

# The nature and scope of psychiatric ethics

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## Abstract

*Both the professional code of conduct required in the practice of psychiatry, and the broader set of moral and ethical problems distinctive to, or at least magnified by, the mental health care setting are reviewed here. Some perennial aspects of mental disorder and its cultural history are introduced, together with problems resultant from recent scientific advances and policy changes. Psychiatric patients' vulnerability to stigma and discrimination will likely persist, it is noted, even when science demystifies mental disorder, and nothing short of the elimination of mental disorder will obviate the need for a serious and sustained attention to ethical issues in psychiatry.*

**Keywords:** *Ethics, Psychiatry, Stigma*

Psychiatric practice and psychiatric care seem to give rise to their own distinctive ethical dilemmas and issues, their distinctive codes of conduct, and their own uses of moral theory and theorizing. The domain of psychiatric ethics spans not only the professional ethics governing actions permitted, required or forbidden in the practice of psychiatry, but also the set of moral and ethical problems and dilemmas distinctive to, or at least magnified by, the mental health care setting which are the source of more theoretical debates about paternalism, freedom, personal responsibility, agency, rationality, individual and community, and the self.

Even understood solely as professional ethics, the scope of psychiatric ethics is shaped by the different aspects of psychiatric practice. In forensic settings where legal liability, professional censure and other legal and quasi-legal matters arise professional rules of conduct are the single concern. In the educational context attention can be paid not only to rules of conduct but to the ideals and values of the practice and the moral theoretical issues raised by mental disorder and mental health care.

The review which follows is organized into two parts: Part 1 contains a selection of issues in psychiatric ethics which are part of the nature and or cultural history of mental disorder and mental health care. Although perhaps not recognized as such, they have existed, it is safe to say, as long as mental disorder and mental health care themselves. Part 2 reviews a group of issues emerging with recent advances, trends, and policies in, or affecting, mental health care.

## Part 1: Four Persisting Issues

### *The Patient as Autonomous Agent*

If only temporarily and partially, psychiatric patients are often deprived of the very capabilities required for an exercise of autonomy

(and of their best defenses against exploitation): their judgement in matters concerning their long-term self interest; their reasoning ability, their self-control, their personal and psychic integration and their capacity to communicate their concerns and needs to others. At the heart of modern day biomedical ethics is the model of patient as autonomous agent capable of giving or withholding informed consent as to treatment, and a 'client' able to contract psychiatric services.<sup>1,2</sup> Because autonomy is so frequently affected by mental disorder, one central philosophical and moral challenge is to determine whether or to what extent the autonomy model is applicable to psychiatric patients.

This inquiry is a delicate one. Modern day efforts to extend the presumption of autonomy (by replacing the designator 'patient' with that of 'client,' for example) attempt to undo the ill effects of past stigmatizing and prejudicial attitudes which entirely denied rational capabilities to mental patients. Nonetheless, it must be possible to acknowledge and avoid the wrongs associated with the cruel and discriminatory attitudes of the past without resorting to a misapplication of the autonomy model. Unwarrantedly attributing capabilities to the psychiatric patient when such capabilities are compromised involves an equivalent injustice.

This issue is far reaching. It underlies the many problems with which psychiatric ethics still grapples, such as treatment refusal, involuntary hospitalization for care and protection, responsibility in the criminal setting, and the whole range of questions surrounding the criterion of competence (competence to stand trial, competence to refuse and consent to treatment, competence to undertake legal contracts, and so on).<sup>3,4,5</sup> Recent philosophical work on paternalism or 'parentalism' explores the alleged duty to provide care for those who, while not a threat to others, are a threat to themselves or otherwise in need of mental health care, even when this care is unwelcome.<sup>6,7,8</sup> Within the tangle of issues here one debate presents itself as a kind of paradox or dilemma: sometimes, it may be morally necessary to violate the psychiatric patient's expressed wishes and thus their 'autonomy,' in order to restore or enhance their autonomy. The opponents of such paternalism invoke the dangers voiced by Millian liber-

