entail that psychiatrists would be involved in assessing the capacity of an individual to opt for euthanasia.

In this paper, I offer a discussion which I hope may be useful to psychiatrists as they seek to formulate (or perhaps reiterate) their own ethically responsible position on the issue.¹

Some definitions and principles

The word “euthanasia” comes from the Greek, where it means simply “a good death” or “dying well”. But as philosophers rightly point out, we do well to use the term only in a much more precise sense, viz. to refer to situations in which death is sought for the sake of the person who dies.² Thus, even when a patient is provided with a gentle or easy death, it would not be right to describe this death as euthanasia when it is brought about not because it is thought to be in the patient’s interest that he dies, but because, for example, his continued living would place a great burden, of suffering or of cost, upon his family, or a burden of cost upon the medical services provided by society, or for some similar reason involving the interests of others. And this proper, precise sense of “euthanasia” allows us to identify as merely outrageous certain historic uses of the word. The Nazi regime had a so-called euthanasia programme under which hundreds of thousands of medically unfit persons, unable to be rehabilitated for work, were exterminated. The fact is, of course, that what was

done to those people had no connection whatsoever with what was in their interests. Here the term “euthanasia” was simply a euphemism for the massacre of persons regarded as undesirable by others in power.

All the same, in defining the term “euthanasia” in this correct, precise sense, to refer to cases in which the death is sought for the sake of the person who dies, we have not yet said anything about the morality of euthanasia. That question still lies before us. For all that the definition shows, it may or it may not be morally permissible to seek a person’s death intending that death to be for their sake.

Kinds of euthanasia can be distinguished in a number of important ways. There is, first, the distinction between active and passive euthanasia. Active euthanasia is the intentional killing of a person (for their sake). Passive euthanasia is the intentional allowing of a person to die (for their sake). Secondly, there is a three-part distinction between voluntary, involuntary and non-voluntary euthanasia. Voluntary euthanasia (whether active or passive) is euthanasia at the express request of the person who dies. Involuntary euthanasia is contrary to the expressed wish of the person who dies, i.e. they wish to go on living. And non-voluntary euthanasia occurs without the express request of the person who dies, either because they are not asked what they wish or because they are unable to give an answer to this question, perhaps because they are comatose, or infantile, or senile, or in some other way incompetent to state a wish. Again, in defining these terms we have not yet said anything about the morality of what is being referred to. (One might think that involuntary euthanasia is defined in such a way that it is obviously immoral: how could it ever be permissible to kill a patient against his will? But it is possible to argue that there could be cases in which a patient wants to go on living even though it would be best for them to die, and that in such cases there is a very real moral question of what we ought to do. So, for the time being, let us simply note the issue.)

And finally there is “physician assisted suicide”. This term applies to cases where a person brings about their own death, but with the assistance provided by a doctor – for example, by using

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lethal drugs supplied by the doctor. Where it is used in contrast to physician assisted suicide, the term "euthanasia" applies to cases where the death is brought about not by what the patient does to themselves, but as a result of the course of action taken by the doctor or some other person, whether that course of action be an act of direct killing (active euthanasia) or a withholding of something that would sustain the patient's life (passive euthanasia).

It is also helpful to be reminded of the four principles of biomedical ethics made famous by Beauchamp and Childress.³ These are the principles of beneficence ("act for the patient's good"), of non-maleficence ("act so as to avoid harm to the patient"), of autonomy ("act in such a way as to give due regard to the patient's own wishes"), and of justice ("act justly with respect both to the patient's own interests and to the relevant interests of others"). These are vague and general principles, and what they entail, and how their demands are to balance one another, need to be worked out in detail in various kinds of case. But each principle refers to an important ethical norm, and together they can constitute a framework within which many biomedical ethical problems can be tackled - a framework, furthermore, which is very generally accepted in contemporary biomedical ethical deliberations.

The duty to sustain life

Moral thinking on these issues does not take place within a vacuum: one does not start out with a morally neutral attitude to life, and to the saving or taking of life, but with a presumption. This is the presumption that life is a good, and that the duty of care to patients standardly requires the medical professional to sustain their lives. It is presumed, in other words, that the duty of beneficence entails the sustaining of life, and that the duty of non-maleficence entails refraining from acting against life. Moreover, it is presumed that one owes the same duty of care to each patient. Care, in other words, is not to be compromised by judgements about the relative values of patients' lives. Indeed, the obligation to care, and in particular the obligation to sustain life, is especially an obligation to care for sub-optimal human life - life which is damaged or diseased or deranged or weak or helpless.

