American Handbook of Psychiatry

ETHICS IN PSYCHIATRY

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e-Book 2016 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 7* edited by Silvano Arieti

Created in the United States of America

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Introduction

While reflection on medical ethical issues has been intrinsic to medicine throughout its history, it is only in the past twenty-five years that the study of medical ethics has expanded to embrace the biological and behavioral sciences—an inquiry now conducted under the rubric of bioethics. This development of a more sustained inquiry in bioethics has occurred simultaneously with the various civil and human rights movements. Like these movements, the renewed and growing interest in bioethics reflects our culture's reexamination of value commitments and the proper bounds that may be placed upon institutions that wield power and authority. The consequent convergence of intellectual and social forces has culminated in formal examinations of ethical issues in medicine.

The Scope and Character of Ethics in Psychiatry

Perhaps the most prominent ethical issue in medicine has been the use of human subjects in medical research. Multidisciplinary deliberations about the ethical dimensions of this practice achieved a public character in 1973 with the establishment of the National Commission of the Protection of

Human Subjects in Biomedical and Behavioral Research in the U.S. Department of Health, Education and Welfare. In addition to general considerations of ethical issues occasioned by human research, the commission has addressed issues that bear directly on research in psychiatry; for example, research involving mentally ill subjects. The commission has also considered the ethical dimensions and procedures employed for psychiatric complaints; for example, psychosurgery.

This concern with ethical issues in psychiatric research did not arise apart from the broader concern with the ethical dimensions of medicine and psychiatry. In fact, the interest in the ethics of human research was pursued concurrent with, and in part gave rise to, inquiry into the rights of patients, in particular hospital patients. The ethical dimensions of rights and of rights language also have a direct bearing on psychiatry. They are associated with such issues as due process in the civil commitment of the mentally ill and the rights to treatment of those confined to mental hospitals. Thus, the scope of ethics in psychiatry has not been limited exclusively to research but includes inquiry into the ethical dimensions of psychiatric practice.

There has been another change concerning the inquiry into medical ethics. Its character, as well as its scope, has altered. The discussion of ethical issues in psychiatry, and for medicine generally, has become more philosophically sophisticated. There is a growing appreciation for the importance of those basic concepts that structure ethical issues in psychiatry. This development is clearly evidenced in the burgeoning literature in bioethics, including an *Encyclopedia of Bioethics* and numerous books and journals wherein the full range of ethical issues in psychiatry are addressed.

Five Senses of Ethics in Psychiatry

There are at least five different senses of ethical reflections in psychiatry. First, one might refer to generally accepted views of proper conduct of practitioners within a particular culture. What one will discover in such an inquiry are various and often poorly examined views about what is proper in life, including sexual and other social taboos. Such informal views are often the subject of sociological or orthological study A second and similar sense of ethics in psychiatry derives from a traditional understanding of medical ethics vis-a-vis canons of professional etiquette. In this respect, one might examine professional codes or procedures that are meant to guide both professional and civil conduct. A third and more general sense of ethics consists in following legal rules and procedures. This sense of ethics, however, should be distinguished from the more basic ethical notion of man’s right to refuse on certain justifiable occasions to act in ways that are socially or legally sanctioned. Consider the case of a psychiatrist subpoenaed to testify in court about a patient who has been in therapy for several years and is charged with consensual sodomy. Under oath, the psychiatrist is asked by the prosecuting attorney whether the patient has confided that he has engaged in the actions with which he is charged. Because the psychiatrist may regard the patient's utterances during therapy and his own written record and notes to be protected by a moral obligation of confidentiality, he may be ethically justified in refusing to answer, even though he could be in contempt of court for not answering a direct question. Thus, ethics in the sense of abiding by legal rules and procedures may generate conflicts with well-founded moral obligations and so does not by itself provide a reliable guide to proper conduct. Hence, it should not be confused with that more fundamental sense of ethics. (One might think here of the conflict that Sophocles depicts between Antigone and Creon, as well as the remarks made by Hegel on this subject.)

A fourth sense of ethics in psychiatry relates ethical conduct to various religious codes or religiously grounded views of proper conduct. This view, because it appreciates the need for critical assessment of socially and legally sanctioned conduct, is closer to the more basic understanding of ethics. Its shortcoming is that, in a pluralistic society, ethics requires more general views about human values and proper conduct. This is so for two reasons. First, ethics should provide the basis for persons to inquire into issues of common interest and concern. Second, ethics should provide a common ground to critically assess socially and legally sanctioned patterns of conduct. Thus, the fifth and most fundamental manner in which to understand ethics is to perceive it as an enterprise through which we negotiate divergent moral intuitions. Such an undertaking is crucial for a professional concern such as psychiatry, since it deals directly with the anxieties, conflicts, and interests invoked in patients by the various axiologic dimensions of life. The goal of philosophical ethics, therefore, is not simply an ethic that is nothing more than a general impression of the good life as it is understood by certain groups in a particular society, but rather it is the development of reliable means for analyzing ethical issues and indicating how ethical disputes can be reasonably negotiated. As such, ethics applied to psychiatry should be understood more as a set of modes for analyzing problems and solutions than as a series of final answers to assorted questions. alternative to force does not mean that ethics is more efficient than open force or subtle coercion in the settling of disputes concerning what choices of human conduct are proper. Rather, one faces ethical issues only when one is asking a question that is at once intellectual and practical: How, to what extent, and on what grounds, can reasonable individuals reach agreement about disputed or uncertain areas of moral conduct? Such ethical reflections face up to the problem of pluralism. Thus, in a fundamental sense, philosophical ethics demands a commitment to explore the possibilities of the logic of a pluralism of moral values.

Psychiatry in Ethics

Psychiatry has provided a number of important insights into how and why particular ethical viewpoints have developed. For example, various ethical viewpoints might be understood as different ways of coming to terms with anxieties provoked by certain conflictual situations in life. Of course, such causal accounts of ethical systems do not impugn the intellectual validity and practical importance of ethical analysis. After all, an account of how particular personality traits lead individuals to study quantum physics would not undercut the validity and meaning of quantum mechanics. In other words, identifying hidden or unconscious motivations for ethical views does not provide an exhaustive account of ethics as an intellectual and practical enterprise. What such an inquiry into causal and, in particular, motivational forces does yield is the view that ethics is a form of intellectualization that offers a peaceful mediation of interpersonal conflicts and values. This is a useful notion, for it points to the understanding of ethics as an alternative to force, an attempt to negotiate different and sometimes conflicting moral intuitions without recourse to coercion.

Characterizing philosophical ethics as an alternative to force does not mean that ethics is more efficient than open force or subtle coercion in the settling of disputes concerning what choices of human conduct are proper. Rather, one faces ethical issues only when one is asking a question that is at once intellectual and practical: How, to what extent, and on what grounds, can reasonable individuals reach agreement about disputed or uncertain areas of moral conduct? Such ethical reflections face up to the problem of pluralism. This, in a fundamental sense, philosophical ethics demands a commitment to explore the possibilities of the logic of pluralism of moral values.

