

UNESCO Chair in Bioethics

**PSYCHIATRIC ETHICS AND THE
RIGHTS OF PERSONS WITH
MENTAL DISABILITIES IN
INSTITUTIONS AND
THE COMMUNITY**

By

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The International Center for Health, Law and Ethics
Faculty of Law, University of Haifa

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Israel National Commission for UNESCO

**The International Center for Health, Law and Ethics
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Chairholder: Prof. Amnon Carmi

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Kris Gledhill came to the area of mental health law as a practitioner involved in cases before the English Mental Health Review Tribunal system and through the English administrative court and appellate system. In addition to arguing some of the cases which have played their part in developing mental disability law in England, Mr. Gledhill has lectured and written extensively on the impact of human rights law on mental health practice; in addition, he edits the Mental Health Law Reports, which report both UK and European Court cases which relate to the law affecting mentally disordered people. He has recently moved into academic life, accepting a position as a lecturer at the University of Auckland Law School in New Zealand.

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PSYCHIATRIC ETHICS AND THE RIGHTS OF PERSONS WITH MENTAL DISABILITIES IN INSTITUTIONS AND THE COMMUNITY

Introduction

The past thirty-five years has seen an astonishing explosion in the law as it relates to persons with mental disabilities. This expansion encompasses statutes and court decisions; domestic and international law civil, constitutional, criminal and private law, and a staggering proliferation of literature (academic, practice-focused and clinical) by lawyers, psychiatrists, other mental health professionals, and ethicists.

Although there has been much inconsistency in these developments (and, in the shop-worn metaphor, the pendulum has swung – often wildly – in many directions), there is no question that this proliferation continues. Before 1970, there were virtually no cases establishing substantive and procedural limits on a civil commitment hearing, and many jurisdictions had not amended their statutes on this topic in a century or more. In all aspects of medicine (including psychiatry), informed consent was rarely discussed openly; rather, the title of Jay Katz's book – **The Silent World of Doctor and Patient** – better reflected reality. Before the mid-1970's, there were no cases or statutes declaring a right to treatment for those hospitalized. Before the mid-1970's, courts had not considered with any level of thoughtfulness the difficult issues raised when it is alleged that a mental health professional ought to breach confidentiality so as to warn or protect a likely victim of her patient. Before the late 1970's, there was no sense that institutionalized psychiatric patients had a right to refuse treatment. By the early 1980's, although informed consent was increasingly recognized by clinicians and the courts as important, it was nonetheless all too often institutionally regarded as simply *pro forma* rather than a regular part of process. Before the mid-1980's, in many jurisdictions, an indigent

criminal defendant had no right to psychiatric assistance to help him mount an insanity defense, or to rebut arguments at a death penalty case as to his likely future dangerousness. Before 1990, it was rare for jurisdictions to have enacted anti-discrimination laws (such as the Americans with Disabilities Act). Before 1991, no arm of the United Nations had ever published principles dealing with the rights of persons institutionalized because of mental disability. Before the early 1990s, courts had rarely confronted the difficult issues raised when a criminal defendant – at trial, while proffering an insanity defense, while resisting attempts to make him competent to be tried or to be executed – sought to interpose a right to refuse treatment. Before the late 1990's, courts rarely considered whether there was some sort of right to deinstitutionalization. Fifteen years ago, sexual offender acts were gathering dust on law library shelves. Fifteen years ago, the phrase “assisted outpatient commitment” did not appear in the literature.

This merely scratches the surface. This has truly been a revolution, and it is one whose effects have been felt by all who practice professionally in any of the relevant substantive areas. At the same time, society has started paying greater attention to the ethical issues that are inevitably raised by the questions listed above (ones that involve knotty issues of autonomy, competency, professional judgment, professional responsibility, and basic human rights). Groups such as the World Psychiatric Association, the American Academy of Psychiatry and Law, and the American Psychology-Law Society have promulgated codes that seek to give practitioners guidance in many of these areas of policy and practice. However given the reality of professional self-interests and the substantial, and at times undue influence that third parties (including many pharmaceutical organizations) exerted, and continue to exert, on professional organizations, there is a low likelihood that such professional codes can be relied upon to be fairly administered in all settings, or that, by way of example, professional trade organizations will universally ask their members to disclose to patients the true contours of their relationships with drug companies.

Thus, there is also a concomitant greater responsibility on the courts – at all levels, from local trial courts to the highest courts in nations and regions – to “get” these issues. The death of the “hands off” doctrine – an approach that, for many decades, led judges to turn their backs to questions of institutional treatment, reasoning (incorrectly) that such decisions should be left in the purview of the institutional keepers and professional organizations – meant that courts were now required to grapple with these issues (and others), and that, inevitably, the ethical “piece” of these issues was going to be “on the table” in many cases. While the ethical issues in this context remain under discussed in both the legal and behavioral literature, there is no question that more attention will be focused on them in future years.

In this volume, we offer vignettes of some of the recurring issues that vex practitioners and that raise difficult ethical issues. We do not profess to solve all of these, but rather we write about them to inspire the reader to think about all of them more closely and more carefully. Many of the vignettes come from real cases, and in those instances, we provide the citation of the case in question; others are composites of cases the authors have dealt with or observed in their practices. Most of the vignettes are quite short; a few are longer. In one case, we have presented alternative readings of the same issue (the right of currently-incompetent criminal defendants to refuse medication that is ordered so as to ostensibly make them competent to stand trial). This does not reflect our view that these are somehow more “important” than the others, but rather that the decisions in these cases may appear more provocative (and even, perhaps, more personally roiling to mental health professionals). We hope they are all of interest.

The editors of this volume also want to thank and acknowledge our colleagues for their invaluable contributions: Beata Anna Zolovska, a coauthor of Part I, Chapter 2; Omar Sultan Haque, a coauthor of the “duty to warn” aspects of Part I, Chapter 4, and Robindra Paul and Lisa Cosgrove, coauthors of Part II. We also want to thank Jason Huffman, Prof. Bursztajn’s research/

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Part I: Persons with Mental Disabilities in Institutional and Community Settings

Chapter 1. Involuntary Civil Commitment

A. Civil patients

1. Need to use formal powers in the commitment process

Case 1:

HL, a middle-aged man with severe learning disabilities and autism, had spent much of his life in a hospital setting. As part of the process of moving patients out of long-stay institutions where possible, HL was found a place with carers, Mr and Mrs E. HL attended a day care centre. One day in late July, when at the day care centre, HL became particularly agitated and began to self-harm: a doctor was called, who administered a sedative, but HL continued to be agitated. He was taken to the local hospital, where the psychiatrist who had been responsible for his care for many years was in attendance, Dr M. With the agreement of a colleague, she decided that HL should be admitted to the psychiatric unit of the hospital. HL accompanied Dr M to the appropriate unit. Dr M did not make any arrangements to formally detain HL because he was compliant with her wishes and was willing to remain in hospital (though not as the exercise of a capacitated choice). However, Dr M also made it plain that formal powers would be used if HL attempted to leave; and she also indicated that Mr and Mrs E could not visit, since HL would then wish to leave with them.