This presumption in favour of sustaining life is so important, and so fundamental to the ethos of the medical profession, that it can hardly be overstated. Nevertheless, powerful as it is, it is a presumption, not an absolute principle. It has its limits. We are all mortal: our death is an inevitability which medicine cannot finally ward off. Yet medicine may have at its disposal the means of prolonging life at a certain level; and there are situations in which it can recognise that it ought no longer to employ those means, that it ought to desist from further attempts to sustain life, because they would now be out of place.

Some of these limits to the duty to sustain life are relatively clear and uncontroversial; and it is worth mentioning them because they can, I think, be reasonably distinguished from what is at issue in the question of euthanasia.⁴

Limits to the duty to sustain life

One limit occurs at the point at which life can be sustained only at a vegetative level. The treatment which sustains life only ever at this level is often called futile treatment. There could be much discussion of this notion of futile treatment, but I find Grant Gillett's account of the matter helpful.⁵ He argues that the medical team has a duty to do all it can to ensure that patients can enjoy what he calls an acceptable minimum of human function - that is, a level of function in which things can matter to them, at

least in a primitive personal way. But of course there are conditions - the genuinely, or irreversibly, persistent vegetative state would be one of these - in which, though one has the means of sustaining life, nothing can be done to restore the patient to that level of function: nothing can be done to restore the patient to a point where he can experience or be aware of anything, where he can appreciate in any way the care of others. Gillett describes these means of sustaining life as providing, in such conditions, futile treatment. And he argues that one has no duty to sustain life if it can only ever be sustained by futile treatment. For to sustain life in this way is to do nothing from which the patient, as a person, can benefit; it does nothing to serve the patient. It merely prolongs his dying. We might say of these cases, then, that the artificial sustaining of biological life is not the preservation of worthwhile or potentially worthwhile personal life, nor the genuine care of a patient, but merely an attempt to deny the mortal human condition.

Another limit to the duty to sustain life occurs at the point where the treatment required to sustain life would impose upon the patient a burden of harm or suffering which is out of all proportion to any good that it can provide. For instance, it may be that one can win for a patient a short prolonging of conscious life, but only at the cost - in terms of harm and suffering - of a highly distressing resuscitation, whose outcome is dubious, or of a massive surgical operation, with all its trauma and after-effects. And in such a situation it may well be judged that the benefit, for the patient, simply does not justify the cost, for the patient.

Some such decisions will be relatively easy; others will be harder. But it seems to me that the principle of autonomy has an especially important role in such cases: the patient's own wishes are especially significant. Those wishes are always significant, but in these cases it may be that one simply cannot quantify the harm/benefit ratio of the treatment option with which one is presented unless one does so by reference to the patient's own judgement of the matter. For instance, imagine the following situation. Mrs. A, who is 87 years old, is now facing the choice between, on the one hand, another very burdensome surgical operation, which offers the promise of some weeks or months of further life of suffering and disability, and, on the other hand, swift death. She prefers not to have the operation. "I feel that my time has come," is the way that she puts it. "I've had a good innings, and I've made my peace with God. And I want to go peacefully with my family around me." Mrs. B, however, who is the same age, in the same condition and facing the same choice, desperately wants to have the operation: her criminal son is due to be released from prison in a few weeks, and it is very important to her that she be reconciled to him before she dies.

There we can see, I think, that Mrs. A and Mrs. B are both making perfectly legitimate decisions - different decisions, even though their clinical condition is exactly the same. The individual patient's particular weighting of relevant factors may in this kind of way be an essential determinant of the harm/benefit ratio of treatment.

In cases in which life-sustaining treatment exceeds these limits - where it is futile or too burdensome - the standardly presumed connection between the duty of care towards the patient and the sustaining of the patient's life is a connection which comes apart. Where the treatment is futile, it cannot achieve any good for the patient; hence it is not required by the duty of beneficence. Where the treatment is too burdensome, the good it would or may achieve is outweighed by the harm that it would impose;

hence it is contrary to the duty of non-maleficence. And so there is no obligation to administer treatments of either of these kinds, and one may, indeed, be obliged to withhold or withdraw them.

In doing so, one allows the patient to die. So it can be argued that, in justifying such a course of action, we have justified cases of passive euthanasia - cases in which, for the patient's sake, one allows him to die, even though one could (by administering the futile or unduly burdensome treatment) keep him alive. Nevertheless, it does not seem to me helpful to think of these situations as cases of euthanasia, since one is not aiming at death. Rather, in these cases one is recognising that certain kinds of treatment would be out of place, for these kinds of treatment are no longer required by one's duty of care. (Though other kinds of care for one's dying patient may well be very importantly required.)