Rights, Duties, and Values

If ethics vis-à-vis psychiatry must take into account the problems inherent in a pluralistic notion of moral values, it is first necessary to understand the nature of a logic of pluralism and the application of that logic to the resolution of disputes. As with disputes in other areas of moral conduct, those in psychiatry tend to be expressed in the general philosophical language of rights, duties, and moral values. For the purpose of this essay, and in order to display more clearly what is at stake in such disputes, two senses of rights claims are distinguished: (1) those advanced as a way of enjoining the pursuit of a certain set of goods or values, and (2) those that hold independently of any interest in particular goods or values.

One sense of rights claims is consequentialist or teleological (from the Greek, *telos,* “end”). That is, rights claims can be taken as goal-oriented ways of appreciating legitimate claims of patients and the corresponding duties or obligations of professionals. For example, if one claims that psychiatrists should tell the truth to their patients, one might mean that the practice of recognizing such a duty will lead to the realization and protection of important goods and values in the conduct of psychiatric treatment and care. Leon Salzman has developed this line of thought in considering Sigmund

Freud’s analysis of the importance of truthfulness in psychiatric treatment. Freud54 stated that “psychoanalytic treatment is founded on truthfulness. A great part of its educative effect and its ethical value lies in this very fact.” Here Freud is arguing, in effect, for a particular moral obligation—telling the truth to patients—on the grounds that fulfilling that obligation will lead to the realization of an important goal: maintaining the authority of the psychoanalyst in the context of the therapy. The realization of this good, of course, serves another: the care and treatment of the patient. These goods apply to the patients’ right to truthfulness and the psychiatrist’s corresponding duty to the patient in a manner characteristic of the teleological sense of rights.

The second sense in which rights claims can be understood proceeds from the recognition that one cannot understand ethics as an alternative to force without agreeing at the same time that one must respect the free choice of persons. After all, respect for freedom is the single alternative to force or coercion in some form. Thus, one may hold that there are rights in the therapeutic context that exist by virtue of the very nature of a community based on neither force nor coercion. Rights based on the notion of such a moral community are not reducible to interests in goods and values.

This second justification of rights claims is deontological (from the Greek, *deon,* “obligation”). One such deontological argument has made respect for the freedom of rational persons a condition for moral conduct. That is, the moral community is to be founded on mutual respect of each individual’s autonomy. Insofar as psychiatry is practiced in a pluralistic society, which lacks a single, coherent view of the good life, and insofar as one views it as inappropriate to use the therapeutic relationship to impose one particular view of the good life upon another person, one is forced to acknowledge respect for the autonomy of patients as an indispensable condition for proper professional conduct. Such a deontological concern with freedom or autonomy should be familiar to psychiatrists, since it has been advocated by such individuals as Thomas Szasz, who contended that psychiatry should exist in order “to liberate the patient, to support the autonomy and free choice of patient.” Similarly, Peter Breggin has argued that psychiatry is a form of applied ethics because of its encouragement of an ethic of autonomy.

A deontological approach to ethics in psychiatry, though, has received its sharpest focus in the context of informed consent. Because of the pluralism that characterizes our society, neither patient nor therapist should routinely assume that there exists between the two a ready-made consensus on basic values and goals. Indeed, such an assumption on the part of the therapist might lead, inadvertently, to subtle forms of coercion. This consideration points up the inadequacy of the Golden Rule as a moral maxim, especially for ethical inquiry into psychiatry. The problem here is that the injunction “Do unto others as you would have them do unto you” may inadvertently, or even advertently, become the occasion for imposing upon patients the psychiatrist’s own view of the good. Respect for persons, as an alternative to coercion in even subtle forms, leads to quite a different moral maxim: “Do not do unto others what they would not have chosen to have done to themselves.” It should be noted that respect for the autonomy of the patient does not require that the therapist surrender his autonomy to the patient. That is, the therapist’s autonomy should be respected by the patient. Thus, the therapist need not accept or endorse every expression of a patient’s values. Indeed, an interest in the patient’s autonomy may justify the therapist’s probing or even challenging a patient’s choice of values as part of the therapeutic process.

Even so, voluntary and informed consent functions primarily to maintain patient autonomy. Indeed, the practice of obtaining free and informed consent becomes increasingly important as the likelihood of disagreement between psychiatrist and patient increases. Thus, for example, the National Commission for the Protection of Human Subjects, in its *Belmont Report*, stressed that respect for autonomy grounds concern for free and informed consent by competent individuals.

Among psychiatrists there has been an understandable difficulty in interpreting the force of consent by *all* individuals who come under their care. After all, individuals under the care of psychiatrists may often be in circumstances where their competency is in question or where a choice or pattern of choices by the individual may appear to be somewhat bizarre. At the same time, however, there is a legitimate concern that lack of competence might be assumed without reliable evidence. This concern is complicated by the equivocal nature of the concept of competence. Indeed, the exact relationship between psychiatric diagnoses and levels of competence is a far from settled matter. This concern is reflected in those laws regarding civil commitment that guarantee due process as the means to assure that the prerogatives of competent individuals are not abrogated. A correlative concern is for those whose competence is clearly and substantially diminished, for whom the same legal procedures are meant to be a means to define and support the best interests of the individuals thus affected. These concern for protecting the patient's autonomy and best interests have been tied to arguments that the involuntary commitment of a patient ("for his own good") imposes the obligation to treat that person adequately once committed.

In summary, then, it seems fair to say that issues of a genuine ethical character are an ingredient in psychiatry. These issues cannot be resolved unless one understands that they exist as points of tension concerning the best interests and free choices of individuals, of professionals, and of society. Attempts to resolve these complex conflicts will be expressed in the way in which the psychiatric profession frames particular institutions for therapy. Inevitably, resolutions will embrace practices aimed at assuring some but not other guarantees of autonomy, and they will achieve some but not other goods and values.

It is important to emphasize that these two views of ethical analysis, which are designed to address questions of autonomy and moral goods and values, are not to be taken as competing forms of ethical inquiry. Treating the two views as extremes, one of which must be chosen at the expense of the other, would create an artificial polarity that would only impede attempts to understand the complex ethical issues at stake. Instead, the complexity of the issues demands that these two approaches be understood and employed, when possible, as complementary modes of analysis. One might, by way of illustration, consider the ethical dimensions of psychiatrists engaging in sexual intercourse with their patients as a part of therapy. Leonard Riskin, for example, has argued that this practice should be subjected to a study designed to determine its costs and benefits. From the perspective of philosophical ethics, this proposal amounts to an invitation to reexamine basic practices of the profession to determine whether they can be justified in light of their consequences; that is, whether the goods and values that constitute the goals of the profession will be achieved. An analysis and evaluation based on these goods and values could thus help to determine the consequences of such “therapies” for treatment and the chances for therapeutic success.