Mr and Mrs E arranged for a challenge to be brought to the situation. The trial court dismissed the claim, but the appeal court agreed that HL was detained and that the only way to achieve this was via the use of the formal committal process. As a result, HL was formally

detained, which was in late October. He was subsequently discharged by the managers of the hospital in December, and he returned to living with his carers. In the meantime, the appeal court's decision was appealed further to the final appeal court. It reinstated the trial court decision, finding that HL had not been detained (as he was compliant) and that it was appropriate to treat him on the basis of his best interests (as he did not have capacity to make his own decisions).

A complaint was then made that HL's fundamental rights had been breached. The issue was whether it was necessary for formal detention powers to be used.

What happened in the court case:

The decision of the human rights court hearing was that the formal committal process was the only way to ensure that detention was necessary and so not arbitrary. On the facts, HL had been deprived of his liberty: the professionals exercised complete control over his movements, including access to his carers. Although it could be proper to detain someone on account of mental disability, and there was sufficient evidence to suggest that HL had a mental disability of a nature which might require hospitalisation, human rights standards required adequate procedural protection against the risk of arbitrary detention. There was a contrast between the requirements of the formal committal process – which required compliance with the statutory criteria for detention, medical evidence, the involvement of a representative of the patient, and a requirement for ongoing assessment of whether the criteria for detention were made out, together with a court review to provide an independent review – and the use of a decision based solely on the doctor's view of the best interests of the patient. The purpose of the procedural safeguards in the formal process is to protect individuals against any misjudgements and professional lapses.

Ethical issues arising:

The natural inclination of any lawyer given the task of

representing a patient who is under a formal committal order is to investigate whether the element of compulsion is necessary: the argument put forward is often that the client does not need to be under compulsion because he or she is willing to remain in hospital on a voluntary basis. The important point arising from this decision is that this approach may only be correct in relation to those who are able to make a choice: so for patients such as HL, who was compliant and without capacity to make decisions for himself (or at best with very limited capacity), a different approach is required. In short, if the situation of the patient in hospital is in fact that he or she is detained because the medical professionals have complete control, then allowing the patient to remain on an informal basis is not proper because the formal process is the only way to ensure that detention continues only for so long as it is proper. The detention of the patient on an informal basis means that he or she is subject to professional judgment: whilst most professionals most of the time will do what is right, the purpose of the legal system is to ensure that there are safeguards in place to guard against mistakes or lapses of judgment. The facts of the case make the point: the release of HL was secured because it was possible to make an application to the hospital managers on his behalf, which only arose because he was placed under the formal detention powers. Had he be simply treated on the basis of the doctor's view of his best interests, HL would not have had this avenue open to him.

This leads on to a much wider point. Most medical decisions are taken by people who are able to exercise their choice on the basis of the advice they receive from the medical professionals involved (and such family and friends as they choose to involve in the process). This is subject to the obvious point that engagement with medical services may be subject to limitations of access on the basis of financial or other practical matters, but for the purposes of the ethical point assume that those problems are not present. The paradigm of choice is not applicable if the patient is without the capacity to make a decision. There has to be some alternative mechanism. Various options are possible: there can be a form of substituted decision-

maker, who is given the power to make the decision on behalf of the patient; such a decision might be governed by a test of what the substitute decision maker would do in the situation, or it might involve a test of determining what the patients would decide if they did have capacity (in other words, the substitute has to put themselves in the shoes of the patient). In the case of children, it is usually the case that there is a substitute decision-maker, namely a parent, who will take a decision based on his or her view of what is best for the child; but at some stage, the point is reached when a person classified as a child nevertheless has the capacity to make his or her decisions.

Another option – which is what had happened in HL’s case - is to allow the professionals to take a decision on what they perceive to be the best interests of the patient who is without capacity. In many situations, the same result will be reached by whatever method is chosen. However, this will not necessarily be so. The motif of patient choice is entrenched, and is consistent with the conception of humans having rights to control their destiny. Moreover, it is also relevant to look at the question of the quality of the decision at the end of the process: an independent review of a professional’s decision – whether in the form of the patient having to be persuaded as to what is best or a substitute process – provides a checking and balancing structure which should provide a guard against lapses of judgment and so result in a better decision at the end of the process. This is the whole point about having procedural requirements. They are not hoops which have to be gone through: they are designed to ensure that fundamental rights are respected.

2. Preventive detention

Case 2:

B was convicted of a criminal offence in the Netherlands and also found to be suffering from a mental disorder which meant that he was assessed as being dangerous for the future. The court imposed an order of preventive detention, which required that B spend time in an appropriate psychiatric institution after he had served the appropriate prison sentence for his offending. Dutch law provided that a person subject to a preventive detention order could continue to be held in a prison until the relevant psychiatric institution had been found, but this was supposed to occur within 6 months. It did not occur in B's case, which meant that he was held in prison for an additional 14 months despite the basis for his ongoing detention being his mental disorder and the need for treatment for that. The problem was the lack of capacity to hold people who were subject to preventive detention. B brought a claim that since his detention was on the basis of mental disorder, he had to be detained in an appropriate setting, namely a hospital.

What happened in the court case:

The loss of liberty to which B was subject was based on both his criminal offence and the fact that his mental disorder meant that he was assessed as dangerous by the court: so it rested on the court order, even after he had served the prison sentence part of his detention. The mere fact that the punitive term had ended did not mean that he had to be transferred immediately to a clinical setting for detention to remain lawful, but the preventive detention was of a non-punitive nature and so what was necessary was that the balancing that was carried out between such matters as the need to make efficient use of the clinical settings and the need to place a detainee in an appropriate setting, particular weight had to be given to the right to liberty. The fact to be borne in mind was that a significant delay in the process of admitting a patient to a clinical setting would affect the time-frame of the treatment, making it more likely that the patient's detention would have to be renewed

on the basis of ongoing risk. The factual information revealed that the delays experienced in B's case were not exceptional and unforeseen, but rather there had been ongoing problems with lack of capacity for those who were subject to preventive detention for several years, and the authorities had not done sufficient to deal with this. Even a delay of 6 months, as the law permitted, was inadequate to offer adequate protection of the right to liberty.

