An Overview of Psychiatric Ethics

By **Dr Michael Robertson**

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Foreword

Medical ethics is an important concern for all junior doctors but also for anyone working in mental health. This engaging text is written specifically for junior doctors who have an interest in psychiatry. Dr Robertson presents actual cases to explore the major dilemmas that have confronted frontline clinicians using both a historical perspective in the Chelmsford enquiry to more contemporary issues relating to mental health issues in the NT intervention into Aboriginal communities and the justice system. The context of these cases is Australian, with a focus on issues that have confronted the NSW mental health system, making the text especially useful for psychiatry trainees who are intending to practice as consultants in this State. I am pleased that the NSW Institute of Medical Education and Training (IMET) and IMET's Network Oversight Committee have been able to support the Editorial Group in developing this resource, which IMET is making available to all junior doctors and their supervisors via the IMET website.

Dr Murray Wright
Psychiatry Clinical Chair
NSW Institute of Medical Education and Training
Director Clinical Operations, Mental Health, Drug & Alcohol
Greater Southern Area Health Service

Introduction

What Is 'Ethics'?

Socrates once posed the question "how should I live?" The essence of this challenge was the question of a 'good life'. By 'good', one does not mean 'not bad', but rather some overriding sense of value to a life. For many, religious texts provide a workable foundation of such an ethical life. For others, the concept of being a responsible member of a community or a society provides such foundations.

Psychiatry is a specialty of the profession of medicine. Professions possess their own codes of ethics, often formulated by learned members of the group. Such codes of ethics are recognised as standards of professional conduct by which acts are judged. Whilst this may work from a public perception, these do not necessarily provide a comprehensive or even substantive account of what it is to be an ethical psychiatrist. Many have argued that ethical physicians are possessed of virtue and therefore perform virtuous acts, whereas others regard the caring aspect of medicine as the value providing the foundation of medical ethics.

The word 'ethical' has many connotations. Many confound the description of an act or a person as 'ethical' as meaning 'right' or 'lawful'. As such, to describe something as 'unethical' does not mean it to be illegal or even necessarily incorrect. To best understand ethics one must understand the values from which they emerge. Put simply, Socrates' question is best answered in the notion that living a good life is to live in accordance with a set of values. Such values may be handed down by Divine command, may emerge as part of broader social values or may be simply constructed by individuals in the course of their lives.

Is there a distinct discourse in psychiatric ethics?

Bioethics emerged in the 1980s as a separate discourse in moral philosophy. Medical ethics has been subsumed under the umbrella of bioethics, although the Hippocratic tradition of *primum non nocere* (first do no harm) still enjoys some status in the moral deliberations of medical practitioners. The field of biomedical ethics became more formal with the publication of the authoritative text *The Principles of Biomedical Ethics* (now in its 6th Edition)[1] by two American philosophers, Tom Beauchamp and James Childress. Much of the focus of biomedical ethics has been on the implications of technological advancement in medicine, such as therapeutic cloning, reproductive assistance and the use of embryonic stem cells. Psychiatric ethics, by contrast, has tended to languish in obscurity and has been referred to as the "bioethical ugly duckling".[2]

Campbell and collaborators[3] see psychiatric ethics as having a special status in biomedical ethics, given the effect of mental illness on autonomy. They argue that psychiatric ethics should adhere to three basic tenets of beneficence and non-maleficence: using validated methods to return the patient to proper functioning as a responsible and self directed individual; refraining from any treatments which are harmful and preserving the distance between psychiatrist and patient by acting without an 'emotional entanglement'. They appear to have little time for academic debates about the relative merits of one ethical theory over another, arguing that "patients should not be adversely affected by such Olympian struggles among the demigods of the medical pantheon (p.163)"
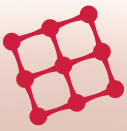
Radden offered a more comprehensive case for the uniqueness of psychiatric ethics.[4, 5] She argued that psychiatry differentiates itself from other medical specialties in the unique role of the therapeutic relationship in therapeutic outcome; the vulnerability of psychiatric patients; and the features of the psychiatric therapeutic project – defined as "re-forming the patient's whole self or character…akin to the responsibilities of raising children". As such, she argued that virtue ethics are profoundly important to psychiatry. Other writers have defined the uniqueness of ethical issues in psychiatry, particularly in regards to treatment, as arising from the stigma of mental illness and issues surrounding autonomy.[6] Radden thus argued that special virtues required of the psychiatrist are compassion, humility, fidelity, trustworthiness, respect for confidentiality, veracity, prudence, warmth, sensitivity, humility and perseverance.

Dyer[7] argued that psychiatry's status as a discipline of the profession of medicine needs to be reconsidered. He claimed that a physician is currently characterized more by his or her technological skills or expertise rather than their ethics or values. Medicine, along with the so-called "learned professions" such as the law, teachers or clergy, was originally defined by the knowledge held by its members and by the beneficent application of that knowledge to the needs of fellow citizens. Dyer contended that medicine has become largely a commodity and that market forces have interceded in the doctor-patient relationship. As such a professional relationship in medicine has become more an issue of technical services traded in the marketplace, rendering the Hippocratic tradition in medicine little more than an historical footnote. In Dyer's view this placed psychiatrists in the middle of social tension – on the one hand to be a professional meant to place the psychiatrist in an attitude of service to one's fellow man, yet on the other, market forces required the psychiatrist to earn his or her living by the knowledge and skill they have acquired. Whether one shares Dyer's concerns in full, it is reasonable to assume that much has changed in medicine in the last few decades.

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This monograph is set out in three sections. Section 1 provides the reader with overviews of the main theories in moral philosophy which have been discussed in the setting of psychiatry. Section 2 gives an account of various themes in the recent history of psychiatry, highlighting their salience in the current ethical discourse in psychiatry. Section 3 provides a review of the literature addressing applied ethics in psychiatric practice.

The monograph does not set out to outline a program of ethical behaviour by listing a series of 'shoulds' or 'oughts'. Rather, my intention is to provide readers with accessible accounts of the various ideas in the literature regarding psychiatric ethics, in order to allow them to commence a process of reflection upon the values which will form the foundation of their ethical practice of psychiatry.

Michael Robertson MB BS (Hons), FRANZCP
Centre for Values, Ethics and the Law in Medicine
University of Sydney

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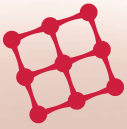
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Normative Ethical Theories and Psychiatry

INTRODUCTION

In this section ethical theories will be outlined and their relevance to psychiatry discussed. Many theories of ethics have emerged throughout history, however, (with the exception of virtue ethics) the main ideas in moral philosophy relevant to psychiatry have only appeared since the Enlightenment. This is a reflection of the intellectual theme of liberal humanism, which places human reason, unconstrained by political, theological or social tyranny, at the centre of moral philosophy.

Theories of ethics are either descriptive or normative. Descriptive ethical theories aim to define 'what is', whereas normative theories aim to define 'what should be'. Whilst descriptive ethics are problematic, because they may lack solid foundations other than those that have emerged out of a culture or society, normative ethics suffer the problem of justifying 'shoulds' and 'oughts'.

The Scottish philosopher David Hume argued that it was impossible to define shoulds and oughts, contending that most humans act ethically in response to their emotions. As Hume proclaimed, "reason is the slave of the passions".[8] Normative ethics try to define shoulds based on various methods of reasoning, an approach that the utilitarian philosopher RM Hare described as "prescriptivism".[9]

In each of the sections I will briefly define the main aspects of the descriptive or normative theory and outline how these relate to psychiatric practice.

PROFESSIONAL ETHICS AND PSYCHIATRY

As a specialty of medicine, the starting point of ethics in psychiatry is that of the values of the psychiatric profession.

The Oxford English Dictionary[10] defines a "profession" as:

> **"An occupation whose core element is work, based on the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning, or the practice of an art founded on it, is used in the service of others. Its members profess a commitment to competence, integrity, morality, altruism, and *the promotion of the public good within their domain.* These commitments form the basis of a *social contract between a profession and society,* which in return grants the profession autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society (my italics)."**

The key elements of this definition appear to be the existence of a contract of sorts between a professional group (or the individual professional) and society; the promotion of public good; and a number of desirable personal qualities, or 'virtues'. In exchange, the group is accorded professional autonomy and the capacity to self-regulate.

The original Hippocratic tradition was of *primum non nocere* (first, do no harm). This holds that any action of a physician must benefit, and in no way harm, the patient. The situation has changed and the Hippocratic tradition in medical ethics has waned[11] due to the presumed effects of the

evolution of Western societies into consumer economies,[12] the commercialization of the health system and the technological advances in medicine.[7, 12] It has been argued that, in the light of such developments, the craft of medicine has evolved into a service industry in which technical skills are traded in a market place. As such, the notions of a physician's virtue and the Hippocratic tradition have been lost. The scale of the practice of medicine has also increased exponentially. In developed countries medicine has changed in one or two generations from a cottage industry to one consuming a significant portion of each country's gross domestic product.[12]

Professional ethics, arguably, have three core components – specialized training and the acquisition of specialized skills; the provision of expert assistance to those who are vulnerable and in need; and the virtues of trustworthiness, efficacy and knowledge which ultimately enhance the common good and aggregate well being.[13]

Several physicians' organizations have jointly outlined a series of principles and responsibilities for the medical profession, which integrate the recent influences on medical practice[14]. In this new code, the principles of patient welfare, patient autonomy and social justice are juxtaposed with the responsibilities of commitment to professional competence, honesty with patients, confidentiality, appropriate relations, improving quality of care, improving access to care, ensuring a fair distribution of finite resources, pursuit of scientific knowledge and maintenance of trust by managing conflicts of interest and professional responsibilities.

Any medical practitioner abides by a social contract[14] as both a healer and professional. Professional ethical autonomy is therefore given on the understanding that professionals will devote themselves to serving the best interests of society and will self-regulate to maintain high quality service.[15]

Social Contract Theories

Humans tend to act primarily out of self-interest. Whilst there may be many instances where people take action out of altruism, the strongest motivation to act for a person is out of self-regard.

The English philosopher Hobbes postulated that humans were, by nature, prone to act in self-interest.[16] In Hobbes' view, society would deteriorate to a violent state of anarchy unless regulated by laws. Hobbes argued that everyone was vulnerable in such a "state of nature", even the most canny or physically capable. In the alternate, humans could agree to abide by a covenant in which they would all act in a way that allowed others to go about their lives without fear of being attacked or exploited. In essence, all members of society would act out of their own self-interest to participate in an agreement in which a set of laws would create a society where no-one was allowed to act in an exploitative or violent manner. The self-interest component of such an arrangement was that each participant would recognize that it was in their interest to have a society where they could pursue their life's goals in safety and harmony. The one potential pitfall in this arrangement would be the so-called "moral free rider", who would still act in an unconstrained manner out of self-interest, yet expect the benefits of the social contract. Hobbes' solution to this was a powerful sovereign (or "Leviathan"), who would enforce the social contract arrangement by punishing or excluding those persons who violated the social contract arrangement. Later social contract theorists such as Gauthier have described less dramatic instances of social contract, such as the so-called "prisoners dilemma" thought experiment, in which two prisoners see a mutual advantage in not informing on each other and therefore act out of mutual self-interest.

Social contract theories have been criticized as historically inaccurate ("not worth the paper they were never written on"),[17] as well as their implicit moral nihilism – they effectively assume the worst of humans and assert that as a species we are incapable of any form of moral responsibility.

Applied to a professional context, the contractarian approach to ethics involves the assumption that a professional group will, primarily out of self-interest, abide by an agreed set of expectations of behaviour and conduct. This is usually in exchange for a level of professional autonomy or self-regulation. When a profession is seen to fail in this agreement, in either a specific instance or an overall manner, society tends to respond through enacting legislation to enforce a particular change. For example, if there are a number of instances of failure of a professional group to maintain standards of practice, then a society's legislators will enact laws to force the profession to introduce such standards. In essence, the penalty for a profession's failing to meet the expectations of the social contract is the loss of various components of self-regulation.

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The social contract tradition in medical ethics is problematic in the setting of psychiatry. Society may evolve certain expectations of the psychiatric profession, which are to the detriment of people with mental illness. This places the psychiatric profession in a position of conflict between obligation to a patient and obligation to society in the professional social contract. The clearest example of this is the one of public safety. After the rare instance of a person suffering a mental illness harming another person, society may, through its legislators or its institutions, emphasize the expectation that psychiatrists must manage risk more effectively. Putting aside the obvious limits of this as an undertaking, this may result in the psychiatric profession being expected to act more coercively in the treatment of people with mental illness in order to protect the public, rather than provide care for their patients. This highlights the fundamental dilemma in the social contract tradition of ethics applied to a professional group – where the presumed 'common good' of society comes into conflict with the interests of the patient.

UTILITARIANISM

Introduction

In seeking to define the 'good life' many philosophers have argued that it aims to maximise pleasure, defined as the absence of pain. As the basis of moral philosophy, ethical hedonism therefore seeks to maximise pleasure. This approach dates from antiquity and the writings of Epicurus, who deemed:

> **"Pleasure is our first and kindred good. It is the starting-point of every choice and of every aversion, and to it we come back, inasmuch as we make feeling the rule by which to judge of every good thing."**[18]

'Consequentialism' is the view that the merit of any act is evident in its ultimate consequences. In the light of ethical hedonism, this was the notion that the merit of any act was the degree of overall utility or pleasure it generated. The method of utilitarianism was first articulated by Jeremy Bentham,[19] who argued that all humans were beholden to a form of hedonism, and as such a moral and political philosophy should aim to maximize pleasure. Bentham's utilitarianism was vulgar, arguing it was "better to be a contented pig than an unhappy human". The evolution of utilitarianism as a credible ethical theory derives from writers since Bentham, particularly John Stuart Mill[20, 21] and Henry Sidgwick.[22] The key ideas underlying the evolution of utilitarianism are summarised in Table 1.

Utilitarianism has been so dominant in moral philosophy, that it could claim to be the starting point for all ethical considerations.[23] It is possible that there is a survival advantage for species which practise utilitarian approaches, where the elevation of group over individual needs may help primitive communities thrive.[24]

Author	Key Concepts	Other issues
J. Bentham (1748-1832)	Maximising utility was to maximise the total amount of pleasure in society[19]	Higher pleasures not preferable to base ones – "pushpin is as good as poetry" Runs into the 'quantification problem' i.e. how to measure pleasure
J.S Mill (1806-1873)	Cultural, intellectual, and spiritual pleasures are of greater value than physical pleasures in the eyes of a "competent judge" [20, 21]	Provides foundation for later formulations of preference utilitarianism, i.e. the good relates to satisfaction of greatest number of preferences. "Act" and "Rule" utilitarianism distinction later outlined by R Smart[25]
H. Sidgwick (1838-1900)	Outlines a method of moral philosophy based on "Universal Hedonism" (utilitarianism)[22]	Sidgwick's Ideas provide the foundation of current conception of utilitarianism and highlights some conflicts between personal and collective pleasure. Rejects motivations as a basis of morality, rather sees "common sense" as the basis of ethical choice
G.E Moore (1873-1958)	No true conception of the ethical good could be formulated. Maximising "ideals", like aestheticism, or love preferred to mere pleasure[26]	Advances the notion of what is later dubbed 'informed preferences' and economic views of personal preferences
R.M Hare (1919-2002)	Levels of moral thinking – "practical" is utilitarian and "analytic" is more complex[9, 27]	Sees Kant's "Kingdom of ends" as utilitarian in spirit. [27, 28] Advances a form of utilitarianism as a method of psychiatric ethics. [29]
K. Popper (1902-1994)	"Negative Utilitarianism" as the responsibility to prevent the greatest amount of harm or evil[30]	Argument *reductio ad absurdum,* against negative utilitarianism is the so-called "pin-prick argument", which states it would be better to painlessly destroy humanity than allow one person to experience a pin-prick.[31] Also criticised by R Smart[32]
P. Singer (1946-)	Utilitarianism requires equal consideration of interests, whatever the species.[33] Utilitarian ideas a form of naturalism – suppressing individual need for that of the collective has survival advantage[24]	Concept of "diminishing marginal utility" argued. Adopts a "journey model" of life, which sees validity of claim to consideration of preferences based in sentience and the stage or capacity to meet life goals. Singer's views are polemic and have led to heated debate, in particular over the manner in which his philosophy appears to validate euthanasia and abortion[34]

Table 1. Key Concepts in the evolution of utilitarianism
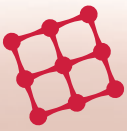
The Philosophical Basis of Utilitarianism

One of the initial problems with the concept of hedonistic utilitarianism is how to quantify the level of pleasure achieved by an action. This 'quantification problem'[35] diminishes the value of Bentham's and Mill's utilitarianism, as it invites relative considerations of the merits of different pleasures. There is simply no way to argue that any one form of pleasure is more worthy than another. The way around this problem is to consider 'preferences' rather than pleasure. Preference utilitarianism, advanced largely by Peter Singer[33] advocates that individuals' preferences are subject to the consideration of a moral deliberation, rather than the mere indulging of their pleasures.

The first problem with considering preferences as the basis of utilitarianism is the issue of adaptive preferences, whereby people accept less because of low expectations (such as the "contented slave").[36] The second problem is the issue of unexperienced preferences (i.e. ones we will never know existed) and preferences that may be harmful.[23] The third problem is of external preferences in which the individual's desires regarding the distribution of preferences to others are considered. An example of this is the idea that a population is allowed to express preferences for how the law deals with the access of homosexual couples to public funding for assisted reproduction. This moves beyond what someone wants for themselves, but also what they desire for others. In the light of this, some have argued that preference utilitarianism be limited to goods which are universally desired or provide basic necessity.[37]

One of the challenges for moral philosophy is the nature of 'moral' truths as compared to factual truths. R.M. Hare, a prominent writer in utilitarianism, identified the problem of "prescriptivism" in moral reasoning.[9, 38] Put simply, prescriptive moral statements containing 'should' or 'ought' have a different status, and verifiability, than those referring to fact. "You should do A" is a different proposition from "This is an A". As such, R.M. Hare sought to define conditions in which prescriptive statements, shoulds and oughts, could be valid. Hare identified two conditions for prescriptive statements – universalisability and the so-called "golden rule". Hare's utilitarianism extended from this approach.[9] Hare distinguished between two levels of utilitarian thinking. The first is the "critical level" of thinking, applying the "Golden-Rule Argument" – could a particular act be considered as the best approach in all circumstances? The second level of utilitarian thinking is the intuitive level that utilizes simple consequentialist principles[39]. In confronting an ethical dilemma, one deliberates *prima facie* using a simple consequentialist approach, i.e. which approach has the best outcome for most members of society. In Hare's method, one then deliberates at the critical level, considering whether such an act is virtuous, legal or practical. The conclusions of the intuitive level must therefore be acceptable at the critical level. It is argued that few people are capable of such deliberation, which gives way to an elitist view that the critical level utilitarian thinking is only the domain of the enlightened few, or what the philosopher Bernard Williams described as "government house utilitarianism".[35]

The distinction between intuitive and critical levels has evolved into 'Act' and 'Rule' utilitarianism.[25] Act utilitarianism is where the moral agent decides to act on the basis of what is most likely to maximise utility in a particular instance. Rule utilitarianism, by contrast, is more prescriptive and has the moral agent acting relative to the notion of maximising preferences generally, rather than in regards to the specific instance.

Evaluating Utilitarianism as a Basis for Psychiatric Ethics

The advantages of utilitarianism as an ethical solution are its intuitive appeal, particularly its apparently scientific approach to ethical reasoning.[25] Utilitarianism's strengths are its power to generate solutions to problems, its practicality and transparency.[40] Utilitarianism therefore fits well with approaches to public policy.

There have been, however, a number of challenges to utilitarianism.

The replaceability problem[41]
The replaceability problem is based on a thought experiment involving the utilitarian justification of one healthy person being killed to provide transplant organs for half a dozen others in need. Another scenario questions whether we would kill one man to save dozens of others.[35] Many have argued that these challenges are somewhat 'straw man' in nature (i.e. reducing utilitarianism to a simplistic view to justify criticism of it). Utilitarian approaches to ethics work extremely well in

common situations, and the elaborate or unrealistic scenarios devised by the critics of utilitarianism are not comprehensive arguments against it.[42] Rather than be purely beholden to the principle of utility in a vacuum, the moral agent should also reflect upon the critical level of moral reasoning proposed by R.M. Hare for example, how a utilitarian act relates to issues such as one's duty to other persons. The alternative, unreflective option is the unrealistic prospect of the "U-Agent",[43] who is totally devoid of any personal morality and wedded solely to the outcome utilitarian abacus. In reality, physicians incorporate "agent relative values" by considering a utilitarian calculation morally wrong if its consequences affront the 'do no harm' tenets of a healing profession.[44] Workable forms of utilitarianism based professional ethics require adherence to a process of critical reflection in order to promote the welfare of others.[45]

The responsibility problem
The other main criticism of utilitarianism is the notion that moral agents are responsible for all of the consequences of their choices, including the failure to prevent negative consequences and the consequences of consequences, placing an unreasonable burden on the person who enacts a utilitarian conclusion to a dilemma.[35] The more balanced view of this problem related to utilitarianism is the view that the responsibility for ongoing consequences of utilitarian choice should diminish over time.[46]

Utilitarianism and Psychiatry

R.M.Hare advanced a version of utilitarianism as a workable basis for psychiatric ethics,[29] based upon his previous work in moral theory.[27] Hare argued that utilitarian accounts of psychiatric ethics are often abandoned unnecessarily because of the conflict between different agent-relevant duties of psychiatrists towards their patients. Hare suggested that psychiatrists:

> **"need not think like utilitarians; they can cleave to principles expressed in terms of rights and duties and may, if they do this, achieve better the aims that an omniscient utilitarian would than if they themselves did any utilitarian calculation"** (p.30).

Peter Singer's writings on utilitarianism introduced a controversial "principle of equality" encompassing all beings (including other species) with interests and, therefore, preferences deserved consideration in moral deliberation.[33] Whilst all species prefer to avoid pain, only sentient humans maintain an interest in cultivating their unique individual abilities. Singer considers this distinction as the justification of differential consideration of varying preferences. Singer then articulated a concept of "diminishing marginal utility" in which the utilitarian consideration of preferences considers both the need as well as the desire for the preference. This elaborates into a "journey' model" of life, which measures the merits of how preferences fit within an individual life journey's goals. A personal interest in continuing to live and not suffer in order to fulfil an individual life journey is the highest order of preference in utilitarian calculation. Singer's utilitarianism thus justifies both euthanasia and termination of pregnancies carrying foetuses with profound deformities.[34]

Extending Singer's views to psychiatry leads to some unpalatable conclusions. Mental illness, by its very nature, thwarts a life journey's goals compared to other forms of physical illness. Many severe forms of schizophrenia engender profound levels of impairment of individual life projects, particularly where the clinical picture is dominated by negative symptoms or disorganization. Comparing the different prognostic implications of psychiatric diagnoses leads to distinctions made on the value-laden concept of quality of life. Applying Singer's variation of utilitarianism to psychiatry, the preferences of a person with severe, intractable schizophrenia to avoid suffering are placed second to the desire of the patient with phobic anxiety to return to university and continue a fulfilling life journey. Moreover, in the utilitarian based public policy decisions about the allocation of limited health resources, the diminishing marginal utility doctrine takes on even more significance, as the preferences of many in society are gratified by the mildly disabled returning to employment and contributing to society through individual fulfilment, rather than the preferences of those patients with severe psychiatric disability to avoid or reduce suffering. This also introduces a variant of the quantification problem.