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als: we cannot ascertain another's best interests; a high standard of justification is called for in other settings when an individual's freedom and bodily integrity are comparably interfered with; the psychiatric patient is especially vulnerable to exploitation and psychiatric practice to misuse.<sup>9,10</sup>

The unresolved issue of the applicability of the autonomous agent model will similarly influence the extent to which psychiatry is seen as requiring its own unique ethics rather than being subsumed under the principles and rubric of biomedical ethics.<sup>11,12,13,14</sup> If and to the extent that the autonomy model applies to psychiatric patients, ethical demands on psychiatric practice will be derivable from broader principles of biomedical ethics.

### **Diagnostic Categories**

The nature of psychiatric disorder, its epistemological status, and the social and psychological effects of diagnosis, have for long been the focus of psychiatric ethics and remain so today.<sup>15,16,17,18</sup> The belief that diagnostic categories reflect arbitrary social constructions, rather than a taxonomy of biologically based deficits and or dysfunctions of the brain, continues to challenge and subvert the tenets of biological psychiatry. This view finds support in a past history of misuses of diagnosis, most glaring in the former Soviet Union. Nearer to home, it points to the use of psychiatric diagnosis to affirm exclusionary social norms: misogyny and homophobia in diagnostic categories such as masochistic personality disorder, and homosexuality.

Concerns about the epistemological status of psychiatric concepts occur at every level of generality. Notoriously, the category of mental disorder itself wants conceptually satisfactory definition.<sup>15,19,20</sup> From the broadest category of mental disorder itself, to the syndromal categories found in nosological systems such as the DSMs and the ICDs, to the definitions of symptoms and symptom types, conceptual puzzles and confusion have been identified. The dubious epistemological status of diagnostic concepts and categories affects not only the subjects of such labeling but the labelers, who remain ambivalent and unresolved over the meaning and purpose of these linguistic tools.<sup>21,22</sup>

Because major disorders of psychiatry have as yet no known biological markers, those sceptical of the scientific status or of the social meaning and effects of psychiatric diagnosis recognize its witting or unwitting power and remain troubled by its potential for abuse.

### **A Professional Ethics for Psychiatry Alone**

Despite the obvious and important similarities and analogies between psychiatry and other medical specialities, aspects of the psychiatric patient, the treatment offered that patient, and the therapeutic relationship each serve to distinguish psychiatric treatment from other medical treatment. In dispute is the extent of the difference, and the extent to which that difference requires a distinctive ethics for psychiatry over and above the principles applicable to all biomedical practice.<sup>23</sup>

Several features distinguishing the practice of psychiatry appear to generate distinctive ethical concerns. The degree of confidentiality required appears more critical, both because of the subject matter raised in therapy, and because of continuing societal stigma branding the psychiatric patient.<sup>12</sup> The use of the relationship or alliance as a therapeutic tool places special constraints on the treater and calls for more precise rules of conduct, customarily expressed in the language of boundaries and boundary 'violations'.<sup>24</sup> The patient's vulnerability is increased because the goals of therapy are so broad, far reaching and potentially significant, moreover. This places a greater responsibility on the treater to act ethically and in the interests of the patient.<sup>7,8,13</sup> A related vulnerability is associated with the patient who, as

was noted earlier, is at least temporarily and partially deprived of those traits most useful in combating exploitation, and this vulnerability also imposes a special burden on the treater. With greater opportunity to exploit and dominate, the treater must adhere to stricter standards of awareness and good conduct.<sup>7,24,25</sup>

### **Gender and Psychiatry**

Formal codes of ethics have often omitted reference to gender and sexism. But gender is inescapably tied to psychiatric practice through epidemiology, associations, theories of psychosexual development, and as part of a systemic patriarchal culture.