Alongside those limits to the duty to sustain life, there is another kind of case which can look almost indistinguishable from a case of euthanasia, but which arguably belongs to a quite different category. I refer to the sort of procedure which traditionally has been justified by appeal to the doctrine of double effect. In the treatment of terminal illness, where palliative care is the only medical option still open, and where the relief of pain and discomfort is of predominant importance, it might perhaps become the case that the dosage of drugs required to provide effective relief increases to the point where it could shorten the patient's life. Many doctors and others feel that it would be justified to administer such a dosage of drugs, but only if one's purpose is the relief, not the death, of the patient, and only if the importance of this relief is great enough to outweigh the harm that is done (which may merely be the elimination of some hours or days of terrible distress).

This way of thinking is often criticised on the grounds that there is only a spurious distinction between such a course of action, on the one hand, and direct killing, on the other. The issue could be discussed at great length. Here it is simply noted that it seems that there is a real distinction to be drawn here; and that such a course of action, seeking the effective relief of the patient's symptoms, may be not only justified but morally required. If this course of action fulfils the conditions noted, then, once again, one is not aiming at death. Rather, one is pursuing the kind of treatment required by one's duty of care - the treatment that will properly manage the patient's symptoms.

And once again, such a case presents an exception to the normal connection between the duty to sustain life and the principles of beneficence and non-maleficence. Whereas the duty of non-maleficence normally requires one to avoid any course of action that would threaten the life of the patient, the claims of the principle of beneficence may be so powerful, in requiring the relief of the patient's suffering, that they override this claim of the principle of non-maleficence.

Euthanasia

But unlike the courses of action so far discussed, euthanasia properly so called is directed at the patient's death. When one performs euthanasia, one acts with the intention and purpose of bringing about the patient's death. A paradigm case of euthanasia - e.g. the administering of a lethal injection - unambiguously displays this intention. And the argument for euthanasia surely has its best chance of success when it concerns an action expressly requested by the patient. So let us begin our moral evaluation of euthanasia by considering voluntary active euthanasia. What is said about it will also enable the evaluation of euthanasia of other kinds.

The issue under consideration is located in the neighbourhood of enormous philosophical issues. There is the issue of the ethics of killing - whether it can ever be right, and if it can, under precisely what conditions. There are also metaphysical issues, or issues concerning what we might refer to as the meaning of life. For instance, consider the way in which different world-view commitments would variously colour one's thinking about voluntary euthanasia. One such world-view commitment might express itself in the following kind of way: "My life is my own; I am my own master, subject to no other authority. And this life, with its suffering or happiness, is the only life there is...." A very different commitment might be expressed as follows: "My life is a gift and trust from God. It is not mine to dispose of at my own behest. Rather, I am to use it faithfully, subject to God's authority; and I am answerable to him beyond this life for the way that I do use it. But God promises to uphold me in his care through whatever I have to endure in this life, and there may be redemptive possibilities hidden in the darkest episodes I have yet to face...." Anyone can see that these contrasting commitments could very naturally lead to diametrically opposite positions concerning the permissibility of voluntary euthanasia.

An adequate discussion of euthanasia would properly investigate its connection with those massive issues. But in this paper one can only attempt something more superficial and much less ambitious: to follow a line of thought which proceeds in a fairly simple way from the kinds of attitudes and principles which provide fairly common ground within the medical profession.

If working with ordinary and uncontroversial principles of medical ethics, one can state the case for voluntary active euthanasia by means of a straightforward appeal to both beneficence and autonomy. The argument from beneficence would stress that, when a person is suffering terribly, and their suffering will only end, sooner or later, in death, the good that is owed is release from that suffering. It may be the case that suffering can be diminished through palliation, but this will still involve prolonged suffering, albeit at a lower level. The good owed is the minimisation of suffering, and this requires the swiftest, surest release. Hence euthanasia. The argument from autonomy would stress that this release is precisely what the patient wants: it has been expressly requested. If we are to give due regard to what the patient wishes, if we really respect them as a person, then we will be governed by what they want. It is their life, and their death, not ours. The right to decide what happens to them is their right. Hence euthanasia.

The weight of the case for voluntary active euthanasia, then, is the accumulated weight of those two arguments. If one seeks to rebut those arguments by appeal to the principle of non-maleficence, by saying that to kill the patient would be to breach this principle because it would entail doing terrible harm to the patient, then the proponent of euthanasia can respond that this is a mistake. For, it can be said, the harm that matters is the patient's suffering. Because all that is now left for the patient is a period of suffering, our duty is to release them from that harm. Killing, in this situation, does not cause harm: it minimises harm. So it would be no breach of our duty of non-maleficence.