It is part of a psychiatrist's responsibilities to attend to the economic aspects of treatment decisions.[47] The international standard measure of utility in this regard is the Disability Adjusted Life Year (DALY)[48] and the Quality Adjusted Life Year (QALY).[49] Singer argued that the use of QALY justified the favouring of the preferences of those not severely disabled by mental illness,[50] despite the fact that these are insensitive measures applied to psychiatric disorders.[51]

In recent times two factors extraneous to psychiatry, may have promoted utilitarianism's position in psychiatric ethics. First, legislated responsibilities of psychiatrists, particularly in relation to issues of risk of harm, have effectively trumped any ethical code of conduct intrinsic to the psychiatric profession.[52] Such legal imperatives are invariably utilitarian in nature and have usually emerged in the context of social and political responses to issues such as public safety.[53, 54] This has led to utilitarian justifications of the otherwise vexed 'double agent role' in regards to forensic patients.[55]

The other factor promoting utilitarian thinking in psychiatric ethics has been the changes to healthcare systems in the face of globalisation and financial pressures, particularly in the US and Australia. Indeed, as Dyer has stated, medicine has become a three-way relationship between doctor, patient and third-party provider.[7] This issue was given close consideration by Green and Bloch, who identified that when applied to mental health care decisions in a managed care setting in the US, the problem emerged that "maximizing the common good encompasses a central limitation — the indifference to the uniqueness of the person".[56] Green and Bloch go as far as to suggest that the psychiatrist may be ethically compromised submitting to a market-driven approach in the management of mental illness.

DEONTIC ETHICS

Introduction

"Deontic" refers to duty (from the ancient Greek "déon", meaning "that which is binding or proper"). The ethics of duty, or deontic ethics, are usually attributed to Kant and his later followers. Kant's moral philosophy is outlined in three main works: *Groundwork for the Metaphysics of Morals* (1785) *('Groundwork')*[57]; *Critique of Practical Reason* (1787)[58]; *The Metaphysics of Morals* (1797).[59] To Kant, the central ethical question was prescriptive – "what ought I do?" Kant's valuing of human reason dictated that the answer to this question had no reference to a conception of what was good or the concept of virtue. Kant sought, in essence, principles of action which could be adopted by anyone without any specificity about desires, circumstances or social relations. In developing a prescription for duties, Kant differentiated between so-called "perfect" duties, which are required of all moral agents at all times, and "imperfect duties". The latter refers to a double negative – not neglecting our duties to others in need.

Kant's Ethics

Kant's philosophy is a product of the Enlightenment. The "Enlightenment" refers to the period beginning in the late Eighteenth Century around the time of the French Revolution, in which the principles of liberty, fraternity and equality challenged the divine right of kings and religion to control society. An intellectual movement, liberal humanism, evolved in tandem with the political changes of the Enlightenment. Liberal humanism (what is now termed "modernism") was based upon the human capacity for rational thought and was characterized by notions of absolute truth; that the world can be controlled and ordered and accurately represented. Enlightenment thinkers believed in ordered linear development and the idea that history progressed according to an overall idea, theme or what was later termed by post-modern philosophers "metanarrative". Kant had proclaimed that the motto of the Enlightenment was *"sapere aud"* (dare to know).

The two key concepts in Kant's ethical philosophy are the notions of individual autonomy and duty. Kant defined "autonomy" as the capacity for free, rational moral choice – the ability of a person to formulate his or her own laws of morality. Kant described this as "practical reason", in which man is not beholden to divine commands or superstition, but rather a notion of secular morality based upon rational thought. Kant rejected other forms of moral action, such as those based upon emotions or filial bonds. To Kant, the sign of a good moral agent is little more than the possession of "good will" or dedication to duty. The moral worth of an act is its relationship to a good will – not its intentions or consequences. In other words, deontic ethics can be reduced to the notion of doing the right thing for the right reasons.

Kant's conception of autonomy is therefore profoundly different from the more modern conception of autonomy as the right to negative liberty, i.e. the freedom to pursue one's own ends, to satisfy one's desires, and to exercise independence of choice without the undue interference of others or the state. In Kant's "Kingdom of Ends" each moral agent is both a moral self-legislator and beholden to a common law. Kant did not believe in individual autonomy existing at the expense of the rule of law.

The issue of duty is defined in Kant's ethics as the notion of the "Categorical Imperative" (CI), articulated in the Groundwork. Kant argued that, in day-to-day dilemmas, we develop maxims that guide decision. The universalisability of moral maxims is tested against the Categorical Imperative.

The CI has multiple formulations. The First Formulation articulates the principle of universalisability by directing:

> **"Act only according that maxim whereby you can at the same time will that it should become a universal law"** (p.421)

The Second Formulation of the CI is the injunction:

> **"Act as if the maxim of your action were to become through your will a universal law of nature"** (p.421).

Arguable, this formulation of the CI seeks to define a relationship between the laws of nature and the moral law.

Kant's Third Formulation of the CI is often dubbed the "formula of humanity". It reads:

> **"Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means"** (p.429)

If ethics are a guide to relations between individuals, then this is the most important of Kant's ethics. The purpose of good actions is respect for people as beings who are intrinsically valuable. To understand how the CI works, one must first define a moral law which is universalisable and in some way naturalistic. Kant wrote of the specific example of lying. Even though a lie may have desirable consequences, it does not occur in accordance with good will and is therefore unethical. Based upon the application of the CI to lying, the person develops a set of maxims (specific rules for different situations) that they apply to their moral agency. The third test is whether these maxims value humans intrinsically or not. One can see a contrast here between Kant's view of ethics and that of the utilitarians. It may be quite feasible to lie in the eyes of a utilitarian, if the desired result maximizes preferences or pleasure. To Kant, lying is never permissible, regardless of the consequences.

Kant's formula of humanity is his main argument against suicide. Kant argues that destroying oneself in order to avoid pain or achieve another end violates the formula of humanity. He argues in the Groundwork:

> **"To annihilate the subject of morality in one's person is to root out the existence of morality itself from the world as far as one can, even though morality is an end in itself. Consequently, disposing of oneself as a mere means to some discretionary end is debasing humanity in one's person"** (p.423)

The intrinsic value of persons, core to the practice of psychiatry, is justified in the fourth formulation of the CI. This defines "the idea of the will of every rational being as a will that legislates universal law"(p.431). To Kant, individuals are intrinsically valuable because they are free, rational (or autonomous) agents. This reflects the original view of Aristotle, who saw that human functioning was ultimately based on their capacity for reason. It is also significant in the context of psychiatric ethics, given the impairment of reason that is a fundamental part of severe mental illness. Much of psychiatric ethics is focused upon situations where self-legislation and reason are impaired, and so Kant's formula of autonomy is arguably diminished in the context of mental illness. In other words, the formula of humanity, the basis of our ethical obligations to persons, is compromised in the context of mental illness.

'Kantian' Ethics

Contemporary deontic ethics are not specific applications of Kant's writings. Onora O'Neill[60] distinguishes between Kant's ethics and "Kantian ethics". The distinction lies within the neo-Kantian ideas of writers like John Rawls, whose description of liberal autonomy is "Kantian" in spirit. Moreover, there has been some revisionism in the interpretation of some of "Kant's Ethics", particularly his use of the term *"Menschheit",* interpreted as either "humanity" or "man/ kind".[61] It has been argued that the phrase "Humanity in a person" in the *Groundwork* refers to the characteristics of personhood. Humanity is distinct from animality by the capacity to define ends of intelligent behaviour. As such humanity must be respected, even though the most foolish or impaired may "throw away" one's humanity.[61] This latter interpretation appears to factor in the limitations to the formula of humanity posed by mental illness.

Problems with Kantian Ethics

Kant's ethics have numerous limitations. O'Neil lists common criticisms of Kant's ethics[60]:

i. *"Formalism"* – the Categorical Imperative is empty or vacuous

ii. *"Rigorism"* – Deontic ethics are rigid and insensitive sets of rules with no nuance or subtlety

iii. *"Abstraction"* – The Categorical Imperative is too abstract to guide action

iv. *"Conflicting Grounds of Observation"* – there is no guide as to what to do when duties come into conflict with each other

v. *"Place of the Inclinations"* – Deontic ethics do not account for moral impulses

vi. *"No Account of Wrong doing"* – Deontic ethics provide no guide as to wrong actions.

Many find the concept of acting purely from duty morally repugnant. Acting from duty does not really countenance compassion for others, but is merely fulfilling a responsibility. This would seem anathema to a psychiatrist dedicated to the relief of human suffering. Moreover, acting merely out of duty, and denying human impulses such as care, empathy or compassion, may nurture attitudes of objectification towards others. If we have mere "obligations" towards the psychiatric patients, rather than "care" or "compassion" for people who suffer from mental illness, we run the risk of objectifying our patients. This gives way to examples of the "all-too-obedient soldier, or the good Nazi citizen who overcomes feelings of compassion to turn in the Jews hiding in the neighbour's home (p.117)" as being arguments against Kantian ethics.[62]

Kantian Ethics and Psychiatry

Despite the prominence of Kantian ethics in moral philosophy, very little has been written about their specific application to psychiatry. The Kantian concept of autonomy is qualitatively different from the conception usually applied in biomedical ethics, however, the notion of 'reason' as the mark of human function is a useful construct in psychiatry. Aristotle's idea that human flourishing is one of excellence in reason has been argued as a critical issue in understanding mental health and illness.[63,64] The core of mental illness is a harmful dysfunction of that rational capacity, and this has been recently debated as a key ethical issue in the provisions of mental health legislation in NSW.[65,66]

Kant's *Menschheit* concept may help us approach patient autonomy in psychiatry in a different way. The Code of Ethics for the RANZCP (Appendix 4) directs its Fellows to "respect the essential humanity" of their patients. The Kantian construct of the human person as a rational being, able to construct maxims of rational moral action, helps us to conceptualise what is involved in this principle. The essence of the humanity of our patients is not in their suffering, their circumstances or their rights as citizens, but in their capacity to legislate moral action. Kant's Formula of Humanity thus highlights that any action we take in regards to our patients must be beholden to their reason, no matter how deviant it may seem relative to our own. This then guides us as to what the essence of mental illness may be. Wakefield argued, convincingly, that a theory of mental illness must entail "harmful dysfunction"[67,68] and saw the dysfunction in evolutionary, non-relativist terms. In the Kantian perspective, the dysfunction is in that of rational Kantian autonomy. The rational capacity that facilitates moral action is the function that must be impaired for the patient to be subject to coercive or involuntary treatment. Moreover, the restoration of that reason is the goal of psychiatric intervention. The *Menschheit* concept is not focussed upon actions or choices, but rather the capacity to make such choices.

In terms of "duties", one might take the view that codes of ethics are prescriptive duties and, as such, are Kantian in spirit. The proscription of the exploitation of patients, whether it be sexual, financial or in research settings, is clearly relevant to the third formulation of the Categorical Imperative. The principles of the RANZCP codes of ethics are arguably maxims of action formulated in the light of the first and third formulations of the Categorical Imperative. Such duties guide action in all circumstances, without regard to contextual factors. The devil is in the detail of the notion of what is a "universal law". For a law to be truly universal is to assert that any psychiatrist at any time would accept such a fact. Prescriptive duties such as RANZCP Code of ethics Principle #2 – "Psychiatrists shall not _misuse_ the inherent power differential in their relationships with patients, either sexually or in any other way" or #6 "Psychiatrists shall not _misuse_ their professional knowledge and skills" rely on a question-begging argument as to what the term "misuse" means. These are surely the most relativistic of all injunctions, relying on value judgments as to what the core concept of "misuse" means. Whilst a different category from the charges that Kantian obligations to duty gave oxygen to the projects of "dutiful ethnic cleanser(s)"[69] like Eichmann, the idea that the maxims specified in codes of conduct like the RANZCP's are truly timeless and universal are problematic. In the 1930s, when 'mental hygiene' was the dominant paradigm in psychiatry, would the sterilisation of mentally ill people in order to eradicate mental illness from the population be considered a misuse of knowledge? As it has been claimed "the past is another country. They do things differently there".[70]

VIRTUE ETHICS

Virtue in Antiquity

Most people understand virtue as a quality of moral excellence. In antiquity, the four cardinal virtues were courage, temperance, justice and prudence. The concept of virtue, or αρετη (arete), is clearly articulated in Aristotle's _Nicomachean Ethics_[71] as "a settled disposition of the mind determining the choice of actions and emotions, consisting essentially in the observance of the mean relative to us… as the prudent man would determine it." (Book II, Ch. 6). Aristotle had made a study of great men of his time and attempted to define what it was that made them great. He concluded that the definitive character of mankind was the capacity for reason, and so the "ratiocentric thesis" of the good life was central in Aristotle's thought. Happiness, or εμδαιμονία (eudaemonia), was found in the life of rational excellence. The Aristotelian concept of virtue is a habit of choosing the golden mean between the extremes. In the case of justice, for example, the mean lies between being excessively generous or forgiving and being excessively harsh or austere. As such, the habit of choosing the golden mean is a form of dialectic reasoning in that the synthesis of an action or thought arises from the tension between two alternate views.

Phronesis as a Substantive Ethical Model

The habit of finding the mean requires prudence or "phronesis" (practical wisdom) being conceptually prior to the other virtues. In other words, the virtuous individual possesses the judgment to find the mean and the practical ability to apply it. Phronesis can be seen as having a number of components:[72]

i. The citation or acknowledgement of specific ethical principles where appropriate;

ii. The integration of past experience into the present situation;

iii. The capacity to argue by analogy from paradigm cases to particular ones;

iv. The capacity to 'paralell-process' other issues to guide moral inquiry by e.g. psychodynamic implications; and

v. The capacity to combine all four aspects to formulate a mode of praxis.

Applied to psychiatry, virtue involves an integration of its goal _(telos)_ and the use of skills _(techne),_ to achieve it. The virtuous psychiatrist possesses practical wisdom to find the right actions, in the specific role of alleviating suffering of the ill. Munson had highlighted this distinction, to some degree, in the separation of science and medicine: science and the knowledge it created was instrumental, rather than intrinsic to, the telos of medicine.[73]

Recent Conceptions of Virtue Ethics

More recent incarnations of virtue theory have provided useful points of reflection. Hannah Arendt observed the trial of Adolf Eichmann*, the architect of the Holocaust, and realized the "banality" of his evil related purely to the failure to reflect upon the nature of his actions and his mindlessly servile attitudes to duty.[74]

> **"Except for an extraordinary diligence in looking out for his personal advancement, (Eichmann) had no motives at all… He merely, to put the matter colloquially, never realized what he was doing"** (p.114)

Arendt's later development of the concept of virtue distinguished the virtues of individual life and that of the world of action *(viva activa).*[75] For Arendt, the public and private spheres were distinct, the former moving beyond pure self-interest.[76] This revision of virtue ethics clearly occurs in the context of the totalitarian excesses of the twentieth century and raises an issue that is pertinent to contemporary psychiatric ethics – can the psychiatrist be truly virtuous without taking part in the public or political sphere?

The virtue ethics of Alisdair MacIntyre[77-79] further develop the concept of the socially situated, contextualized virtue. In Athenian society, the concept of the 'good' – αγαθος '(agathos – good angel)' – related to how a man discharged his allotted social functions within the community, or polis. As such, the measure of the virtue of a man was his functioning as a successful citizen. In ancient Athens, this involved political action. To hold on to this as the archetype of virtue risks anachronistic versions of the moral philosophies, which are "overwhelmingly the creation of dead-white-male heads of household, including some slaveholders and misogynists".[80] This has been a particular focus of MacIntyre's arguments about the limits of all moral philosophies; that they are situated within a particular culture at a specific point in history. MacIntyre's solution is to emphasize the parts of human existence which are universal, such as birth and death, and the establishment of community, or what the feminist philosopher Martha Nussbaum refers to as "non-relative virtues".[81] As such, MacIntyre sees it as inconceivable that friendliness, courage and truthfulness would not be valued in any society at any historical point.

MacIntyre's concept of practical wisdom integrates virtue, *telos, techne* and *arete.* He considers "practices", which are the exercise of human excellence in the pursuit of a collectively defined good. MacIntyre holds that in Greek ethics we begin with society where evaluative language is tied to the concept of a socially established role. He argues that ethical questions "about ourselves and our actions depend(s) on the kind of social structure of which we are a part (p.91)".[82] In MacIntyre's view, "bricklaying is not a practice; architecture is. Planting turnips is not a practice; farming is (p.188)".[77] Applied to psychiatry, the practice of the virtuous psychiatrist is the pursuit of expert knowledge, sound judgment and the other components of clinical skill and the application to the conception of a collective good.

The Virtuous Psychiatrist

Applied to biomedical ethics, various authors and professional groups have provided checklists of desirable virtues in physicians, often extrapolated from the four classical virtues. Beauchamp and Childress[40] listed compassion, discernment, trustworthiness, integrity and conscientiousness. Engelhardt[83] listed tolerance, liberality and prudence as virtues required of a physician. Pellegrino provided a hierarchy of physician virtues, with the most sublime necessitating such selfless supererogatory acts that they could not be sustained by even the most devoted physician.[84] Indeed, the main critique of virtue ethics as a moral philosophy in psychiatry is that it seems to have impractical expectations of individuals and places the individual amidst a potentially disabling psychodynamic process of identification with the idealised ethical superman.[7] Radden outlined the virtues necessary of a psychiatrist[4] (Table 2).

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* Adolf Eichmann was an Obersturmbannfuehrer (Lt Colonel) in the SS in Nazi Germany. In 1942 he coordinated the Wannsee conference, where the so-called "Final Solution to the Jewish Question" was resolved. Eichmann was tasked with coordinating the deportation and mass murder of millions of European Jews. After the war, he fled to Argentina where he lived under an alias. Mossad agents kidnapped him in 1960. He was taken to Israel, where he was tried and convicted of crimes against humanity and then hanged. The philosopher Hannah Arendt watched the trial and then published her reflections on the case in her now famous book *Eichmann in Jerusalem.*

The desirable virtues of psychiatrists
I. Compassion
II. Humility
III. Fidelity
IV. Trustworthiness
V. Respect for confidentiality
VI. Veracity
VII. Prudence
VIII. Warmth
IX. Sensitivity
X. Humility
XI. Perseverance

Table 2 – The desirable virtues of a psychiatrist (after Radden, 2002)

Virtue ethics have been proposed as a foundation of psychiatric ethics,[85] with some argument that the sole virtue of phronesis (practical wisdom) can provide a comprehensive account of ethics in psychiatry[86] or at the very least, inform more prescriptive codes of ethics in psychiatry.[87]

Robertson and Walter have argued that, whilst virtue ethics are of great importance, there are significant limits to their instrumental value in psychiatric practice.[88] The virtuous psychiatrist reflects upon his or her motivations and the "big picture" aspects of their actions, which are usually based on a balance of utility and duty. The habit of incorporating this process and finding the "golden mean" is the pathway to phronesis and this, in itself, may provide the psychiatrist with a substantive moral philosophy. As such, virtue ethics can provide a means of informing more practical deliberations, such as those based on consequences, or abiding a social contract.

COMMON MORALITY THEORY

One potential source for a concept of the good life are those values which are held broadly by a society. Citizens in democratic societies vote for law-makers, whose legislative proposals represent the wishes of the majority of citizens. Such a notion of the good life therefore moves away from criticisms that ethical theories represent 'ivory tower' views of life. The philosopher Bernard Gert coined the term "common morality theory", which reflects the broad values of citizens living in a stable democratic society.[89, 90] Such values are descriptive, as they reflect what people actually do in different situations. According to Gert, his normative moral system is based upon five basic harms – death, pain, disability, loss of freedom, and loss of pleasure. From these five harms, Gert derives ten morals, reflecting the common morality of a society:

1. Do not kill
2. Do not cause pain
3. Do not disable
4. Do not deprive of freedom
5. Do not deprive of pleasure
6. Do not deceive
7. Keep your promises
8. Do not cheat
9. Obey the law
10. Do your duty

The first five rules directly prohibit inflicting the five basic harms, whereas the second five prohibit actions which may cause those same harms indirectly. These ten moral rules are not absolute because their violations are not always wrong.

Gert described a two-step method for justification of acts that appear to violate these injunctions. The first step is the establishment of all of the morally relevant facts to give an account of the action. This involves answering a series of questions in relation to the act including:- What moral rule would be violated? What harms would be avoided, prevented, and caused by the rule violation? And what benefits would be gained by the rule violation?

The second step involves estimating the consequences of everyone knowing that this kind of violation is allowed or the consequences of everyone knowing that this kind of violation is not allowed. The likely harmful and beneficial consequences of the two estimates are then compared. If the general knowledge that such violations are allowed leads to a better outcome than a general knowledge that they are not allowed, then the violation is justified. In other words, there is a quasi-consequentialist feature to this approach.

Gert justified his philosophy by arguing that every rational agent would ultimately endorse adopting a moral system that required everyone to act morally in regards to other moral agents. The basic harms would be seen to be almost universalisable in that all rational people would agree that these are the basic values of stable societies. Gert calls this "the blindfold of justice", because these rules are independent of religious, cultural or scientific beliefs. Gert's original philosophy has formed the basis of some approaches to bioethics. With Gert, Clouser proposed that medical ethics is little more than an application of common morality to specific medical ethical dilemmas.[91-94]

Common morality theory has been criticized as being insensitive to changes in history, culture and society, as well as being misleading in its claims to universalisability.

PRINCIPLES BASED ETHICS

Overview

Principles based ethics have become the dominant paradigm in Western biomedical ethics.[40, 95, 96] They were first developed by the American philosophers Tom Beauchamp and James Childress. Their methodology owed much to the work of W.D Ross, who argued that ethical duties were related to *prima facie* responsibilities to irreducible ethical principles.[97] It was also influenced by a form of common morality theory which governed public behaviour.[89] The four principles approach to bioethics advocates that, when approaching a moral dilemma, physicians deliberate over a conflict between four core principles relevant to it:[97]

i. *Respect for autonomy:* respecting the decision-making capacities of people and enabling individuals to make reasoned informed choices;

ii. *Beneficence:* considering the balance of benefits of treatment against the risks and costs so as to act in a way that benefits the patient;

iii. *Non-maleficence:* avoiding causing harm to the patient, or at least harm disproportionate to the benefits of treatment;

iv. *Justice:* distributing benefits, risks and costs fairly and treating patients in similar positions in a similar manner.

