Chapter 1

The scope of psychiatric ethics

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In the third edition of *Psychiatric ethics*, we began the introductory chapter with a question that we no longer believe we need to pose: Why a book on psychiatric ethics? The subject has found a secure place in both clinical and research practice. We devoted several pages in the second edition to the reasons for this positive development; the interested reader is referred to that volume for a detailed account. Suffice to say here, a growing commitment to accountability on the part of the mental health professions coupled with an informed ‘consumer’ movement have lead to a deeper appreciation of the ethical dimension.

**Ethics: theoretical considerations**

Dealing effectively with this ethical dimension is much enhanced by knowledge of the philosophical underpinnings of moral decision-making. To that end, we draw the reader’s attention to these theoretical considerations (discussed in detail by Tom Beauchamp in Chapter 3; also see Chapters 4–6). Ethics, derived from the Greek *ethikos*, meaning ‘disposition’, has a philosophical home in the discourse of moral philosophy, the study of conduct with respect to whether an act is right or wrong, and to the goodness and badness of the motives and ends of the act. Moral philosophers, in various ways, have tackled questions of whether ethical propositions can be proven and have shown how value judgments are arrived at. They examine concepts like good, bad, right, wrong, should, ought, justice, duty, obligation, responsibility, and many other evaluative terms. A core premise is that where people have a choice of one or another course of action and their activities are not entirely constrained, the question follows as to whether the decision made and action taken are right or wrong.

How do the above concepts apply to psychiatry? Clinicians acquainted with relevant moral theory are at an advantage since they can consider an ethical quandary encountered in their practice by using a structured framework and also compare the strengths and limitations of different theoretical approaches. The principal ones are deontology, utilitarianism, the 4-principle perspective (commonly referred to as principilism), virtue theory and casuistry. Narrative ethics is a relatively new approach applied to clinical practice and attracting increasing attention, but given the chapter devoted to it in this edition (see Chapter 4) by Richard Martinez, we will not deal with it here. On the other hand, we will introduce another newcomer to the field, care ethics, and, in so doing, take the opportunity to offer briefly our own preference for how psychiatrists may best make ethical judgments.
Deontological theory (often called Kantianism (1) after its creator) holds that we do the right thing out of a moral duty, and this is based strictly on rational grounds. Thus, it may be argued, for example, that we always have a duty to tell every patient the truth about his prognosis. The disadvantage with this ‘absolutist’ position is it does not allow the clinician any leeway in possibly withholding grim news at a point when a patient is ill-equipped to cope with additional emotional burdens. Kantianism also makes it difficult to resolve conflicting obligations. For instance, the psychiatrist is not only immobilized if he is always duty-bound to respect a patient’s self-determination, but is also always morally obliged to protect the patient from committing suicide.

J. S. Mill’s (2) utilitarian theory holds that an act is morally right if it yields the greatest possible balance of good outcomes or the least possible balance of bad outcomes when compared with alternative options. Thus, we might not disclose the grim news in the above example if we judged that this would lead to deterioration in a patient’s mental state. The obvious drawback is the marked difficulty in calculating accurately the benefits and risks of a particular decision and the possibility that clinicians would resort to quite different criteria in reaching their determination. In addition, each decision must be unbiased and attend equally to the interests of every person affected.

Principlism (3) was introduced in the late 1970s in an attempt to reconcile the discrepancies between utilitarianism and Kantianism, by basing moral decision-making on mid-level principles (see Chapter 3). These are: first of all, do no harm (non-maleficence); act to benefit others (beneficence); respect a person’s autonomy; and treat people fairly (justice). The approach holds that these widely accepted principles provide a useful starting point in clinical ethics, and can be both applied in conjunction with other pertinent information such as empirically derived scientific knowledge and systematic clinical observation, and used flexibly.

Virtue theory, most closely identified with Aristotle (4), argues that the character of a person is the foundation of moral agency. Acquiring traits such as honesty, trustworthiness, cooperativeness and humility which contribute to virtuous behaviour is the basis of living ethically; this in turn enhances the common good. Critical limitations of this theory are lack of consensus about which attributes are essential for a person to become virtuous and how these are acquired. In the dialogue between Socrates and Meno, Plato (5) poses, but does not answer, the question of whether virtue can be taught, developed through practice or is an innate disposition. The theory can also be criticized for not defining clearly the good to which we should aspire. Lacking objective criteria of that good, clinicians may be heavily influenced by personal values and thus arrive at idiosyncratic judgments.