Ethical issues arising:

This set of facts raises a number of questions. Although there is a criminal conviction underlying the action taken by the court in imposing the order for preventive detention in the first place, that provided merely the background to the preventive detention. In the absence of mental disorder showing that B was dangerous, there would be no basis for preventive detention. So the presence of mental disorder was the key feature in detention after the end of the retributive sentence for the criminal offence.

But where is detention permissible? The basic proposition is that detention on the basis of mental disorder is something which has to occur in a hospital setting; the reason for that is obvious, namely that something has to be done to attempt to treat the patient's disorder, since otherwise detention will amount to little more than containment or warehousing. This suggests that the failure to place the patient in a hospital setting – and placing him or her in a prison setting pending a hospital place becoming available – breaches this basic requirement and should lead to the release of the patient.

But it may not be quite as simple as that. If someone poses a danger to others, then the others to whom a danger is posed have a fundamental right in play as well, which is the right to be protected against that danger. There are often instances where rights have to be balanced, and so a decision will have to be made as to where the balance will be drawn. In other words, the need to protect the public may provide a justification

for detaining someone in a non-therapeutic institution, at least for a short period of time until a place in an appropriate institution becomes available. The question on which this case focused was where should the balance be drawn. The point which is made in this case is that in answering this question, two particular issues have to be borne in mind. The first is that the right to liberty is one which is of particular importance. (Part of the obvious point to make when defining the balance is that detention on the basis of a risk of harm involves a certainty of breaching the right to liberty weighed against the prospect of the rights of others being breached, namely something less than a certainty.)

The second point is that it is not enough to analyze just the current situation, i.e. whether there is at present a lack of resources. Instead a more longitudinal approach may have to be taken, because there is a difference between a situation which has arisen because of a temporary factor (for example, a sudden and unexpected increase in the number of people for whom a place has to be found) and a problem which has been prevalent for some time or predictable. In the former scenario, it is easier to reach a conclusion that the fundamental right to liberty of the patient is something which may have to suffer, albeit only on a temporary basis, because society does not always run smoothly. But if it is a long-standing problem, then the failure of the authorities to do something about it makes it less acceptable that the individual patient should suffer detention which amounts to warehousing and prevents them receiving the treatment they merit on account of their disorder and which also provides them with a prospect of regaining their liberty by dealing with the dangerousness which is the basis for their detention.

There is another way of expressing this. Fundamental rights are designed not merely to be exhorter: they are meant to be practical and effective, which means that when they require the making available of resources, then that is what has to be done. It had not been done in B's case, and so his rights were breached because they were not given sufficient weight.

That, however, is not the end of the ethical problems to which

this factual scenario gives rise. On the facts, the issue was tested after B had been moved to a proper setting, namely an appropriate clinic where he was in receipt of treatment. (In fact, he had only been moved after he commenced the legal action.) The legal action proceeded as a claim to establish both that his rights had been breached and to award him financial compensation for that. But suppose that the factual scenario was that the legal action was brought at a stage when there was no hospital place even on the horizon, but enough time had passed in a non-therapeutic setting that the right to liberty would be infringed in a disproportionate manner by keeping the patient in the prison setting. Would it follow that the would-be patient had to be released? If you start with the proposition that the answer is an obvious "yes", consider first the fact that legal systems have a mechanism for valuing even fundamental rights in monetary terms: so the question becomes whether the breach of the right to liberty can be remedied by an award of damages (and perhaps on a daily and increasing basis to prompt the authorities into taking appropriate action, even if that means finding a temporary fix to whatever long-standing problem is the cause of the breach of the would-be patient's rights).

If damages are not an adequate response, consider a further factual scenario: that the would-be patient poses a specific risk to a specifically-identifiable person or group. That person or group has a right to be protected, which would be breached if preventive action was not taken. But does that mean that the preventive action has to be the inappropriate loss of liberty of the would-be patient? The importance of the right to liberty means that other options would have to be considered, such as providing extra protection for those at risk or moving them.

What the facts of this case and the further potential scenarios make clear are that the ethical features of a situation may involve various twists and turns when there are fundamental rights at stake. Bearing those in mind might provide a framework to assist the decision-making process, which will often involve a process of balancing different rights which may compete

rather than be complementary. Of course, in an ideal situation, there would be no need to carry out such a balance because the appropriate clinical facilities would be available for those subject to preventive detention on the basis of a risk arising from a mental disorder. Unfortunately, however, situations are less than ideal because of competing demands on resources and the ethical debate has to take into account practical realities: but when that necessity arises, it must be done in a way which maintains the primacy of fundamental rights.

B. Sexually violent predator laws

1. The relationship of SVPA laws to the civil commitment power

Case 3:

Each year over 300,000 people are involuntarily committed for inpatient psychiatric treatment in United States alone. Public policy justifies involuntary civil commitment on the basis of providing shelter, protection and access to care to those who are at risk for harming themselves, or secondarily on the basis of isolating potentially dangerous individuals to prevent harm to others. The determination of the dangerousness to self or others is determined either by clinicians or by the courts. In certain situations the state may commit an individual who poses a potential risk to others based on the individual's past behaviour or psychiatric diagnosis. In the case of sexual offenders involuntary commitment to psychiatric institutions is a demonstration of the public's fear of sexual predators and the state's interest in using mental institutions as holding environments for such individuals. The isolations of sexual offenders from the general population has been a problem which has received a lot of attention worldwide in recent years. Problematically sexual offenders are defined differently depending on the country's culture, while in the Anglo-Saxon world sexual offenders are for example rapists, child molesters, in other cultures adulterers and homosexuals might also be included in this category.

The general public has long questioned the validity of the involuntary commitment, as it poses substantial threat to individual's civil liberties and has been misused by governments and individual clinicians in the past. With the global legacy of abuse of involuntary commitment to psychiatric institutions, such as the *psikhushka* of the Communist USSR where those opposing Communism were sent as it was considered that no sane person would dissent against Communism or the Soviet government, or the psychiatric commitment of dissidents in China.

There has been a global trend towards the severe restriction of involuntary commitment through imposition of stricter standards and

regulations. Thus it is crucial to preserve the public's trust in the appropriate use of involuntary commitment and its strict differentiation from punitive restriction of freedom for criminal offences.

LH, who had a long history of sexually molesting children, and who testified that he agreed with the state physician's diagnosis that "he suffers from paedophilia and is not cured and that he continues to harbour sexual desires for children that he cannot control when he gets 'stressed out,'" was committed to a psychiatric hospital shortly before completion of his prison sentence. LH appealed the decision arguing that it violated due process, double jeopardy and ex post facto laws. While he served his time in jail for the criminal charges brought against him, he was not released out of concern for his potential dangerousness, and instead was committed to a psychiatric hospital for care. Since there are no effective treatments for pedophilia at this time, he was essentially committed to be held isolated from the general public for public safety reasons.