These four principles, often referred to as the "4Ps", are the cornerstone of Beauchamp and Childress' principles based ethics. The principles have taken on an almost canonical significance in some bioethics communities, although other authors have advocated the addition of other principles, such as "mutuality",[98] "confidentiality" or "veracity".[98]

Psychiatrists commonly face ethical dilemmas around the issue of involuntary treatment. Within a four principles approach, these dilemmas can be easily couched in terms of a *prima facie* conflict of the patient's autonomous choice to refuse treatment and the need for beneficence to relieve suffering (Figure 1). In many circumstances, the conflict is vitiated by the effects of mental illness, such as psychosis, on the patient's capacity for autonomy and the scales are therefore tipped towards the beneficent obligation to relieve the patient's suffering. When the patient's autonomy is not so clearly diminished, such as in cases involving the involuntary treatment of personality disordered patients or those who abuse alcohol, the required deliberations become more complex. In those circumstances, a more detailed consideration of the effects of the patient's psychopathology on autonomy, and the anticipated benefits of treatment, are required.
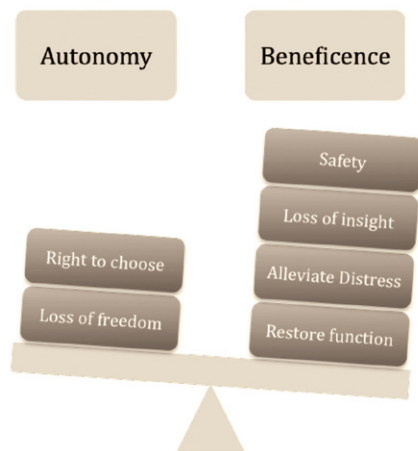
Figure 1: The *prima facie* deliberation on the issue of involuntary treatment

Autonomy in the 4Ps

Many of the conflicts mediated by the four-principles approach involve clashes with the principle of autonomy. Autonomy is the principle of individual self-rule or self-governance. It is now enshrined in the liberties and rights of modern liberal states. One author has defined autonomy in terms of "mental state utilitarianism",[99] or a state of self-regulation, based on reason and self-interest. Feinberg[100] sees at least four aspects to autonomy:-

i.   The capacity to govern oneself;

ii. The actual condition of self-government;

iii. A personal ideal, and;

iv. A set of rights expressive of one's sovereignty over oneself.

Autonomy is a foundation concept in liberal philosophies, and is therefore at the core of ethical theories such as Kant's deontology[101] and Mill's version of utilitarianism.[21] In Kant's theory, autonomy is central to practical reason, and hence our obligation to duty and to regard others as equals. It is therefore the foundation of his "Categorical Imperative". This idea had been expanded by neo-Kantians, such as Korsgaard[102] who sees autonomy as the source of all personal obligations, since it relates to our capacity to impose these upon on ourselves. Beauchamp and Childress[40] see that all theories of autonomy accord with the issues of liberty, and agency.

The principle of autonomy is critical in psychiatric ethics. Reason and agency are faculties that can be profoundly affected by mental illness and its treatment.[103] The concept of autonomy in the 4Ps is focused more on autonomous choice rather than issues of self-governance. Autonomy as one of the 4Ps focuses upon "normal choosers" who act intentionally, with self-control and understanding of their actions.

Whilst autonomy is ostensibly on a par with the other principles, it tends to prevail in *prima facie* conflicts.[104] Moreover, autonomy is argued to be conceptually prior to the other principles,[105] valorising it over the others. As Veatch has argued:

> **"…my own observation is that autonomy has had far and away a pride of place in practice. Justice has given it some competition, but most contemporary theories of justice (for example, Rawls) have an individualistic point of departure anyway; and most renderings of beneficence have had about them the flavour of religion or goody-goodiness, sure losers in the secular world of public policy."[106]**

The centrality of autonomy in moral philosophy is predominantly a phenomenon of the liberal West. Given much of the discourse in bioethics has been Anglo-American, it is clear how autonomy has emerged as a 'first among equals' of principles.

Criticisms of the 4Ps Principles Approach

The undoubted strengths of the 4Ps approach are its clarity and simplicity. The approach is not, however, free of significant problems. Many of the advocates of the 4Ps method have claimed that it represents a universal approach to ethics.[69] It has been advocated as a credible method of medical ethics in cultural settings, including Islamic societies,[107] some African cultures[108] and in Judaism,[109] but others question its application outside the English speaking world.

Indeed, patient autonomy, the very centre of the 4Ps approach, has been described, by Pellegrino, as a cultural artifact.[110] A position apparently supported by a series of studies[111-113] that have provided a cross-cultural comparison of autonomy in medical ethics between American and Japanese physicians. In Japanese patients, prioritising individual autonomy may isolate patients from their families and ultimately compromise patient care.[112] In Japanese culture, diagnostic and prognostic information is often withheld from patients at the request of family members.[111] In the vexed issue of suicide in Japanese culture, issues of autonomy are quite peripheral to the ethical considerations around the area.[113] In African cultures, autonomy is subjugated by communal bonds and responsibilities and is of peripheral relevance in ethical deliberation.[108] In post-communist Russia, physicians are still primarily beholden to the state, despite attempts to legislate on behalf of patient autonomy.[114] In China, bioethical discourse is revisiting traditional morality as a reaction to "a naïve acceptance of North American and Western European moral philosophical approaches and the bioethical perspectives they produced".[115]

Taking other lines of criticism, Clouser dubbed the 4Ps approach "principlism" and criticised its apparent vacuity and incoherence.[92] Along with Gert, Clouser has also criticised the 4Ps approach as doing little more than providing a checklist of obligations with no specific guidance in mediating a *prima facie* conflict. It is often not clear, for example, where the limits of an ethical deliberation are to be drawn. Clouser and Gert also regard Beauchamp and Childress' assertion that beneficence or non-maleficence are substantive principles of obligation as superficial.[116] In response, Beauchamp and Childress have acknowledged Clouser and Gert's critique as being based on a fallacy of relevance – "correct but irrelevant" (p.390). They responded that the 4Ps had never purported to place their theory on the same footing as other grand ethical theories.[40]

Another critic of the 4Ps is the philosopher of medicine, Tristram Engelhardt,[83] who defines the 4Ps as a form of "procedural morality", merely providing a "non-foundational approach" to bioethics. Engelhardt prefers the principle of "permission", rather than autonomy, as permission is constitutive and is philosophically prior to the principle of beneficence. Beneficence is a negotiated or contractarian arrangement, not a universal foundation principle in Engelhardt's eyes. He describes both autonomy and beneficence as "chapter headings", functioning merely to "indicate the sources of certain moral rights and obligations (p.103)". If permission is constitutive and beneficence negotiated, then the former is the only substantive component of morality. As highlighted above, the concept of autonomy as "first among equals" in moral theory is not universal, therefore moral authority, in Engelhardt's view, derives from mutual consent. Moreover, He does not see justice or non-maleficence as substantive concepts, seeing the former as a redundant and defining the latter as "applied beneficence".

Engelhardt thus distinguishes between "moral friends" sharing "contentful" ethics and "moral strangers" who consent to a mutually agreed set of rules of behaviour. As such, he sees that the 4Ps only work when there is an approximation of views between moral strangers – the 4Ps approach is only "feasible when individuals with the same or very similar moral visions or thin theories of the good and justice have reconstructed their moral sentiments within divergent theoretical approaches (p.56)". To Engelhardt the 4Ps method is a helpful device:

i.   To resolve moral controversies between individuals with similar moral sentiments but different approaches;

ii.   To explore the ways different theories reconstruct the same set of moral sentiments or intuitions;

iii. To elaborate differences between moral views and their implications for bioethics and;

iv.   To resolve controversies between those who do not share the same moral vision or sense.

Others have criticised the 4Ps as "imposing a sort of straitjacket on thinking about ethical issues" that "encourage(s) a one dimensional approach and the belief that this approach is all that ethical thinking requires".[117] By this line of criticism, the method's key strength – its simplicity – becomes its major failing. Like many other moral theories, the lack of contextualisation in the 4Ps has been an additional source of criticism. Some have argued that virtue ethics and care ethics can inform the 4Ps approach as a means of achieving a more comprehensive framework in psychiatric ethics[84] and bioethics generally.[69]

CASUISTRY

Background

In essence, casuistry is a method of ethical reasoning based upon cases. It is analogous to the common law based in precedents, which guide subsequent legal judgments. The best account of the historical background of the method of casuistry was provided by Jonsen and Toulmin.[118] They argued that the first account of case-based reasoning can be found in the orations of the ancient Roman figure Cicero. In the early Christian church, the idea of case-based or precedent-based dispensation of penance in the confessional is documented in the *Penetentials.* In medieval times, clerics utilised the method of *Casus Conscientiae* (or "case of conscience"), which would study and discuss difficult or troubling cases. The method of "high casuistry" reached its apotheosis in the hands of the Jesuits in the Sixteenth Century, a period of significant political change in Europe. The controversial influence of the Jesuits, as well as their reputation for sophistry placed the method of casuistry in a controversial light.

The Method of Casuistry

Jonsen and Toulmin argued that moral reasoning had to be based on emphasizing general theoretical moral principles, which generate algorithms that are applicable to difficult moral choices.[118] As such, they argued that there were clear sets of moral paradigms (*prima facie* duties) and that precedent or test cases existed, allowing comparison between the matter at hand and the historical case. As such, casuistic reasoning avoids the perils of moral absolutism and ethical relativism.

Jonsen subsequently articulated a more specific methodology for casuistry.[119-121] He defined a case as an "event" or a "happening".[120] He emphasized that a case is a manifestation of a set of circumstances surrounding a set of maxims at the center of the case. In psychiatry, a case may involve the central maxim of "respect for autonomy" and the circumstances relate to the need to place a patient's financial affairs under the control of a third party. The test case, or "paradigm" may be that of a patient with a severe, chronic psychotic illness, whose incompetence in such affairs results in financial exploitation and disadvantage such as homelessness or self-neglect. The case at hand may involve a patient whose alcohol abuse is problematic and the imposition of financial restrictions upon the patient is primarily aimed at restricting their access to alcohol.

The method of casuistry seeks to order the circumstances of the case relative to the central maxims involved. The first task of the casuist is to "parse" or deconstruct a case into the relevant maxims.[120]

Jonsen's method of analysis nominates four "special topics" as significant in clinical applications of ethics[121]:

i.   *Medical Indications* – Assessment of the objective clinical issues in relation to the case;

ii. *Patient Preferences* – acknowledgement of the individual values and expectations of the patient;

iii. *Quality of Life* – consideration of the over arching goal of the physician is the alleviation of suffering and the enhancement of quality of life;

iv. *Contextual Features* – the broad socio-cultural, historical and psychological circumstances in which the case occurs.

Jonsen argued that in the method of evaluating the case in question, the casuist proceeds in the order specified. This does not indicate that any one topic is prioritized over another, but rather to ensure consistency in the method.

His method then applies a taxonomic procedure to the cases of relevance in relation to the case at hand. In essence, this taxonomy of cases involves "lining up" cases in rank order from the paradigmatic case to the case at hand. The order of these cases is determined by their similarities to the paradigm case. As the features of the particular case are identified, and the similarities to the paradigm established, the case is ordered along the line. The further down the order of similarity to the paradigm case, the less "kinesis" the case possesses. Jonsen offered the metaphor of a billiard ball losing kinetic energy – the further it rolls from the source of movement the less its kinetic energy. As such, the more distant a case appears to be from the paradigm case in the order cases, the less applicable are the conclusions of the paradigm case to the case at hand. To Jonsen, the ability to establish the "kinetic" aspects of case-based moral reasoning is a form of practical wisdom.
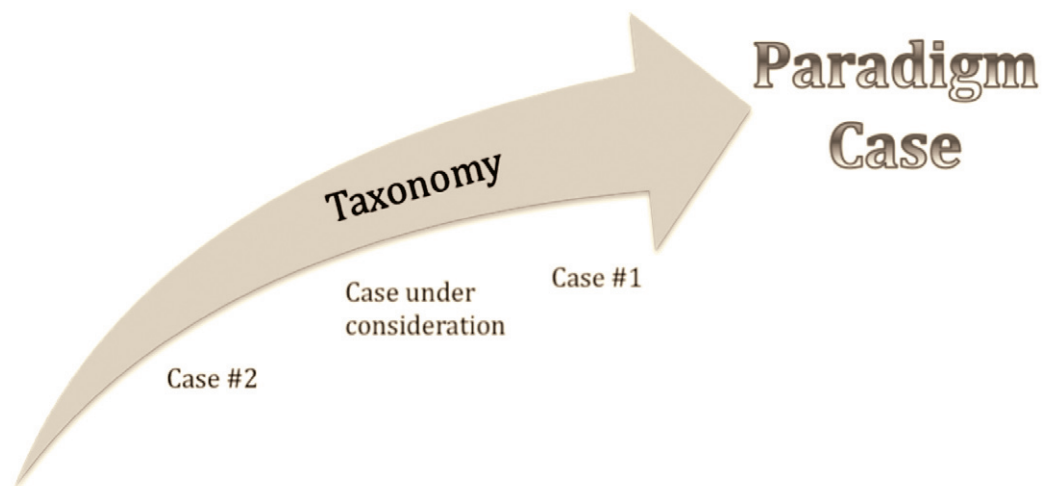
Figure 2 – The method of casuistry – cases are assembled into a taxonomy of cases, with cases most resembling the paradigm case situated closest to it. When the case under consideration is placed in this taxonomic arrangement, the strength of the conclusion that the case under consideration warrants the same treatment as the paradigm case can be evaluated.

This method is identical to the critical approach of normative analogy, whereby the merits of a proposition (the "subject") are compared to that of a precedent proposition (the "analogue"). The subject and analogue of the normative analogy are first compared in terms of the presence of similarities. The more similarities between the subject and the analogue relevant to the ultimate conclusion made regarding analogue, the stronger the normative analogy. The second phase of this method is to identify negatively relevant differences between the subject and the analogue, which may diminish the strength of the conclusion of the similarities between the cases.

Other writers have provided a slightly different methodology to that of Jonsen. Miller's method of casuistry[122] also suggests the use of paradigm cases and moral frameworks, as well as the establishment of "presumptions", which enshrine moral rules and maxims as forms *prima facie* obligations to a case.[97] Miller's method of casuistry involves firstly establishing the relevant paradigm and clarifying the presumptions which define the case's ethical aspects. The context of the case is then defined and the opinions of "authorities" are considered in the light of the case. This brings about a synthesis of the ethical aspects of the case in question. Tallmon's methodology of casuistry[72] involves articulating Jonsen's "topics" relevant to the case, refining these until the critical topics are identified and then constructing the argument accordingly.

Criticisms of Casuistry

The most famous critique of casuistry was articulated by Blaise Pascal in his "Provincial Letters" (1656).[122] Pascal argued first that casuistry promoted a laxity in moral reasoning because it had no solid moral base. Secondly, casuists tended to seek probable opinions on every side of a

difficult case and therefore created a series of possible solutions to moral problems, which could be arbitrarily picked by the whim of the chooser. To Pascal, the method of casuistry had come to represent a form of "Jesuitical" excuse-making. With the decline in scholasticism (the unquestioned authority of clerical wisdom) that followed the advent of the Enlightenment, casuistry was abandoned, until its recent resurrection in biomedical ethical circles.

Despite the intuitive appeal of the method of casuistry, it still suffers from the lack of a substantive theoretical foundation. This is the core of Engelhardt's critique of casuistry.[83] The counter argument made by casuistry's advocates is that the moral foundation of the process is that of "common morality theory".[92] Those who challenge common morality theory[123] question the validity of the assumption that there is a universal, a historical common morality that can serve as a baseline for judging actions and practices at all times. Second, advocates of the common morality approach assume that the common morality is in a state of relatively stable, ordered, wide community-based reflective equilibrium, without any influence of other factors such as culture, the law or political pressures. Third, proponents of common morality approaches assume that it can serve as the basis for particular policies and official recommendations, a process that seems to involve a giant leap from the general set of values to the particular application of them, made without any reference to their context.
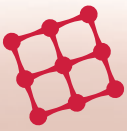
As such, it has been argued by Arras that the casuist's position cannot be seen as truly theory-free.[124] Moreover, there are significant power structures, such as government or the biotech industry, impacting on bioethical discussions. Such influences will affect the selection of paradigm cases and the ethical implications they are seen to present. This highlights the concept that ethics is a form of moral dialogue. Casuistry is therefore argued by Arras to be unlikely to achieve moral consensus outside of particular forms of moral discourse, such as within particular institutions or professional groups. The critical issue is the manner in which any moral discourse is constructed. Two alternate views of discourse are those of Habermas[125] and Foucault.[126] In Habermas' view, the "truth" of any consensus achieved through discussion was a function of the plurality and egalitarian composition of the "discursive formation" or the group discussion. Foucault took the alternate approach in that he saw knowledge and power in societies as the same phenomena, and that the composition of the discursive formation was related to power structures in society. This "power/knowledge" composition has been discussed in relation to psychiatry elsewhere.[127]

Casuistry and Psychiatric Ethics

Like principle based ethics, casuistry presents an ethical procedure, which lacks a substantive theoretical foundation. In order to apply casuistry to psychiatric ethics, there would need to be a series of paradigm cases developed, upon which to base casuistic taxonomies. The lack of undisputed paradigm cases leads to reliance on famous cases for paradigms, rather than those which have been carefully reasoned. At present, the only recognizable paradigm case is the "Tarasoff case",[128-129] a precedent which was largely articulated by lawyers and academic psychiatrists. To use such legalistic cases is to operate under a suppressed assumption that there is integrity between the law and ethics, a notion many would not readily accept.

In attempting to define what constitute paradigm cases, particularly in the light of Arras' critique of casuistry, they would need to be derived from a broad consensus of multiple views of psychiatry, and mental health generally. This resides in the idea of moral discourse, and ethical truths, relying upon a free, democratic consensus approach to such knowledge. This leads to problems relating to discourse as a form of knowledge in general, and the type of relationship between power and knowledge described by Foucault.[126] Who would be sufficiently authoritative to participate in the discussion or discourse that attempts to define ethical norms in seeking to develop paradigm cases is a complex question. Any form of moral conversation would need to be based upon preconditions of equality of access, viewpoints and communication capacities within the group. The level of consultation and public discussion has only been achieved in the case of highly publicized legal cases, such as the Andrea Yates homicide case in the USA.**

** Andrea Yates murdered her children in the context of a severe puerperal psychosis in 2001. She faced a charge of homicide and capital punishment. The case was highly publicised and saw broad debate within the communities of the legal and medical professions, as well as the public domain.

THE ETHICS OF CARE

Background

One recent development in moral philosophy has been the recognition of the place of caring or emotional bonds between persons as the basis of ethical action. The status of the 'ethics of care' remains indeterminate. Some have argued it to be a substantive moral theory,[130] whereas other views describe ethics of care as a virtue, a cluster of virtues, or a version of virtue ethics.[131]

The concept of ethics of care arose as a reaction to the work of Kohlberg,[132] whose study of latency age and adolescent boys delineated the development of moral thinking. Kohlberg argued that at an early developmental stage, individuals behave according to socially acceptable norms because they are compelled by the threat of punishment. The next stage is a form of psychological egoism or self-interest morality, giving way to a "post conventional" level of moral development characterised by the acknowledgment of a social contract and the development of a principled conscience.

Gilligan[133,134] argued against Kohlberg's findings, stating the latter's sample was entirely male and that studies of females reveal that they are more focused on caring for others and maintaining social relationships, rather than defining a rational good. In particular, Gilligan highlighted girls' refusal to make moral decisions out of context, their desire to avoid conflict and their emphasis on relationships in their thinking. Whilst Gilligan was not dismissive of the male impartial voice of justice, she argued that the two options are complementary. In some circumstances, abstract ethics of justice are a more apposite point of reflection, whereas in other situations the ethics of care are more appropriate. As such, Gilligan argued that morality is better defined as occurring within a network of caring relationships and not a preoccupation with abstract notions of individual autonomy. Ethics entailed, in the view of Gilligan, "situation attuned perceptions" to the needs of others regarding the dynamics of a particular relationship and setting. This distinction is not unique to care ethics, as neo-Kantians, such as Onora O'Neil, have recognised the distinction between impartial justice and emotional bonds.[135]

Blum[136] distinguished between care ethics and the idea of justice. He described this in terms of the conceptual differences between "impartialism" and the ethics of care. Blum argued firstly that care ethics do not abstract from the particular situation. Secondly care ethics are involved in a certain context and do not delimit an autonomous, self-legislating individual as against a contextualized agent in a network of relationships. Finally, care ethics involved the integration of emotion, cognition and action, which Blum argues makes them Humean (i.e. after 18th century philosopher David Hume) in nature.

The ethics of care can be thus defined as "the rejection of impartiality as the mark of the moral".[137] Benhabib saw this as the rejection of the "impartial standpoint" of the "generalised other".[138] In other words, the care approach to ethics emerged not out of the duty or obligations we have to the anonymous, objectified "other", but from emotional or compassionate drives towards another person – a fellow human being. This is akin to the central idea of the moral philosophy of Emmanuel Levinas, who argued that our encounter with the "face" of another conferred an identity of another person, not a philosophical "Object".[139] To Levinas, our "face-to-face encounter" constitutes our experience of the essential humanity of the other person. In his later work, Levinas, like the proponents of care ethics, argued that our compassion drives towards "the face of the other" and therefore our natural ethical sensibilities emerge from the fundamental human constitution.[140]

Later views of the ethics of care, like those of Baier[141,142] and Noddings[143] focussed on the limits of abstract moral theories such as Kant's, and how the ethics of care may add to the perspective of the moral agent. Noddings provided a compelling argument in describing that any mother would violate the Categorical Imperative to lie to save her child.[143] Such actions are motivated by care and not by abstract notions of what is right, although such motivations have been argued to leave the moral agent open for exploitation.[144]

The Ethics of Care and Psychiatry

This area has been considered in some depth elsewhere.[88] Like the ethics of virtue, the ethics of care have limited instrumental value in clinical settings. They can certainly inform the ethical standpoint,[84] and Adshead has argued that the ethics of care and the other abstract ethical theories offer different "voices" in psychiatric ethics".[145]

Apart from this, the ethics of care approach to ethics suffers from an inadequate analysis of the concept of "care", which has been argued to be "hopelessly vague".[146] In lacking a descriptive or normative account of morality, care-related language defines the concept of care as being constitutive of a moral good. This introduces a form of prescriptivism, which argues that actions are good if they are caring. The argument suffers from a suppressed premise that care is constitutive of an ethical good. Moreover, the prescriptive argument that 'one ought to care' is weakened by a fallacy of ambiguity – caring about how your football team fares is not the same as care for your family or patients.[147]

In suggesting the ethics of care are a substantive moral philosophy, Held[130] argued that it has five defining features. First, "the focus of the ethics of care is on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility (p.10)". Second, the ethics of care value emotions, and appreciate emotions and relational capabilities that enable morally concerned persons in actual interpersonal contexts to understand what would be best. Third, the ethics of care reject the view that the more abstract the reasoning about a moral problem, the better. Fourth, the ethics of care propose a novel conceptualization of the distinction between private and public moralities and of their respective importance. Finally, the ethics of care adopt a relational conception of persons, which is in stark contrast to the rights-based approaches of modern liberal individualism.
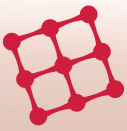
DISTRIBUTIVE JUSTICE

Introduction

Unlike criminal or "retributive" justice, "distributive" justice describes the process of the just or fair allocation of limited social goods. The World Psychiatric Association's *Declaration of Madrid* (1996) states that "psychiatrists should be aware of and concerned with the equitable allocation of health resources".[148] Several articles in The Lancet have also implored psychiatrists to consider issues of just allocation of resources in a global setting as part of their ethical obligations.[149,150]

The philosopher John Rawls crafted a conception of distributive justice during his career.[151-153] Rawls' approach to justice derived from a hypothetical notion of having moral agents conceptualize an "original position", which was pre-social and pre-historical. The participant in this social contract would be blinded as to who they were going to be in this future society through a "veil of ignorance". Based on these constraints, the moral agents would then define a just distribution of goods in this future "well-ordered society". Rawls believed that all choosers would operate on the assumption that they would end up the least advantaged person in the society and through a process of "constrained maximisation", allocate resources accordingly. Such resources were not merely wealth, but also freedom, mobility of labour and equal access to opportunity to achieve fulfilment in life. This approach to justice assumed first, all participants would act out of self-interest and, secondly, be risk averse and conclude that assuming worst case scenarios was the safest approach. Whilst the first assumption is reasonable, the second may not reflect how all people might approach the problem.