We also often hear, as part of the case for euthanasia, an appeal to the dignity of the patient, and the notion of dignity, here, can be linked either to beneficence or to autonomy or to both. The connection with beneficence is made when we claim that a person who is suffering the ravages of a terminal illness is a person whose dignity is thereby undermined - so that a restoration

of dignity would require a release from that degradation and suffering. The connection with autonomy is made when we claim that we are not treating a person with dignity when we override their own wishes. For either or both of these reasons, then, it is claimed that voluntary active euthanasia provides death with dignity.

I do not think that we can take a serious part in this discussion unless we feel the very great weight behind those arguments. Experienced professionals do not require any fertility of imagination to depict for themselves a patient racked by the possible appalling pain and frightful degradation of terminal illness. Anyone who can stand by the bedside of such a patient and not wish for his instant relief is a person devoid of all human compassion.

But does this mean that those arguments for voluntary active euthanasia carry the day? To begin to answer this question, let us consider how the arguments would strike us if they were applied to a different kind of situation, but one with which psychiatrists are all too familiar - the situation in which a patient wishes (or behaves as if he wishes) to commit suicide. Were they in the business of offering argument, the suicidal patient might claim that the greatest good we can do, is to allow them to end their hopeless condition by taking their life; they might also insist that their wishes in this matter ought to be respected. In other words, they might employ arguments from beneficence and autonomy which parallel those for euthanasia. But in his case we would be unpersuaded by those arguments. We do not accept that the greatest good lies in annihilation: we recognise our obligation to provide the kind of care which could discover and treat any underlying pathology, and assist the patient to deal with their personal problems, and so enrich their life. Nor do we consider ourselves bound by the suicidal wish: we recognise that this wish could be reversed if there is proper care and support. Indeed, the suicidal wish may arise from a sense of worthlessness or desolation or despair or fear which is, at least to some degree, due to some failure of care on the part of those in one way or another related to the patient.

Now this consideration of suicide is relevant to the question of euthanasia because there is evidence that a person who requests euthanasia may be in a state of mind similar to that of the suicidal patient. Terminal illness can produce a sense of desolation and hopelessness and fear very similar to that suffered by suicidal persons. Where this state of mind arises, it is surely a duty to provide that personal support and care which affirms the worth of the patient and their life, even through the process of dying, and which is, in this respect, just like the care we owe to the suicidal person. And the testimony of those who care well for dying patients indicates that a request for euthanasia tends to occur when that kind of committed personal care is absent, and it falls away when the care is present. Members of the hospice movement and others who practise expert palliative medicine - all of whom I salute with enormous admiration - report that very few, if any, patients have untreatable pain. The pain and other distressing symptoms of terminal illness, they tell us, can almost always be managed at a tolerable level by good palliative medicine. And interestingly enough, it is not those patients with the least manageable symptoms who issue a request for euthanasia. Rather, the request seems typically to arise from that sense of despair and worthlessness we have noted - a sense which can be dispelled by real personal support and care.^{5,6,7}

This is tremendously interesting testimony from the experts in palliative care, for it strongly suggests that the desire for eu-

thanasia should be presumed to belong in the same category as the desire for suicide. And if this is the case, then our moral response to a request for euthanasia ought to be parallel to our moral response to a request for assistance in suicide. In particular, our answers to the arguments for assistance in suicide ought to provide parallel answers to the arguments for voluntary active euthanasia.

Thus, the argument from autonomy would be answered in the following way. We ought not to be governed by the request for euthanasia. For the want embodied in this request is a want which is itself due to our failure of care, or which at least indicates the need for our care - care which, when provided, can be expected to dispel the want. By contrast, if we were to accede to the request for euthanasia we would in effect be endorsing the underlying sense of worthlessness, the underlying self-rejection, from which it springs. And what a tragic irony this would involve if the sense of despair were due to our failure of care in the first place! What is at stake here is the contest between what are in effect two utterly different attitudes towards the patient. On the one hand: "You regard yourself as no longer of any worth. We agree. Here, be our guest. End it all." On the other hand: "You may feel yourself to be worthless, but we attach great value to you. And we want to demonstrate your value by our care for you."

Similarly, the argument from beneficence would also be answered by what we have said in response to the argument from autonomy. We do not act for the patient's good in killing them; instead, we extinguish a life, a person, who is still of value. The care that we owe is genuinely life-enriching; and it is the felt enrichment provided by that care which serves to overturn the patient's desire for a premature, unnatural death. Those committed to caring well for the terminally ill testify to the many ways in which patients supported by that personal care can find the last stages of their life intensely valuable and significant.