Alternatively, one might evaluate this practice in terms of respect for patient autonomy, with a view perhaps to determining whether coercion in subtle forms is or is not an inevitable feature of such “therapies.” That is, by inquiring into the ethics of psychiatry we seek to display alternative ethical analyses of various practices, actual and proposed, and to critically evaluate practices from the concomitant perspective. The final goal is to weigh these perspectives, to achieve an adequate, thorough, and—where possible—coherent account of the proper bounds of professional conduct. For the example in question—sexual relations with the patient—this would require an account that gives prominence to respect for patient autonomy and to an interest in maximizing the benefit/cost ratio of therapy. At the very minimum, one would not want psychiatrists to believe that sexual intercourse with a patient would be a good therapy when it is not, either because the patient was not given an opportunity to freely consent to it or because it would, in fact, neither protect nor advance the patient’s choice of values.

As this example indicates, an analysis of ethical issues in psychiatry will rarely provide one with final answers or with concrete admonitions or injunctions. Instead, ethical analysis, when it is done well, will usually suggest how the inquisitive and thoughtful practitioner might display the geography of values and the character of conflicts among diverse moral values, rights, and duties that he is likely to encounter in research and/or practice. Such analyses will allow one to identify better solutions and only rarely hit upon the best solutions. Because the human moral universe is diverse, complex, and perhaps in part incoherent, one is usually forced to choose among values. Therefore, in many important areas of concern, one is often forced to choose among several conflicting obligations. Ethical analyses therefore offer suggestions on how to approach the conflict of values at stake in psychiatric practice. It becomes necessary then to see how some of the more prominent of these concerns arise. These analyses, however, must be appreciated as attempts to suggest how the problem sketched might be understood, rather than as statements of definitive resolutions of those problems.

Diagnosis and Values

The diagnosis of mental illness involves complex conceptual and normative issues. The normative issues involved, however, are not only ethical, but include non-ethical evaluations as well. For example, judging that an individual is abnormal, deviant, ill, or diseased involves, at least according to the arguments of some, appeals to non-ethical norms or ideals of psychological functions. That is, judging an individual to be mentally ill involves more than a judgment that he or she is statistically deviant. The abnormality that is recognized also reflects a judgment that the individual fails to realize a minimum ideal or norm of psychological function. This recognition allows one to hold that a mental illness might be statistically the rule, though still an abnormality. It explains as well why individuals at the lower end of the distribution of IQs are considered to be abnormal in a normative sense, while those at the higher end, while equally statistically abnormal, are considered to be normal. Holding individuals to be healthy or diseased involves not only a description of facts and an explanation of their occurrence, but evaluations of them as well, evaluations that often reflect the broad, transculturally recognized minimal ideals of proper psychological or behavioral function.

In addition, diagnostic labeling casts individuals into sick roles, with not only special privileges but also special obligations. Being placed in the sick role results in limitations on an individual’s liberty and ability to pursue certain goods and values. As a result, diagnosis involves the interplay of (1) non-moral values concerning proper human behavioral and psychological capacities and function; (2) explanatory, predictive, and therapeutic interests that lead to the development of explanatory accounts (for example, notions of particular psychiatric diseases, such as schizophrenia); and (3) special social roles that are established, verified, and given concrete form through the authenticating or diagnosing role of psychiatrists. Thus, psychiatrists not only describe clinical data but join such descriptions with evaluations in explanatory models that certify individuals as falling properly within a sick role.

Now, patients can, and sometimes do, abuse and take advantage of such roles through the manipulation of psychiatrists and the health care system.

Such forms of abnormal illness behavior, as described by Izzy Pilowski, afford patients various forms of secondary gain from certain sick roles. On the other hand, psychiatrists and mental health institutions can be harnessed by social groups in order to impose on others the ideals of those groups concerning proper psychological and behavioral functions. The recent debate concerning the classification of homosexuality in the *Diagnostic and Statistical Manual* (DSM-III) of the American Psychiatric Association reflects such concerns about the nature of ideals of sexual function and the social power of diagnostic labeling.

Those opposed to including homosexuality in the DSM-III may believe that terming an individual choice psychologically abnormal, deviant, or diseased is not simply descriptive; it must necessarily involve a normative interpretation of reality, one that can and does have a profound impact on an individual’s autonomy and choice of values in life-style. At the same time, *not* labeling choices of values or life-style as abnormal, deviant, or a stage of arrested development (and thus a form of psychiatric disorder) also involves normative interpretations of reality. Thus, the change in the DSM-III classification of homosexuality from a species of sexual deviation to ego-dystonic homosexuality may be taken to imply that this life-style is normal, healthy, and therefore good for those who choose it. In summary, various senses of mental health and well-being, as well as mental illness, abnormality, and deviance, express different views about not only ideals of function but about what pains and anxieties are to be tolerated and which are to be considered “abnormal” in the sense of being worthy of treatment.

Thus, one prominent set of ethical concerns about psychiatric diagnosis has focused on the creation of a social reality in the form of psychiatric sick roles. In addition to excusing individuals from the consequences of certain behaviors (“He can’t help that he’s mentally ill”), the sick role excuses one from social obligations (“He can’t be expected to work, he is completely disabled due to his being mentally ill”), establishes duties (“He ought to seek treatment for his problem”), and sanctions authorities (“In fact, he should see a psychiatrist”). The normative aspect of diagnosis also establishes certain special rights (“He will receive full disability pay until he is well”). Psychiatric diagnoses can also lead to the loss of rights through the relationship between psychiatric categories of diagnoses and legal concepts of insanity (“He can’t, given his illness, be responsible for his assets or write a new will”). Thus, such specially sanctioned sick roles are multifaceted. They can give special protection against criminal prosecution and can also provide grounds for civil commitment. Because of the social power that such sick roles possess, they raise opportunities for misuse and therefore bring about complex ethical issues.

Ethical Dimensions of Labeling

When non-moral normative judgments are transmuted into performative judgments, they create social roles with socially and often legally enforced rights and duties. Being labeled a mentally diseased individual will, therefore, bring normative evaluation as well as special forces to bear on that individual. For example, a drug addict can be treated not simply as statistically deviant, but responsible for his actions and, therefore, perhaps a criminal. The addict, however, can also be regarded as diseased and hence in need of treatment to turn him aside from a self-destructive habit or life style. A more profound example of the moral import of labeling is the use of psychiatric hospitalization in the Soviet Union. In this context the transmutation of political judgments into psychiatric judgments changes the political role “dissident” into the psychiatric role “insane personality,” a deviant in need of treatment. Placing individuals in the sick role thus involves ethical issues concerning the protection, diminishment, and manipulation of the autonomy of individuals and of their choice of values. Such roles involve a commitment to special transfers of goods and to the sometimes profound alterations in the usual connotations of rights and duties."

Ethical Dimensions of Clinical Judgment

The process of clinical judgment involves several genres of ethical issues. These turn on determination of prudent balances of likely benefits and costs in the process of working toward and then applying a diagnostic label.