Psychiatric diagnosis, practice and research have from their beginnings been influenced by widespread associations and attitudes which saw women as particularly prone to mental disorder. Even today women seem to make up a great, and perhaps (the data is ambiguous) disproportionate number of those seeking help from psychiatrists; and recent studies reveal gender links - in incidence, age of onset, course, and response to therapy, in several mental disorders.<sup>26</sup>

The central categories within which mental disorder was understood in our Western traditions were all strongly 'gendered,' that is, associated with one sex or the other - rationality and the reasoning capabilities, the passions, the mind, beliefs, moods, emotions, the will, the self and self-control. Associations with irrationality, lack of control, unbridled passion, and immaturity, the feminine and madness were linked by powerful strands of cultural influence.<sup>27,28</sup> The categories of race, class and ethnicity, are also implicated in psychiatry. But this long cultural association in which madness and its seat in the mental faculties were all gendered categories renders attention to gender especially unavoidable in psychiatric ethics.

Psychological theorizing has often propounded stereotypical assumptions about sex roles and supported differently valued criteria of mental health for men and women.<sup>29</sup> As was noted earlier, gender bias has been identified in certain diagnostic categories.<sup>30,31</sup> Psychological theories also treated women's dissatisfaction with traditional roles as indicative of psychopathology.<sup>31,32,33</sup>

Finally, the pattern by which male therapists help female patients replicates within the therapeutic relationship the power arrangement in which women usually find themselves in the broader society, transforming the experience of receiving care from a male practitioner for women.<sup>32,34</sup>

The pervasive presence of gender within psychiatric theory and practice suggests a range of additional ethical strictures incumbent on the psychiatric professional, including sensitivity to gendered psychiatric diagnoses, and gendered theoretical models.

### **Part 2: Issues and Problems in the New Psychiatry**

Like bioethics more generally, psychiatry has been transformed by technological advances, trends and policies in the last few decades, and these changes have introduced pressing new ethical problems, issues and dilemmas. Four such changes are selected for attention here.

#### **Psychopharmacology**

A primary concern is that psychopharmacological agents are over-prescribed in schools, nursing homes and other institutions to solve management problems; among the well to enhance already enhanced life experience<sup>35</sup>; among the unwell who would be better treated with talk therapy. This is a polarizing issue, contested not only in the scholarly literature but within the media. Proponents of these wonder drugs label as pharmacological Calvinists those who allege such overuse.<sup>36,37</sup> They are in turn accused of failing to note the far-reaching effects of

the so-called 'anti-depressant era,' and also accused of being the witting or unwitting agents of the drug companies profiting from such remedies.<sup>38,39</sup>

Psychopharmacology has also raised new forensic questions: should the defendant be subject (against his will or voluntarily) to psychoactive drugs to ensure competence to stand trial or even for execution? Does the knowledge of these medications' effects on behavior alter the time honored view that when a crime is committed because of mental disorder the person is not rightly held criminally responsible?<sup>40</sup>

Each of these moral questions is contested, controversial, and polemical in part because of more basic uncertainties about these new medications: data as to their actual effectiveness is contested, as are their long and even short term side - effects.<sup>41</sup> Moreover the sponsorship of research by drug companies has invited suspicion of bias.<sup>39,41</sup>

### **Prodromal Conditions**

Studies offer some early indication that by identifying and aggressively treating those whose behavior, 'signs' and or genetic profile seem to indicate greater risk for developing schizophrenia before the disorder exhibits diagnosable symptoms can lessen the impact of the disorder in cases where it emerges.<sup>42</sup> Serious ethical issues are raised by the identification and treatment of these 'prodromal' states, however. It imposes strong anti-psychotic medications on many 'false positive' adolescents who would not prove to have developed schizophrenia; a stigmatizing label is introduced at the time of identity formation; and it involves medicating a group whose immaturity puts both their brain development, and their informed consent status in doubt, for example.<sup>43,44,45</sup>