In stark contrast to Rawls' liberal egalitarianism was the free-market libertarian ideas of Robert Nozick,[154] who averred that the only constraint the state should place on the free exchange of resources within a society should be to ensure he legitimacy of the acquisition and subsequent exchanges of property. Libertarianism has become the dominant paradigm in post-industrial developed economies and many health systems have evolved based upon the principles of such free exchanges of goods and services between individuals.

Rawls' Theory and Mental Health

Whilst Rawls' contractarian method was ingenious, there are problems with what he defined as "social goods". Rawls saw that all members of a well ordered society had equal entitlement to access social goods to have the opportunity to live fulfilling lives. Rawls took the Kantian view that individual fulfilment is a product of autonomy, or rational self-governance. As such, social goods are instrumental in achieving this, and the just distribution of these social goods assists members of society to achieve this autonomous existence. As Nussbaum points out, such an approach falters when we consider the situation of those whose capacity for autonomy is impaired life-long. A person with disabling chronic schizophrenia may never be truly capable of autonomy and so their needs are

met poorly in Rawls' philosophy. As such, Nussbaum built on the so-called "capabilities approach" to justice[155] to provide a more workable account of the primary social goods at the centre of Rawls' distributive justice.[156] Nussbaum's version of "capabilities" is necessary to reach the capacity for the ultimate end of a life with dignity, rather than Kantian autonomy. The capabilities extend from reasonable life expectancy, sensory and bodily integrity, through to capacity for affiliative behaviour, play and some control over one's environment. Nussbaum thus saw that the ends of just public policy with regards to people with psychiatric or intellectual disabilities is the guarantee of their basic dignity.[157]

Rawl's theories have been extended to the specific areas of health care by Norman Daniels.[158] Daniels defined healthcare broadly, as varying from individual medical services, preventative interventions, public health initiatives, workplace safety and social resources for chronically ill and disabled. Daniels argued that the right to healthcare carries the implicit assumption that access to it is on parity with other civil rights. This equates healthcare with other social goods. Daniels provided a closer consideration of what healthcare actually is by citing an "argument from function" defined as "the needs which interest us are necessary to achieve or maintain *species-typical normal functioning* (my italics)" (p.26). To Daniels, such functioning referred to the individual's capacity to construct a plan for life or a conception of the good.

The rationale for providing healthcare paid for by third parties is, therefore, to help restore normal function by decreasing the effect of disease or disability. This compensates for the 'natural lottery' in which liability for disease is considered an accident of birth, rather than the individual failings of the sufferer. A guarantee of access to healthcare does not have the goal to enhance well being or general capability, but merely the correction of the natural lottery.

Sabin and Daniels have applied these concepts specifically to mental health.[159] They advanced a "normal function model" in the light of how mental illness may affect that function. They proposed that the goal of mental health care is to avert the disadvantage arising from mental illness, thus making everyone equal competitors for social resources. Their model of distributive justice, achieved through mental health care, has three dimensions:

a. A "normal function model" of mental health care seeking to create normal competitors for social resources;

b. A "capability model" seeking to create equal competitors for resources;

c. A "welfare model" addressing the fact that people suffer because of attitudes or behaviours they did not choose and cannot choose to overcome, which should justify access to mental health care.

The first, normal function model allows a society to draw a plausible boundary around the scope for insurance coverage. Sabin and Daniels argued that the capability and the welfare models are the most morally substantive, but are the most problematic in implementation.

MORAL RELATIVISM AND PSYCHIATRIC ETHICS

An inevitable corollary of global considerations in ethics is the issue of moral relativism. This approach to moral theory implies that one cannot understand descriptive ethics unless one lives within the cultural context of a particular moral system. The simplistic view of this is that "anything goes", or what the philosopher Bernard Williams dubbed "vulgar moral relativism".[160] The dilemma of moral relativism is addressed by Mary Midgely,[161] who used a normative analogy between the ancient Japanese custom of *tameshi giri* (Samurai warriors testing their swords on passing commoners) and more troubling contemporary acts such as female circumcision. In the case of psychiatry this could be psychiatrists in different countries participating in executions, euthanasia programs or Soviet-style political repression.

One potential answer to such a dilemma is David Wong's notion of "sophisticated moral relativism",[162] which takes the position that there are universal social goods – or rights – which constitute a basis upon which a society and its morality can be evaluated. In Wong's thesis, it is not the manner in which a society provides these social goods, but rather the adequacy with which they are provided. One can, at least in Wong's thesis, morally distinguish between countries that practise capital punishment, and the human rights violations of Nazi Germany.

Applied to psychiatry, this process may be deployed to understand differences in how societies approach issues related to autonomy, such as involuntary treatment, psychiatric diagnosis, allocation of health care resources or forced breaches of confidentiality. Where this approach collapses is in defining what the basic goods of psychiatry are. The whole notion of good in ethics has proved elusive, and this is also the case in psychiatric ethics. G.E. Moore[26] recognised this in arguing for the intuitionist position that a moral good is a simple, non-natural, indefinable quality of certain things, such as interpersonal attachment or the aesthetic appreciation of beauty. Perhaps the only attempt to define a good in any bioethical context is Pellegrino's assertion that the good in medicine is the good of the patient.[163] Even here, how to define the good of the patient is slippery – Pellegrino postulates the existence of biomedical, patient-defined, and human-defined conceptions of the good.

POST-MODERN PROFESSIONAL ETHICS

Overview

"Postmodernism" is a term variably used to describe any intellectual activity, from art to architecture, which appears to break with the rationalist traditions of the Enlightenment, or "modernism".

Jean-Francois Lyotard[164] summarized the core of postmodernism as being "incredulity to metanarratives", or the rejection of grand, unified conceptual schemes. Psychiatry is argued to be "a quintessentially modernist project" because of its embrace of scientific paradigms.[165] The postmodern approach to knowledge has been applied to psychiatry,[166] which argued that things are more complex than depicted in the modernist project of positivism (rejecting metaphysics) and empiricism (knowledge based upon observation and experience).

Applied to ethics, Hugman argued that the postmodern approach seeks to move away from overarching theoretical structures into individualizing relationships which have virtues in the background.[167] Hugman nominates the work of MacIntyre,[77-79] Foucault[168] and Bauman[169] as being the key works in postmodern ethics applied to the helping professions.

Bauman's Post-Modern Ethics

Like many postmodern theorists Zygmunt Bauman's, intellectual position resulted from the disillusionment with the horrors of the Twentieth Century. He was a Polish writer working in the shadow of the Holocaust and saw ethics as a process involving "a moral party of two (p.82)". Like MacIntyre, Bauman's post modern approach to morality is his response to the failings of post-Enlightenment European moral philosophy. He saw the Holocaust as arising out of the ideas of such philosophy, in particular that of Hobbes.[170] Indeed, as MacIntyre points out, alá Arendt, Eichmann was able to reconcile his crimes with his adherence to the deontic tradition of Kant.[82] As such, Bauman insisted that our moral responsibility cannot be reduced to the fulfillment of a limited set of socially constructed, arbitrary rules. He argues human morality can only be grounded in the "moral impulse".

Bauman's postmodernism was:

> **"…modernity without illusions... (t)he illusions in question boil down to the belief that the "messiness" of the human world is but a temporary and repairable state, sooner or later to be replaced by the orderly and systematic rule of reason (p.32)"**[169]

Bauman described the "aporetic" (confused or difficult to verify) nature of human relations and in the face of this, he rejects the idea of a socially constructed morality. As such, Bauman was critical of bureaucracy and systems. Concerns about bureaucracy are not new. The Nineteenth Century sociologist Max Weber warned of the destructive effects of large bureaucratic institutions.[171,172] Such institutions focused on outcomes, rather than values, and as such had lost touch with social values. To Weber, individuals who were subject to the influence of bureaucracies were in an "iron cage" and that society had dipped into a "polar night of icy darkness".

Foucault's Post-Modern Ethics

Michel Foucault's writings covered many aspects of knowledge and power. His oeuvre made frequent reference to psychiatry. In the tradition of post-modernism, Foucault's ethical project rejected the notions of religious, scientific or conventional moral codes as being the basis of any

moral philosophy. Foucault took the view, akin to that of the Ancient Greeks, that traditional morality must be replaced by ethics based upon the "aesthetics of existence". In essence, Foucault's ethics are primarily concerned with how we decide what kind of person to be and how we seek to be that person.[168] Foucault argued that we have to create ourselves as "works of art",[173] arguing "couldn't everyone's life become a work of art? Why should the lamp or the house be an art object, but not our life?" (p.261).[168] Foucault contended that ethics is the practice:

"In which the individual delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral goal. And this requires him to act upon himself, to monitor, test, improve, and transform himself (p.28)".[174]

Foucault saw that this process is constrained by the fact that many of the practices available to us for such aesthetic realisation have been appropriated by the culture in which we live. This process of self-creation involves us firstly rejecting those forms of identity imposed on us by society and its institutions. Thus, "Foucault's ethics is the practice of an intellectual freedom that is transgressive of modern knowledge-power-subjectivity relations".[175]

This constitutes a form of secular humanism, in which mankind, not God or other conventional practices, determine what is good or right. In this view, we see that Foucault is extending the humanism of Nietzsche, who rejected religion, in particular Christianity, as a form of "slave mentality" and called for the ethical superman, or *"Übermensch",* to rid himself of mundane constraints and take command of his own destiny – what he defined as the "will to power".[176, 177] Nietzsche's philosophy has been linked to the excesses of Nazism,[178] although Foucault arguably distances his philosophy from Nietzsche's in his later work through his concerns about the impact of elitism on disadvantaged groups such as the mentally ill or the homosexual community.[175]

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Psychiatry and Human Rights

INTRODUCTION

In this section I will consider the issue of the history of human rights violations by psychiatrists. The notion of human rights is a product of the Twentieth Century, which brought examples of their violation in the crimes of the Nazis during the 1930s and 40s. The section begins by examining some of the key historical events in the history of psychiatry and human rights. It then considers the crimes of the Nazi doctors and the human rights abuses in the former USSR. The section then examines the history of human rights in Australian psychiatry and provides a discussion of recent controversies.

The section is by no means comprehensive. There have been small scale human rights violations in many other settings, including the former Apartheid regime in South Africa and numerous sporadic instances of human rights violations in many countries. There have been concerns about the possibility of human rights violations perpetrated by psychiatrists in present day China. This is a controversial area and it is still unclear what the extent of the problem is. Those who are interested in this area should refer to the Human Rights Watch website <http://www.hrw.org>, which publishes regular updates on numerous human rights issues in relation to mental health care.

PINEL AND THE ORIGINS OF MODERN PSYCHIATRY

Psychiatry Pre-Pinel

From antiquity, human societies grappled with the notion of madness. Plato had distinguished different components of the soul – rational, appetitive and emotional. In Plato's model, the rational was in a "chariot", driven by the twin horses of appetite and emotion. Throughout the Middle Ages, the insane were considered to be demonically possessed, many were executed as 'witches'. Madness was defined in pre-Enlightenment times as a form of demonic possession and those with mental illnesses were banished to abject conditions of incarceration and exclusion from society. Their confinement often involved physical restraint such as manacles or chains. The mentally ill were the subject of ridicule or demeaning curiosity, best exemplified by the practice of allowing paying members of the public tour the Bethlehem hospital to enjoy the "show of Bethlehem" and poke the inmates with sticks (one penny entry, free on first Tuesday of the month). Psychiatric 'treatments' of this period included bleeding, purging, enemas and blistering. Foucault's *Madness and Civilisation*[179] traced the development of 'madness' through various eras. To Foucault, madness was not a natural static occurrence, but dependent on the society in which the phenomenon occurs. At the time of the Enlightenment, madness came to be seen as the reverse of reason. Foucault described asylums as being the site of psychiatric power, which he defined as the asymmetric exercise of coercive force.[180]

Pinel's Psychiatry

Phillipe Pinel became a psychiatrist at the *Hôpital Bicêtre* in Paris. Pinel is considered a child of the Enlightenment, as he took the approach of the rational wisdom to the care of his patients. Rather than incarceration, coercive restraint and ridicule, Pinel advocated therapy involving close contact with and careful observation of his patients. In 1798 Pinel published a classification of diseases in his *Nosographie philosophique ou méthode de l'analyse appliquée à la médecine.* Pinel argued that his approach to madness *(l'aliénation mentale)* was to emphasize the "moral" component of madness.

Madness needed to be seen in the context of the social and psychological factors affecting the patient. Based upon post-mortem examinations, Pinel argued that there were organic causes to madness, found in the gastrointestinal and peripheral nervous systems. As neurosyphilis was a common cause of madness in the late Eighteenth Century, the Enlightenment methods of tissue examination and pathological science were highly applicable to psychiatry.

Pinel engaged in "moral treatments", involving 'therapeutic' conversations with patients, seeking to encourage them to withdraw from their delusional ideas. He attempted reform of the culture of asylums, choosing to involve patients in the daily life of the asylum and choosing his asylum attendants carefully. Despite the celebrated rationality of Pinel's methods, he still partook in exercises of coercive power and his patients had little choice other than to cooperate with treatment. Moreover, Pinel continued to employ physical treatments such as baths, showers, opium, camphor and laxatives.

Norton Manning – The 'Down Under' Pinel?

Frederick Norton Manning became medical superintendent of the Tarban Creek Lunatic Asylum (Gladesville Hospital) on 15 October 1868. Manning became immediately concerned about the isolation of patients from the rest of the community and described the hospital as "prison-like and gloomy". Patients had inadequate facilities, monotonous and non-nutritious diets and little to occupy them. Manning described Tarban Creek as a "cemetery for diseased intellects", set about minimizing the use of restraint and provided resources for patient activities.

In July 1876, Manning was appointed Inspector of the Insane with responsibility for all mental institutions, except the Parramatta asylum for criminals (now Cumberland Hospital). He was appointed Inspector-General of the Insane in 1879 and introduced a series of reforms to address the problems at the Parramatta asylum. Manning sought to engage the community in the treatment of mental illness by encouraging visits to the asylums (not in the vain of the Bethlehem visits) as well as organizing many public discussions about the care of the mentally ill. Manning made frequent visits to the UK to keep in touch with the advances in psychiatry and was particularly impressed with a psychiatric institution being constructed at Chatham in Kent. Manning obtained copies of the construction drawings and agitated for a similar facility to be built. New psychiatric hospitals were then constructed along similar plans at Callan Park and Goulburn. Manning oversaw professional development programs for staff in the hospitals and argued successfully for improvement in working conditions. Along with John Cade (who described the therapeutic properties of lithium) Manning is regarded as one of the most important figures in the history of Australian psychiatry.

THE CRIMES OF THE NAZI PSYCHIATRISTS

Origins

Prior to Hitler's ascent to power, German psychiatry was enamoured of eugenics, the removal of "inferior genetic stock" from the population. In 1913 German psychiatrist Alfred Ploetz founded the German Society for Racial Hygiene. Another psychiatrist, Ernst Rüdin, became his enthusiastic acolyte. Declaring racial hygiene a "spiritual movement," Rüdin and his disciples aimed to propagate the cause.

Racial hygiene derives from Charles Darwin's ideas about evolution, and the superiority of certain forms of the same species. Conflated with the ideas of Nietzsche and German Romanticism, this became the basis of Nazi racial theory, where Jews, Slavs and coloured people were inferior to Aryans. Amongst the Aryans, the mentally deficient or physically weak were inferior to the Aryan *Übermenschen* (supermen). Hitler came to power in Germany in January 1933. On July 4, 1933 the "Sterilization Act" became law, followed ten days later by the "Law for the Prevention of Genetically Diseased Children". Four hundred thousand people, thought genetically inferior, were sterilized on the orders of a network of over two hundred "Genetic Health Courts". By 1936, many psychiatric patients were being transferred from asylums to Dachau and other concentration camps.

Aktion (Operation) T4

In October 1939 Hitler ordered the killing of patients, or "inmates", of German psychiatric hospitals. Aktion T4 was aimed at eliminating children suffering from "idiocy", Down's syndrome,

hydrocephalus and other abnormalities. The murders were coordinated by a Nazi official, Philip Bouhler, assisted by three professors of psychiatry – Nitsche, Heyde and Hannecke. Bouhler coordinated the process from Berlin at Tiergartenstrasse 4, hence the reference "T4". Aktion T4 resulted in the murders of seventy to eighty thousand people with psychiatric disorders, mental retardation, brain diseases such as epilepsy and those with histories of asoziale (antisocial) behaviour. A questionnaire put to all psychiatrists in German hospitals helped to identify patients who were chronically mentally ill, or had criminal pasts.

Long before the gas chambers at Auschwitz-Birkenau were operational, Nazi Psychiatrists were gassing psychiatric patients. Scloss Grafeneck, a disused castle near Stuttgart, was converted into a "euthanasia centre". Under the supervision of Professor Heyde, carbon monoxide gas chambers were installed specifically for the purpose of killing mentally ill patients. In January 1940, Heyde supervised the gassing of twenty psychiatric patients at Grafeneck. Believing it to be a shower room, the victims were led into the gas chamber by nursing staff. After they were gassed, SS personnel took their bodies on specially designed stretchers to the crematorium furnaces. Some of the victims may not have been dead before they were hurled into the crematorium, prompting Heyde to consider carbon monoxide an inferior killing agent. Over ten thousand patients from "Care Facilities" in Baden-Württemberg, and Bavaria were murdered in Grafeneck, in an old coach shed that was specially converted into a gas chamber. Other euthanasia centres were built at Hartheim, Hadamar and several other sites.

German Psychiatrists and the Holocaust

The effectiveness of Aktion T4 inspired the "final solution" to the so-called "Jewish question". The technical knowledge from Aktion T4 was availed to the architects of death camps like Auschwitz-Birkenau and Treblinka in "Aktion 14f13", named after the file-number containing the information. Dr Imfried Eberl, Professor Heyde's assistant, became the commandant of the Treblinka "extermination facility" near Warsaw in Poland, where the practice of gassing large numbers of people was developed. This was preparation for the larger scale operations to come at Auschwitz-Birkenau. Like Heyde, Eberl realised that carbon monoxide had technical problems as a killing agent. This observation was passed onto Eichman. The later adaptation of the cyanide based pesticide Zyklon B as the means to murder the victims of the later death camps was based upon the observations of psychiatrists. Other psychiatrists involved in Aktion T4 provided consultation and technical advice in the development of other death camps at Belzec and Sobibor.

German Academic Psychiatry in the Nazi Era

The crimes of Nazi psychiatrists were not limited to the murder of "undesirables". Many utilised the numerous opportunities for human experimentation. At the Berliner Wittenauer Heilstätten psychiatric hospital, mentally handicapped children were deliberately infected with tuberculosis. They were then gassed and their brains studied closely. Many PhDs were turned out in this way. Dr Faltlhauser conducted an experiment on children at the Kaufbeuren (near Munich) psychiatric hospital. He restricted the children's diet to potatoes, yellow turnips, and boiled cabbage. The absence of any fat in the diet led to the children suffering demyelinating syndromes and dying as a consequence of bizarre neurological syndromes.

The chemical company IG Farben tested new medicines on psychiatric patients at Hessian Anstalt Eichberg. Buoyed by the 'success' of Eichberg, IG Farben established its own test laboratory at the Bavarian psychiatric hospital, Anstalt Günzburg.

Hitler ordered the cessation of the murders of psychiatric patients in August 1941. This decision was made in response to the strenuous objections of various religious bodies, and even some sections of the Nazi party. Despite this, the killing continued. It is estimated that up to twenty thousand psychiatric patients were murdered by psychiatrists after the Nazis surrendered in May 1945. It is believed that the bulk of the psychiatric profession cooperated with the process, although there were some exceptions. Many of the Nazi psychiatrists evaded justice and went on to academic careers in post-war Germany. Julius Hallervorden was a neuropathologist at the Kaiser Wilhelm Institute during the 1940s. He happily received numerous brains from the euthanasia centres to further his research career. Hallervorden and his supervisor, Hugo Spatz, laid low immediately after the war ended and later ran the Max-Planck Institute for Brain Research in Frankfurt. 'Hallervorden-Spatz disease'

is a rare childhood brain degenerative disorder, described by the pair. There is ongoing debate in neurological circles to rename the disease. The dissected brains of the victims of the euthanasia centres, the so-called "Hallervorden Collection", remained at the Max-Planck institute until 1990, when the tissue samples were eventually buried in a Munich cemetery. Professor Hans Heinze was the director of the Kaiser-Wilhelm Institute from 1939. It is suspected that a number of killings of children for 'scientific purposes' actually took place at the Institute. Heinze was prosecuted in the so-called 'Doctor's trial' in Nuremburg in 1946. He ultimately evaded justice on the basis of ill-health. After his death in 1983, the board of directors of Wunstorf state hospital in Lower Saxony published an obituary stating "At the age of 87, the former director of our department for child and adolescent psychiatry (Prof Heinze) died...We shall honour his memory".

In the light of this Ernst Klee, a prolific writer on Aktion T4, wrote, "those who honour the perpetrators, murder their victims a second time."

SOVIET ERA PSYCHIATRY

Origins

In the 1950s Major-General Pyotr Grigorenko, a Marxist-Leninist senior political figure in Soviet Russia, declared his support for the cause of the Tartar people of the Crimea. Grigorenko had intended to testify on behalf of a number of Crimean dissidents in a series of show trials in Tashkent. Rather than having Grigorenko murdered or exiled to Siberia, Stalin preferred to have him declared "insane" and therefore his views would be discredited. The Soviets believed mental illness, like crime, was a product of the capitalist system and would decline under communism.[181] Grigorenko was arrested by the KGB, and presented to a commission (including three psychiatrists), who found no evidence of mental illness. Relentless in their pursuit of a politically expedient diagnostic label, the KGB then referred him to another commission, presided over by a psychiatrist, Dr. Georgi Morosof. Grigorenko was diagnosed as suffering from "paranoid development of the personality associated to reformist ideals". He was committed to the Serbsky Institute in Moscow, where Morosof was the director.