This process involves a determination of what is in the best interests of a patient, since any clinical judgment will expose a patient to a risk of false positive diagnoses as well as false negative ones. On the one hand, one will be inclined to hold that it is reasonable to be exposed to increased numbers of false positive diagnoses, if the treatment involved has few noxious sequelae, if there is sufficiently efficacious treatment available, if the disease is serious enough to justify the risks of diagnosis and treatment, and if the diagnostic label entails bearable social costs. On the other hand, one must try to avoid false positives, even at the risk of increased false negative diagnoses, if for instance there is not in fact a successful treatment (and the treatment has noxious side effects) or if the diagnostic label carries social risks that outweigh the benefits of treatment. In this respect, one might consider, for example, the social costs of being labeled a schizophrenic. From still another perspective, one must be concerned about false negative diagnoses if, and only if, the disease is serious and there is a sufficiently promising treatment with manageable side effects, and low enough social costs, consequent to the label involved.

Judgments about the prudent balance of benefits and costs are reflected in indications for making a diagnosis. They set the threshold of facts that ought to be established to make a diagnosis, given a risk of being wrong and therefore of needlessly exposing the patient to danger; for example, determining whether or not to recommend that a severely depressed suicidal patient be hospitalized. Even the acquisition of data to make a diagnosis involves risks of anxiety and social loss, as in studies of schizophrenia. Thus, clinical judgment involves the issues of the costs of holding a particular state of affairs to be the case, even if one knows that the probability of a particular diagnosis being true is always less than 100 percent. Ethical questions arise because of differing views of which balances of benefits and risks is justified. In fact, one must ask who in the end should participate in setting such balances, and on what grounds. If it is possible to do so, should the patient be consulted? What weight should be accorded by the psychiatrist to a subsequent acceptance or refusal of a diagnosis and its label by the patient? It should be noted that the concerns expressed in these questions are similar to those raised in medicine generally, with the possible exception of the concern for labeling, for which there are only a few parallel cases in somatic medicine; for example, syphilis and leprosy.

Informed Consent

In a frequently cited essay on the subject of ethics in psychiatry, Fritz Redlich and Richard Mollica present the view that “informed consent is the basis of all psychiatric intervention and that without it no psychiatric intervention can be morally justified.” The only exception they allow is the case of a patient who is “judged incompetent to give his informed consent,” in which case consent should be sought “through proper judicial channels.”

Informed Consent in Psychiatric Practice

An interesting insight into the nature of the principle of informed consent in psychiatric practice can be gleaned from a consideration of the legal understanding of informed consent as mandated by the Department of Health, Education and Welfare (now Health and Human Services)* rules for consent in research, and which has been expressed in much of case law. Together these developments direct attention to certain obligations arising from a patient's right to informed consent. The psychiatrist should respect the freedom and integrity of patients by keeping them apprised of their diagnosis, alternative methods of treatment, the risks and benefits of each treatment option, and the prognosis under each treatment modality. At the same time, however, there has been a tendency in the law to recognize limits on a strict adherence to informed consent. For example, there might be a need to balance the principle of informed consent with prudential judgments concerning the benefit/cost ratio of premature and thus anxiety-provoking revelations in a therapeutic context. Thus, the psychiatrist might choose to time carefully the revelation of new diagnoses of schizophrenia or latent homosexuality when the diagnosis itself might be perceived as threatening by the patient.

Both deontological and teleological aspects of the principle of informed consent must be considered. As indicated earlier, the deontological understanding of moral rights, duties, and values makes respect for persons an indispensable condition for proper moral conduct. This mode of ethical analysis captures a central feature of the principle of informed consent: respect for autonomy. Recent philosophical analyses of the concept of autonomy have distinguished its two dimensions. The first of these is authenticity: that is, any person's right to self-integrity, to choose and live out whatever values one wants. The second dimension of autonomy is independence: that is, the right of any person to control the circumstances of his own life. With this understanding, the practice of informed consent can be justified as enhancing autonomy, independent of the considerations of particular goods or evils such a practice might promote. Consideration of a patient's autonomy will lead to the practice of informing patients, in a timely and routine manner, about the features of their disease and the appropriate treatment for it.

The practice of informed consent can have beneficial results for the therapeutic relationship. A patient may, with the psychiatrist's assistance and guidance, begin to appreciate that he creates problems for himself because of confused or even contradictory choices. Or the patient, through a process Isaac Franck terms "reflexive thought," might discover that in certain circumstances he makes compulsive choices, a feature of his life that until then was hidden. In the absence of such information about themselves, patients will remain ignorant of their unconscious motivations and thus of the full ramifications of a mental disturbance, disorder, or illness. That is, in the absence of a practice of informed consent in psychiatric treatment, certain goods and values deriving from an increased awareness of obsessions and compulsions may be lost for the patient. Informed consent, because it increases the patient’s knowledge of his disorder and promotes bonds of trust between the patient and the psychiatrist, leads to increased participation by the patient in his own care and treatment. Informed consent thus comes to be appreciated as aiding the therapeutic process and, in effect, becomes a central element in that process. This is but another way of saying that a right to informed consent can be claimed as a way of securing already well-recognized goods and values in the therapeutic process.

The deontological and teleological analyses of informed consent thus converge on, and provide a justification for, the principle of informed consent for which Redlich and Mollica argue. Indeed, this principle of mutual participation is at the heart of a common model of psychiatric treatment. Because many forms of mental disorder or illness are best approached through this model of patient-therapist interaction, the practice of informed consent encourages respect for the patient’s autonomy, and protects, defines, and advances the patient’s best interests.

There are, however, limits on a principle of informed consent, because mental disorders and illnesses can often imperil autonomy or distort choices for goods and values. Indeed, it is in such terms that the very meaning of many psychiatric diagnostic categories can be understood; for example, psychoses. The severely psychotic will not be able to have full control of the basic circumstances of their lives or to choose values in a consistent and meaningful manner. In such cases the bases for informed consent may not obtain, because the patient is unable to render an informed consent. Generally, one implication of a psychiatric diagnosis is that competence is diminished. But does the same mental illness diminish autonomy equally in all those who suffer from it? And what does diminished autonomy imply for levels of competence in making decisions? These questions suggest that the connection between psychiatric diagnostic categories and levels of competence is not of a fixed or logical nature, but is more open-textured and nuanced. Close study of the issues involved is required before reliable assessments of that connection can be offered.

This is a significant undertaking because in clinical judgments concerning diminished competence what is at stake are the future freedom and best interests of the patient. That is, the patient can become an incapacitated coworker. As a consequence, one must recognize that patients in such straits are susceptible to even well-intentioned manipulations. If the psychiatrist, for example, acts on the Golden Rule, he may inadvertently choose a view of the good life for the patient that is inconsistent with what the patient might have chosen were he not incapacitated. As a counterpoise, what is required is a practice that respects what has been the patient’s coherent choice of nondestructive values. That is, decision of consent to treatment should be fashioned in a manner that is maximally consistent with the patient's previous history and with a view toward avoiding the sort of choices that resulted in the present incapacitation. In short, for such patients there ought to be a procedure of substituted consent based on the goal of reestablishing competence and on the best estimation of what values the patient would choose to act upon were he fully competent to choose.