Casuistry, (6) a case-centered perspective, is more a method of how to engage in moral deliberation than an ethical theory and differs from rule-based approaches like the deontological and utilitarian in which general guidelines are applied to specific situations; here, by contrast, ethical insights evolve and moral confidence grows through analysing specific cases, some of which come to serve as precedents for future cases. The main criticisms are three-fold: analysis is at risk of being embedded in a social context (e.g. pressure to conform) that could foster unethical practices; moral
thinking is restricted to concrete cases, making it difficult to examine larger issues like allocation of resources; and the method is not readily applicable in contemporary societies where pluralistic values prevail.

Care ethics (7) is a recent arrival in medical ethics (it has attracted more attention in nursing). Drawing on virtue theory, developmental psychology, feminist thinking and the work of the Scottish philosopher, David Hume (8), primacy is accorded to certain aspects of character and the realm of the interpersonal. Care ethics is grounded in the value of the capacity of human beings to extend care to people who are feeling vulnerable and therefore stresses empathizing with the experience of others and manifesting concern for them rather than adopting an impartial stance. The criticism can be leveled against care ethics that it is not conceptually driven and is therefore open to the charge of subjectivity with the corresponding risk of psychiatrist bias (a propensity, for instance, to infantilize highly vulnerable patients).

As can be readily discerned, all the above have drawbacks. The strengths they have are vitiates by their limitations. Psychiatrists could be hampered in applying them to manage a moral dilemma. We have argued elsewhere that principlism and care ethics are a complementary and synergistic framework, offering an opportunity to the clinician to consider flexibly the ‘ethical nuts and bolts’ pertinent to a particular clinical situation and at the same time enabling her to gain the trust of a vulnerable patient through empathy and a genuine display of concern (9). Readers, of course, have the prerogative to examine all extant approaches to determine which one/s they find most appealing.

Applying psychiatric ethics effectively

Psychiatric ethics has been used since 1981 by, among others, newcomers to psychiatry who seek to apply ethics effectively during their careers. In an editorial on this topic in 1980, Sidney Bloch expressed the hope that ‘trainees [would] come to recognize the subject as an integral component of their professional education’ (10). In a follow-up commentary (11) of how trainees in psychiatry (and students of related disciplines) might acquire relevant knowledge and skills, we have argued that objectives of educational programs need to be carefully delineated. Currently cited objectives can be grouped as: promoting moral character; developing skills in moral reasoning; moral consciousness raising; and becoming familiar with what the mental health professionals regard as desirable ethical norms. When educators offer such diversity, the result is bound to baffle the novice. Michels and Kelly (12, p. 504) have put it cogently: ‘The failure to recognize … the tension between [different objectives] can seriously undermine the effectiveness of a teaching program in ethics’.

Consider the goal of molding moral character. Though laudable, changing trainees’ traits so that they become more considerate, sensitive, humble, self-critical and the like is unrealistic. Such development is a lifelong pursuit and part of a professional’s maturation into a person who has accumulated what Aristotle referred to as phronesis, or practical wisdom. Moreover, the questions arise as to which virtues warrant attention in training and how to map out strategies to promote those selected. The goal of sensitizing the novice to the moral dimension of clinical practice is, on the face of it, necessary but not sufficient. To distinguish between scientific and ethical
aspects of such phenomena as involuntary treatment and suicide prevention is a pre-requisite to sound ethical decisions but only constitutes a first step. The other two goals we have mentioned lie between these poles in their level of complexity. Thus, developing skills in moral reasoning requires familiarity with moral theory (see above and Chapters 3–6) and knowledge about how to apply them. Becoming acquainted with the values (see Chapter 5) and principles agreed upon by one’s professional group (see Chapter 6) calls for yet another form of learning (see Chapter 10).

We contend that setting coherent goals is the first priority in psychiatric ethics education. Underlying the process is the notion that ethics is pivotal to improving the quality of patient care. In the light of the elusiveness of the nature of educational goals, we supplant them with ‘competencies’ – namely, what do we want to see in the trainee in respect to proficiency in ethics. Given the complexity of ethical decision-making, we propose the following: (1) more than one competency is probably necessary; (2) there is no logic to place them hierarchically as each has merit; (3) any competency warranting attention is clearly articulated; and (4) competencies are formulated in a way that allows them to be systematically assessed. We must therefore establish that the trainee has acquired a relevant body of knowledge, can demonstrate a specific set of skills and has cultivated certain attitudes. In the light of this process, we propose the following competencies:

1. The trainee appreciates the relevance of ethical aspects of clinical practice and accords them the same importance as the scientific dimension.
2. The trainee identifies the particular ethical issues in a given situation (e.g. treating patients against their will, breaching confidentiality, proxy consent, etc).
3. The trainee acquires the skills needed to handle these ethical matters (such as identifying the role of covert values influencing his/her decisions, realizing when principles clash, understanding the nature of dual agency and recognizing the place of obligation, responsibility and duty).