Over the next 30 years, politically loyal psychiatrists used diagnostic labels for political ends. According to one author, Psychiatric hospitalization offered a "gentler" face to dealing with political dissent and offered the advantage of discrediting the dissidents and their causes as "crazy".[182] The Soviet psychiatrists "genuinely believed the diagnosis they were making".[183, 184] Soviet psychiatrists championed numerous diagnoses such as "schizophrenia forme fruste" and "paranoia with delusions of reform". The most infamous of these labels was "sluggish schizophrenia". Originally thought a subtype of schizophrenia, the diagnosis was not supported by research or clinical experience and had jettisoned from mainstream psychiatric practice. The criteria for sluggish schizophrenia included reformist delusions, characterised by the belief that improved social conditions can be achieved only through the reformation of attitudes. Sluggish schizophrenia also burdened the sufferer with "litigation mania", a false belief that one's human rights are being violated.

Soviet Psychiatry

There were two Soviet schools of psychiatry. There was the politically obedient Moscow school and the more traditional Leningrad school. The Soviet Union had two networks of psychiatric hospitals. One was an ostensibly mainstream network administered by the Ministry of Health, another comprised a network of "forensic" hospitals (психушка – psikushka – asylum), administered by the Ministry of the Interior under the auspices of the KGB. In some facilities, the two groups were mixed. People were sent to forensic hospitals following orders by Soviet courts and psychiatric tribunals.

Vladimir Bukovsky's book To Build a Castle[185] provides a window into the experience of a psikushka. Bukovsky, a problematic dissident and agitator, was first arrested in 1963 and charged with being in possession of anti-Soviet literature. He was proclaimed insane and interned in a special psychiatric hospital for 14 months. In 1965 he was arrested again for his involvement in a demonstration on behalf of other dissident writers and sent to a series of forensic mental hospitals until 1966. In 1967 he was again arrested after a demonstration, but was sent to a labour camp for three years. Bukovsky spent 1971-6 in prison and was then exiled.
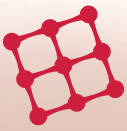
Bukovsky's account of his treatment in various special forensic hospitals is chilling. In the early 1960s, psychiatric prisoners were subjected to insulin coma therapy, excessive doses of antipsychotic or barbiturate tranquilizers and unanesthetized ECT. One particular form of restraint used was the so-called "roll-ups" in which a wet canvas strip was wrapped around a patient; the strip shrank as it dried effectively strangling the victim. Bukovsky noted that the orderlies in these facilities were in fact criminals who had been co-opted into the role. Bukovsky told an interviewer of the broken spirit of inmates in these facilities, whose torment continued after they were ultimately released:

> **"If you're just out of psychiatric hospital it's twice as bad because of the psychological tension there. You're constantly wondering if you're normal. Even though you know you were diagnosed for political reasons you still watch yourself. Perhaps I am mad? Those big nobs in white coats with diplomas and professorial status decided I was. There must be something wrong. You keep analysing yourself, comparing yourself with others. It's an additional burden."** [39]

International Response

The World Psychiatric Association (WPA) became aware of the malfeasance of psychiatric diagnosis and "treatment" in the USSR in 1971, after being notified by a document written by Bukovsky. It took six years to respond formally, although a WPA committee investigating the political abuse of psychiatry, the "Geneva Initiative on Psychiatry", was founded in 1974. In 1977 the WPA held its triennial congress in Honolulu. By that time the British Royal College of Psychiatrists and the American Psychiatric Association had agitated for action in the case of Soviet psychiatric abuses. The WPA formally condemned the practices in the Soviet Union and similar abuses in South Africa under the Apartheid regime and other Eastern Bloc countries.

The 1977 *"The Declaration of Hawaii"* called for the psychiatric profession to respect patient's autonomy and maintenance of beneficence and non-maleficence. Furthermore, it addressed issues of informed consent, confidentiality, and provided guidelines for forensic evaluation of psychiatric patients and involuntary treatment. There was also an obligation for psychiatrists not to "misuse" their professional skills. Particular reference was made to the use of involuntary treatment in the absence of psychiatric disorder. By 1982, the Soviets faced expulsion from the WPA, and voluntarily withdrew to save face. Soviet psychiatric practices were abandoned in the face of Gorbachev's *glasnost* and *perestroika*.

The USSR was readmitted to the WPA in 1989.

ABORIGINAL MENTAL HEALTH AND HUMAN RIGHTS

Early Influences in Indigenous Mental Health

Racist attitudes towards indigenous Australians were evident in early writings of Australian psychiatry. Aborigines were characterised as "crude and simple, childish and devoid of reasoning, and often sexual and animal in nature" and as such "Aboriginal insanity was interpreted as the most exaggerated expression of their innate primitiveness and savagery".[186] Apart from the modernising influences of Norton Manning, the emergence of serious consideration of the unique issues of Aboriginal mental health are credited to the psychiatrist John Cawte.[187,188] In addition to meticulous ethnographic studies, Cawte's work placed Aboriginal mental health in the context of the tension between old and new world influences.[189] Indigenous mental health emerged as a substantive area of expertise internationally due to the wave of decolonisation after World War II and a dedicated World Health Organisation report into the mental health of Indigenous peoples.[190]

Themes in Aboriginal History

The relationship between Aboriginal and white Australia has been perpetually traumatic. The arrival of white settlement in Aboriginal Australia resulted in dispossession of traditional lands, degradation of Aboriginal culture and a sporadic program of murder, all of which have been equated with the genocides of other native populations by Europeans in the Nineteenth Century.[191] As Kiernan notes in his world history of genocide:

> **"The British rarely pursued extermination, but frequently forsaw it. Officials and settlers brought to the colonies the prevailing Lockean notions of property based on land usage. The Aboriginies' perceived inability to value the land and mix their labour with the soil purportedly put them beyond civilization"** (p.252)[191]

Frequent instances of virtual "ethnic cleansing", either through mass murder or attempts at assimilation of Aboriginal people with mainstream white Australia, betrayed a social Darwinist agenda, which viewed indigenous Australians as inferior beings, possessed of a primitive culture and unworthy of the lands they had lived in for millennia.[192]

A more recent and troubling issue in indigenous mental health was the recognition of the profoundly destructive impact the policy of forced removal of Aboriginal and Torres Strait Islander children had in the period from 1869-1969.[193] The policy was based upon legislation in different states and involved the forced removal of such children from their families and their placement in the care of church missions or state-run facilities. Whilst the removals were argued to have been based on concerns for children of mixed background, there is clear evidence that this was, in essence, a policy based upon Darwinist ideology, eugenics, fears of miscegenation and a desire to maintain Caucasian racial purity in the face of mixed race children.[194] The Northern Territory Protector of Natives, Dr. Cecil Cook argued the imperative that *"all native characteristics of the Australian Aborigine are eradicated. The problem of our half-castes will quickly be eliminated by the complete disappearance of the black race, and the swift submergence of their progeny in the white"* (quoted in Markus[195] p.93). Apart from the effect of traumatic separation on the children and their families, and the frequent instances of abuse and maltreatment in care, the truly abhorrent nature of the practice was that it represented a form of ethnic cleansing. Moreover, such notions of racial purity paralleled those in 1930s Germany, inviting the assumption of a moral equivalence between two different forms of ethnic cleansing.[196] The racist motivations of this policy were not lost on the survivors. As one attested during the investigation which led to the *Bringing Them Home* report:

> **"We can go home to ourselves as Aboriginals, but this does not erase the attacks inflicted on our hearts, minds, bodies and souls, by caretakers who thought their mission was to eliminate us as Aboriginals"**[193]

The psychological consequences of this process not only included commonly recognised DSM-IV psychiatric disorders, but an existential challenge of the "devaluation of Aboriginal parenting, state paternalism devaluing distress of the family, forced geographic, cultural and emotional isolation, devaluation of Aboriginal culture".[197] Whilst Australian Prime Minister Kevin Rudd referred to this systematic violation of human rights as a "blemished chapter in our nation's history", the country remained polarised along political lines as to the approach needed to the issue. An acrimonious debate occurred in the media between those who saw the spectre of the "stolen generation" as a national disgrace, and those who advocated polemic denials of the policy's existence or its negative impact.[198] Whilst the Federal Parliament of Australia formally apologized to the "Stolen Generation" on February 13th 2008,[199] negative attitudes and state paternalism towards indigenous Australians still persist.

The Chief Minister of the Northern Territory released the report of the *Inquiry into the Protection of Aboriginal Children from Sexual Abuse* on 15th June 2007 (subsequently known as the "Little Children are Sacred Report").[200] On 21st June 2007 the Australian Federal Government announced the *Northern Territory National Emergency Response Act 2007* in response to the report's findings of widespread violence and sexual abuse of Aboriginal children in indigenous communities in the Northern Territory. Whilst the 'NT intervention' was ostensibly based upon a desire to save Aboriginal children from their alleged plight, the process was highly political. The conservative government of the time prosecuted the intervention using the military, forced medical examinations of children and abolished the so-called "permit system", which had provided Indigenous communities with autonomous control of their traditional lands. The latent racism of the intervention was evident to many:

> **"It is hard to find another example, recent or past, of one race being so singled out for failing to nurture its children...we were asked to accept that Aborigines, after 60,000 years of survival in some of the most hellishly harsh country known to humans, had, in the last forty years, forgotten how to raise children".**[201]

The NT Intervention also had the political utility of criticising the failure of state governments to protect Aboriginal children and challenged the custom of judicial deference to local tribal law in matters of violence in Aboriginal communities.[202]

Historically, the approach to the relationship between indigenous and non-indigenous Australians was predicated on the assumption of terra nullius. In 1992, the High Court of Australia determined in the "Mabo" case that pastoral leases did not extinguish native title in the common law. The High Court found that native title was tied to the long-standing and unique relationship between the Aboriginal population and the land. This decision was seen to herald a new era of reconciliation with indigenous Australia. In 1996 the terra nullius issue was resuscitated when the High Court ruled in the "Wik" decision that competing claims between native title and pastoral leases could co-exist. The newly elected conservative government subsequently implemented The Native Title Amendment Act 1998, which undermined much of the progress in reconciliation. A parallel cultural process emerged in the so-called "history wars", where questions were raised about the historical accuracy of the accounts of the genocide of Aboriginal peoples in the 19th Century.[203]

The social and political discourse of the period from the "Wik decision" to the more recent Federal government apology to the "Stolen Generations" was deleterious to the psyche of Aboriginal Australians. The alleged "black armband" view of Australian history gave credence to *terra nullius* and then dwelled on the trauma of Aboriginal history, whereas the "white blindfold" view denied this and emphasised the triumph of white settlement in Australia.

Indigenous Australia continues to be a profoundly divisive theme in Australian history. There is a contemptuous and latent racist approach towards Aboriginal Australians in mainstream Australian political and social discourse. Despite an intermittent and sporadic desire for true reconciliation between indigenous and non-indigenous Australians, there remain profound divisions within both communities. Aboriginal Australia suffers from the consequences of dispossession, the trauma of colonization and the status of being second class citizens. Violence, social instability and appalling health statistics remain the challenge for indigenous Australia, yet there is no consensus on how to respond. As the Aboriginal community leader Noel Pearson noted:

> **"There is an arc of views held by non-indigenous Australians that goes from denial to moral vanity, to acknowledgement and responsibility. For Aboriginal people the arc of views goes from separatism to victimhood and to pride and principled defence."**[204]

Contemporary Ethics and Indigenous Mental Health

The ongoing situation of injustice faced by indigenous people in Australia manifests as physical and mental illness and social discord.[205] Arguably, disrespect and a sense of inferiority become physically manifest as immune suppression, inflammation, and acute and chronic illness. Externally, these social processes emerge as substance misuse, risk-taking, violence and social discord.[205,206] It also indicates that for indigenous populations, physical health, mental health and social deprivation are inseparable. Whilst it is evident that indigenous people suffer common DSM psychiatric disorders,[207] these are often experienced in the context of factors such as guilt or self-reproach arising from the experience of injustice and deprivation. This profoundly influences help seeking amongst indigenous people, whose relationship with health care professional – from non-Indigenous society is often characterised by problematic power relationships such as the political authority that government employed non-indigenous health workers possess.[208] There are frequent breakdowns of order in indigenous communities, leading to demoralization and anomie.[209] As representatives of a more powerful group in society, non-indigenous health care workers find themselves in a difficult situation. This has created a discourse in indigenous mental health which has realised the need for culturally respectful and sensitive mental health services.[210] Aboriginal communities are based upon kinship and linkages with the natural world granting an "ontologic legitimation",[197] poorly grasped by traditional Western models of mind and mental illness. Experience in this area indicates that workable approaches to indigenous mental health care require empowerment of their community and, in particular, their health care workers in a process of what is being described as 'deep listening' to the community[211] and more extensive consultation.[212]

At the time of the NT Intervention, the RANZCP issued a press statement expressing its concern at the implications of the plan which appeared to lack a long-term perspective to the issues of the mental health of indigenous children and their families.[213] Doubts about the efficacy and ethical implications of the NT Intervention were also voiced by other medical organizations. Critics of the Intervention argued that its paternalistic approach was disrespectful of Aboriginal people, undermined their community leadership structures and utterly devalued their culture and community order, thus exacerbating the mental and physical health of this population.[214] A particularly critical editorial was published in the *Medical Journal of Australia,* stating that the NT Intervention was meaningless or tokenistic, if the Federal Government failed to support "any national or international requirement or responsibility to recognise and acknowledge native title, cultural integrity, self-determination, and preservation of Indigenous knowledge and sovereignty".[215] The Aboriginal Medical Services Alliance of the Northern Territory (AMSANT) argued that the medical intervention (was) "in serious and ongoing breach of medical ethics, including National Health and Medical Research Guidelines, Medicare and guidelines on health screening issued by the Royal Australian College of General Practice".[216] AMSANT also expressed concern that the intervention was a "Trojan horse", which allowed politically motivated acts, such as scrapping the permit system and the Community Development Employment Program (CDEP) and the quarantining of welfare payments. Other concerns included preliminary data indicating that by late 2007, only 10% of children had undergone medical examinations.[217]

Counter to these arguments was the brutal reality of endemic violence and trauma in some Aboriginal communities. Regardless of the political ramifications of taking a position on the NT Intervention, it highlights the problem of trauma experienced by indigenous patients and their communities.

AUSTRALIAN PSYCHIATRY AND HUMAN RIGHTS VIOLATIONS

Background

Australian psychiatry has an ambivalent history. Milton Lewis highlighted this by saying that the 1950s Australian psychiatry was not only "divorced from the mainstream of medicine" but it was also "not a very highly regarded area of medical specialisation" (p 99).[218] Two historians have highlighted that the official history of the RANZCP[219] has a tone of negative self assessment.[220] Moreover, psychiatry in Australia has endured a series of scandals, either involving moral lapses on the part of individual psychiatrists resulting in sexual abuse of patients, or in one extraordinary incident, the murder of a senior psychiatrist, Dr Margaret Tobin, by a disgruntled and paranoid colleague in 2002.[221] More recently, a public scandal involved the failure of psychiatrists, working inside immigration detention facilities, to identify a severely psychotic Australian citizen, Cornelia Rau. As Coleborne and MacKinnon note in their history of Australian psychiatry "Psychiatry's public 'image' is not enhanced by media coverage of events such as the internment of Cornelia Rau in an immigration detention centre".[220]

Chelmsford Psychiatric Hospital

The Chelmsford Hospital scandal involved the criminally negligent use of the discredited practice of continuous narcosis or 'Deep Sleep Therapy' (DST). Under the direction of a psychiatrist, Dr Harry Bailey, and a local general practitioner, Dr Ian Herron, DST was performed at Chelmsford from 1963 until the mid-late 1980s. Patients were induced into continuous profound sedation with barbiturates, fed through nasogastric tube and administered ECT. Those who did not respond to Bailey's satisfaction were referred to a local teaching hospital for cingulotractotomy. Apart from severe medical negligence, Chelmsford Hospital was also culpable in its use of inexperienced nurses in the care of such patients. Moreover, when the hospital's medical board prohibited the use of DST, Bailey subverted the process by admitting patients under Herron's name.

After a series of complaints, a Royal Commission was established in 1988/89[222] and concluded that, at the very least, 24 patients had died as a result of DST at Chelmsford. Another 19 patients who had undergone DST had committed suicide within a year of their admissions to Chelmsford Hospital. Much of the agitation about Chelmsford had been by the Church of Scientology's main anti-psychiatry organ, the Citizen's Commission of Human Rights. Bailey committed suicide in 1985.

Unrepentant, his suicide note stated "Let it be known that the Scientologists and the forces of madness have won".[223]

The ultimate impact of Chelmsford on the Australian psychiatric profession was the loss of a degree of professional autonomy. Much of the subsequent legislation leading to the regulation of medicine by external bodies has been influenced by the shadow cast over medical ethics by the Chelmsford tragedy. As a direct result of the crimes by Bailey and Herron, mental health legislation in NSW now prohibits private psychiatric hospitals admitting patients on an involuntary basis, psychosurgery has been outlawed and independent tribunals now closely regulate the administration of Electroconvulsive Therapy.

The Townsville Hospital Scandal

Just as the Chelmsford scandal was resolving, another emerged in Queensland. Dr John Lindsay, the director of the psychiatric ward of Townsville Base Hospital (Ward 10B) had run the inpatient unit along the lines of a therapeutic community. By 1986, 123 complaints had been made to the Townsville Hospital's Board about Lindsay and the care on Ward 10B.[224] These complaints included allegations of sexual and physical abuse and gross medical negligence.

In 1991, the Queensland government established a commission of inquiry.[225] The commission received testimony that patients in Ward 10B were subjected to "cruel and inhumane" treatment and identified sixty-five deaths attributable to either suicide or iatrogenic causes. Like Chelmsford, 10B affected psychiatry in Australia:

"Although (Townsville Ward 10B) suggests that problems at Townsville can be attributed to Lindsay's desire for innovation, and refusal to recognise mistakes, further investigation reveals that this is not an unusual problem within psychiatric practice in Australia."[224]

Social Justice and mental illness in modern Australia

In the 1960s, the global trend to community care led to a process of deinstitutionalisation in Australia,[218] although this resulted in those suffering mental illness being "removed from one form of incarceration only to end up in another".[226] Subsequent years saw significant levels of divestment of government in community mental health services and the defaulting of many services to poorly funded non-Government organisations.[227] In 1993, the *Burdekin Report*[228] estimated that around one in five adults in Australia suffered from some form of mental disorder, but that only about 3% accessed mental health services. The *Burdekin Report* concluded that this was a function of ignorance and stigma in the community. This clearly presented a significant imperative for advocacy to the RANZCP. In 1993 the Australian Health Ministers' Conference (AHMC) endorsed a National Mental Health Strategy, facilitating the decommissioning of an institutionally focussed mental health system to one that was consumer-and community-focused.[229] The RANZCP was heavily involved in informing this policy, although the strategy seems to have been far less successful than anticipated.[230] Rather than seeing the blossoming of community psychiatry, Australian psychiatrists have witnessed a process of transinstitutionalisation of the mentally ill from large psychiatric hospitals to overcrowded low cost accommodation, homelessness and, increasingly, prisons. In Australia, much like the rest of the developed world, the prevalence of psychiatric disorder is significantly higher in the prison population than the community,[231] inviting the critique that prisons have become de-facto psychiatric institutions.[232] Whether this can be reasonably depicted as a failure of advocacy on the part of Australian psychiatry or not, the abject state of services for the mentally ill in Australia is a significant ethical concern for the profession.

The Asylum Seeker Debate

The most recent and arguably internecine debate over advocacy involved psychiatry's perceived role in regards to policies of mandatory detention of refugees seeking asylum in Australia. Whilst the issue of border protection and treatment of asylum seekers is highly political and has figured as a significant issue in Federal elections,[233] there is robust evidence of psychological harm arising from the policy of mandatory detention,[234, 235] and indefinite periods of uncertainty about immigration status.[236] As such, the policy represents a public health issue.

Many psychiatrists chose to involve themselves in the plight of the asylum seekers. The issue of children being held in what were tantamount to concentration camps was anathema to many in the profession. Involvement of psychiatrists varied from the provision of clinical services for those in detention to very public advocacy. The dilemma, simply put, was the virtual futility of trying to alleviate the psychological distress arising from traumatic imprisonment and in the face of persisting social injustice. As one psychiatrist noted of tending to children in detention:

> **"Treatment of much of the disease and distress was meaningless without addressing the causes (indefinite mandatory detention, family separation, impermanent protection). Prevention always being better than cure, the options were limited. It was not enough to be sympathetic, to sit with, to listen and to nod. The only choice was advocacy"** (p.218) [237]

Several prominent psychiatrists signed a formal letter of protest at the Australian Government's treatment of asylum seekers.[238] Such public forms of advocacy created tension within the RANZCP membership, frequently along partisan political lines. This led to an at times rancorous debate in scientific literature [239,240] and popular media,[241] including allegations of government interference in some psychiatrist's research into the mental health of asylum seekers.[242] The debate over asylum seekers prompted consideration of the role of psychiatrists in such social debates, with one survey identifying the majority of the RANZCP's constituency supporting some form of activism.[243]

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NOTES

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Applied Psychiatric Ethics

INTRODUCTION

In this section, I will provide an overview of the main themes in applied psychiatric ethics. Applied ethics refers to the process of considering ethical quandaries or dilemmas in specific settings, and considering how such dilemmas may be resolved using either normative theoretical approaches, or other methods. Like any discourse, the field of psychiatric ethics is evolving constantly, and therefore this section will become redundant quickly. As such, I have included the topics of discussion in psychiatric ethics, which are well known in the field. I have chosen to reference the landmark or classic papers and books. Developments in the study of psychiatric ethics regularly appear in journals such as *Current Opinion in Psychiatry, The Journal of Ethics* and *Mental Health, The Journal of Medical Ethics and Philosophy, Psychiatry and Psychology.* In addition, ethical pieces appear in mainstream journals such as the *British Journal of Psychiatry, Australasian Psychiatry, Psychiatric Services and Psychiatric Bulletin.*

ETHICS AND FORENSIC PSYCHIATRY

The Dual-Role Dilemma

Forensic psychiatry has been the most fertile area of ethical discourse. This is hardly surprising, given the distinct status of forensic psychiatry, situated between medicine and the law. A significant dilemma faced by forensic psychiatrists is the manner in which their work appears to move away from the Hippocratic principle of *primum non nocere.*[244] This concept, defined as the "dual role"[245-249] posits that there is a *prima facie* conflict between the role of "treater" and that of "evaluator". This is most vexed in the issue of the role psychiatrists play in the administration of the death penalty. On the one hand, it has been argued that psychiatrists, simply, should not participate in assessments which may lead to execution.[250] On the other hand, some do not distinguish between the morality of psychiatric examinations made of prisoners on death row, as against those made at any other point of the criminal justice process.[251] Even more troubling is the issue of treating psychotic patients on death row, whose psychosis presents a barrier to their execution.[252]

The dual role dilemma also emerges in the context of occupational health.[253] Pre-employment assessments identifying vulnerabilities to mental illness present an opportunity to contribute to safe work places on the one hand, yet may also represent barriers for career progression for some workers on the other.