The question at this stage is: Who makes determinations of competence? And, in cases of substantially diminished competence, who should provide the substituted consent? The answers turn on a consideration of the goods and values that substituted consent is meant to protect. The patient thought to be incompetent should be shielded from those moral judgments ingredient in the process of both clinical judgment and treatment, whose consequences may not redound to his benefit or maximal future freedom. This shielding on matters of great moment can best be provided by a third party who acts as an advocate for the patient's interests. In our society an institutional practice most closely approximating a formal assessment of a patient's competence and needs by a third party would be court review. Thus, on teleological grounds, Redlich and Mollica's proposal for court review of consent to treatment by the mentally incapacitated is justifiable.

A clear disadvantage of adopting such a procedure is that it is both cumbersome and time-consuming. Our earlier reflections on the value dimensions of clinical diagnosis, labeling, and judgment, however, suggest that these inconveniences may prove a prudent price to pay to protect patients from potentially destructive alterations in the texture of rights and duties, which the practice of informed consent is meant to protect. Still, most concrete choices of therapy will need to remain in the hands of the therapists or the institutions that the court or guardian chooses. It will surely be inconvenient if not ridiculous to review all such choices in a formal fashion. Nor will it be justified in most circumstances to place the burden of proof on families and guardians with respect to the propriety of every choice they make on behalf of the patient. Avenues of review and protection, however, should be provided, as they are incorporated (at least in theory if not in fact) in procedures for determining an individual's level of competence.

Informed Consent in Psychiatric Research

As in other areas of medicine, psychiatry depends on research to make new discoveries and to test new therapies. Historically, the limitation on medical research was the classic "do no harm" principle: So long as harm was not done to the patient, research in medicine was permissible, even obligatory. Since the revelation of Nazi medical war crimes at the Nuremberg Trials, however, the research community and the public have recognized the need for additional protection *of* subjects of medical research. Indeed, beginning with the Nuremberg Code a consistent view has been developed: The voluntary and informed consent of the research subjects is the preeminent ethical consideration. This view is explicitly set out in the various procedural safeguards established in the Department of Health, Education and Welfare's National Commission on the Protection of Human Subjects in Biomedical and Behavioral Research, including guidelines for research on the mentally infirm, as well as for the use of such techniques as psychosurgery.

Here, too, both deontological and teleological analyses converge. On the one hand, a rigorous application of the principle of informed consent in psychiatric research respects the subject's autonomy. On the other hand, such a practice minimizes the chances that an individual's or group's goods and values will be sacrificed for the sake of securing the goods and values of others. Obviously, the one best situated to make such value judgments is the potential research subject, and the principle of informed consent protects his freedom to make such judgments on a voluntary and fully informed basis. At the same time, the principle of informed consent is meant to protect those who might be vulnerable to manipulation or public forms of coercion, particularly those suffering from mental disorders. These two considerations have a special bearing on informed consent for research in psychiatry. The first bears on problems of deception in research, and the second on the use of institutionalized patients as subjects of research.

Research Involving Deception

In obtaining informed consent of a potential subject for psychiatric research, the person must be told of the method(s) to be employed in the research project. After all, for consent to be meaningful, it must be consent to the particular research project and not to research in general. Thus, if a research project on behavioral responses to stressful or anxiety-provoking situations will employ concealed observers to record and evaluate each subject’s responses, the potential research subject should be informed of the possibility that his reactions will be monitored. The psychiatric researcher, however, may be concerned that such information is likely to render the data useless. It may well be that there is no clear-cut, final resolution of the ethical dilemma that emerges here. On the one hand, obtaining informed consent respects the subject’s autonomy and enhances the likelihood that he will be a more willing and thus cooperative participant in the research project. On the other hand, deception may advance the goals of the project while sacrificing respect for autonomy, thus challenging the project’s integrity and risking a cynical view on the part of others about such research when the deception is discovered, as in the much-cited studies on homosexuality by Laud Humphries.

A similar sort of problem occurs in drug experiments matching a possible effective agent and a placebo, as in the testing of tranquilizers. In such circumstances, must potential research subjects be informed that placebos will be used? A strict application of the principle of informed consent requires that we answer “yes.” But then the “placebo effect” may be diminished and the reliability of resultant data called into question. The use of double-blind trials in such cases rescues the psychiatric researcher from the dilemma. If the subject consents to the possibility of deception, the researcher at once maintains the ignorance of both the subject and the administrator of the “drugs” tested and gains the informed consent of the subject to participate.

Unfortunately, this sort of resolution to the problem of deception in research may not be possible in research of the first type, which uses concealed observers, unless a blanket permission has been given to some form of deception. There are parallel examples in ordinary life of permission to be subjected to various forms of deception, for example in the game of poker where permission is given to some, though not all, forms of deception. The clear trend in the public debates on these matters and in the National Commission’s deliberations, however, is to emphasize the practice of informed consent, at the expense of the possible good to be gained from research that does not easily accommodate such a practice. That is, a choice has been made to protect individual freedom and individual choices at the possible expense of a larger, common good. Like other ethical judgments involving prudential balances of risks and benefits, these should not be regarded as final and forever certain, but should be routinely subject to review and evaluations.

Research Involving the Institutionalized Mentally Ill

The use of institutionalized mentally ill patients as subjects of psychiatric research is attractive, for it maximizes a number of conditions for effective research. One is dealing with an easily identifiable and controllable population. Moreover, using this patient population for research overcomes the difficulty of securing sufficient numbers of noninstitutionalized patients to serve as subjects in research that is sometimes promising and thus felt to be important or even urgent. Finally, it is often difficult to find a sufficient number of individuals with a particular affliction except in an institutional setting. Thus, one might argue, unless we move ahead with research programs involving institutionalized subjects, we shall impede the development of possibly more effective therapies, thus harming the interests of those who may be afflicted in the future with the mental illness to be studied.

The problem, though, is that obtaining informed consent from institutionalized patients may be difficult, if not impossible. The potential subjects may be so incapacitated by their mental illness, their treatment regimen, or the institutionalization itself that they are incompetent to render an informed consent to participate in a research project. Here again, as in the case of informed consent for psychiatric treatment, substituted consent by a third party would be an appropriate practice to adopt.

The issues to be considered by the psychiatric researcher can, however, be more complex than those involved in treatment decisions, which are therapeutic in nature. First, a research protocol surely may involve therapeutic measures. Second, it may be designed to determine if a treatment regimen is in fact therapeutic for the subject’s condition. Third, research may be interested in more basic and sustained study of psychiatric disorders in and of themselves. The acquisition of such knowledge is not, by itself, therapeutic for the subjects of the research, though it may someday lead to benefits for others similarly affected. Those goods, one might argue, would be jeopardized by an overly strict practice of informed consent. Thus, along with respect for autonomy, important goods and values are at stake in psychiatric research.