It was presumably for these reasons that Dame Cicely Saunders, pioneer of the hospice movement, said that euthanasia "should be unnecessary and is an admission of defeat".⁸ It should be unnecessary because good palliative medicine can provide the relief which the patient needs. It is an admission of defeat because it would occur voluntarily only when the patient has not received the care and support which we ought to provide for them - the care and support that would displace their request for euthanasia.

Our responses to the arguments from autonomy and beneficence also provide for us an answer to the appeal to the dignity of the patient. We can now claim that it is not euthanasia which provides death with dignity. The dying patient is accorded true dignity, not when death is hastened by a false sense of worthlessness, but when genuine value as a person is honoured through the real care and support provided.

So our answers to these arguments have led us to a general moral conclusion concerning voluntary active euthanasia. Euthanasia is not where the medical professional's duty lies. It would seem, indeed, to be contrary to the duty to the terminally ill, which is to provide them with good palliative medicine and genuine personal support. Thus we arrive at a conclusion which sits quite comfortably within the traditional medical ethos. This is not merely because medical ethics has traditionally viewed euthanasia with disapproval; it is because at the heart of this ethos lies a commitment of care for the patient - of care which is offered without regard to the relative value of the patient's life, of care especially for sub-optimal life, for life which is tenuous, for life

which is passing away. "To heal, sometimes; to relieve, often; to care, always" - not least when the patient is dying.

And this conclusion entails a further specific conclusion concerning the role of the psychiatrist. If a request for euthanasia ought to be presumed to belong in the same category as the desire for suicide, then the psychiatrist ought no more to endorse the one than the other. The psychiatrist is not in the business of assessing the validity of a suicidal wish; rather, that wish is properly regarded as symptomatic of some problem which needs to be addressed. The question of the patient's capacity to decide for suicide is a question that does not properly arise. But then nor should the question of the patient's capacity to request euthanasia.

Our conclusion concerning voluntary active euthanasia provides consequent conclusions concerning the other species of euthanasia. If voluntary active euthanasia is clearly impermissible, then involuntary and non-voluntary active euthanasia are even more clearly impermissible. The same can be said for passive euthanasia, where this would involve withholding some treatment which would support life and which would be owed as part of the normal duty of care - except for the following qualification. The extent to which one can impose treatment, even life-sustaining treatment, upon the patient is severely constrained by what the patient wants. Where a patient adamantly and consistently refuses treatment, one may, in the end, sadly have to accept such refusal. And this means that, in principle, one may have to acquiesce in what is effectively the patient's suicide. We could call this a case of voluntary passive euthanasia but for the fact that one would not be seeking, or not properly seeking, the patient's death; hence it is better not to call it euthanasia at all.

This case against euthanasia can be reinforced by various further arguments. Even if it were true that certain particular acts of euthanasia are morally permissible, it could also be true that a policy of allowing euthanasia would have its own bad consequences; and many commentators believe that the risk of these bad consequences would itself render such a policy irresponsible.

Further arguments against the acceptance of the practice of euthanasia

There are legitimate concerns about the kind of slippery slope which opens out when doctors' attitudes shift in such a way as to embrace the possibility of euthanasia. When doctors accept that there is such a thing as a life not worth living, what kinds of patients, what kinds of persons, might eventually be included within that category? And when the normal social and psychological barrier against killing is removed through a "medicalization of killing", where will the killing policy eventually lead? These were the beginnings of the German medical profession's collaboration in mass murder under Hitler.³ Can we confidently calculate that, despite the same shift in basic attitudes, other doctors would not slide into some similar kind of abyss?

There are very real concerns about the possibilities of abuse of a policy permitting euthanasia. For instance, might patients be killed, or allowed to die, when it is not (as the policy would require it to be) for their good? As Philippa Foot remarks:

*Many people want, and want very badly, to be rid of their elderly relatives and even of their ailing husbands or wives. Would any safeguards ever be able to stop them describing as euthanasia what was really for their own benefit?*²

Or might patients be killed, or allowed to die, when it is not

(as the policy would require it to be) what they want? In fact, there is a particular social experiment which appears to show that exactly this kind of abuse does occur. For some years in the Netherlands there has been a policy of permitting voluntary active euthanasia under certain stringent conditions. But at least one study has shown that during the period of this policy a large number of killings have occurred without the required voluntariness.³

There is also the concern that, under a policy permitting euthanasia, some patients may issue a request for euthanasia, not because this is what they really want, but because they feel some, supposed or real, pressure from elsewhere - for instance, pressure from their family or others paying the medical bills, pressure from their medical aid scheme, pressure from the hospital providing their care, and so on. Pressure can, of course, be subtle yet effective. In other words, what would look like voluntary euthanasia would not be truly voluntary.