Alan Stone argued that the role of evaluator moves the forensic psychiatrist away from the role of physician and the fundamental notion of non-maleficence.[254] Taking a contrary view, Paul Appelbaum argued in his paper "The parable of the forensic psychiatrist"[255] that beneficence and non-maleficence were not central in forensic psychiatry, which therefore necessitated a distinct set of ethics for the area. Appelbaum sought to distinguish forensic psychiatry, arguing for the concept of a "forensicist", as distinct from clinical psychiatrist.[256] The central responsibility of the forensicist is to justice, not the patient. The ethics of the forensicist will therefore evolve with society.[257] To Appelbaum, the success of an ethical theory was how it satisfied its "audience", not how correct or morally plausible it may seem to all observers.[258]

Other authors have sought to define forensic psychiatric ethics as principles based ethics informed by narrative[259], or justice and welfare.[260]

These dilemmas seem to be more relevant to the USA, where forensic psychiatry has a particular profile in relation to justice. In the UK, the issues are arguably quite different. Prominent UK forensic psychiatrist John Gunn does not see the distinctions in the so-called "dual-role".[261] The ethical dilemmas faced by UK psychiatrists are primarily related to their role in the clinical care of mentally disordered offenders.[262] British forensic psychiatrists face the challenge of political pressures impacting on the welfare of their patients,[54] and the dilemmas faced by changes to procedure in the proposed new Mental Health Act, such as participation in mental health tribunals.[263] An additional dilemma is the prospect of pre-emptive detention facilitated by the mooted "Dangerous Severe Personality Disorder legislation".[53, 54, 264]

Similar dilemmas are emerging in the context of the participation of mental health professionals in interrogations of "unlawful combatants" in sites like Camp X-ray in Guantanamo Bay,[265] highlighting disparities between civilian and military codes of ethics for medical practitioners.[266]

In Australian literature, the ethical implications of "mentally disordered" legislation, in which persons can be detained on the basis of irrational behaviour in the absence of psychiatric disorder has been discussed. One view is that such legislation is inconsistent with the Declarations of Hawaii and Madrid[65] (which argue that involuntary psychiatric treatment is only justifiable when there is a disease of the mind), whereas the alternate view factors in notions of the transitive nature of personhood, and psychiatrist's obligations to the individual patient outside of the immediate context.[66]

Mental Health Pleas in Criminal Justice

One other area of ethical debate in forensic psychiatry has been the status of the so-called "insanity plea", particularly in the case of murder. In jurisdictions where legal systems are derived from English judicial system, the paradigm of criminal responsibility in the context of mental illness is the so-called "M'Naghten rules". Daniel M'Naghten was a Scottish wood turner who possessed a highly systematized delusional system involving persecutory ideas relating to the English government and the Papacy. M'Naghten shot and killed Edward Drummond, parliamentary secretary to Prime Minister Peel on the basis of these beliefs. M'Naghten was found not responsible for his crimes, however was detained at Her Majesty's pleasure at Broadmoor Hospital until his death. The case provided the precedent for the so-called "M'Naghten rules", in which the English House of Lords defined that prisoners suffering "defective reasoning" (rather than the capacity to distinguish between lawful and unlawful acts) could not be held criminally responsible for their actions. In the commission of any offence, the crime involves both the *mens rea* ("guilty mind") and *actus reus* ("guilty act").

This discussion segues into the broad philosophical debate about free-will and moral responsibility. The earliest, and perhaps most workable account of this is in Aristotle's *Nicomachean Ethics,*[71] in which he argued that the responsibility for an act must consider two aspects. The first is that the act emanates from the individual agent and the second is that the individual agent is aware of the consequences. The former raised concerns about the determinism of an act, and in particular the concept of weakness of will, or what Aristotle termed "akrasia". In essence, a person may be excused from responsibility for an act if it emerged as a result of some form of irresistible compulsion, or a constitutional weakness in resisting an impulse. One of the problems here is to what degree psychosis represents such a process. Psychotic patients act on a variety of bases; however the most recognized is acting on the basis of delusional beliefs. Illnesses such as schizophrenia and severe mood disorders are now understood to convey a degree of cognitive impairment (particularly executive dysfunction) that contributes to the person's akrasia. Recent formulations of personality disorders indicate that people, who are diagnosed with borderline personality disorder, may also experience degrees of akrasia, which may account for certain impulsive offences.[267]

The second of Aristotle's criteria is also qualified. The knowledge of consequences of an act is an epistemological issue that is far from clear. Indeed, actions, which may ultimately be, harmful, may

not be motivated by malicious intent. One well-established approach to this issue is the "doctrine of double effect", attributed to Thomas Aquinas.[268] It is used to explain the acceptability of an action causing serious harm as a side effect of promoting some good end. According to the double effect doctrine, a person may be morally correct in performing an action that he or she foresees will produce a good effect and a bad effect, provided that four conditions are verified at the same time:[269]

1. That the action in itself is "good" or at least indifferent;
2. That the good effect and not the harmful effect be intended;
3. That the good effect be not produced by means of the harmful effect;
4. That there is a proportionately grave reason for permitting the harmful effect.

In the light of these considerations, a significant degree of reflection and thoughtfulness is required in order to provide a particular act with full consideration of its consequences. Mindful of the cognitive impairments evident in many mental illnesses, this is as problematic as the issue of akrasia. In the light of these philosophical debates, some have argued strongly that a provision like the insanity plea is integral to the moral basis of a society,[270] whereas others see it as an arbitrary distinction made in the already muddied waters of personal responsibility philosophy, calling for the concept to be abolished.[271]

PSYCHOTHERAPY AND ETHICS
Boundaries and sexual exploitation

The area of ethical boundaries in clinical practice have been outlined well by authors such as Guthiel[272] and Gabbard.[273-275] Sexual abuse of patients by psychiatrists is invariably catastrophic for victims[276] and is considered by some as part of a network of exploitative gender power relations in society generally,[277] prompting some to advocate for taking regulatory matters out of the hands of the psychiatric profession[278] or even the criminalisation of the behaviour.[279] The status of sexual contact after termination of the therapeutic relationship has also been discussed,[280-282] as well as sexual contact between trainee psychiatrists and supervisors.[283] It seems that recent attention to the phenomenon appears to have reduced its severity.[284] Attempts have been made to better identify clinicians at risk of the behaviour and provide frameworks to detect small boundary violations before they evolve into more egregious sexual boundary violations.[285]

Gabbard defined boundaries as simply the rules that govern the therapeutic relationship. "In general, they are the parameters that describe the limits of a fiduciary relationship in which one person (a patient) entrusts his or her welfare to another (a physician), to whom a fee is paid for the provision of a service".[19] Boundaries imply professional distance and respect, which, of course, include refraining from sexual involvement with patients. As a rule of thumb, any act which benefits primarily the therapist at some expense to the patient represents a potential boundary violation. Australian data suggest the prevalence of such behaviour amongst psychiatrists varies from 2-6%.[277]

Gabbard believes strongly that all sexual boundary violations begin as a series of smaller breeches of the rules that are not sexual in nature, what he refers to as the "slippery slope". To Gabbard, the non-sexual boundary violations include benign acts such as gifts or services. Prolonging consultations, reducing or waiving fees and self-disclosure are also minor transgressions, which may summate into larger, more egregious ones.[286]

He described four distinct categories of sexual boundary violators.[273] The members of the first group are those suffering a serious mental illness, such as an untreated manic-depressive disorder. Such clinicians should suspend practice, only to return when well, and under medical supervision. The members of the second group were, in Gabbard's own words, "predatory psychopaths". Psychiatry is a fertile ground for a remorseless sexual predator in search of victims. These individuals are often highly intelligent, having masked their psychopathic ways sufficiently to complete medical and specialist training. They are often able to make their conduct plausible. They can make their victims seem vexatious and inauthentic.

The degree of disturbance of the last two groups is subtler, and more common. They tend to only transgress with one patient and experience psychopathology on a continuum between narcissism and omnipotence to self destructive masochism. At one end of the spectrum are the "lovesick" and at the other are those who submit to a "masochistic surrender", in which the boundary violation

occurs as a result of an unconscious drive to seek punishment or humiliation. These are vulnerable therapists, usually male, who typically encounter disappointments and setbacks in life. They have often stagnated and lost a sense of meaning. In such a state they are susceptible to misinterpret transference and countertransference for true love.

Psychotherapy and Values

Another area of interest in this stream of psychiatric ethics has been the implications of psychotherapy for the autonomy of patients, particularly in regard to the imposition of the values of the therapist on the patient. It has been argued that in creating the "talking cure" Freud had attempted to convert moral discourse into a scientific one.[287] Psychotherapy has been described as a masked form of moral discourse, with allusions to a quasi-religious conception of the good[288] "veering" – as Hinshelwood argued – "between being a scientific and a moral activity (p.195)".[289] Indeed psychotherapy has been conceptualised as the integration of a nonreligious but spiritual view in the pursuit of empathic understanding.[290] Psychotherapy often works best when the value systems of both patient and therapist approximate each other, but not necessarily converge.[288] Jeremy Holmes argued, "Psychotherapy reflects and transmits the values of the prevailing culture" and "makes its own unique contribution to cultural and ethical development within our pluralistic societies" – through its advocacy for the inner world and self-reflection.[291] By liberating from disease, psychotherapy can be considered as enabling patients to become moral agents[292] and enhancing autonomy by encouraging self knowledge.[293] This process involves the outgrowing of infantile narcissism and imparts values operating at an unconscious level. This necessitates an injunction for therapists to deliberate on how their own values affect their work.[291]

Psychotherapy and Distributive Justice

The other main theme in the psychotherapy ethics literature considers the impact of market forces on the practice of psychotherapy. As Holmes asked "is it ethically correct to prescribe the most cost-effective (psychotherapies), thereby freeing resources for other potential beneficiaries?" (p.227). Chodoff examined the effect of the intrusion of third party payers into the patient therapist relationship, particularly in regard to the dilemmas created by issues such as breaches of confidentiality and control of the provision of treatment.[294]

ETHICS AND CHILD AND ADOLESCENT (C&A) PSYCHIATRY

The Concept of Childhood

Childhood and adolescence are not biologically determined states. Whilst the concept of development is a biological entity, the status of child or adolescent is a social construct. Green and Bloch refer to childhood as a "social construction" with a "brief history"[295] in that previous societies had little concern with child labour or the sexual exploitation of children. The capacity of children and adolescents to partake in rational self-governance is both dimensional and highly individual. As such, the conceptualization of childhood and adolescence within the context of psychiatric ethics relates primarily to the differentiation between children and adolescents and autonomous, self-legislating adults.

Autonomy and Childhood

Autonomy is time and task specific. The capacity for a child of 8 to consent to treatment is clearly different from that of a child of 15. Regardless, in the eyes of the law and the tenets of best practice, neither patient can consent to treatment without a parent or guardian. A child's capacity to make autonomous decisions about their health develops with their cognitive and emotional development, thus evolving into increased future autonomy,[296] this is significant for clinical decision making.[297] Like autonomy in other settings, it is not a categorical process. As a consequence some of the literature in child psychiatry has considered the viability of the construct of informed consent in childhood, and in particular how decisions made by parents or guardians on behalf of the child should reflect the wishes of the child.[298,299] In this setting, the role of psychiatrist is one of juggling the complex relationship between a child's confidentiality, their capacity for consent, and their responsibility to advocate for the child's interests.[300] Indeed, the therapeutic relationship in child psychiatry is unique in that it frequently casts the therapist in the role of de facto parent or authority figure.[301]

Psychopharmacology and Childhood

The issue of pharmacological treatment of childhood psychiatric disorder is among the most controversial in the area, however, it has received little in the way of rigorous ethical consideration. The use of stimulant medication in the spectrum of Attention Deficit Hyperactivity Disorder (ADHD) has received some attention, much of it in the form of polemic. Amongst the most recognized of the polemics are those of Peter Breggin,[302, 303] who disputes the validity of the diagnosis of ADHD and the evidence that pharmacotherapy actually helps. Other authors have asserted that commercial pressures brought to bear by pharmaceutical companies have influenced the evidence supporting the use of psychopharmacology of children with ADHD.[304, 305] This speculation is given oxygen by the controversy in the lay press over increased sales of methylphenidate for children in the USA[305] and recent, albeit unsuccessful, class-litigation against the American Psychiatric Association and the pharmaceutical company marketing methylphenidate as "Ritalin", Novartis.[306] Amidst the emotiveness of the arguments in this area, one more balanced review of the situation has concluded that the supposed ethical arguments against stimulant use in ADHD are not factually sound when treatment is provided under proper psychiatric supervision.[307]

The other recent ethical controversy in child psychiatry has been the use of antidepressants in children, particularly newer agents. Like the debate over stimulants and ADHD, this area has not had rigorous ethical consideration. The issue of newer antidepressants and the alleged over-diagnosis of depression has been the subject of writers such as David Healy,[308] who has championed the argument that the introduction of the serotonin reuptake inhibitor class of antidepressants has led to increases in suicidal behavior in patients.[309] The scientific literature in this field indicates an overall trend for newer antidepressants to be of benefit in childhood depression,[310] despite some legitimate concerns about slight increase in the risk of suicidal behavior in children.[311] Most balanced reviews of this issue indicate that antidepressants should continue to be used in childhood depression.[312] The "safety issue" appears to be the main focus of ethical discussion, knowledge in this area is limited by the concerns over psychopharmacological research in children.[313]

THE ETHICS OF INVOLUNTARY TREATMENT

Introduction

One of the most recognized ethical issues in psychiatry is that of involuntary or coercive psychiatric treatment.[2,314-317] Access to psychiatric treatment has been defined in terms of the right to be free from "dehumanizing disease",[314] whereas the other justification used is the prevention of suicide or other forms of self-inflicted harm.[315]

The Moral Justification of Involuntary Psychiatric Treatment

John Stuart Mill argued in On Liberty that the state had no right to paternalistic action over an individual, unless his or her actions were harmful to others. Mill specifically stated that potential or actual harm to self was not grounds for state paternalism.[21]

Mill had argued that:

"That the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others."

This so-called "harm principle" has been used as an argument for involuntary psychiatric treatment of suicidal patients, in that the suicidal patient him or herself is an individual who can be harmed by their own actions.[318] Mill made some attempt to qualify mental illness based on his harm principle:

"And even …if the consequences of misconduct could be confined to the vicious or thoughtless individual, ought society to abandon to their own guidance those who are manifestly unfit for it? If protection against themselves is confessedly due to children and persons under age, is not society equally bound to afford it to persons of mature years who are equally incapable of self-government?"

Whether applied to the dangerous criminal or mentally ill person, the critical issue is harm to others and not to self. So far, the issue seems straight forward. But Mill seemed to hedge a little, when he wrote:

> **"No person is an entirely isolated being; it is impossible for a person to do anything seriously or permanently hurtful to himself, without mischief reaching at least to his near connexions, and often far beyond them. If he injures his property, he does harm to those who directly or indirectly derived support from it, and usually diminishes, by a greater or less amount, the general resources of the community. If he deteriorates his bodily or mental faculties, he not only brings evil upon all who depended on him for any portion of their happiness, but disqualifies himself for rendering the services which he owes to his fellow-creatures generally; perhaps becomes a burthen on their affection or benevolence; and if such conduct were very frequent, hardly any offence that is committed would detract more from the general sum of good. Finally, if by his vices or follies a person does no direct harm to others, he is nevertheless (it may be said) injurious by his example; and ought to be compelled to control himself, for the sake of those whom the sight or knowledge of his conduct might corrupt or mislead."**

This moved away from the concept of a mentally ill person being a danger to himself or others, to one who defaults on personal responsibility. One might reasonably take the view that this appears to undermine the very liberty Mill sought to establish in his philosophy.

In applying Mill's philosophy to justify paternalistic involuntary psychiatric treatment, the preconditions to such paternalistic acts are that the individual in question is not responsible for their actions; the individual's incompetence is about to cause harm; the "paternalization" will ultimately enhance the individual's competence, and/ or prevent further deterioration and; the "paternalization" takes place in the least restrictive manner. As such, Mill would have supported involuntary psychiatric treatment.[319]

Counter to the "harm principle" justification of involuntary psychiatric treatment is the "capacity argument", which posits that the state ought to intervene under the tenets of the concept of *"parens patriae"* (father of the people). The *parens patriae* argument defines the paternalistic role of the state's intervention in the lives of its incompetent citizens as being one of ensuring that such people are able to access treatment or have proxy decisions made for their benefit. In essence, this justification arises from the principle of the state providing vicarious autonomous choice for the person whose mental illness has deprived them of such capability.

Utilitarianism, communitarianism, and the principle of beneficence all, arguably, support the use of involuntary psychiatric treatment,[316] although as Chodoff has argued in the light of human rights abuses perpetrated under the guise of psychiatric treatment, there is a need for a "self critical and chastened" paternalism.[314] Rosenman has argued a method to approach this dilemma.[317] He argued for the definition of psychiatric disorder along a continuum of social definition or biomedical definition and harmfulness to self or others. In Rosenman's model, he argues that coercive treatment of socially defined disorders occasioning harm is the most problematic ethically.

The Obligations of Involuntary Psychiatric Treatment

One aspect of the ethical implications of involuntary treatment is the obligation of the state to provide a reasonable standard of care. As was discussed previously, the level of resources for mental health services has declined significantly in Australia, yet the scope of the potential grounds for psychiatric admission have broadened. Beyond simple issues of fairness or the state's duty of care, there are specific ethical dilemmas for psychiatrists in the form of obligations to the patient subject to involuntary treatment. It is well established that chronic exposure to first generation anti-psychotic medications carries the risk of drug-induced movement disorder. More recent observations of the propensity for second-generation antipsychotics to create atherogenic states and convey significant risks for diabetes and cardiovascular disease emphasize such concerns. Such dilemmas may represent a good example of the doctrine of double effect. The simple fact that the patient is not

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able to refuse treatment arguably heightens the need for the treating psychiatrist to exercise greater care in the use of such treatments. This represents a more specific consideration of the patient's best interests in terms of the risk-benefit analysis underlying treatment decisions.[320] In many such situations the risk of untreated mental illness, psychological, social and physical, in both short and medium term, has to be carefully considered against the high likelihood of iatrogenic harm coming from the use of antipsychotic treatment in the setting of involuntary psychiatric treatment.

The Process of Civil Commitment

The actual process of civil commitment is also of ethical concern. Medical practitioners are cast in the de facto role of both expert witness and prosecuting counsel, thus placing their therapeutic relationship in peril. As Appelbaum has argued, the interaction between justice and mental health systems is more preoccupied with process than clinical outcome.[321] This issue has been particularly acute in the UK, where proposed reforms to the 1983 Mental Health Act have the potential to place psychiatrists in quasi-legal roles[322] in a process which has been highly politicized.[53, 54]

Advanced Directives

Another issue considered recently in relation to consent to treatment has been that of advanced directives in mental health, or the so-called "Ulysses contracts".[323-329] Such directives, when adopted, seem to reduce rates of admission to hospital[323] and can either defer decision making to a nominated third party, or make specific requests in the case of the onset of illness.[327] Such directives can be influenced by the narrative of a patient's life,[329] although the uptake of this approach to care is surprisingly low, given the only credible alternative appears to be legal orders for treatment in the community.[328]

CONFIDENTIALITY

Introduction

Confidentiality is instrumental to the therapeutic relationship in psychiatry and hence its ethical significance.[330, 331] Regardless of its clinical necessity, the maintenance of patient confidence has been the subject of much discussion in the light of necessary breaches and potential implications for the extension of the therapeutic obligations of psychiatrists beyond the individual therapeutic relationship.[128] Indeed, as Green and Bloch have argued "confidentiality can never be absolute, and therein lies its ethical intricacy" (p.154).[332]

The Tarasoff Case

The pivotal instance of confidentiality and the so-called 'duty to inform' was the so-called "Tarasoff Case".[333] In August 1969, Prosenjit Poddar (a Bangladeshi man) was in treatment with the psychologist Dr Lawrence Moore. Dr Moore was on staff at the University of California at Berkeley. During the course of his psychotherapy, Poddar disclosed the intent to murder a woman, Tatiana Tarasoff, on her return to the USA from Brazil in summer. Poddar and Tarasoff had kissed casually at a party and he had become obsessed with her. Being very concerned about the threat, Moore discussed the issue with two of his superiors. The decision was taken to arrange Poddar's admission to a state psychiatric hospital for observation and Moore spoke with two campus police officers, and then wrote a letter to the Chief of Police, requesting their assistance in detaining Poddar. Tarasoff's family was not notified of the risk posed by Poddar. Poddar was apprehended and questioned by police, and subsequently released without charge or referral to psychiatric treatment. Poddar murdered Tatiana Tarasoff on 27 October 1969. The Tarasoff family took legal action against the Regents of the University of California for their failure to warn them of the danger. The resultant verdict highlighted the obligation of a duty to inform someone of the risk posed by a patient.

Whilst the implementation of this Californian legal ruling has been variable across jurisdictions,[334] the issues raised by the case have formed the basis of much ethical reasoning in this area.[248] The issue has presented another manifestation of the "dual role dilemma".[335]

Other Areas of Confidentiality in Psychiatry

In the preparation of medico legal reports confidentiality is waived by the patient when they consent to the preparation of the report.[330, 336] One of the complexities of this area is whether a report is being prepared by a treating psychiatrist, or a psychiatrist in the role of an independent expert witness. Whilst patients provide consent for the preparation of medico-legal reports to be tendered as evidence in criminal or civil proceedings, they may not be aware of the contents of the report, particularly sensitive personal information. This highlights the need for psychiatrists preparing such reports to highlight the various aspects of the process before the report is prepared.

Much information is either stored or transferred electronically, either on data-bases or by email. Given the sensitive nature of psychiatric clinical information, this highlights the need for data security in such processes.[337]

In the United States, and increasingly in other settings, where health insurance programs are in operation, there is a continual tension in the requirements of psychiatrists to provide information about patients in order to secure payment for treatment.[338] In the Australian setting, this is particularly the case with Medicare Rebate Item number,[319] which provides for more than 50 consultations per annum for patients with specific psychiatric diagnoses (such as borderline personality disorder or eating disorders) or levels of impairment.

Confidentiality is particularly problematic in community mental health settings,[339, 340] where the patient's privacy can be imperiled by clinicians visiting the patients in their home, or conducting assessments in public places. This might involve the patient's family members, neighbours or acquaintances being made aware of the involvement of community mental health practitioners in the patient's life.

