THE PRINCIPLES OF ETHICS IN PSYCHIATRY

I. The Ethical and Professional Basis of the Physician-patient Relationship.

II. Central Ethical and Professional Practices in Psychiatric Care.

III. Involuntary Psychiatric Treatment.

Literature

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Psychiatrists share the same ethical ideals as all physicians and are committed to compassion, fidelity, beneficence, trustworthiness, fairness, integrity, scientific and clinical excellence, social responsibility, and respect for persons. Psychiatrists endeavor to embody these principles in their diverse roles as diagnosticians, treating physicians, therapists, teachers, scientists, consultants, and colleagues. Mental illnesses directly affect thoughts, feelings, intentions, behaviors, and relationships – those attributes that help define people as individuals and as persons. The therapeutic alliance between psychiatrists and

patients struggling with mental illness thus has a special ethical nature. Moreover, because of their unique clinical expertise psychiatrists are entrusted with a heightened professional obligation: to prevent patients from causing harm to themselves or others. Psychiatrists may consequently be required to treat patients against their wishes and breach the usual expectations of confidentiality. Psychiatrists may also be called upon to assume duties of importance to society, such as legal or organizational consultation, that are beyond the scope of usual clinical activities. These features of psychiatric practice may therefore create greater asymmetry in interpersonal power than in other professional relationships and introduce ethical issues of broad social relevance. For all these reasons, psychiatrists are called upon to be especially attentive to the ethical aspects of their work and to act with great professionalism.

Psychiatrists are entrusted to serve in a special role in the lives of ill persons and in society as a whole. Psychiatrists' ability to serve in this special role is predicated on the fulfillment of the ethical principles that ground the field. This is the cardinal feature of a profession: professionals apply specialized knowledge in the service of others, and are part of a distinct group that affirms a code of ethics and engages in self-governance. Members of the profession, by definition, must exercise strong self-discipline and accept responsibility for their actions. They must seek to adhere to a specific set of standards.

Respecting patients' confidentiality is especially important for psychiatrists because patients entrust them with highly personal and often sensitive information. Patients' willingness to make painful, stigmatizing, or embarrassing disclosures depends on their trust in the physician-patient relationship and its expectation of confidentiality. Beyond this therapeutic rationale, there are ethical duties that arise from principles of beneficence and nonmaleficence.

The exchange of patient information with families and others should occur with the patient's explicit informed consent and when it is consistent with the psychiatrist's best clinical judgment. The psychiatrist's goal when involving families in a patient's treatment is to facilitate the coordination of care, the

gathering of data, and the management of expectations. Although family members may have been excluded from treatment discussions in the past, evolved conceptualizations of patient autonomy now recognize the importance of the patient's relationships more fully. Thus, the absolute — even routine — exclusion of families and significant others may not be ethically or clinically justified.

Explicit permission is important for the ethical disclosure of patient information by psychiatrists to family members, teachers, or others. However, psychiatrists may accept or receive information under many circumstances. Psychiatrists should be sensitive to the feelings this kind of information disclosure may raise for patients and maintain communication with them when it occurs.

Several important considerations guide the confidentiality of medical information:

1. Patients should be told of the limits to confidentiality at the beginning of the physician-patient relationship and as events arise that create potential revelations.
2. Disclosure of confidential information should occur only if informed consent has been given by the patient or if it is necessary to protect the patient or third parties from imminent harm, in a manner consistent with relevant legal statutes.
3. Disclosure of patient information should always be limited to the requirements of the situation. This limitation is particularly relevant when state privacy rules provide a lower standard of protection.
4. In their progress notes, psychiatrists should record only the information necessary for continued patient care.
5. Psychotherapy notes may afford further, although not absolute, protection of patient information when kept separate from other components of the medical record. Psychotherapy process comments, therapist formulations and hypotheses, details of patient's dreams and wishes, and intimate personal details of patients or related individuals should be recorded in these psychotherapy notes rather than the medical record.

In psychiatric practice, as in other areas of medicine, however, the patient may seek care because of distress from significant mental and physical symptoms.