Here, it would seem, we are faced with a conflict between respect for freedom and an interest in the goods and values of the research subject and future patients, for which there is no readily apparent, exclusive solution. On the one hand, out of respect for autonomy and a keen appreciation for the already incapacitated status of the institutionalized mentally ill, one might argue for provision of special protection or even complete immunity from research for those already at increased risk. On the other hand, a vigorous research program may increase the likelihood that research subjects or others in the future could be deinstitutionalized, brought to the point that their disorder is manageable with minimal supervision, or even cured. With such a view one might argue that such research ought to be undertaken. In short, we are faced with a classical ethical problem: how to strike a justifiable balance between assuring some level of autonomy, while still achieving certain goods and values. This conflict should be a familiar one to psychiatrists, since it mirrors a basic conflict between psychiatric roles of physician and therefore cure-giver for a particular patient, and scientist and therefore researcher.

Confidentiality and Privacy

The moral issues raised by the practice of confidentiality may be understood in terms of rights to privacy, including the right to expect that confidences will be kept and that areas of privacy will not be intruded upon without consent. There are two ways in which privacy can be intruded upon. First, others can directly or indirectly disrupt one’s person or circumstances. Second, information about oneself can be released by others into the public domain. It is the latter feature of violation of privacy that is especially pertinent here, since the obligation of confidentiality is designed to prevent dispersion of private information into the public arena.

One way to understand confidentiality is to perceive an analogue with the patient’s personal property: The patient’s autonomy is his to dispose of as he wishes. That is, issuing from autonomy as both a value and a constraint is a right to privacy: One claims the right to control information in order to protect the integrity of one’s person. Thus, the burden of proof falls upon those who would use that information in ways other than those that the patient would permit. In other words, information about a patient, revealed by a patient under the assumption that it will stay between the patient and the psychiatrist, is protected by the notion of a moral community founded in respect for freedom, not force. Unauthorized disclosure of information about patients would, therefore, be a form of violence against patient autonomy. The scope of the right to confidentiality is broad, encompassing all information about patients obtained under the guarantee of confidentiality. In addition, the canons of informed consent apply: Permission by the patient to release information must be explicit, voluntary, and informed.

Now, the shortcoming of this view is that it does not apply so readily to the patient who is less than fully autonomous. It may be difficult, if not impossible, to gain permission to release information about the patient who is substantially incapacitated by a mental disorder or illness, even when it might be in the patient’s own best interests. For patients whose autonomy is not wholly intact, how should psychiatrists understand their obligations of confidentiality?

In seeking an answer to this question, we should attend to the basic purposes of professions like psychiatry. We should, in part, appeal to the goods and values that shape the relationship between patient and psychiatrist. An interesting suggestion along these lines has been made by Stephen Toulmin, who has argued that confidentiality is a key feature to that relationship, because it is a means to protect the patient in situations of vulnerability. Patients are vulnerable (1) to mental disorders and illnesses, (2) to the psychiatrist because of special feelings of trust and dependence, and (3) to society because of the increasingly strong interest in psychiatric patients by third parties. Thus, the patient's privacy should be accorded special protection. Moreover, choices of values may be distorted by illness, subjected to manipulation or subtle coercion by psychiatrists, or jeopardized or even sacrificed to the goods and values of others. By protecting and sustaining the patient's own best interests in these respects, in particular interests concerning privacy, confidentiality emerges as a fundamental obligation within the patient-psychiatrist relationship. Thus, interestingly, deontological and teleological lines of reasoning converge, resulting in a strong obligation to protect the patient's privacy.

There are, however, a growing number of conflicts causing concern and anxiety for psychiatrist and patient alike. On the one hand, such accepted practices as having secretaries type or transcribe notes, or presenting case histories of patients at staff conferences, can raise substantial risks to confidentiality. On the other hand, conflicts between different social institutions can raise special problems. What, for example, is the proper disposition of divergent responsibilities on the part of the psychiatrist in private practice whose patient has expressed deep and abiding hostility toward another person and now confides that he intends to physically harm or even kill that person? Should the psychiatrist in such circumstances reveal to third parties that they are in danger of harm from a patient who has expressed anger and growing hostility toward them? The *Tarasoff* case in California has described the legal conflict here: The privilege to warn endangered third parties has been replaced by a *legal duty* to warn. But what of the moral obligations at stake here? How then can the conflict between the moral obligation to maintain confidentiality and the moral responsibility to warn third parties be resolved?

One might consider here the extent to which the psychiatric profession should guarantee confidentiality in the face of court subpoenas for information when there exists the risk of danger to third parties. The choice of a rule for practice in this regard frames a profession of a particular ethical character. What should that character be regarding confidentiality?

Consider the view that it is legitimate or even obligatory for psychiatrists to report to police authorities that a patient is likely to be dangerous to a third party. One can, on utilitarian grounds (a form of teleological ethics that holds that the right act is the one that ensures the greatest good for the greatest number) argue that such a practice is justifiable if and only if one or more of the following conditions is satisfied: (1) possibly dangerous individuals will *not* be dissuaded from seeking treatment when they know that full confidentiality will not be offered to them; (2) psychiatric treatment does not actually diminish the threat of such persons to third parties; or (3) individuals in a society would, as a rule, feel greatly ill at ease at the thought that a psychiatrist would not make such a report, even if a practice of strict confidentiality would in the long run actually diminish their risk of violence at the hands of such patients. (That is, if strict confidentiality would effectively bring individuals to treatment, it would reduce the general level of risk. In the last case, if one still did not allow strict confidentiality, a greater general value would have been assigned to the perturbation attendant to the thought of such strict confidentiality existing, than to the risk of the violence that strict confidentiality would diminish.) Such choices frame psychiatry as a profession more willing to be cognizant of the impact of certain practices on the common good, even at the expense of the goods and values of individual patients.

In contrast, one might argue that patients require at least one reliable sanctuary from conflicts with the interests of others and thus from the sanctions of society while they struggle to come to terms with their anxieties and mental conflicts. From such a view, one would urge that psychiatrists withholding patients’ threats to others be accorded full privilege against criminal and civil liabilities. Thus, along the lines suggested at the beginning of this section, psychiatry can be regarded as a profession whose fundamental obligations are consistent with respect for freedom and the maintenance of the moral community, even when in some respects some larger, common goods and values might (occasionally) be diminished.

Thus, in deciding a practice of confidentiality for psychiatry, one would expect to find a conflict between two basic roles of the psychiatrist: (1) the psychiatrist as a particular patient’s therapist and therefore protector of the patient’s freedom and best interests; and (2) the psychiatrist as a public health officer and citizen and therefore responsible for the commonweal. The preceding analysis shows that alternative resolutions of this conflict frame the moral character of the professions of psychiatry in starkly different ways.