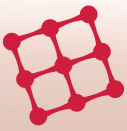### ETHICS AND THE PSYCHIATRY OF OLD AGE

Autonomy in Psychiatry of Old Age

The key themes in ethics relating to psychiatry in older people have been orientated around the nuances of managing permanent cognitive impairment arising from dementing illness. These have been primarily issues of patient competence and testamentary capacity, particularly in regards to financial estates and decisions about the health care.[341] This discussion has extended to the cognitively impaired patient's right to refuse disclosure of diagnosis of dementia themselves,[342] highlighting the complexity of breaching confidentiality in a clinical setting.[343]

Like other areas in psychiatric ethics, the deliberation over autonomy in later life has required its consideration as a dimensional rather than categorical process. One particular approach has been the use of "precedent autonomy" in which proxy decisions are made on behalf of the patient, based upon their attitudes to life prior to the onset of dementia.[344] This and other forms of surrogate decision making in the face of cognitive impairment have been explored in detail.[345] One particular approach to this process is the concept of the "situated embodied agent" view of people. This argues that the embodiment of the person links them with their culture and their history, assisting their carers to estimate decisions on behalf of the person which assist in the notion of integrity with their life's philosophy.[324] Related to this area is the consideration of advance directives, or so-called "Ulysses contracts" made by older patients. Considerable efforts have been made to develop models of such decisions which are contextualized to the individual person.[324, 346] Such approaches need to distinguish a patient's "critical interests" (higher order aspects of one's life such as dignity and autonomy) and their "experiential interests" (those which bring stimulation and pleasure).[347]

Elder Abuse

Elder abuse represents instances of harmful actions involving older persons. Elder abuse is considered present when such harm occurs within any relationship involving an elder where there is a betrayal of trust. Types of elder abuse include:

i.   **Physical:** assaults, excessive restraint, abuse of psychotropic medication;
ii. **Psychological:** Harassment, bullying, intimidation, humiliation, withholding necessary or desirable goods;
iii. **Financial:** unauthorized use of a person's property or finances, fraudulent misrepresentations to social institutions;
iv. **Sexual:** Sexual abuse of varying forms;
v.   **Neglect:** depriving a person of food, or basic social goods, residing in unhygienic or squalid homes, physical neglect e.g. bed sores, hypostatic complications.

Up to 25% of vulnerable older adults report abuse in the previous month, which equates with 6% of the general elderly population being subject to such treatment.[348] Despite these alarming statistics very few cases of elder abuse are reported.[349] In jurisdictions where there are mandatory requirements to report elder abuse there is a tension between breaching the patient's confidentiality and the clinician's obligation to beneficence.[350]

Pharmacological Treatment in Dementia

One particular area of concern in the psychiatry of old age is the use of psychotropic drugs in the care of patients in nursing homes suffering from dementia. Australian figures indicated that 47.2% of nursing home residents were being administered one or more psychotropic drugs regularly, with 3.5% given such medications *pro re nata.* In recent times, there has been a clinical trend towards the use of second generation antipsychotics, particularly for the management of behavioural disturbances arising from dementia.[351] The main ethical concerns raised by this issue relate primarily to the capacity of such patients to provide informed consent to such treatment. Whilst there are guidelines in various settings as to how consent may be obtained from sources other than the patient, a UK study highlighted that up to 15% of nursing home residents were not capable of consenting to either being in a nursing home or taking medications. This study showed that up to 6% of these patients were given psychotropic medications without consent.[352] Moreover, an Australian study demonstrated that in the vast majority of cases, the legal processes for proxy consent to such treatment were not being adhered to.[353] The issue is made more problematic by the recent concerns that the efficacy of newer antipsychotic medications in behavioural disturbances arising from dementia is disputed, and more alarmingly, these medications appear to be associated with an increased risk of stroke or other cardiovascular complications.[354]

Distributive Justice in Old Age Psychiatry

The other theme which emerges in the literature is in relation to access to psychiatric treatment for elderly patients. One argument, based on presumably utilitarian grounds, holds that the access the elderly should have to psychiatric treatments should be limited, purely on the grounds of age,[355] akin to the views of Daniels about healthcare in the elderly in general[158] or the utilitarian approaches of Peter Singer.[33] Such a view has been argued to value a person's productivity over their freedom from distress, or preservation of dignity.[356]

RESEARCH IN PSYCHIATRY

The Nuremburg Declaration

Concerns about the ethics of psychiatric research emerged following the revelations of human rights abuses in the Nazi era,[357] resulting in international declarations of ethical guidelines for research, such as the Declaration of Helsinki[358] (See Appendix 3), and the requirements for ethical approval of studies as part of the process of scientific publishing.[359] The crimes of the Nazi doctors were described earlier, and the main focus of the "doctor's trial" in the Nuremburg war crimes tribunal in 1945 was the issue of research conducted on prisoners in concentration camps or patients in psychiatric institutions. The kinds of experiments conducted by criminals such as Josef Mengele (the doctor at the Auschwitz-Birkenau death camp) were both cruel and of poor quality scientifically.

The crimes of the Nazi doctors have been well documented and the reasons for such moral lapses have been analysed from various angles. Lifton's account[357] of the mechanism of 'doubling', in which those involved in abuses of patients dissociated their personal and professional lives, remains the

most compelling examination of the question "how did this happen?", although the "why did this happen" remains elusive. This is the most critical question, as any attempt to prevent recurrence of such crimes requires a clear articulation as to why they occurred, so that such preconditions can be identified and prevented in the future. Dudley and Gale noted that the "why?" emerged through a process of peer pressure, uncritical devotion to duty, careerism, denial facilitating deceptive language, and the influence of a faceless bureaucracy.[360]

The intellectual origins of the Nazi doctors require some consideration in order to try to frame the kind of ethical oversight that would prevent such crimes from re-occurring. Many bioethicists have grappled with the apparent intellectual preconditions to the Nazi project. As described previously, the sociologist Max Weber warned us that bureaucracies had lost sight of values and concerned themselves only with outcomes. This loss of values led to humans in the social system being placed in a moral void, or what he described as a "polar night of icy darkness".[172] Despite the contribution of an amoral, pragmatic bureaucracy in the Nazi era, the eugenic movement remains the main culprit in the crimes of the Nazi doctors. Malthus had warned humanity that expanding populations threatened the very existence of human-kind on the planet.[361] Malthusian ideas encouraged the viewpoint that the intrinsic value of human beings was negotiable. Eugenics was by no means unique to German psychiatry. The British academic Francis Galton was so enamoured of the seminal thesis of Darwin, that he called for all public policy to be based upon the notion of natural selection.[362] Eugenic ideas permeated American psychiatry contemporaneously with German psychiatry.[363] In 1913, the German psychiatrist Alfred Ploetz founded the "German Society for Racial Hygiene". Another psychiatrist, Ernst Rüdin referred to the cause of removing inferior genetic stock from the population as "Schädlingsbekämpfung" (pest control). In 1918, Emile Kraeplin called for strong political leadership to effect 'a decline in mental debility'.[364]

Hitler's moral philosophy was predicated upon Darwinian principles. Many leading Darwinian biologists and social thinkers in Germany believed that Darwinism had superseded traditional Judeo-Christian and Enlightenment ethics, in particular the value such philosophies placed upon all human life. The moral relativism which emerged from the exaltation of the evolutionary "fitness" of the species as the source of a moral good was at the core of this "pseudo-ethics".[365] O'Mathúna argued that five key ideas were central to the actions of the Nazi doctors – moral relativism, blurred distinctions between animals and humans, the existence of human inequality, the notion that some lives have no value and natural selection as a valid determinant of human dignity.[366]

Regardless of the intellectual bankruptcy of Nazi racial ideology, Darwinian ideas and evolutionary psychiatry are still popular. Indeed, there is a strong evolutionary psychiatry movement, which seeks to understand human psychopathology in terms of the natural history of our species.[367] Moreover, the conceptualization of psychiatric disorder is moving inexorably towards the molecular level,[368] where depression or anxiety may be defined more in terms of the possession of particular alleles of genes, rather than the traditional verstehende Psychologie of Jaspers.[369] Whilst it is not reasonable to assume a moral equivalence between the current, somewhat reductionist paradigms of evolutionary psychiatry or genetics, there is a need to reflect upon neuropsychiatry potentially losing sight of the intrinsic value of humans. Kant's notion of "Menscheit" refers to the human potential for autonomy, or unconstrained rational self–governance.[370] This is one approximation of the intrinsic value of humans, even the most irrational or intellectually disabled person. Kant's formula of humanity has it that humans must be ends in themselves, and never a means to such an end.[59] Such notions were clearly lost in the Nazi era, a fact made all the more tragically ironic in that Adolf Eichmann, the Nazi functionary who was responsible for the so-called "Final Solution", proudly proclaimed at his trial for crimes against humanity that he was a Kantian.[74]

Losing sight of the essential value of humans seems to be at the core of the of the Nazi doctors' crimes. The moral philosophy which emerged in the aftermath of the Holocaust, through the works of Baumann[170] and Levinas,[371] emphasized that the crisis in Western ethics brought about by the Nazi era resided in the perceived loss of the value of human beings, no matter what their background.

A common method of argument in bioethical debate is to position a particular issue with reference to Nazism. Polemicists like Peter Singer, whose advocacy for termination of grossly deformed fetuses is often compared to the excesses of Nazism, contribute to such emotive debates. What is not clear are the specifics of the fundamental moral failure of the Nazi doctors. Many rationalizations were

offered by defendants in the "Doctors' Trial", yet it remains difficult to define a core moral failing. As such, the invocation of the Nazi doctors is problematic in contemporary bioethical discourse.[372] "The Nuremburg Code", the declaration of ethical principles which formed the basis of current Codes of Ethics for research, emphasizes the importance of informed consent to research participation. Informed consent to participate in psychiatric research is amongst the most vexed of issues in the field.[373, 374]

One lingering question is the notion of the universalizability of the Nuremburg Declaration. The Nuremburg Declaration, arguably, sees the global imposition of liberal Anglo-American values under the rubric of the emergent notion of 'human rights'.[375] Regardless of the apparent validity of such constructs, the question of the universalizability of the concept of informed consent is problematic. A particular issue is whether data obtained from research participants from settings other than a researcher's own institution are subject to the same valid forms of consent as required in the researcher's own country. There is emerging evidence that informed consent to participate in research programs is challenging in settings such as China[376] and West Africa,[377] where increasing amounts of psychiatric and neuropsychiatric research are performed, presumably due to cost benefits and the availability of research participants. This then raises the question of what the ethical grounds are for publishing such research, if there are credible doubts about the adequacy of informed consent to research into psychiatric treatment.

In conducting research in psychiatry, there is an ever-present tension between the duty to protect vulnerable individuals and the duty to advance scientific knowledge. It is argued that concern about vulnerability of psychiatric patients has contributed to slow progress in psychiatric research.[378] The process of obtaining informed consent and competence to participate in psychiatric research have tended to be the main focus of the literature in the area of research ethics in psychiatry.[374, 379]

There are four commonly used standards for a person's competency evidencing a choice in regard to research participation.[380] The first is the patient's ability to acknowledge they have a choice to not participate in the research study. The second is the patient's factual understanding of the issues involved in their participation in the research study. The third is the patient's capacity for rational manipulation of information provided to them about the research, such as the possibility of being allocated to a placebo or control condition and the risks associated with this. The fourth and final is the patient's appreciation of the nature of the situation, in particular the ability to distinguish between their access to care being independent of whether or not they choose to participate in the research project. These standards move from a basic grasp of the issue through to a more abstract understanding of the totality of the situation, a process which is not always the case with severely ill patients. Clearly, the closer the consent to the higher standards, the more comprehensive is the level of informed consent in the study.

Clinical trials involving psychotropic medications are problematic, given the enforced nature of much psychiatric treatment, particularly in the chronic mentally ill.[373] Many such patients feel obligated to participate in such research, as they may misunderstand the imperative to participate. Moreover, the use of children as subjects in psychiatric research represents a similar concern of the vulnerability of such patients in the therapeutic relationship.[381-383]

ETHICS AND CONSULTATION-LIAISON PSYCHIATRY

The Nature of C-L Psychiatry

One of the fundamental features of the role of a C-L psychiatrist is the ambiguous nature of the relationship with the patient. C-L consults are frequently sought by the treating team and not the patient, which creates a fundamentally "social role" in C-L psychiatry.[384] This social role focuses on the relationship between primary physician or non-medical health professionals and consultant psychiatrist who works within an institutional setting.

The Ethics of Managing the System

A frequent pretext of the involvement of a C-L psychiatrist in a clinical situation is to provide an intervention at the level of a system, such as where there is a problematic relationship between a difficult patient and a medical team. In such circumstances, the C-L psychiatrist is expected

to be "all things to all people".[385] Indeed, it has been argued elsewhere that by virtue of its broad perspective, C-L psychiatry has a credible role providing ethical guidance in difficult clinical situations.[386, 387] Such circumstances create a tension between the expectations of the patient and that of the referring physician or indeed the institution itself., It has been claimed that in some instances interventions by the C-L psychiatrist are directed at the staff, rather than the patient, creating a "bipolarity of practice".[388] Interventions such as a reframing of a patient's challenging behaviour on a medical ward serve to improve the functioning of the therapeutic relationship between the patient and other health professionals by engendering an attitudinal shift in the staff on a medical ward. This often makes use of what has been described as a "situational diagnosis",[389] in which a diagnostic statement, integrating multiple perspectives of a situation regarding a patient, is made in order to help resolve a therapeutic impasse on a medical ward. An example is the frequent use of the diagnosis of "adjustment disorder" in C-L settings, in which the emphasis on the overwhelming stressor of a physical health crisis removes the focus from the patient's more difficult interpersonal behaviours.

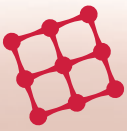### C-L Psychiatrists and Medical Decision Making

C-L Psychiatrists often encounter broader dilemmas in medical ethics in their liaison roles within medical units. C-L psychiatrists routinely assess patients for their suitability for transplantation, and while such evaluations are not the ultimate arbiter of the allocation of transplant resources, they are highly influential. A particularly contentious instance of this is the assessment of patients for liver transplants, particularly following paracetamol overdose. This is a vexed area, as this frequently represents an end-of-life decision given the fulminant nature of paracetamol induced hepatotoxicity. C-L psychiatrists are often requested to consult in clinical situations, in which a patient with a severe, life-threatening illness refuses treatment. In some circumstances, such refusal occurs against the background of an acute confusional state or severe mood disorder, where there are clear grounds to regard the patient's refusal as being attributable to the effects of such illnesses.

In other circumstances, C-L psychiatrists sometimes find themselves in the midst of controversial clinical situations such as the procurement of late-term termination of pregnancy.[390] In these settings, the C-L psychiatrist is asked for a clinical opinion on the prospective psychological effects of the procedure occurring or not. Whilst this information is not, of itself, ethical, it may be highly influential in the final clinical decision. As such, psychiatric opinions require careful reflection on the potential influences impacting on their formation, including pressures on the part of the patient or other clinicians to obtain a speculative statement of psychological impact, which will facilitate a particular decision.

ETHICS AND TRANSCULTURAL PSYCHIATRY

Psychiatric diagnosis occurs in a specific cultural context. The cultural background of the psychiatrist and the patient influence how specific observations of the patient are interpreted. In the sociological literature, the concept of "cultural relativism" is frequently discussed in relation to psychiatric diagnosis and treatment. Cultural relativism is the view that the normative mores, customs and practices of particular cultures can only be truly known within the culture in which they are occurring. In other words, the alien observer cannot know or understand the norms of a particular culture. Applied to the concept of mental disorder, cultural relativism takes the position that mental disorders are social constructs. A social construct is an idea, which may appear to be natural and obvious to those who accept it, but in reality is an invention or artefact of a particular culture or society. The implication of this view is that social constructs are in some sense human choices rather than natural phenomena.[391] Social constructions are, by nature, processes which are historically and socially contextual and inform both knowledge and action.[392]

Ruth Benedict's classic book *Patterns of Culture*[393] provided an anthropological foundation of the process of social constructionism and cultural relativism in defining psychiatric disorder. Benedict observed that each culture chooses a few characteristics, which become normative for it. From the position of cultural relativism, each culture thus creates its own moral imperatives that can be understood only if one studies that culture as a whole. Normality or morality is relative to the values of the culture. A person whose behaviour or views are deviant from the rest of the culture (or a

"normal" member of that culture placed in another) would be deemed "mentally ill" in the view of cultural relativism. This explains the position that delusions, for example, must be beliefs inconsistent with the person's culture. In clinical practice, such a perspective requires that the clinician be aware of the need to see the patient's experience in the context of their particular culture. In other words, the question must be "how would a typical member of this group view this situation?"

Alienism and Mental Hygiene

The term "alienism" refers to the 19th Century view in Western psychiatry that persons suffering from mental illness were thought to be "alienated" from society and themselves. This view derived predominantly from the study of mentally disordered offenders and the assumed relationship between mental illness and criminality. In forensic settings, psychiatrists were termed "alienists". Mental hygiene is defined as the process of "preserving the mind against all incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements".[394] The mental hygiene approach addressed all factors in society which may be injurious to mental health. The movement gained prominence in post-war Western psychiatry and reached its peak in the work of Adolph Meyer in the USA.

Colonial and Post-Colonial Psychiatry

The trauma of cultural displacement and the legacy of colonisation are critical in conceptualising the mental health of indigenous populations. Under colonial rule, psychiatry was often co-opted into the subjugation of indigenous populations, such as in French Algeria. Frantz Fanon's book *The Wretched of the Earth*[395] highlighted how European psychiatry functioned in a colonial setting to alienate the colonized population from their society by forcing a questioning of identity through the European psychiatric prism.

Fanon, like Che Guevara, was a medical practitioner and revolutionary. In addition to his revolutionary politics, Fanon pursued a project of reform in the psychiatric profession in Algeria, creating a dialectic of psychiatrist or street fighter.[396] Indeed, Fanon's double life as a colonial-era psychiatrist and as an Algerian Front de Libération Nationale (FLN) activist has invited much criticism in revisionist views of his life. His most recent biographer refers to his reputation as a "talented hater",[397] and other critics cannot look past his complicity in FLN atrocities, such as bombings and sabotage.[398]

Fanon identified colonial psychiatry in Algeria as Eurocentric and as exerting a hegemonic cultural influence upon the population as a perpetuation of the "colonizer-colonized" dynamic. The cultural estrangement and institutionalized racism brought about by Eurocentric psychiatry creates a sense of "the Other" in the colonized population, forcing them to constantly question "Who am I?" Whilst much of the psychiatric material in Fanon's other works, *The Wretched of the Earth*[395] and *Black Skin, White Mask*[399] was co-written and possibly anecdotal,[400] his main contribution to the field of psychiatry was the requirement of a "common culture" between psychiatrist and patient.[401] Fanon reformulated Lacan's notion of *méconnaissance*[402] to the alienation of the colonized Other from cultural, social and political elements, through a process of internalizing injustice.[403] Fanon rejected Eurocentric psychiatry as it presented a means of conforming to the "psychology of the colonized". Madness was therefore sociogenic in Fanon's view, and so psychiatric treatment, in the tradition of Pinel, took place in psychiatric institutions that functioned as institutions of social change. Indeed, Fanon has been described as a "social psychiatrist driven by humanism to unmask inhumanity".[396]

Even in post-colonial societies, there are remnants of alienist themes in psychiatric institutions which have evolved largely as recreations of those of the previous colonizing power.[404] One possible instance of this are the "Culture Bound Syndromes", including such diagnoses as *"amok"* found in the Malay culture, and *"uqamairineq"* among the Yupik Eskimos. Culture-bound syndromes are seen as "folk illnesses" in which changes of behaviour figure prominently.[405] The phenomenon of *"amok"*, found in Malaysia and Indonesia, involves a person (usually male) exhibiting a deranged state of agitation and hostile aggression, often leading to destruction of property. From the perspective of the person's culture, such behaviour is viewed as being within the bounds of normal behaviour. In the era of British colonial rule, and its associated psychiatric institutions, such behaviour represented grounds for involuntary psychiatric treatment. Thus a Western pathologizing of a normal behaviour represented an example of the use of psychiatry as a process of exerting social control. The

argued limitations of the DSM-IV-TR in non-Western patients, is apropos of the concept of cultural relativism.[406] Fabrega contended that psychiatry reflects a cultural interpretation about personal experience, responsibility, and social behaviour.[407] The argument that unusual behaviour, which might be normative in one setting, is grounds for a psychiatric diagnosis in a Western setting represents a quandary. Indeed, one author has argued that the existence of culture-bound syndromes in the DSM-IV evokes notions of the "crazy native".[408]

The second theme in the ethics of transcultural psychiatry is concerns about the presence of a possible latent racism in psychiatric diagnosis and treatment decisions.[395, 408, 409] Non-Western patients are more frequently diagnosed with psychotic disorders than Western patients, receive higher doses of antipsychotic medication and are more likely to be secluded whilst on inpatient wards.[408] Non-Western patients are viewed as being more likely to be dangerous or unpredictable, and are therefore subject to greater levels of coercive psychiatric treatment.

Appendices

APPENDIX 1 – THE DECLARATION OF HAWAII (1977)

As approved by the General Assembly of the World Psychiatric Association in Vienna, Austria,
on 10th July 1983

1. The aim of psychiatry is to treat mental illness and to promote mental health. To the best of his or her ability, consistent with accepted scientific knowledge and ethical principles, the psychiatrist shall serve the best interests of the patient and be also concerned for the common good and a just allocation of health resources. To fulfil these aims requires continuous research and continual education of health care personnel, patients and the public.

2. Every psychiatrist should offer to the patient the best available therapy to his knowledge and if accepted must treat him or her with the solicitude and respect due to the dignity of all human beings. When the psychiatrist is responsible for treatment given by others he owes them competent supervision and education. Whenever there is a need, or whenever a reasonable request is forthcoming from the patient, the psychiatrist should seek the help of another colleague.

3. The psychiatrist aspires for a therapeutic relationship that is founded on mutual agreement. At its optimum it requires trust, confidentiality, cooperation and mutual responsibility. Such a relationship may not be possible to establish with some patients. In that case, contact should be established with a relative or other person close to the patients. If and when a relationship is established for purposes other than therapeutic, such as in forensic psychiatry, its nature must be thoroughly explained to the person concerned.

4. The psychiatrist should inform the patient of the nature of the condition, therapeutic procedures, including possible alternatives, and of the possible outcome. This information must be offered in a considerate way and the patient must be given the opportunity to choose between appropriate and available methods.

5. No procedure shall be performed nor treatment given against or independent of a patient's own will, unless because of mental illness, the patient cannot form a judgement as to what is in his or her own best interest and without which treatment serious impairment is likely to occur to the patient or others.

6. As soon as the conditions for compulsory treatment no longer apply, the psychiatrist should release the patient from compulsory nature of the treatment and if further therapy is necessary should obtain voluntary consent. The psychiatrist should inform the patient and/or relatives or meaningful others, of the existence of mechanisms of appeal for the detention and for any other complaints related to his or her well being.