This need for clinical care, especially in cases of severe illness, creates an asymmetry or disparity in the relationship: patients are relatively less empowered than physicians. This disparity creates a special ethical obligation for physicians who must place the unique needs of the patient above their own professional or personal interests. Physicians, furthermore, must be vigilant for situations that can reasonably be expected to cause physical, sexual, psychological, or financial harm to the patient. For psychiatrists, ethical obligations to the patient arise from a special sensitivity to the trust and dependence created, in part, by the communication of highly personal information.

At times, the nature and specific obligations of the physician-patient relationship can vary because of a patient's age or cognitive capacity. For instance, when a seriously ill patient's cognitive capacity is compromised, the process of informed consent may include the next of kin or a legally recognized substitute decision-maker.

Third party obligations and the clinical context may also influence the ethical expectations of the physician-patient relationship. For instance, a psychiatrist providing psychoanalytic treatment to a long-term patient should not, under ordinary circumstances, disclose key aspects of the treatment to anyone else. On the other hand, a psychiatrist who serves as a consultant in providing a psychosomatic medicine evaluation undertakes different clinical duties, will have different responsibilities in the patient's care, and may have different ethical obligations in comparison with the long-time psychotherapist. The consulting physician retains the fundamental responsibility to serve the well-being and interests of the patient, but will naturally share clinical information, diagnostic impression, and treatment plan recommendations with appropriate clinical staff members. Similarly, in forensic, employment, or military settings, the physician's obligation to preserve a patient's confidentiality may be limited or redefined because of obligations to a third party.

Because of the complex variations in physician-patient relationships, the reasonably anticipated duties and limits of these different relationships should,

when possible, be discussed with the patient. For example, in treating an adolescent in psychotherapy, it will be important to talk with him or her about the kinds of issues that can be «kept private» in their discussions, and which kinds of issues require informing others (e.g., parents, state officials, referral physicians, clinical staff, etc). In a health care system where patients are transferred from one physician to another, the patient should receive appropriate clinical information, such as the reasons for subsequent treatment, the consequences of foregoing treatment and the reasons for transitioning the patient's care to another clinician.

Because of their special expertise, psychiatrists sometimes use their training to serve specific social institutions (e.g., employers, the judicial system, the military). Under a variety of circumstances, a psychiatrist may have competing duties to an institution and an individual patient, for instance, or to two patients or two institutions.

When dual or overlapping roles cannot be minimized (e.g., clinical research situations, employee health centers, correctional settings, school-based mental health programs) it is especially important to inform the patient about the role issues and conflicting ethical obligations. Informed consent «cautions» or «warnings» about overlapping roles should be commonplace in these settings. Attention should be paid to subtle changes in the patient's view of the relationship; cautions and reminders should be repeated if potentially harmful self-disclosures are anticipated. Language must be clear on any limitations of the professional opinion, using terms and phrasing that describe the appropriate level of uncertainty. Through such efforts, institutions and patients — or individuals undergoing evaluations — are reminded that the psychiatrist fulfills two roles, and that disclosures may be used in ways that are not therapeutic.

There is one role that, despite its basis in medical knowledge, is absolutely prohibited in all fields of medicine. Physicians may not ethically participate in any manner that supports, facilitates, or enacts human torture or the development and monitoring of interrogation techniques that involve torture.

Honesty and trust are elemental values of a profession and fundamental expectations for the patient seeking psychiatric care. Discussions and interactions in psychiatric practice often deal with highly sensitive and personal information. Psychiatrists may be occasionally tempted to skirt or «soften» the truth in order to avoid harm to a patient. In general, omission (intentional failure to disclose) and evasion (avoidance of telling the truth) will undermine a trusting and constructive relationship between physician and patient and is not appropriate. In addition, releasing inaccurate or misleading clinical information to insurers or employers is a specific example of dishonesty and may constitute fraud. Such behavior undermines trust in the profession as a whole and in third-party interactions in particular. At the same time, out of respect for patient privacy, the ethical physician should reveal only the minimum information necessary for third party review.

Protecting patients from harmful disclosures, as in very acute situations, in therapy with fragile or minor patients, or in end-of-life decision-making — when deemed essential — must occur with the strictest concern for patient values and autonomy. This protective measure should be temporary, and ideally will occur with prior discussions with appropriate persons who are in accord with such an approach.