Several issues are raised by the civil commitment of LH. The use of civil commitment of a convicted criminal to psychiatric care suggests a punitive aspect to involuntary commitment, placing depressed suicidal patients in the same category as dangerous criminals. Use of psychiatric institutions as holding places for those whom the state does not want to release from prison into the general population conveys the same message to the general public – that involuntary commitment is an acceptable alternative to jail for individuals deemed to be socially undesirable.

In addition, the commitment of a person completing a jail term raises the issue of discrepancy in determination of competency. Other ethical questions include these:

1. Is the decision in LH therapeutic for the public or for victims?
2. Does the (allegedly) "dispassionate" police power give way so as to satiate public rage?
3. Is it possible for *any* such scheme to be therapeutic without the provision of mandatory post-release outreach?
4. Does the fact that therapy does not start (under the Kansas

- statute, at least) until after the defendant's sentence ends attenuate any potential therapeutic outcomes?
5. Is coerced sex offender treatment therapeutic?
 6. Is there any incentive for a defendant to engage in any meaningful therapy programs while in prison if what is said during such participation can be used against the defendant after his sentence terminates?
 7. Will the Supreme Court's decision in LH's case lead to long-term commitments of those who "act out" sexually at civil mental hospitals?
 8. Will LH lead some prosecutors to use involuntary civil commitment as a means of "boosting" criminal cases?

LH was convicted criminally to jail because he was determined to be criminally responsible, based on determination that he had an intent to commit a crime, and that was able to control his conduct at the time of committing the crime. Subsequently, upon completing his prison term, LH was civilly committed based on the involuntary commitment statutes that detain people who are unable to control their behaviour and thereby pose a danger to the public health and safety. Thus LH was determined both to be in control of his conduct at the time of committing a crime and to be unable to control his conduct. This clear inconsistency raises questions as to the validity of restricting LH's autonomy.

In addition, the civil commitment of LH based on his diagnosis of paedophilia and perceived continued threat to the general public raises question about the extent of use of involuntary commitment to isolate violent criminals from the general public. The question of isolating sexually violent predators is especially important, as this population is targeted more than other categories of violent criminals. Many states permit restriction of liberties of sexual predators, listings of sexual offenders are publicly available and in some areas are posted online.

While isolating sexually violent predators is potentially socially desirable, involuntary civil commitment to psychiatric hospitals of a convicted criminal undermines the validity of involuntary

commitment policy and raises questions about the extent of use to other categories of convicted criminals, such as those convicted on illegal drug charges or child abuse. Should all convicted criminals who might pose a threat to the general public be considered for commitment for psychiatric treatment instead of release from jail? Why are those who committed sexual crimes treated differently? Does the mental health system have anything to offer to sexual offenders in terms of treatment?

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1. This is based on the case of *HL v. UK* [2004] Mental Health Law Reports 236
 2. This is based on the case of *Brand v. Netherlands* [2005] Mental Health Law Reports 148
 - 3.. The case discussed here is *Kansas v. Hendricks*, 521 US 346(1997)

Chapter 2. Institutional Rights

A. The right to sexual interaction

1. Autonomy issues

Case 1:

VF, a chronically mentally ill woman, was hospitalized as an incompetent person at a long-term mental health facility. She was alleged to have a history of proclivity toward irresponsible sexual behavior. While hospitalized, she conceived a child with another patient and gave birth to a boy, RF. Since the pregnancy was not detected until two weeks prior to the delivery, VF did not have the opportunity to consider termination of the pregnancy, and no prenatal care was provided. The child was born healthy, but VF and RF sued the facility, the treating physicians and the mother's public guardian claiming that the birth of RF was due to the negligence of the mental health facility.

Question: Does VF have the right to sexual autonomy, including sexual activity, contraception, reproduction and prenatal care at a mental health facility?

YES. Hospitalized patients with a mental illness should have all the rights that other persons have, unless such rights are specifically restricted. The right to sexual autonomy and the right to reproduce are fundamental human rights and mentally ill persons should not be prevented from exercising these rights. Compulsory celibacy in institutions is at odds with autonomy and the goal of providing a treatment milieu supportive of increasing a patient's capacity to use their best judgment in social contexts including in the context of emotional and physical intimacy.

NO. A mentally ill person who is deemed incompetent cannot make informed and consensual choices about sexual activity and reproduction, and the doctors and nurses should have pre-

vented VF from engaging in sexual interactions.

NO. A mentally ill person should not be allowed to have sexual interactions at a psychiatric facility because nurses and doctors are uncomfortable about the sexual activity of patients and cannot be expected to provide counseling on sexuality or contraception. Moreover sexual interactions between patients in a psychiatric facility can easily become a matter of gossip, anxiety, conflict and splitting which can disrupt the need for a therapeutic milieu, or a holding environment which is not overwhelmingly anxiety provoking to vulnerable patients. Finally the line between autonomous and compulsory sexual activity in institutional contexts may be too difficult to maintain.

Discussion:

The rules governing the sexual activities of patients in psychiatric hospitals are for the most part unwritten. There are frequently no explicit guidelines for determining whether either competent or incompetent patients should be permitted to have sexual interactions while they are hospitalized. In the absence of formal guidelines the decisions about whether to permit or to prevent sexual interactions among inpatients are left to the nursing staff and clinicians at individual institutions. Due to fear of potential emotional or physical damages to vulnerable patients, out of concern for potential litigation, or implicitly identifying a therapeutic milieu with a celibate milieu, various mechanisms of supervision are in place at majority of institutions, making sexual interactions of patients less likely to happen. Moreover the impact of policies regarding patient/patient or patient/visitor consensual sex on the overall function of a psychiatric unit might well differ given the nature of a unit population e.g. acute versus chronic, high level functioning versus low level functioning, voluntary versus involuntary. There is little in the existing literature to guide clinicians in deciding whether sexual interactions of psychiatrically hospitalized patients with each other or with visitors can be therapeutic or antitherapeutic. Those studies that exist with regard to the potential harmful or beneficial effects of sexual activity for

psychiatric inpatients are generally ignored. Considering the discomfort of the general public (not to mention of clinicians and some hospitalized patients) with the sexuality of the severely mentally ill, it is not surprising that the issue of sexual activity on inpatient wards has been and continues to be a taboo subject, one that is rarely discussed or studied.

In light of the history of eugenics and forced sterilization of persons with severe mental disabilities (a history that continues to the present day), the issue of sexual autonomy and reproductive rights in persons with mental illness is important to address in a careful manner.