Conflicts regarding confidentiality are heightened for psychiatrists who, because they are employed by someone other than the patient, have obligations, not just to their patients, but to their employers. These conflicts may be relatively minor, as in the case of a psychiatrist employed by a Health Maintenance Organization (HMO). The psychiatrist may recommend means of treatment more to maintain the cost effectiveness of the HMO than to aid the patient in the best manner possible. More serious conflicts, however, are likely to be encountered by industrial psychiatrists, military psychiatrists, school psychiatrists, and psychiatrists retained to evaluate individuals for job fitness, court proceedings, and the like. Consider the case of a psychiatrist who diagnoses a patient and discovers a condition that could prove to be very costly to his employers, as in the case of an alcoholic airline pilot or a soldier who fears combat. On the one hand, the psychiatrist is bound to his patient by the obligation of confidentiality not to disclose his findings and their implications. On the other hand, he is obligated to his employers as well as to the public, and thus must report his diagnosis and its implications as to future fitness. One escape from this dilemma may be found in the psychiatrist informing patients at the beginning of the relationship that he is bound by two sets of duties and that, when duties to the patient regarding confidentiality conflict with duties to their employer, the psychiatrist will take himself to be obligated to disclose certain or all of the relevant information to the employer —even if doing so might result in loss of pay or even the end of a career for the patient. The drawback of this approach, of course, is that it may result in less than fully frank disclosure by the patient and thus compromise the therapeutic process. The alternative seems to be not informing the patient of the built-in set of conflicts, which amounts to deception.

Similar conflicts arise in the context of therapy involving married couples. For example, in obtaining a sexual history a patient may relate details of an extramarital affair of which the spouse may be unaware. Such information is protected by the obligation of confidentiality, unless the patient explicitly and in advance consents to its being shared with the spouse. The advantage of such a practice is that it protects the psychiatrist from manipulation by the patient, in the form of imposing unjustifiable burdens on the psychiatrist or of drawing the psychiatrist unwillingly into a neurotic conspiracy against the other spouse. The patient is also protected from manipulation by the psychiatrist who may attempt to press one party to a level of candor with the other party to which the first (and perhaps the second) party has not consented.

Patient Rights

This chapter began by noting that many moral disputes in psychiatry are expressed in the language of rights. It will close its inquiry into ethics in psychiatry by considering how rights language bears on a series of issues regarding treatment, nontreatment, and civil commitment. While some of the issues have already received a great deal of attention in the law, our interest will not be in strictly legal issues but rather in understanding how moral obligations of psychiatrists to their patients can be framed in response to rights claims (1) in treatment, (2) to treatment, (3) to refuse treatment, and (4) regarding civil commitment.

Rights in Treatment

One area in which rights claims have direct bearing on psychiatry is in rights in treatment. That is, in the therapeutic process itself respect for persons and an interest in securing certain goods frame psychiatrists' obligations to their patients. This involves: (1) therapies involving barter systems; (2) ethical dimensions of deinstitutionalization; and (3) patient access to records. As will become clear, each of these rights claims is an implication, in practice, of a more basic moral right: informed consent.

Some therapeutic styles involve a form of barter economy, especially in institutional settings where part of the goal of therapy is to encourage and sustain responsible behavior. Thus, for example, a weekend pass is offered as a kind of reward for a set of specified actions. Some patients may be best treated through the use of such barter measures. Indeed, it may be that these patients only respond well to therapy when it includes the features of a barter economy. Thus, important goods are secured for patients through the employment of this practice. At the same time, however, such practices may involve subtle and perhaps unconsented to (by the patient) forms of manipulation. Such concerns can be mitigated, though only to some extent. After all, patients who are best suited to such a therapeutic approach may already have their autonomy substantially diminished by their mental illness. And not employing barter practices will not only not help such patients but might also result in further diminishment of autonomy.

The issues at this point intertwine paternalism and informed consent. Recent philosophical analyses of the concept of paternalism indicate (the view is not necessarily a settled one) that two criteria must be satisfied to justify coercion on paternalistic grounds: (1) the person to be coerced must be in a state of substantially diminished autonomy; and (2) the coercion must be the only means to avoid serious, far-reaching, and irreversible diminishment of autonomy in the future.

One may then argue that such barter measures will be appropriate when they are designed to restore autonomy. Thus, forms of barter economies that diminish patient autonomy, and thus amount to coercion, could not be justified on the account just given. Here, respect for patient’s freedom acts as a side constraint on institutional practice and forms the basis of a right in treatment: the protection against even subtle forms of coercive therapies.

Similar rights claims can be advanced on behalf of patients who are appropriate candidates for the transition from institutionalized to deinstitutionalized care. Presumably patients become appropriate candidates for such a change because (1) deinstitutionalized care will be of greater benefit to them, and (2) they can more or less manage the new responsibilities that will devolve upon them in a noninstitutionalized setting. A number of questions should be raised about this policy change. Is deinstitutionalization indeed what the patient really wants? Are these people being moved out of institutions where, at least in some cases, they might prefer to stay? Will these people, because of the area and conditions in which they will be newly located, be subjected to greater risks without commensurate benefits? Do we sufficiently understand the benefits and costs of deinstitutionalization, and are these benefits and costs explained to candidates for deinstitutionalization or their guardians? All of these questions focus on the issue of consent by candidates for deinstitutionalization. Long-range studies and policy recommendations should take into account these questions and the issues they raise.

Given a justifiable emphasis on a practice of informed consent in psychiatric practices, questions concerning patient access to records will inevitably arise. Does the patient have the right regarding his own records and what are the justifiable limits on these rights? Before attempting an answer, it will be useful to distinguish *rights to* and *rights in* patients' records. The former set of rights can be claimed by those, such as psychiatrists and hospitals, who own the records and thus have special interest in them. The latter rights can be claimed by those who do not own the records but have participated in the production directly, or indirectly, and thus have rights *in* the record. These include the rights of consultant psychiatrists or family members whose remarks are recorded in the record but that were originally offered under a promise of confidentiality by the attending psychiatrist. In these circumstances, one's colleagues or the patient's family members can legitimately demand not to have their confidential reflections released to the patient. Thus, a patient’s right to see these portions of his record may be overridden by claims of confidentiality on the part of third parties. Moreover, revelations of this material may not redound to the patient’s benefit and progress in therapy, thus giving additional weight to the view that the right of access to records by patients may be a limited one.

The Rights to Treatment

Rights to treatment have been claimed principally on behalf of institutionalized psychiatric patients. Historically, people have been institutionalized without their consent for specialized care or psychiatric supervision for a variety of reasons, including: (1) public offensiveness—for example, compulsive public exposure; (2) long-term incapacity to function in our complex and demanding society, as in the case of those suffering profound mental retardation; (3) the collapse of alternative social institutions so that many in psychiatric institutions (especially public ones) are there, in part, because they have nowhere else to go; (4) dangerousness to others; and (5) dangerousness to self. It is with respect to the last of these, dangerousness to self, that the concept of a right to treatment has been articulated in legal terms. From an ethical standpoint, such a right can be articulated in a fairly straightforward manner. If patients have been institutionalized because of dangerousness to self, for example, presumably they have been treated in this way “for their own good.” This phrase can be analyzed in terms of goods served by traditional goals in psychiatry: diagnosis and effective treatment to restore a person to mental well-being. Thus, in order to secure the goods and values of psychiatry for institutionalized patients, courts have claimed on their behalf: (1) a right to treatment, and (2) a right to public funding to provide adequate treatment. The right to treatment, if there is an effective treatment, secures the means to restoring autonomy. In addition, it serves the good of returning to society an intact, productive citizen. The right to funding for adequate levels of treatment is tied logically to the right to treatment, as its necessary condition. That is, a *quid pro quo* arrangement is analyzed in terms of a teleological justification for the conjoint rights to treatment and to funding to provide adequate treatment.