Psychiatrists communicate with numerous agencies and individuals during patient treatment. They are responsible for the usual physician contact with funding and reimbursement agencies, families, employers, and other third parties. However, because of their expertise in human behavior, psychiatrists are often asked, formally and informally, for information justifying or excusing patient actions. This offers numerous opportunities for ethical missteps.

Ideally, principles of trustworthiness and integrity will over-ride inappropriate attempts to benefit an individual patient or psychiatrist. Deceptive conduct of any kind cannot be generalized as a model for others, and, when it becomes known, undermines patient trust in the profession as a whole.

Specific examples of fraud in psychiatric practice include making false or intentionally misleading statements to patients, falsifying medical records, research, or reports, submitting false bills or claims for service, lying about credentials or qualifications, supporting inappropriate exemptions from work or school, practicing outside one's area of professional competence or beyond one's authorized scope, providing unnecessary treatment, and taking credit for another's work. Further illustrations of overt (and legally actionable) dishonesty include writing a prescription for a patient in a family member's name, or writing prescriptions for a larger number of pills than necessary in order to reduce insurance co-payments. These actions are not ethically acceptable in the practice of psychiatry.

The field of psychiatry as a whole is attentive to the use of language and the interpersonal aspects of obtaining informed consent. The manner in which information is presented, the choice of facts that are included or omitted, and the selection of alternatives that are offered have distinct effects on patient choices. Distorting influences on the consent process may consequently arise from the simplest patient interactions. These include telephone conversations, cross-coverage, and curbside encounters in the clinical setting. Even language used in informal interactions with patients can carry the weight of professional opinion and is colored by the vulnerabilities of knowledge and power inherent to the patient role. When seeking consent, psychiatrists thus must be careful not to influence the patient unduly.

Adults are presumed capable of making their own decisions, with the clinical and legal burden of proof falling on those who wish to prove otherwise. Assessments of decision-making capacity should follow clinical models of assessment and the legal standards of the jurisdiction.

Physicians maintain the highest standards of informed consent when they become familiar with, and endeavor to honor, the specific authentic and enduring personal values of their individual patients. The requirement of voluntariness in informed consent thus affirms the autonomous and values-shaped decision making

of the individual and it prohibits coercive pressures in the consent process. In the practice of psychiatry, these issues may be particularly salient because some symptoms of certain mental illnesses can prevent an individual from discerning, expressing, and enacting his or her specific authentic and enduring personal values in some circumstances. Furthermore, the experience of dependence, societal marginalization, and insufficient access to clinical care may create a situation of desperation that may interfere with voluntary decision making. It is important to note that these vulnerabilities need not confer incapacity. Nonetheless, they should be explored in order to optimize a patient's decision-making. This is particularly important in psychiatry where, even if patients are decisionally capable, both internal and external factors (e.g., the patient's illness, stigma, lack of resources) can make them vulnerable to coercive influences.

Important exceptions to informed consent exist:

1. Genuine emergencies do not require informed consent. Emergency care occurs in the framework of implied or presumed consent. That is, in emergency situations in which reasonable persons would want the intervention it is ethical to proceed as if consent exists.
2. Care for children or incompetent patients requires consent from parents or legally recognized surrogates. Assent of incompetent individuals (i.e., acquiescence as opposed to informed consent) is obtained whenever possible.
3. Patients may also waive their right to informed consent. This exception, however, presumes competence to do so.
4. Finally, the doctrine of therapeutic privilege allows a physician to withhold information if it is truly damaging to the patient. But such an exception should be rare. Withholding information about side effects, for example, in the hope of increasing compliance is not acceptable.

Because the concepts of autonomy and informed consent have a legal basis, they may cast the clinical situation in an adversarial light. This view is antithetical to ethical practice. Although the ultimate choice to consent is made by an individual patient, autonomous choice does not take place in a vacuum; it must be

nurtured by continued dialogue. Ultimately, the ideal understanding of informed consent is clinical, an important reminder of respect for the strengths of patients and the need for transparent, collaborative, and enduring alliances. Psychiatrists who strive to develop these relationships with their patients will easily exceed the requirements of ethics and law.

Common assessment standards expressed in ethics and law include evidencing a choice, understanding relevant information, manipulating information rationally, and appreciating the situation and its consequences. Elements of each standard are often necessary to a competent decision and apply to the specific task at hand.