As a result of a lack of research evidence about the effects of sexual activity on psychiatric inpatients and the prevailing discomfort about sexuality of severely mentally ill patients, consensual sexual interactions of persons with mental illness are in general severely restricted on psychiatric hospital wards. This is often accomplished through indirect measures such as checks, which involve a staff member looking at the patient, and which happen on many inpatient units every 5 to 30 minutes for reasons of safety, and not explicitly for the purpose of limiting patients' sexual interactions. The outcome, however, is the same. Nor are patients told that they are allowed to have sexual interactions, and in the atmosphere of frequent checks, the impression of not being permitted such liberties is created.

There are no explicit universal legal or ethical guidelines on the question of sexual autonomy of hospitalized patients, but much can be deduced from the general guidelines for care of institutionalized persons. A handful of United States state statutes provide that, every institutionalized person is entitled to individualized treatment under the least restrictive conditions feasible and the institution should minimize interference with a patient's individual autonomy, including his or her personal privacy and social interactions. If the least restrictive conditions feasible should be applied, and if the individual's right to personal privacy and social interactions is to be respected, sexual interactions of hospitalized patients should be permitted when feasible and not specifically clinically contraindicated.

From both a clinical and ethical perspective, the risk that institutionalized individuals with mental disabilities may be emotionally coerced into sexual relations, especially in a confined environment with limited choices, must be considered seriously, although this consideration may be tempered by the realization that sexual coercion occurs all too often among people otherwise exercising free choice in the outside world. This includes such phenomena as the high incidence of "date rape" among teenagers.

In VF's case it was argued that the treating physicians or guardian should have supervised her contacts with men to see that she did not engage in sexual relations. The court rejected the suggestion inherent in this argument that under no circumstances should a woman considered to be incompetent be permitted to bear a child, or indirectly to have sex in a mental institution. This attitude was seen as an expression of eugenics. Should mentally ill patients who are institutionalized have the same legal rights and responsibilities guaranteed to all other persons, except those which are specifically denied them? If the answer is yes, then mentally ill patients have the right to sexual activity and reproduction, unless these rights are specifically denied.

VF also argued that she was not provided contraceptive counseling and medication, which contributed to her becoming pregnant and bearing a child. This claim was recognized as valid by the courts, implying that inpatient facilities are expected to provide contraceptive options to institutionalized patients. Yet the denial of the sexuality of the patient with mental illness contributes to the continued withholding of contraceptive care from many hospitalized mentally ill patients. In none of the inpatient units at a certain state facility in New York were condoms available to patients. Psychiatrists are not experts on contraception, yet some forms of contraception such as condoms are simple to use and relatively free of potential negative side effects. Additionally condom use provides protection from the spread of STDs; most crucially, they reduce the risk of contracting HIV. Should

inpatient units routinely dispense condoms? Should condoms be provided on the inpatient units, or only when patients leave the hospital on passes?

Another issue raised by VF's case was the right to have a pregnancy detected in a timely manner, so that abortion could have been considered, or prenatal care provided. The fact that in VF's case the pregnancy was not detected until two weeks prior to delivery raises questions of clinical competency of her doctors. The delay in detection of the pregnancy also reflects the prevalent attitude of denial about sexual activity in institutionalized mentally ill patients. VF's child was born free of major defects, yet the absence of prenatal care carries multiple risks. The late detection of the pregnancy also eliminated the patient's choice to terminate the pregnancy. Since VF was not competent to make any medical decisions about her care, the decision about possible termination would have been made by her guardian. Abortion is an extremely charged question for those *not* mentally ill, and in an institutionalized incompetent patient the question of abortion becomes ever more complicated. Should legal guardians of mentally ill patients have the same decision making capacity about reproductive matters as about all other medical questions? What about decisions on procedures resulting in sterilization of mentally ill patients?

Without question, inpatients should be protected from sexual assault, and there need to be unambiguous guidelines forbidding sexual interactions between patients and staff members. Least restrictive conditions and minimal interference with social interactions do not include interactions with staff members. The risk of sexual exploitation is especially high in power dependency relationships such as those which exist between staff and hospitalized patients. Poorly selected, trained, and supervised staff is especially prone to engage in sexual exploitation of patients as well as other forms of abuse and neglect. Professional ethical codes in the United States and elsewhere prohibit sexual interactions between clinicians and patients. This prohibition is for the purpose of protecting

the patient from engaging in a sexual activity in a relationship that is clearly unequal in power and personal knowledge, one in which the caregiver has a fiduciary duty to act in the patient's interest, not in his or her own. However, mere awareness or public postings of ethics codes is no substitute for proper staff selection, in service training, and supervision.

Sexual interactions a patient can have are necessarily limited to those with other patients or the patient's guests. A slippery slope policy argument can be made that having a bright line, one which prevents any sexual activity on inpatient units, is easiest to administer and enforce. However such an argument needs to be balanced with individual patient autonomy and informed consent considerations, as well as the question as to what makes for the best therapeutic milieu. Autonomy itself is not a self-evident concept. The notion of sexual autonomy is even more individual and context dependent. What sexual autonomy means for an individual patient however is a matter which needs to be explored rather than presupposed. Patients in despair who seek self-affirmation via compulsive sexuality can no more be said to be sexually autonomous than patients who out of overwhelming fear isolate themselves from intimacy and shroud themselves in compulsive celibacy. The vitality, variety, controversy and complexity of the long-neglected questions that need to be addressed in this area beckon intrepid mental health, law and ethics explorers prepared to undertake challenging individual and organizational case analysis and empirical research.

2. Refusal to provide condoms to detained patients

Case 2:

RH was detained in a high-security hospital setting. The hospital, which had a significant number of long-stay patients and kept patients on single sex wards, did not allow patients to have sexual intercourse (either in the form of conjugal visits or as a result of relationships between patients), and the nature of the regime to which patients were subject was supposed to involve levels of observation that would prevent patients from engaging in sexual relations with each other. In addition, there was a prohibition on patients having access to condoms: they were not allowed to obtain their own, nor could they be prescribed by medical staff or otherwise provided. RH challenged the policy: he indicated that he was homosexual in sexual orientation, that some patients did indeed have sexual relations with each other despite the policy, and the failure to allow him to use condoms meant that his life and bodily integrity was put at risk because he could not follow safe sex practices.

Question: Should condoms be provided to a patient at a mental institution where sexual interactions are prohibited?

YES. Even if sexual activity is formally not permitted, in the event that it does take place, patients should be provided with condoms to allow for safe sex practice.

YES. Sexual interactions are an essential right and mental institution should not prohibit sexual interactions of patients or prevent them from obtaining condoms.

NO. A mental health institution can prohibit the sexual interactions between patients and providing condoms would undermine such a policy.