We might be concerned that a policy permitting euthanasia would diminish patients' trust in their doctors - the trust on which good health care so critically relies. In a society such as South Africa's, in which many members of the public operate with a relatively unsophisticated understanding of health-care policy, the fact that doctors are known to be killers as well as sustainers of life might well cause a real loss of this trust.

And finally, such a policy could alter, very much for the worse, our general attitudes towards the elderly and towards the chronically ill or disabled; and it could similarly alter those persons' attitudes towards themselves. Again, Philippa Foot, to whom I give the last word:

*... the possibility of active voluntary euthanasia might change the social scene in ways that would be very bad. As things are, people do, by and large, expect to be looked after if they are old or ill. This is one of the good things that we have, but we might lose it, and be much worse off without it. It might come to be expected that someone likely to need a lot of looking after should call for the doctor and demand his own death. Something comparable could be good in an extremely poverty-stricken community where the children genuinely suffered from lack of food; but in rich societies such as ours it would surely be a spiritual disaster. Such possibilities should make us very wary of supporting large measures of euthanasia, even where moral principle applied to the individual act does not rule it out.*²

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Modern psychiatry – a change in ethics?

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Ethics in psychiatry is a complex, controversial and often confusing topic. Psychiatrists in different areas bring their own values to their work, but they must also deal with the values of their colleagues and patients. This intermixing of such values sometimes leads to conflict, which may arise about issues such as confidentiality, informed consent, involuntary hospitalization, the right to treatment, the right to refuse treatment, duties to third parties, and regulation of psychiatric research. Laws may change, as they have in regard to involuntary hospitalisation and treatment, or may be ambiguous, as they are in regard to the limits of patient confidentiality, further complicating the situation.

The papers by Radden, McLean and Kaliski address separate areas of ethical concern in contemporary psychiatry. Yet, they have a common thread in the application of ethical standards to a changing face of modern psychiatric practice. Historically mental health has been neglected and resource allocation inadequate. Conditions in psychiatric facilities remain generally poor, increasing stigma with both the mentally ill and intellectually disabled discriminated against. Diagnosis in psychiatry includes a whole range of conditions and severities requiring the various therapeutic situations to be carefully considered as to the ethical issues applicable. The need to provide culture appropriate care requires that ethical issues are addressed in particular contexts. Monitoring of the quality of standards of care and the implementation of mental health legislation is essential. Although there are common themes to general medicine, some of the dilemmas are quite different but care must be taken to avoid overgeneralisation. General principles may be utilised but there are no universal solutions. Each situation has to be analysed and solutions sought as to the best interests of the patient. In psychiatry this occasionally involves others in the community as well. The risk of exploitation due to the vulnerable nature of the psychiatric patient extends the ethical issues particularly in long-term psychiatric management.

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Professional codes

Since ethics involves a set of principles guiding individuals in deciding what is right or wrong, good or bad, doctors are often seeking answers to the problems they encounter in professional codes of ethics. Such approaches do not necessarily solve problems. Mental health professionals are not required to take any further declaration or oath on qualifying or registering. The Madrid Declaration on Ethical Standards for Psychiatric Practice issued by the World Psychiatric Association (WPA) is a comprehensive document displaying significant advances for setting ethical standards for psychiatrists.¹ There are also further statutory obligations in various codes of conduct. These become important guidelines in psychiatric practice and have been endorsed by all member countries of the WPA. Codes clearly reflect the consensus about the general standards of appropriate professional conduct. They include references to the use of new treatments, scientific techniques and medications. Self-regulation of misconduct within the profession, and respect for the rights and needs of patients, families, colleagues and society form part of the codes. Such codes are reinforced by the standard ethical principles, such as beneficence, autonomy, respect for the persons and justice.

A criticism of professional ethics codes, in psychiatry and in other professions, is that they may have limited effect on education, on advanced training, or on routine professional practice. The efficacy of a mechanism of enforcement for the codes is absent because of the lack of suitable actions against those psychiatrists who have acted unethically. Codes of ethics as with the legal statutes are also subject to change and are frequently reviewed. Ethical principles can support the goals of psychiatric practice and research and an awareness of the relevance of these principles can help clarify treatment options and justify particular decisions in treatment and management.

The ethical issues peculiar to the mentally ill person should be recognized in general medicine and not result in further discrimination. The World Medical Association's statement on ethical issues concerning patients with mental illness reflects the situation, focusing on the patients.² This document reflects the progress in psychiatric therapy which allows for better care of patients with mental illness. Recognition that more efficient drugs and other treatments are ca-

pable of curing mild cases and bringing about long remissions for patients whose conditions are more serious is addressed. The document further states that patients with mental illness are to be viewed, treated and have the same access to care as any other patient.