Psychiatrists in particular have special preparation with respect to the mental status examination and certain cognitive evaluation procedures. Rather than screen all individuals, psychiatrists may use capacity assessments in a targeted fashion when patient decisions or discussions raise concerns. Psychiatrists may be asked to perform capacity assessments when patients or research participants exhibit cognitive deficits, appear to lose decision-making capacity, or manifest atypical behaviors and decisions. Although any physician may conduct the assessment, psychiatrists are specially trained to identify the vulnerabilities of persons with mental retardation, delirium, or hopeless outlook as well as to identify cognitive strengths of even severely ill persons. Psychiatrists recognize that deficits in decision-making capacity may be overcome by targeted educational and clinical interventions. These often include part-by-part and repeated information disclosures, or use of a single trusted clinician to communicate information. Interventions to reduce anxiety, diminish psychotic symptoms, or reduce sedating side effects are equally valuable in overcoming incapacity. Other interventions may include videotape, written, or group education sessions.

Psychiatrists may apply assessment standards on a «sliding scale», with more stringent assessments and higher thresholds of capacity required for decisions that are more consequential, complex, or risky. When incapacity persists surrogate decision makers may be invoked in accordance with local law. Surrogate decision-

makers themselves should also be held to appropriate standards of decision-making capacity.

Capacity assessment is particularly relevant for determining the wishes of patients who want treatment or research procedures after they become incapacitated. In such circumstances capacity assessment tools or independent interviewers may be helpful in maintaining standards of surrogate decision-making and adherence to patient wishes. Reminding patients of their earlier preferences can also serve to enhance their decision-making. These techniques, however, do not, overcome the clinician or investigator's primary obligation to provide appropriate information and assessment.

For psychiatrists, mandated treatment creates inherent ethical tensions. It requires great sensitivity to principles of respect for persons and social responsibility because psychiatrists are contributing to decisions directly controlling patient choices. This kind of power — in which a patient's personal freedoms are limited and treatment decisions are being made — is generally exercised by careful balancing of principles that value both the individual and the community.

Involuntary hospitalization is usually justified by patients' imminent dangerousness to themselves or others, or their inability to meet basic needs. To meet these criteria, dangerousness must be likely in the near future, and related to a major mental illness. In acknowledgement of the seriousness of depriving a patient of freedom, involuntary commitment usually requires judicial review, access to legal counsel, and consideration of the least restrictive alternative to hospitalization.

Separate authorization is often required for treatment with psychiatric medications. In collaboration with the patient (and/or surrogate decision-makers) ethical psychiatrists discuss those treatments that are most likely to restore the patient's freedom – if necessary, in incremental fashion. This requires sensitivity to the coercive nature of commitment, the informed consent process, and the patient's decision-making capacity. When there is a treatment refusal, and efforts to engage

in collaborative decision-making have been insufficient to prevent harm, administrative or legal appeals may be available to review treatment and may require a showing of impaired capacity.

Another common form of involuntary care is mandatory outpatient treatment. Although many states retain the same criteria for outpatient commitment as inpatient commitment, the focus is increasingly on repeated deteriorations that require hospitalization. The likelihood of continued deterioration without intervention, a treatment plan that holds the prospect of stabilization and involvement of the community treatment team are important ethical requirements. Outpatient commitment should be informed by concern for patient values, past clinical history, and decision-making capacity. Specific procedures that address non-adherence to recommended treatment should be clear to patients and clinicians, from mandated emergency evaluations to court hearings.

Expectations for taking psychotropic medications should be clearly stated in a formal treatment plan. Forced medication, however, remains a matter of some legal controversy. The ethical problem, as in inpatient settings, remains one of creating a class of persons for whom psychiatrists are required to care, yet who they are unable to treat.

Ethical obligations to patients committed in the community may require psychiatrists to advocate for greater resources, community-based services, and parity with other forms of medical care. Active outreach and intensive service coordination are among the means for meeting these obligations and ending the suffering of people living with mental illness who may not receive adequate care without such intensive efforts.

Psychiatric commitment of children by parents or guardians requires even greater attention to the effects of confinement and loss of liberty. In such cases psychiatrists endeavor to assure a balance between the fewest obstacles to treatment and the greatest protections from unnecessary institutionalization. The ethical ideal is one of the child’s best interest, appropriate high quality care, and psychiatric participation.