### **Psychiatry and Genetics**

Recent work on psychiatric genetics must proceed mindful of the ugly history of the eugenics movement wherein the presence of alleged genetic defects justified policies violating fundamental rights of the mentally ill, including basic reproductive freedoms.<sup>46</sup> Even today misunderstandings about the knowledge and predictive usefulness of psychiatric genetics seem as likely to harm as to help those with mental illness. Thus, it is sometimes naively assumed that genetic testing could be appealed to in practical and public policy dilemmas, though in fact tests for most mental illnesses are many years off, and today's genetic screening relies on the family mental health record alone. Even were genetic tests available, the information they would provide seems likely to remain limited, because in the more common kinds of severe mental disorder such as schizophrenia and bipolar and unipolar affective conditions, there is not a simple one-to-one correspondence between genotype and phenotype. Without straightforward Mendelian patterns of inheritance, the accuracy of predictive testing will never approach anything close to 100%. A corollary of a this polygenic or oligogenic basis of mental disorder detracts further from the future usefulness of such testing: these conditions are likely to show genetic variants or alleles of high frequency in the general population. For example, a putative risk factor for schizophrenia is an allelic variant at the gene encoding for the 5-HT<sub>2A</sub> serotonin receptor. But this variant is found in 60-70% of the population. Thus, compared with those lacking this variant, those with it apparently have a very modest increased risk.<sup>46</sup>

A better understanding of the genetic aspects of mental disorder will have other important benefits, it is true. Research into the genetics of psychiatry is expected to help in the development of targeted treatments and is believed by many to be warranted for that reason alone.<sup>46</sup>

### **Managed Care**

As Morreim predicted more than a decade ago, the economic overhaul of medicine undergone in the US (among other nations), with its imperatives of increasing profits and containing costs, has affected mental health care in a distinctive way and posed special ethical challenges for psychiatry.<sup>47,48,49,50</sup> A range of interconnected ethical tensions have been spawned by these changes in practice and policy, each of which affects not only patient rights and treater responsibilities but the quality and effectiveness of mental health care.<sup>51</sup>

(i) Managed care places new strains on confidentiality, privacy and trust. The patient's need to trust the treater with extremely sensitive information is jeopardized by increasingly bureaucratized systems of care and payment. Erosion of such trust in turn affects the therapeutic relationship, as do other aspects of the new regimens.<sup>52</sup>

(ii) Managed care generates many new conflicts of role and ethical obligation for the treater. In addition to acting as advocate for the patient and as exclusively committed to that patient's health and well being, a traditional medical role usually believed incompatible with any other, the treater now must act as health care rationer and gate keeper. These and other conflicts of role and responsibility generate innumerable, daily, ethical dilemmas, and leave many working within psychiatry today frustrated, confused and resentful, a state itself affecting care.<sup>22</sup>

The four issues raised here represent only a sampling of the ethical problems and dilemmas introduced by the new psychiatry. Equally pressing are, for example, the injustices associated with uneven access to mental health care<sup>53,54</sup>; the issues of 'parity' between third party coverage of (other) medical and psychiatric conditions; the cluster of special considerations surrounding children's mental health; the so-called global burden of mental disease understood as morbidity, mortality and disability and viewed as a public health crisis<sup>55</sup>; mental health policy dilemmas around deinstitutionalization and community psychiatry<sup>56</sup>; and mental disorder in relation to disability concepts and law.<sup>57</sup>

### **Conclusion**

Ethical issues in psychiatric practice and mental health care seem almost ineliminable as long as mental disorder occurs. New or newly critical ethical dimensions will emerge with each change in the understanding and treatment of mental disorder. (For example, genetic tests for disorders would place extra pressure on issues of privacy and knowledge and invite new kinds of discrimination).<sup>21</sup> Moreover, even if science eventually permits us to identify and explain states of mental disorder with reference to specific biological markers, thus eliminating much of the negativity, mystery and fear presently surrounding them, still the systemic prejudice and stigma attaching to such states seem likely to remain as long as our cultural values include autonomy, rationality, self-control, personal identity and psychological integrity. Until mental disorder is eliminated entirely, it would seem, the need for a serious and sustained attention to ethical issues in psychiatry will remain.

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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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup>

### 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.
2. *World Medical Association Statement on Ethical Issues Concerning Patients with Mental Illness*. Adopted by the 47th General Assembly Bali, Indonesia, September 1995.
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*.