Informed consent

Informed consent questionably transfers responsibility from doctor to patient. Informed consent is the basis of autonomy theory. Adult patients are assumed to have the right to consent to or refuse treatment. To permit competent adults to make important personal choices about life-styles, careers, relationships, and other values is one way to demonstrate respect for persons. The disabling effects of illness, especially mental illness, influences this issue. When the capacity to choose is compromised by the symptoms for which the treatment is offered, can this person be expected to decide? A document of informed consent serves only as a record of the completion of a process. That process should include enough uncoerced time and information to make an informed choice about treatment. Even voluntary patients have a degree of coercion. The authority of psychiatrists is well documented. Patients often regress in response to mental and physical illness and may become especially vulnerable to influence and exploitation. Psychiatrists must guard against the tendency to dominate their patients' decision making in such circumstances.

Right to die

The right to die suggested in discussions on euthanasia is more appropriately referred to as "end of life decisions". The patient's right to refuse treatment is part of the rationale used to support seriously ill patients' right to forgo life-sustaining treatment. It has been recognised that patients who believe that their quality of life would be compromised by continued treatment have the right to demand that such treatment be withheld or with-drawn. Patients who expect to lose their capacity to make decisions may express their wishes on a prospective basis. This is usually through the use of an advanced directive or "living will". These directives have legal standing in some countries and can elsewhere be used as evidence of a patient's wishes. Living wills present problems because they are often too general, making it impossible to cover all the eventualities in the course of a serious illness within the knowledge of a layperson. The role of the psychiatrist is complex in these situations. Often the psychiatrist is only involved at the end stage of the process. Evaluation of competency by a psychiatrist has been suggested in the proposed legislation. Can the psychiatrist contribute more than the regular attending clinician? Closely related are the circumstances of the suicidal patient. Should all patients who attempt suicide be treated? Some patients who attempt suicide refuse treatment. These patients are invariably treated by referral to hospital. Many questions remain difficult to answer. Is this treatment justified? The assessment comes down to justify the sufficiency of competency and rationality to be allowed to die. The importance of competence cannot be over emphasised. Are they really deciding what is good for themselves or acting on their own conceptions of the situation? Can a person

competently desire to die? The concept of a refusal of treatment certificate (red ticket) is common in hospital clinical practice. Are "red tickets" acceptable in psychiatric patients? Which persons ought to be allowed to die in so called passive euthanasia? Is suicide different to a seriously ill dying patient. Danger to self is one of the indications used for involuntary hospitalisation. Does the psychiatrist have to decide what makes a person's choice rational? This must be made in the face of all relevant available information, consequent to all the various options to be chosen with intelligence that is rational and adequate.

Surrogate decision making

A surrogate is designated to make treatment decisions for patients who have lost decisional capabilities. The surrogate may be selected by various procedures or by the courts. The designated surrogate is usually a next of kin, although next of kin, may not always be the appropriate decision makers. Relatives may have psychological and other agendas that interfere with their ability to make just decisions. In the past, surrogates made decisions for patients on a "best-interests principle". The surrogate was supposed to decide which treatments could be reasonably expected to be in the patient's best interests. Present autonomy-based approaches require surrogates to decide on the basis of what the patient would have wished. The surrogate would need to be familiar with the patient's values and attitudes. These substituted judgments present problems because it may be difficult to determine whether the surrogate is really able to determine what the patient would have wished. Does the psychiatrist have a role in the assessment of the surrogate?

Involuntary psychiatric treatment

This arises from the refusal to consent to treatment or when involuntary treatment is considered justified as compulsory treatment. Preventative detention of a potentially dangerous patient who has not committed an offence remains problematic.

Treatment of those who actively resist treatment is different to other areas of medicine and is the focus of mental health legislation. Mentally ill persons incapable of giving consent are different to physical treatment patients. It must be emphasised that involuntary patients have the right to appropriate treatment despite having their freedom restricted. This is important in considering the problems of substandard facilities to which psychiatric patients are frequently admitted. This in itself presents further ethical issues. The principle of beneficence is invoked to justify treatment of some persons against their will. If a person has a mental disorder and is dangerous to self or others, the law permits involuntary treatment. The legal ground for treatment of persons dangerous to others is "to protect public safety." The legal basis for treatment of suicidal or gravely disabled persons is to protect their lives or safety. In both cases the ethical basis is to benefit the patient by treating the mental disorder. There are legal and ethical limits to involuntary hospitalisation. Involuntarily hospitalized patients must have the right to a judicial review of the grounds for their confinement and treatment.³ Because involuntary treatment restricts a person's freedom and per-

sonal choice, the mental health law requires that this be done. Hospitalization may no longer be indefinite. From an ethical perspective, involuntary treatment may be considered if it is time-limited. The law usually permits a longer duration of involuntary treatment for persons dangerous to others than it does for patients dangerous to themselves.