Discussion:

Outcome of the court case:

RH lost his case. The trial judge accepted evidence from the hospital that it was unlikely that sexual activity took place, and

that there was, in any event, a limited risk because only a very small number of patients had a sexually-transmissible disease. He also accepted that the no-sex policy was lawful in light of the fact that a large number of patients in the hospital were perpetrators of sexual offences or victims of sexual abuse (and sometimes both). As a result, he found that allowing sexual relations could have implications for the prospects of treatment, and providing a therapeutic milieu and could give rise to bullying, could be dangerous, and would require such high levels of observation. Such levels of observation would be inconsistent with allowing privacy for sexual relationships to be practiced as well as undermine the privacy needed for emotionally intimacy and self-integration in the course of a hospitalization. Whether for an individual patient sexual intimacy is autonomous or compulsive, whether it can be a help or a barrier to self-integration is another question which needs to be explored, yet is difficult to explore with patients in deep pain and despair

It is to be noted that the case was one in which the question was whether the hospital, as the body which had to make a decision and had access to all the relevant facts, had reached a decision which was lawfully open to it: this in turn involved the judge asking whether the decision reached was one within the area of discretion given to the hospital. It was not the same as an appeal against a decision, when the judge would take his or her decision on the evidence relevant to the substantive question, but a review of whether the decision-maker had acted properly. It is also to be noted that RH's lawyers did not challenge the no-sex policy: rather, his case was based on the suggestion that it was a policy which did not prevent sexual relationships (or sexual encounters) and so a different policy should apply as regards the distribution of condoms.

Ethical questions arising:

The question underlying the decision of the hospital is one that highlights a number of important issues. In the first place, there is the issue of sexual relationships: many would see the ability to

participate in sexual relationships as a basic human right. The context, of course, is that this involves patients in hospital, not prisoners serving some sort of punitive sentence, where it may be more readily acceptable that a loss of the right to engage in sexual activity is part of the regime which should be applicable (although note that, in many prisons, conjugal visits *are* allowed). At the same time, any sexual interaction should be on a fully consensual basis, since otherwise there is a risk of abuse taking place. In the third place, there are legitimate security concerns relating both to visitors (and the potential for contraband) and whether patients who require high levels of security can safely be allowed privacy.

The court case did not consider the question of the propriety of resolving these tensions by having a blanket policy of banning sexual encounters or relationships, because RH's lawyers did not challenge this policy. This might be understandable on the ground that there are some issues, which are not well-suited to determination through the process of litigation. So what are the issues behind the question? As noted, there are aims which may be in conflict: the basic right to have consensual sexual relations and concerns about security. The question of whether sexual encounters are consensual may be particularly important if, as was the case in this hospital, and may be the case in many secure hospitals, there are patients who have been involved in sexual offending as assailants and/or as victims.

But does that justify a complete ban on sexual relations or does it justify policies being put in place which allow conjugal visits from visitors together with appropriate security checks before and after the visit (to deal with risks of contraband being smuggled), and which allow consensual relationships between patients, but with safeguards and monitoring to ensure that they are truly consensual and that bullying behavior and the like does not pressure patients into situations which are non-consensual. In other words, is a complete ban the appropriate solution to the tensions between the differing aims which are relevant to the issue in light of the secure nature of the institution and the patient population?

Turning then to the separate question of whether condoms should be supplied, the judge noted that a simple policy without exceptions was appropriate, and it would not put staff in the position of having to make assessments of whether or not they should take action which was inconsistent with the no-sex policy. Is this a sensible approach to take? The fact that something is prohibited does not mean that it does not happen. The hospital evidence was to the effect that it is unlikely that it happens, and that there is close observation by staff: but the close observation makes the point that there is a risk. If there is a risk, then it is important to note that there are two elements which are usually assessed in deciding how to respond to a risk: one is the seriousness of the consequence, and the other is the likelihood of it occurring. So a relatively small risk of a particularly serious consequence may nevertheless require that practical action be taken to guard against it. Thus, a small risk that unprotected sex will take place RH because of the potential consequences of that RH should perhaps be guarded against by the practical measure of condoms being made available.

B. The right to refuse treatment

1. Medication

Case:

Mrs. R is a 29-year-old married woman with two young children. She has been experiencing depression since a recent miscarriage. For several weeks, she spent most of her days in bed, crying intermittently and expressing little interest in the outside world. Prior to the miscarriage, she had been a full-time homemaker and mother, but since the depression began, members of her immediate and extended family have been helping extensively with household jobs and with child care, as Mrs. R seems incapable of performing these tasks.

A few days ago, Mrs. R was hospitalized due to physical complications related to her miscarriage. During a meeting with Mrs. R's husband and other family members, her doctor was informed of her recent mental status, and a psychiatrist was referred to evaluate the condition. The evaluation confirmed the presence of clinical depression. When asked about thoughts of suicide, however, Mrs. R appeared shocked and told the psychiatrist that she could never harm herself, since she could never leave her two children motherless. Mrs. R's family, in a private consultation, asks the psychiatrist to prescribe an anti-depressant to help Mrs. R "regain her former self and tend to her family." Mrs. R does not want to take any medications, saying that she simply needs "time" to work through her intense feelings of loss. Her family worries about the impact this prolonged grieving might have on the two children.

Question: Should the psychiatrist comply with the family's wishes to medicate Mrs. R for her depression?

Yes. Because Mrs. R is otherwise incapable of caring for her two children.

Yes. Because Mrs. R may become suicidal.

No. Because Mrs. R is presumptively competent to refuse treatment.

No. Because Mrs. R is the only one who can make the decision about the medications she is willing to take.

Comments:

Without any evidence that Mrs. R is imminently dangerous to herself or to her children, there is no basis for medicating her against her will. And while Mrs. R's depression is clearly having a negative effect on her quality of life, as well as the quality of the lives of her children and family, this situation does not rise to the level of a grave disability which might serve as justification for involuntary treatment. Mrs. R's family is free to discuss their concerns with her psychiatrist – and the psychiatrist can discuss her care with the family, *with Mrs. R's permission*, but the family cannot dictate the course of treatment.

Based on the available information, there is nothing to suggest that Mrs. R is incompetent to make decisions regarding her treatment. She has clearly stated that she needs time to cope with her loss. The recency of the miscarriage further suggests that her depression is reactive and grief-based, and other forms of treatment may be available. Psychosocial interventions, such as individual therapy, family counseling, and/or support groups are less restrictive alternative forms of treatment and, therefore, must be considered first. *Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.*³

2. Restraints

Mr. H is a 68-year-old widower who has been living in an extended care facility for the past year, since he became unable to care for himself at home alone. He has been diagnosed with bipolar disorder, and his nursing staff is beginning to suspect that Mr. H also has some dementia. The bipolar disorder has been difficult to manage, as Mr. H is unable to take lithium due to a history of kidney problems. As a smoker, Mr. H likes to spend much of his time on the grounds of the facility, smoking his cigarettes and talking to others. However, recent increases in his levels of agitation and disorientation have raised concerns about the possibility of his wandering away from the facility. This has resulted in a policy not to permit Mr. H to go outdoors unless accompanied by a staff member.