The Right to Refuse Treatment

The right to refuse psychiatric as well as medical treatment is based principally on concerns for respect for autonomy. If, in the moral community, we accord persons the right to control the fundamental circumstances of their lives, then surely refusing psychiatric treatment falls within the scope of autonomy and can be recognized formally in a right to that effect. This view is coincident with the already recognized legal and moral right of competent adult citizens, once fully informed of their condition and need for medical treatment, to refuse such treatment. To coerce medical or psychiatric treatment in such cases is clearly to resort to force and thus to violate the notion of a moral community.

Again, a recurrent problem is that many patients are substantially diminished in their capacity to make free choices of values, a necessary condition for the right to refuse psychiatric treatment. Thus, the question of the right of such patients to refuse treatment is arguable. What is the conscientious psychiatrist to do when a substantially less than autonomous patient refuses treatment because of his mental illness? It is unlikely that the long-range interests of such patients will be well served by respect for their refusals. At the same time, respect for freedom cautions against the possibility of the psychiatrist imposing his own view of the good life on the patient, because commitment, by itself, may not eliminate the right to informed consent to treatment. Such considerations might lead one to argue that review of the refusal of treatment should be provided, perhaps by courts, as in the context of informed consent for treatment of the mentally incapacitated. Such a mechanism seems best suited to satisfy the ethical requirements of determining the patient’s best interests, the actual absence of autonomy, and that reasonable criteria for incompetence have been fairly and impartially applied (that is, in a way that all would accept, even for themselves).

Civil Commitment

Decisions regarding involuntary commitment are made on a variety of grounds, but principally on dangerousness to self and to others. The latter concerns the state's legitimate interest in providing for the safety of its citizens. The arguments made in support of such authority are traditional ones, appealing to constitutionally mandated police power and the rights of innocent third parties to protection from gratuitous acts of violence against their person or possessions. The former involves committing someone involuntarily, for his own best interests, for his "own good." This practice raises fundamental and troubling ethical issues concerning the proper bounds of psychiatric and (taken broadly) institutional authority.

The first set of issues concern the special status of psychiatric diagnoses. First, alone among physicians, psychiatrists possess a peculiar sanctioned authority: to recommend involuntary commitment. Second, there are subtle incentives—tied to risks of error on the part of the psychiatrist—to commit people involuntarily. Little or no harm comes to the psychiatrist who mistakenly commits someone. But if the psychiatrist mistakenly diagnoses someone as a non-candidate for commitment and that person subsequently harms himself or others, then the psychiatrist may be open to malpractice actions as well as social opprobrium. Thus, there may be considerable legal and social pressure to diagnosis in favor of diminished mental (and consequently moral and legal) status.

A second set of issues centers on the concept of dangerousness. Is dangerousness, for example, a disease or medical concept, or is it a social concept? And how best (or at all) can dangerousness be determined? Even if we could answer these questions in a reliable way, a third set of issues would emerge, for involuntary civil commitment involves justifying coercive paternalistic intervention in the choices of a citizen for his “own good.”

Thus, for example, on the basis of criteria for justifying such paternalism, a rational willed dangerousness to oneself in the form of suicidal intentions or actions, for example, might not warrant involuntary commitment. Recall here that respect for freedom and an interest in preserving the moral community require that each of us respect another’s free choice of values. It may be unfortunate or even tragic that someone comes to view suicide rationally, deliberately, and with due consideration as the only solution, but such is the scope of freedom. Here, themes concerning manipulation of patients have bearing. An interest in the moral community and, consequently, respect for freedom together entail an obligation for the psychiatrist not to impose his view of the good life on the autonomous patient.

By contrast, a teleological approach, expressed perhaps in utilitarian terms, might take a dimmer view of a practice of so-called “rational” suicide because of likely or feared negative consequences for important social institutions such as being a parent, employer, employee, public servant, or friend. With this in mind, psychiatrists can attempt a more intrusive paternalism, a development that might give pause to those who practice psychiatry in societies committed to individual freedom. The upshot of this teleological view of matters is, of course, increased obligations on the part of psychiatrists to discourage suicidal intentions and to assist in the commitment and treatment of those who arrive at even a “rational” determination to end their lives. Perhaps, as Daniel Creson has suggested, civil commitment does in fact function as an alternative social means (even if often unjustified) of dealing with deviance.

A final complication here are religious injunctions against suicide. From a number of religious perspectives, suicide is regarded as one of the most serious offenses a believer can commit against God, and hence it is almost always absolutely prohibited. Based on the notion of respect for autonomy and the analysis of defects in the Golden Rule approach, the psychiatrist should avoid imposing his own religious views on the patient, either directly by recommending commitment or indirectly in arriving at a clinical judgment of incompetence. The case of a patient whose religious views prohibit suicide, but who nonetheless is considering such an act, is more complex. Should the psychiatrist regard such intentions as contradictory and thus evidence of diminished autonomy and therefore a warrant for protection? If so, then the psychiatrist encounters the problems of the role of a moral enforcer. Or should the psychiatrist take expressions of suicidal intentions as a genuine change of belief? If so, then one must thread one's way through the difficulties involved in making such a clinical judgment in a reliable way.

On all of these issues, the moral options clearly diverge, and the profession of psychiatry is faced with a stark choice. If it moves in one direction, psychiatry will be conceived as a liberal profession, in the sense that it is committed to preserving and fostering the moral community, perhaps at some cost to particular social institutions. If it moves in the other direction, psychiatry will be conceived as a profession committed to the preservation of fundamental social institutions, perhaps at some cost to the moral community. The resolution to be found here, perhaps, is not a factual one that we could somehow discover and thus, in an empirically reliable way, settle upon. Instead, the resolution will have to be more created than discovered, on the basis of fundamental moral choices whose character and bearing on psychiatry this chapter has attempted to sketch.

Conclusion

The final resolution of ethical conflicts may not always be possible. This is so because the logic of pluralism in moral values must be broad enough to embrace the full spectrum of free choices for values by moral agents. The risk of such a generous view of ethics is that it may not be able to resolve tough issues in a way that will prove satisfactory, once and for all, to everyone. That this is sometimes the case has been vividly illustrated in the issue of civil commitment. Even on more tractable issues, where diverse ethical approaches begin to assume the form of coherent analyses, difficult and fundamental questions nevertheless emerge, as in the case of confidentiality. The most urgent of these questions addresses the ethical center of the profession of psychiatry: How shall it frame its enterprise so that it at once protects and sustains the notion of a moral community not based on force, while fostering those moral goods and values to which persons freely commit themselves? It seems reasonable that the answer to this question cannot be discovered, but instead must be created as the fruit of sustained inquiry into the complex dimensions of ethics in psychiatry.

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