Ethics in Psychiatry

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Psychiatrists in the UK have recently lamented the need for a code of ethics for psychiatry.[1-3] There is a clear difference between a code of ethics and a code of practice (such as the non-statutory one of the UK Mental Health Act of 1983) or indeed a code of conduct. Sarkar and Adshead (2003) argue for the need to protect the patient in a world which is becoming more and more contractarian and utilitarian. Indeed the public often views psychiatrists as having to protect it from psychiatric patients and because of this the latter are put at a higher risk for detention. Codes of conduct and practice are therefore not sufficient for psychiatrists[1] as patients put trust in these professionals to "protect their interests when they are not well enough to protect themselves".

There are a number of issues in which psychiatric ethics differs from mainstream clinical ethics, mostly having to do with the vulnerability of this group of patients and indeed their mental incapacity. Indeed Sarkar and Adshead argue that the relative incapacity of patients to make decisions for themselves puts them in an especially vulnerable situation because they depend on others. In the UK this translates often into a 'complete loss of autonomy' and even patients' competent refusal may, under British law, be over-ridden, even though psychiatric patients, even in-patients, may be perfectly capable of taking some decisions and participating in one's choice for treatment.[2] Even in forensic psychiatry it has been noted that for public interests, the interests of the patient may not be fully observed and that a code of ethics which trumps justice over other principles needs to be addressed in these specific areas.[3]

A common point raised is the vulnerability of patients, which may lead to sexual abuse – an exploitation of the vulnerability. This has been raised frequently in the United States, but certainly, according to General Medical Council data and information from voluntary groups, Sarkar and Adshead point out that the problem is not uncommon in the UK. In point of fact it seems to be entirely legal in the UK to have sexual relationships with a psychiatric patient 'so long as the patient is not detained'.[3]

Thirdly, the Royal College of Psychiatrists[4] points out the need for psychiatrists to ensure that the risk of detaining patients more than necessary is reduced. Psychiatry risks harming people by treating them unjustly and in fact those patients who commit offences may actually be kept in psychiatric detention for longer periods than they would actually have spent in prison for the same offence.[1]

Current legislative frameworks in the UK seem to protect third parties more than they protect the mentally ill patient. It sees the professional role of psychiatrists as having an obligation to protect the public from these people. This conflicts with the altruistic role of psychiatrists and indeed, the profession complains that such attitude is in conflict with the Declaration of Madrid[5] which puts values towards patients and altruism as the defining intention of the profession.

These problems therefore frequently put psychiatrists at odds with the principle of nonmaleficence[6] and the current western view of the relationship between a doctor and a patient being a contract is at odds with Hippocratic ideals. It also risks making the psychiatric encounter too utilitarian, that is, based on the value of a person balanced against his or her value/risk to society.[7] This risk/benefit analysis on patients is perhaps a morally repugnant reflective equilibrium, which justifies the plea of modern psychiatrists. This, apart from the fact that patients may in the long run loose trust in the profession.

Michele Foucault[A] has noted how 'madness' was not always seen as a responsibility of the medical profession. Indeed mental patients were often detained with criminals in France. In time they fell under the care of doctors and eventually the field of psychiatry came to be. Moreover treatment in psychiatry was often unorthodox, especially those preceding current Electro-convulsive therapy. Certainly hitting someone in the head with a stick is not normal. Detaining people in cages and boxes seems repulsive today, yet we still occasionally detain people in strait jackets and others locked up in small rooms without proper facilities; and if nursing staff are unavailable patients may not get their daily walk outside. This is more often the responsibility of the state than the institution itself. But the vulnerabilities of mental patients remain. Unfortunately, locally, only patients who suffer from more severe mental illness are entitled to free medication, through the Schedule V (Yellow Card) scheme.

One has to acknowledge that if the field is not to recede back to a state where psychiatric patients are locked away (at least for longer periods than they should) then society must certainly listen to the psychiatrists themselves, who are the people entrusted by society to look after, in the best possible manner, our mentally ill. They are the profession who can see what kind of treatment and/or action is justified and what is not. Societies' feelings should not trump, because of fear, over the limited autonomy of mentally ill patients. For this reason alone it is imperative that the all-important field of biomedical and clinical ethics is not left only to legislators and other professionals who are not medical people and certainly cannot share the same encounter with patients.

References

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[A] French philosopher renowned for his book 'Madness and Civilisation'