Due to recent staff shortages, Mr. H is now often asked to wait to go outdoors for his cigarette. One morning last week, he approached the nurses' desk repeatedly, asking to go outside to smoke. He was asked to wait until a staff member became available. Mr. H became increasingly agitated as he waited throughout the morning. His demands to go outside became louder and more aggressive, and he was asked to step away from the desk. When he refused to do so, screaming obscenities at the nurse on duty, an orderly was called. In his agitated state, Mr. H struck the orderly as he approached. The psychiatrist on duty was called, and Mr. H was ordered to be placed in restraints until he calmed down. It required every staff member available to place Mr. H in restraints. He continued screaming until a staff member came in to check on him and asked if he would calm down for a cigarette. Mr. H responded angrily and threateningly. However, the third time the staff member entered the room to check on him, Mr. H asked to be released and promised to "behave" if he could "go out for a smoke". The restraints were removed – with the psychiatrist's approval – when Mr. H appeared significantly more calm and rational. The staff member accompanied Mr. H outdoors for a smoke, and the day passed without further incident.

Question: To ensure that the staff would be equipped for such circumstances in the future – particularly in light of the shortage of staff at the facility – should the psychiatrist write a standing order for restraints in Mr. H’s chart?

Yes. To ensure the safety of the staff, and to prevent the escalation of Mr. H’s behavior.

No. Because each incident should be evaluated individually and personally by the psychiatrist.

No. Because the use of restraints in such circumstances is inappropriate

Comments:

To the extent that physical restraints are ever used, they are to be used *in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others.*⁴

These procedures for restraint must conform to applicable law, as well as professional, ethical and human rights standards. A so-called “standing order” for restraints is not permissible, as the need for restraints must be determined on a case-by-case, situation-by-situation by the authorizing psychiatrist.

However, the use of restraints in Mr. H’s circumstances was problematic for further reasons. The escalation of the situation was precipitated by the restriction on Mr. H’s smoking and the shortage of staff. As such, the incidence is likely to recur, and restraints are not an appropriate solution to the problem. The treating psychiatrist and the direct care staff must devise a way to ensure that Mr. H is safely able to spend time outdoors, within the realistic constraints of staff time and availability. The shortage of staff is an administrative issue and problems that arise from such a shortage cannot be addressed using forcible interventions and restraints.

C. The right to deinstitutionalization

Case.

Ms. L is a 38-year-old woman who was diagnosed with schizophrenia almost 15 years ago ⁵. She had been hospitalized only twice during that time, perhaps largely due to the support of her mother, with whom she had always lived. However, Ms. L's mother was diagnosed with lung cancer four months ago, and died less than six weeks later. Ms. L's mental status deteriorated rapidly after her mother's death, and she admitted herself voluntarily to the psychiatric unit of her regional hospital. Through careful adjustment of her medications and structured therapy sessions, the symptoms of her schizophrenia were stabilized within a few weeks, and Ms. L's mental status improved significantly. Her treating psychiatrist noted that Ms. L was ready for discharge and that her schizophrenia could be treated appropriately in a community-based setting. However, one year later, Ms. L still resides on the psychiatric unit, as community placements are difficult to find. Ms. L appears content with the arrangement, enjoys her daily routine, and calls the hospital "home."

Question: What action, if any, should be taken by Ms. L's treating psychiatrist?

None, as long as the inpatient bed is available for Ms. L's continued residence on the psychiatric unit.

None, as long as Ms. L appears content and remains on the psychiatric unit voluntarily.

Ms. L should be discharged as soon as possible.

Comments:

Access to community care may be limited, but treating physicians in inpatient psychiatric settings and other residential institutions must actively seek such placements for individuals who do not require inpatient or residential treatment. Persons capable of living in community settings should be discharged safely to such settings, where their needs can be met within the least restrictive therapeutic environment possible.

Unjustifiable institutional isolation may well amount to arbitrary detention, professional misconduct, and an ethical violation of appropriate standards of care. *Psychiatrists should devise therapeutic interventions that are least restrictive to the freedom of the patient.*⁶

Making discharge decisions solely based on the availability (or lack of availability) of inpatient beds distorts a clinical decision into an administrative one. The voluntary nature of Ms. L's admission, and her ongoing acquiescence, are also not adequate to justify unnecessary hospitalization. Additionally, extended hospitalization would likely increase Ms. L's dependence on such a setting, making eventual discharge increasingly difficult with the passage of time.

The decision to discharge must take into account all relevant clinical considerations, including – but not limited to – Ms. L's mental status, her ability to care for herself, and her safety and the safety of others in the community. Unless one or more of these factors justify ongoing treatment in an inpatient psychiatric setting, Ms. L should be discharged as soon as an acceptable residential environment is identified.

1. The case is *Foy v. Greenblott*, 190 Cal. Rptr. 84 (Ct. App. 1983).

2. This is based on the case of *R (RH) v Ashworth Hospital Authority* [2001] Mental Health Law Reports 241.

3. *Principles for the protection of persons with mental illness and the improvement of mental health care* (Principle 9), Approved by United Nations General Assembly resolution 46/119 of 17 December 1991.

4. *Principles for the protection of persons with mental illness and the improvement of mental health care* (Principle 11), Approved by United Nations General Assembly resolution 46/119 of 17 December 1991.

5. This case is loosely based on the fact underlying *Olmstead v. L.C.*, 527 U.S. 581 (1999).

6. *Madrid Declaration On Ethical Standards for Psychiatric Practice* (Ethical Standard 1, Approved by the General Assembly of the World Psychiatric Association on August 25, 1996 and amended by the General Assembly in Yokohama, Japan, in August 2002.

Chapter 3: Tort law

A. The failure to commit

Case 1:

Mr. C had a long history of serious psychiatric illness. He was placed in a hostel on account of his needs, where he attacked a fellow resident. The police became involved and he was charged with assault. The criminal court remanded him in custody to prison, and administrative action was taken to transfer him to a secure psychiatric hospital for treatment. The criminal case was withdrawn, but C remained unwell and was placed under civil detention, from which he was released after he improved. Fresh accommodation was arranged for him in a different area and his hospital based consultant made arrangements for him to be seen the next month by the community-based psychiatrist for his new area, Dr S. This was in October. C missed the appointment; Dr S.'s office sent him a letter offering a further appointment a month later in November, which C also missed. Dr S telephoned C's general practice physician to ask for assistance in making sure that contact was made with C. Having been told that C had been reported to be acting aggressively, Dr S asked the local authority to make a formal assessment of C's mental health state to determine whether he needed to be placed under civil detention. The local authority made the necessary arrangements, but on a non-urgent basis, that being what Dr S advised, for late November. C avoided the assessment team, which included Dr S, when they attended his accommodation: he walked out from the building when they arrived, and none of them knew him and so did not recognise him; at the same time, none of the team asked him if he was C. Further attempts were made to contact C and discussions were held amongst the professionals about his ongoing treatment, including matters such as finding a hostel which was staffed with mental health specialist workers, but he was not actually seen. In early December, C attended social services offices and asked to be seen: he was offered an appointment for 10 December, but he did not turn up to that.