7. The psychiatrist must never use his professional possibilities to violate the dignity or human rights of any individual or group and should never let inappropriate personal desires, feelings, prejudices or beliefs interfere with the treatment. The psychiatrist must on no account utilize the tools of his profession, once the absence of psychiatric illness has been established. If a patient or some third party demands actions contrary to scientific knowledge or ethical principles the psychiatrist must refuse to cooperate.

8. Whatever the psychiatrist has been told by the patient, or has noted during examination or treatment, must be kept confidential unless the patient relieves the psychiatrist from this obligation, or to prevent serious harm to self or others makes disclosure necessary. In these cases however, the patient should be informed of the breach of confidentiality.

9. To increase and propagate psychiatric knowledge and skill requires participation of the patients. Informed consent must, however, be obtained before presenting a patient to a class and, if possible, also when a case-history is released for scientific publication, whereby all reasonable measures must be taken to preserve the dignity and anonymity of the patient and to safeguard the personal reputation of the subject. The patient's participation must be voluntary, after full information has been given of the aim, procedures, risks and inconveniences of a research

project and there must always be a reasonable relationship between calculated risks or inconveniences and the benefit of the study. In clinical research every subject must retain and exert all his rights as a patient. For children and other patients who cannot themselves give informed consent, this should be obtained from the legal next-of kin. Every patient or research subject is free to withdraw for any reason at any time from any voluntary treatment and from any teaching or research program in which he or she participates. This withdrawal, as well as any refusal to enter a program, must never influence the psychiatrist's efforts to help the patient or subject.

10. The psychiatrist should stop all therapeutic, teaching or research programs that may evolve contrary to the principles of this Declaration.

APPENDIX 2 – THE DECLARATION OF MADRID (1996)

In 1977, the World Psychiatric Association approved the Declaration of Hawaii which set out ethical guidelines for the practice of psychiatry. The Declaration was updated in Vienna in 1983. To reflect the impact of changing social attitudes and new medical developments on the psychiatric profession, the World Psychiatric Association has once again undertaken a review of ethical standards that should be abided to by all its members and all persons practicing psychiatry.

Medicine is both a healing art and a science. The dynamics of this combination are best reflected in psychiatry, the branch of medicine that specializes in the care and protection of those who are ill or infirm, because of a mental disorder or impairment. Although there may be cultural, social and national differences, the need for ethical conduct and continual review of ethical standards is universal.

As practitioners of medicine, psychiatrists must be aware of the ethical implications of being a physician, and of the specific ethical demands of the specialty of psychiatry. As members of society, psychiatrists must advocate for fair and equal treatment of the mentally ill, for social justice and equity for all.

Ethical practice is based on the psychiatrist's individual sense of responsibility to the patient and judgment in determining what is correct and appropriate conduct. External standards and influences such as professional codes of conduct, the study of ethics, or the rule of law by themselves will not guarantee the ethical practice of medicine.

Psychiatrists should keep in mind at all times the boundaries of the psychiatrist-patient relationship, and be guided primarily by the respect for patients and concern for their welfare and integrity.

It is in this spirit that the World Psychiatric Association approved at the General Assembly on August 25th, 1996, amended on August 8th 1999 and on August 26th 2002 the following ethical standards that should govern the practice of psychiatrists universally.

1. Psychiatry is a medical discipline concerned with the prevention of mental disorders in the population, the provision of the best possible treatment for mental disorders, the rehabilitation of individuals suffering from mental illness and the promotion of mental health. Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient and seek advice in areas of their work about which they do not have primary expertise. While doing so, psychiatrists should be aware of and concerned with the equitable allocation of health resources.

2. It is the duty of psychiatrists to keep abreast of scientific developments of the specialty and to convey updated knowledge to others. Psychiatrists trained in research should seek to advance the scientific frontiers of psychiatry.

3. The patient should be accepted as a partner by right in the therapeutic process. The psychiatrist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. It is the duty of psychiatrists to provide the patient with all relevant information so as to empower the patient to come to a rational decision according to personal values and preferences.
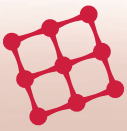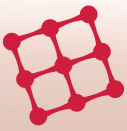
4. When the patient is gravely disabled, incapacitated and/or incompetent to exercise proper judgment because of a mental disorder, the psychiatrists should consult with the family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or the life of others. Treatment must always be in the best interest of the patient.

5. When psychiatrists are requested to assess a person, it is their duty first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when psychiatrists are involved in third party situations.

6. Information obtained in the therapeutic relationship is private to the patient and should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient. Psychiatrists are prohibited from making use of such information for personal reasons, or personal benefit. Breach of confidentiality may only be appropriate when required by law (as in obligatory reporting of child abuse) or when serious physical or mental harm to the patient or to a third person would ensue if confidentiality were maintained; whenever possible, psychiatrists should first advise the patient about the action to be taken.

7. Research that is not conducted in accordance with the canons of science and that is not scientifically valid is unethical. Research activities should be approved by an appropriately constituted ethics committee. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Because psychiatric patients constitute a particularly vulnerable research population, extra caution should be taken to assess their competence to participate as research subjects and to safeguard their autonomy and their mental and physical integrity. Ethical standards should also be applied in the selection of population groups, in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centres.

GUIDELINES CONCERNING SPECIFIC SITUATIONS

The World Psychiatric Association Ethics Committee recognizes the need to develop a number of specific guidelines on a number of specific situations. The first five were approved by the General Assembly in Madrid, Spain, on August 25, 1996, the 6 through 8 by the General Assembly in Hamburg, Germany, on August 8, 1999, the 9 through 12 by the General Assembly in Yokohama, Japan, on August 26, 2002, and the 13 through 15 at the General Assembly in Cairo, Egypt, on September 12, 2005.

1. **Euthanasia:** A physician's duty, first and foremost, is the promotion of health, the reduction of suffering, and the protection of life. The psychiatrist, among whose patients are some who are severely incapacitated and incompetent to reach an informed decision, should be particularly careful of actions that could lead to the death of those who cannot protect themselves because of their disability. The psychiatrist should be aware that the views of a patient may be distorted by mental illness such as depression. In such situations, the psychiatrist's role is to treat the illness.

2. **Torture:** Psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts.

3. **Death Penalty:** Under no circumstances should psychiatrists participate in legally authorized executions nor participate in assessments of competency to be executed.

4. **Selection of Sex:** Under no circumstances should a psychiatrist participate in decisions to terminate pregnancy for the purpose of sex selection.

5. **Organ Transplantation:** The role of the psychiatrist is to clarify the issues surrounding organ donations and to advise on religious, cultural, social and family factors to ensure that informed and proper decisions be made by all concerned. The psychiatrists should not act as a proxy decision maker for patients nor use psychotherapeutic skills to influence the decision of a patient in these matters. Psychiatrists should seek to protect their patients and help them exercise self-determination to the fullest extent possible in situations of organ transplantation.

6. **Psychiatrists addressing the media:** In all contacts with the media psychiatrists shall ensure that people with mental illness are presented in a manner which preserves their dignity and pride, and which reduces stigma and discrimination against them. An important role of psychiatrists is to advocate for those people who suffer from mental disorders. As the public perception of psychiatrists and psychiatry reflects on patients, psychiatrists shall ensure that in their contact with the media they represent the profession of psychiatry with dignity. Psychiatrists shall not make announcements to the media about presumed psychopathology on any individuals. In presenting research findings to the media, psychiatrists shall ensure the scientific integrity of the information given and be mindful of the potential impact of their statements on the public perception of mental illness and on the welfare of people with mental disorders.

7. **Psychiatrists and discrimination on ethnic or cultural grounds:** Discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others is unethical. Psychiatrists shall never be involved or endorse, directly or indirectly, any activity related to ethnic cleansing.

8. **Psychiatrists and genetic research and counselling:** Research on the genetic bases of mental disorders is rapidly increasing and more people suffering from mental illness are participating in such research. Psychiatrists involved in genetic research or counselling shall be mindful of the fact that the implications of genetic information are not limited to the individual from whom it was obtained and that its disclosure can have negative and disruptive effects on the families and communities of the individuals concerned.

   Psychiatrist shall therefore ensure that:

   - People and families who participate in genetic research do so with a fully informed consent;
   - Any genetic information in their possession is adequately protected against unauthorized access, misinterpretation or misuse;
   - Care is taken in communication with patients and families to make clear that current genetic knowledge is incomplete and may be altered by future findings. Psychiatrists shall only refer people to facilities for diagnostic genetic testing if that facility has:
   - Demonstrated satisfactory quality assurance, procedures for such testing;
   - Adequate and easily accessible resources for genetic counselling.

   Genetic counselling with regard to family planning or abortion shall be respectful of the patients' value system, while providing sufficient medical and psychiatric information to aid patients make decisions they consider best for them.

9. **Ethics of Psychotherapy in Medicine:** Medical treatments of any nature should be administered under the provisions of good practice guidelines regarding their indications, effectiveness, safety, and quality control. Psychotherapy, in its broadest sense, is an accepted component of many medical interactions. In a more specific and restricted sense, psychotherapy utilizes techniques involving verbal and non-verbal communication and interaction to achieve specified treatment goals in the care of specific disorders. Psychiatrists providing specific forms of psychotherapy must have appropriate training in such techniques. The general guidelines that apply to any medical treatment also apply to specific forms of psychotherapy in regard to its indications and outcomes, positive or negative. The effectiveness of psychotherapy and its place in a treatment plan are important subjects for both researchers and clinicians. Psychotherapy by psychiatrists is a form of treatment for mental and other illnesses and emotional problems. The treatment approach utilized is determined in concert by the doctor and patient and/or the patient's family and/or guardians following a careful history and examination employing all relevant clinical and laboratory studies. The approach employed should be specific to the disease and patient's needs and sensitive to personal, familial, religious and cultural factors. It should be based on sound research and clinical wisdom and have the purpose of removing, modifying or retarding symptoms or disturbed patterns of behaviour. It should promote positive adaptations including personal growth and development.

Psychiatrists and other clinicians responsible for a patient have to ensure that these guidelines are fully applied. Therefore, the psychiatrist or other delegated qualified clinician should determine the indications for psychotherapy and follow its development. In this context the essential notion is that the treatment is the consequence of a diagnosis and both are medical acts performed to take care of an ill person. These two levels of decisions, interventions and responsibilities are similar to other situations in clinical medicine; however, this does not exclude other interventions such as rehabilitation, which can be administered by non-medical personnel.

i. Like any other treatment in medicine, the prescription of psychotherapy should follow accepted guidelines for obtaining informed consent prior to the initiation of treatment as well as updating it in the course of treatment if goals and objectives of treatment are modified in a significant way.

ii. If clinical wisdom, long standing and well-established practice patterns (this takes into consideration cultural and religious issues) and scientific evidence suggest potential clinical benefits to combining medication treatment with psychotherapy this should be brought to the patient's attention and fully discussed.

iii. Psychotherapy explores intimate thoughts, emotions and fantasies, and as such may engender intense transference and counter-transference. In a psychotherapy relationship the power is unequally shared between the therapist and patient, and under no circumstances shall the psychotherapist use this relationship to personal advantage or transgress the boundaries established by the professional relationship.

iv. At the initiation of psychotherapy, the patient shall be advised that information shared and health records will be kept in confidence, except where the patient gives specific informed consent for release of information to third parties, or where a court order may require the production of records. The other exception is where there is a legal requirement to report certain information as in the case of child abuse.

Conflict of Interest in Relationship with Industry: Although most organizations and institutions, including the WPA, have rules and regulations governing their relationship with industry and donors, individual physicians are often involved in interactions with the pharmaceutical industry, or other granting agencies that could lead to ethical conflict In these situations psychiatrists should be mindful of and apply the following guidelines.

1. The practitioner must diligently guard against accepting gifts that could have an undue influence on professional work.

2. Psychiatrists conducting clinical trials are under an obligation to disclose to the Ethics Review Board and their research subjects their financial and contractual obligations and benefits related to the sponsor of the study. Every effort should be made to set up review boards composed of researchers, ethicists and community representatives to assure the rights of research subjects are protected.

3. Psychiatrists conducting clinical trials have to ensure that their patients have understood all aspects of the informed consent. The level of education or sophistication of the patient is no excuse for bypassing this commitment. If the patient is deemed incompetent the same rules would apply in obtaining informed consent from the substitute decision maker. Psychiatrists must be cognizant that covert commercial influence on the trial design, promotion of drugs trials without scientific value, breach of confidentiality, and restrictive contractual clauses regarding publication of results may each in different ways encroach upon the freedom of science and scientific information.

Conflicts Arising with Third Party Players: The obligations of organizations toward shareholders or the administrator regarding maximization of profits and minimization of costs can be in conflict with the principles of good practice, Psychiatrists working in such potentially conflicting environments should uphold the rights of the patients to receive the best treatment possible.

1. In agreement with the UN Resolution 46/119 of the "Principles for the Protection of Persons with Mental Illness", psychiatrists should oppose discriminatory practices which limit their benefits and entitlements, deny parity, curb the scope of treatment, or limit their access to proper medications for patients with a mental disorder.

2. Professional independence to apply best practice guidelines and clinical wisdom in upholding the welfare of the patient should be the primary considerations for the psychiatrist. It is also the duty of the psychiatrist to protect the patient privacy and confidentiality as part of preserving the sanctity and healing potential of the doctor-patient relationship.

Violating the Clinical Boundaries and Trust between Psychiatrists and Patients: The psychiatrist-patient relationship may be the only relationship that permits an exploration of the deeply personal and emotional space, as granted by the patient. Within this relationship, the psychiatrist's respect for the humanity and dignity of the patient builds a foundation of trust that is essential for a comprehensive treatment plan. The relationship encourages the patient to explore deeply held strengths, weaknesses, fears, and desires, and many of these might be related to sexuality. Knowledge of these characteristics of the patient places the psychiatrist in a position of advantage that the patient allows on the expectation of trust and respect. Taking advantage of that knowledge by manipulating the patient's sexual fears and desires in order to obtain sexual access is a breach of the trust, regardless of consent. In the therapeutic relationship, consent on the part of the patient is considered vitiated by the knowledge the psychiatrist possesses about the patient and by the power differential that vests the psychiatrist with special authority over the patient. Consent under these circumstances will be tantamount to exploitation of the patient.

The latent sexual dynamics inherent in all relationships can become manifest in the course of the therapeutic relationship and if they are not properly handled by the therapist can produce anguish to the patient. This anguish is likely to become more pronounced if seductive statements and inappropriate non-verbal behaviour are used by the therapist. Under no circumstances, therefore, should a psychiatrist get involved with a patient in any form of sexual behaviour, irrespective of whether this behaviour is initiated by the patient or the therapist.

Protection of the Rights of Psychiatrists: Psychiatrists need to protect their right to live up to the obligations of their profession and to the expectations the public has of them to treat and to advocate for the welfare of their patients. Psychiatrists ought to have the right to practice their specialty at the highest level of excellence by providing independent assessments of a person's mental condition and by instituting effective treatment and management protocols in accordance with best practices and evidence-based medicine. There are aspects in the history of psychiatry and in present working expectations in some totalitarian political regimes and profit-driven economical systems that increase psychiatrists' vulnerabilities to be abused in the sense of having to acquiesce to inappropriate demands to provide inaccurate psychiatric reports that help the system, but damage the interests of the person being assessed.

Psychiatrists also share the stigma of their patients and, similarly, can become victims of discriminatory practices. It should be the right and the obligation of psychiatrists to practice their profession and to advocate for the medical needs and the social and political rights of their patients without suffering being outcast by the profession, being ridiculed in the media or persecuted.

Disclosing the Diagnosis of Alzheimer's Disease (AD) and Other Dementias: AD patient's right to know is now a well established priority, recognised by healthcare professionals. Most patients want all information available and to be actively involved in making decisions about treatments. At the same time, patients have the right also not to know if that is their wish. All must be given the opportunity to learn as much or as little as they want to know.

The alteration of patient's cognition makes the ability to make judgements and gain insight more difficult. Patients with dementia are also often brought by family members which introduces a third partner into the doctor-patient relationship.

Doctors, patients and families who share the responsibilities for fighting and coping with Alzheimer's disease for years all require access to information on the disease, including the diagnosis.
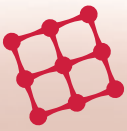
In addition to the "patient's right to know", telling the patient has many benefits. Patients and/or families should be told the diagnosis as early as possible in the disease process. Having family (or informal carer) involved in the discussion of the disclosure process is highly beneficial.

The physician should give accurate and reliable information, using simple language. He should also assess the patient's and the family's understanding of the situation. As usual, the bad news should be accompanied by information on a treatment and management plan. Information on physical or speech therapy, support groups, day care centres, and other interventions should be provided. It should also be emphasised that a reorganised family network can alleviate the carer's burden and maintain quality of life as far as possible.

There are some exceptions, some of them transitory, to the disclosure of the diagnosis to a patient with dementia: 1) severe dementia where understanding the diagnosis is unlikely, 2) when a phobia about the condition is likely, or 3) when a patient is severely depressed;

Dual Responsibilities of Psychiatrists: These situations may arise as part of legal proceedings (i.e. fitness to stand trial, criminal responsibility, dangerousness, testamentary capacity) or other competency-related needs, such as for insurance purposes when evaluating claims for benefits, or for employment purposes when evaluating fitness to work or suitability for a particular position or specific task.

During therapeutic interactions conflicting situations may arise, if the physician's knowledge of the patient's condition cannot be kept private or when clinical notes or medical records are part of a larger employment dossier, hence not confidential to the clinical personnel in charge of the case (i.e. the military, correctional systems, medical services for employees of large corporations, treatment protocols paid by third parties).

It is the duty of a psychiatrist confronted with dual obligations and responsibilities at assessment time to disclose to the person being assessed the nature of the triangular relationship and the absence of a therapeutic doctor-patient relationship as well as the obligation to report to a third party, even if the findings are negative and potentially damaging to the interests of the person under assessment. Under these circumstances, the person may choose not to proceed with the assessment.

Additionally, psychiatrists should advocate for separation of records and for limits to exposure of information so that only elements of information that are essential for purposes of the agency can be revealed.

APPENDIX 3 – DECLARATION OF HELSINKI (1964)

Recommendations guiding physicians in biomedical research involving human subjects, adopted by the 18th World Medical Assembly, Helsinki, Finland, June 1964, amended by the 29th World Medical Assembly, Tokyo, Japan, October 1975, and the 35th World Medical Assembly, Venice, Italy, October 1983.

Introduction

It is the mission of the physician to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfilment of this mission.

The Declaration of Geneva of the World Medical Association binds the physician with the words, "The health of my patient will be my first consideration," and the International Code of Medical Ethics declares that, "A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient."

The purpose of biomedical research involving human subjects must be to improve diagnostic, therapeutic and prophylactic procedures and the understanding of the aetiology and pathogenesis of disease.

In current medical practice most diagnostic, therapeutic or prophylactic procedures involve hazards. This applies especially to biomedical research.

Medical progress is based on research which ultimately must rest in part on experimentation involving human subjects. In the field of biomedical research a fundamental distinction must be recognised between medical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research the essential object of which is purely scientific and without implying direct diagnostic or therapeutic value to the person subjected to the research.

Special caution must be exercised in the conduct of research which may affect the environment, and the welfare of animals used for research must be respected.

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to every physician in biomedical research involving human subjects. They should be kept under review in the future. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Physicians are not relieved from criminal, civil and ethical responsibilities under the law of their own countries.

I. Basic Principles

1. Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific literature.

2. The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experimental protocol which should be transmitted to a specially appointed independent committee for consideration, comment and guidance.

3. Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given his or her consent.

4. Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

5. Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interests of the subject must always prevail over the interests of science and society.

6. The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject's physical and mental integrity and on the personality of the subject.

7. Physicians should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Physicians should cease any investigation if the hazards are found to outweigh the potential benefits.

8. In publication of the results of his or her research, the physician is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication.

9. In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The physician should then obtain the subject's freely given informed consent, preferably in writing.

10. When obtaining informed consent for the research project the physician should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a physician who is not engaged in the investigation and who is completely independent of this official relationship.

11. In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation. Whenever the minor child is in fact able to give a consent, the minor's consent must be obtained in addition to the consent of the minor's legal guardian.

12. The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present declaration are complied with.

II. Medical research combined with professional care (clinical research)

1. In the treatment of the sick person, the physician must be free to use a new diagnostic and therapeutic measure, if in his or her judgment it offers hope of saving life, re-establishing health or alleviating suffering.

2. The potential benefits, hazards and discomfort of a new method should be weighed against the advantages of the best current diagnostic and therapeutic methods.

3. In any medical study, every patient – including those of a control group, if any – should be assured of the best proven diagnostic and therapeutic method.

4. The refusal of the patient to participate in a study must never interfere with the physician-patient relationship.

5. If the physician considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in the experimental protocol for transmission to the independent committee. [1, 2]

6. The physician can combine medical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value for the patient.

III. Non-therapeutic biomedical research involving human subjects (non-clinical biomedical research)

1. In the purely scientific application of medical research carried out on a human being, it is the duty of the physician to remain the protector of the life and health of that person on whom biomedical research is being carried out.

2. The subjects should be volunteers – either healthy persons or patients for whom the experimental design is not related to the patient's illness.

3. The investigator or the investigating team should discontinue the research if in his/her or their judgment it may, if continued, be harmful to the individual.

4. In research on man, the interest of science and society should never take precedence over considerations related to the well-being of the subject.

APPENDIX 4 – THE CODE OF ETHICS FOR THE RANZCP

1. Psychiatrists shall respect the essential humanity and dignity of every patient.

2. Psychiatrists shall not misuse the inherent power differential in their relationships with patients, either sexually or in any other way.

3. Psychiatrists shall provide the best possible psychiatric care for their patients.

4. Psychiatrists shall strive to maintain patient confidentiality.

5. Psychiatrists shall seek informed consent from their patients before undertaking any procedure or treatment.

6. Psychiatrists shall not misuse their professional knowledge and skills.

7. Psychiatrists shall continue to develop and share their professional knowledge and skills with medical colleagues and trainees in psychiatry.

8. Psychiatrists shall share the responsibility of upholding the integrity of the medical profession.

9. Psychiatrists have a duty of care to the health and well-being of their colleagues, including trainees in psychiatry.

10. Psychiatrists involved in clinical research shall adhere to ethical principles embodied in national and international guidelines.

11. Psychiatrists shall strive to improve the quality of, and access to, mental health services, promote the just allocation of health resources and contribute to community awareness of mental health and mental illness.

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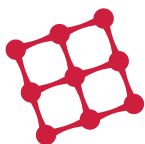
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NOTES
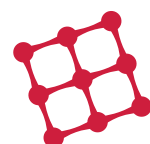
IMET

NSW Institute of Medical
Education and Training

Building 12
Gladesville Hospital
Victoria Road
Gladesville NSW 2111

Tel: (02) 9844 6551
Fax: (02) 9844 6544
email: info@imet.health.nsw.gov.au

www.imet.health.nsw.gov.au