Confidentiality and privacy

Large computer databases store information which is more freely accessed. Advanced technology has brought issues of privacy and confidentiality to the fore. The problem is further exacerbated in that the databases that store information can be accessed, for example, by managed health care companies with different motivations. Problems arise relating to the extent of access to the relevant information. Reasons for complying with the obligation of privacy and confidentiality may be advanced but these must be cautiously considered. Privacy and confidentiality are often confused but are distinct concepts and the differences must be appreciated. Some information about individuals is in the public domain and is in reality not private. The privacy of information lies in the detail, for example, of the patient's condition etc. A dichotomy has developed in practice as to what is sensitive and nonsensitive with a spectrum in between. Again guidelines may be derived from the principle of respect for autonomy. Privacy for psychiatric practice remains an absolute condition for the relationship necessary in therapy. Infringement of confidentiality only occurs when the individual to whom the information has been granted, in confidence, fails to take care in disclosure especially when another statutory circumstances present.

Forensic settings

For those working in forensic settings ethical issues are becoming of even greater concern than previously. Forced medication has been discussed and considered in making an individual competent to stand trial, as well as in incompetent psychotics in involuntary settings and for the violent patient. The least intrusive procedure should always be utilised. Psychiatrically ill persons in prison pose another ethical dilemma when considering patient rights. The right to refuse treatment, as well as the right treatment must be considered in these settings.

In forensic psychiatry, the role of the professional is aimed at documenting, obtaining, preserving and interpreting evidence in evaluations for the courts and other bodies. This is designed to assist in gathering evidence for decision-making bodies. The evaluator must retain a duty to respect the human rights of the persons being assessed and to adhere to strictest ethical standards of the profession, including the duty to inform the person about the nature and objective of examination. Disclosure of fact that examination is not confidential with respect of findings must be specifically addressed. The conflict between the role as forensic evaluator and as health professional results in a dual loyalty. The psychiatrist cannot accept that a terminology change to that of the evaluation role frees him or her from ethical duties to the patient being evaluated. The dilemma can be partially resolved by performing the assessment consistent with the rights of an individual in-

dependent from influence of others. If the patients are incompetent then disclosure must be made to the person authorised to act on behalf of the patient. An obligation to treat in an emergency and refer for treatment to another facility when the condition assessed so requires remains.

Justice

Justice is an ethical principle that is especially relevant to mental health policy. It should be understood, in this context, as the fair distribution and application of psychiatric services. New advances require new resources which are ever increasing. With deinstitutionalisation, discharge of patients into the community without the ability to cope or with the occurrence of risk behaviour places even more strain on limited resources and requirements for a comprehensive service. This is perhaps a political concern and not an ethical issue. Cross-cultural issues are important in all areas and their influence on illness contributes to ethical debate. The ethical issues arise in public health policy. In the debate about the right to health care, opinions remain divided between the professionals and the providers, both public and private. Some believe that health care is a right to which all persons are equally entitled. Others think that health care is a privilege that must be privately purchased. Still others believe that some amount of health care should be provided for all those with significant health care needs who are unable to obtain them with their own resources. The argument states that if not as a matter of right, as an act of benevolence. Various proposals for a national health insurance are being considered and this will extend the dilemma. Private insurance appears to be continually moving toward a reduction of psychiatric coverage. Many persons' psychiatric needs are inadequately provided for or not at all by their medical aid companies. As result of policy, many indigent persons and even people with moderate financial resources who have serious and chronic psychiatric needs go inadequately treated.

Modern psychiatry requires ethical issues to be considered even more carefully and illustrates the dynamic nature of appropriate ethical consideration in specific instances.

" It is the duty of all psychiatrists responsible for taking major decisions with a patient's function to constantly backup the opinions through dialogue and transparency concerning the approach adopted vis-a-vis their peers, they patients and the community at large." - Council of Europe Committee on Bioethics.⁴

References

1. *Madrid Declaration on Ethical Standards for Psychiatric Practice of the World* Psychiatric Association. As amended by General Assembly WPA, Yokohama, Japan, August 2002.
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3. *Mental Health Care Act No 17 of 2002*.
4. *Council of Europe Committee on Bioethics (2000) White Paper on the Protection of Human Rights and Dignity of people suffering from mental disorder*.