Since there are diverse theoretical approaches with varied rationales, as we have seen above, trainees cannot possibly graduate as junior philosophers. On the other hand, if they are acquainted with the strengths and limitations of the principal models, this can enable them to draw on pertinent moral concepts. These skills are complemented by the necessary empathy to facilitate the sensitive deployment of moral rules. Linked to the last competency is an ability to appreciate the utility of collegially agreed-upon principles (usually in the form of codes of ethics). The use of consensual guidelines in this way informs the trainee that he is not obliged to ‘re-invent the wheel’ each time he encounters a moral quandary.

Finally, we re-iterate the hope expressed in the 1980 editorial that trainees will see psychiatric ethics as a prominent part of their educational experience. We also wish that the psychiatric profession (and other mental health disciplines too) pursues an active role in ensuring that the ethics of clinical practice and research are as central to our enterprise as the science and the art. Naturally, we hope that *Psychiatric ethics* can play a role in this process.
Changes in the fourth edition

As part of our thinking about the needs of trainees, as well as of qualified clinicians, we have identified five new topics for the fourth edition. We believe these chapters – in conjunction with those updated from its predecessor – provide a text that encompasses the core ethical issues facing the contemporary psychiatrist. The new material covers narrative ethics, the relationship between the psychiatrist and the pharmaceutical industry, neuroethics, ethical aspects of consultation-liaison psychiatry and trauma and ethics. Narrative ethics has earned growing recognition as a means to reach ethical judgments in clinical medicine, especially in the US. Richard Martinez, a forensic psychiatrist, shows how it may have a role in clinical psychiatry; he weaves in two poignant case illustrations to substantiate his points. The association between doctors generally, and psychiatrists specifically, and the pharmaceutical industry has been examined with increasing interest, particularly industry’s influence on clinicians’ prescribing patterns, educational activities and researchers’ objectivity and scientific integrity. Stephen A. Green reviews these complex developments and raises relevant ethical questions. Neuroscience is expanding dramatically as an area of study, with notable implications for treatment. In terms of both the research problems thrown up hitherto and the clinical implications of the emerging findings, the psychiatric profession will have to think deeply about how to traverse relatively uncharted moral territory. Stephen Morse, a constitutional legal scholar and psychologist, teases out the ethical strands. The relevance of trauma in mental health care has been heightened by wars waged in several parts of the world over the past decade. Debate has continued on the construct of post-traumatic stress and the diagnostic validity of post-traumatic stress disorder (PTSD) in combat as well as following natural calamities. Michael Robertson and Garry Walter, both psychiatrists working in Australia, raise a series of ethical implications related to diagnosis and treatment. We are puzzled that we have not hitherto included a chapter on the many and variegated ethical challenges encountered by consultation-liaison psychiatrists. Marguerite Lederberg and Tomer Levin, both psychiatrists working in the psycho-oncology field, have considered these methodically in their chapter.

Three chapters that appeared in the third edition – on ethical aspects of electro-convulsive therapy and psychosurgery by Harold Merskey, psychiatric diagnosis as an ethical problem by Walter Reich, and teaching psychiatric ethics by Robert Michels and Kevin Kelly – will be found on the website of Oxford University Press (www.oup.com/uk/isbn/9780199234318). They are in the same form as in the third edition since the original material remains apposite; rather than publish them in the new edition unchanged, a convenient remedy is to make them available electronically. Readers who wish to download any of this material are advised to locate the website and follow the relevant links.

Conclusion

Perusal of the new edition reveals that psychiatrists grapple with a broad range of vexing ethical problems. Although these differ according to the type of psychiatry practiced,
certain themes are pervasive. These include: how to assess the moral costs and benefits of an intervention; how to maintain confidentiality in the face of competing loyalties; how to seek patients’ consent for a procedure or treatment; how to define the boundaries of their professional task without recourse to hubris or undue timidity; how to strike a balance between the ethos of contractual equality and a benevolent paternalism; how to satisfy the interests of patients, their families and the broader community especially when they clash; how to avoid discriminating against or exploiting patients; and how to advocate for patients, many of whom are disenfranchised and powerless.

As editors, we are confident that our contributors help to shed light on these themes which impinge on the practitioner, and in which elements of the human, the contingent and the ambiguous are interwoven.

References