In mid-December, the police contacted Dr S to report that C had

been brandishing knives and speaking in a manner suggesting that he was responding to hallucinations. Dr S then contacted the local authority team again and advised that C be assessed as soon as possible. However, that afternoon, C killed a stranger. He was arrested, charged with murder, and eventually sentenced to indeterminate detention in hospital for manslaughter on the basis that his responsibility for the killing was substantially diminished by his mental illness².

C brought an action for failure to provide him with adequate treatment: his case was that the information known about him suggested that more urgent steps should have been taken to ensure that he was seen by a psychiatrist, and that this would have resulted in his placement in hospital – compulsorily if he had not consented – and treatment; that had this been done, he would not have been involved in a homicide, the effect of which was that he had to live with that responsibility on his shoulders. There were also practical consequences, namely that as a result of his conviction he was viewed as a more risky individual and was accordingly more likely to spend longer in hospital and in higher secure conditions, meaning that he was subject to a greater restriction on his liberty and other aspects of his life.

What happened in the court case:

The English Court of Appeal decided that C was not permitted to proceed with his action. In short, it decided that the claim that the authorities had not assisted C when they should have done so ran up against an insurmountable hurdle. The claim was based in a legal action of negligence: this requires that there be a duty of care between the plaintiff and the defendants, that there be a breach of that duty, and that the breach cause loss. The relationship between a doctor and a patient is one which gives rise to a duty of care. But, although Dr S and her employers were under a public health law duty to provide services to C, he had to make himself available and had not done so: and no doctor-patient relationship had been formed, so there was no duty of care in the circumstances. This meant that it was not necessary to consider the further questions of

whether there was a breach of the duty of care and whether that breach caused loss. There was a supplemental reason as well: C's action was in reality based on his criminal conduct (for which he remained at least partly responsible) and so to allow the claim to continue would amount to the law aiding illegality, which was not something the legal system would permit.

When C then raised arguments that his human rights had been breached by the failure to allow his claim to proceed further, this claim was also unsuccessful (before the European Court of Human Rights). It was decided that he had had a fair trial³ to determine whether or not he could bring a claim based on the allegation of negligence, which the English court had found could not be raised as a matter of applying the law to the facts. On the question of whether there had been respect for him as a person⁴, including his needs as a person with a mental disorder, the European Court noted that there might be cases in which the state had positive obligations to make provision for care (though the core right was to have the state refrain from unnecessary interference). This was a matter of striking a fair balance, and it was for the countries in question, which were bound by the European Convention, to decide where the fair balance was to be drawn. This was tied up with the question of whether there was a legal duty of care to ensure that services were provided to C or whether it was his responsibility to make contact. In addition, it could not be shown that there was a link between any failures by the national authorities and the prejudice C alleged that he suffered as a result, because it could not be said that they led inevitably to the homicide and the resultant adjudication and sentence.

Ethical issues arising:

The conclusion of the court case was that the medical professionals had no liability – at least no legal liability – towards C because the doctor-patient relationship had not been formed, and in any event C was responsible for his own predicament, namely his criminal actions. Is this a case where

legal rules – which have the purpose of deciding whether consequences are enforceable through the legal machinery – do not coincide with ethical rules? It is worth noting that the English Court of Appeal was pressed into action because the trial court had ruled that C should be allowed to take his case further, and so the trial judge had reached a different conclusion on the law: so it was not necessarily that clear. The ethics are certainly not clear either.

First, when does the obligation of the doctor arise? C was a person whose needs were plain, as he suffered from an enduring illness of the sort that was liable to relapse, and more so in the absence of treatment; he was released from hospital on the basis that he would fall under the care of Dr S. In addition, steps were taken by Dr S and colleagues to try to make direct contact with C and assess his needs: they were poorly executed, which is why contact was not made. But the fact that steps were taken to find C rather than wait until he visited the doctor reflects a realization that it is not appropriate to view C in the same light as the typical patient who will make an informed choice as to when to see a doctor. Does this in turn raise questions about whether the same standards are applicable to C as to the typical patient — namely, that no duty of care arises until the doctor and the patient have met?

This does not mean that psychiatric patients are not allowed to make informed choices: it merely means that the facts of a particular case may require a different standard to be applied. If, for example, the effect of the illness is that a patient cannot be expected to make the same choice as to keeping a doctor's appointment, the commencement of the relationship under which a duty of care is imposed should not depend on keeping such an appointment. What should be concluded from the facts of this case? At the outset, there can be no concerns about Dr S offering appointments to C: that involves treating C as able to make choices, and as someone whose engagement with psychiatric services would be on the basis of his cooperation. But perhaps a combination of growing concerns about his condition and the fact that he did attend a social services office

to ask to see someone suggests that the time had come to take more proactive action to ensure that C be located and seen. It seems unnecessarily technical to say that no meeting had actually taken place and so no duty of care could arise, particularly when the failure to see C was the central part of the complaint.

Secondly, was it right to say that there was no link between the failure to offer treatment to C and the homicide he committed? This was part of the reasoning of the European Court of Human Rights. It must be noted at the outset that there are comparatively few homicides committed by mentally disordered people: it is a factor which aggravates risk only in a small number of cases. (Most acts of violence are committed by young adult males: that does not mean that all young adult males are dangerous. Alcohol is implicated in lots of acts of violence: that does not mean that everyone who takes alcohol, even to excess, turns violent. The same applies to those who are suffering from mental illnesses such as schizophrenia.) C had been involved in violence before, and there were reports of aggressive behavior in the period before the killing. He was convicted of manslaughter on the basis that his mental illness substantially diminished his responsibility: in other words, his action was clearly linked with his disorder. It may be that professional intervention would not have changed the end-result – namely the homicide – but (a) common sense suggests that to be a possibility to be evaluated in probabilistic terms, and (b) the bold statement that there was no link between the failure to offer treatment and the homicide pre-supposes an answer to the very question which C wanted to raise in the legal proceedings.

Thirdly, would it be right to allow C to make a claim that he was suffering because he killed someone? The legal judgment made here was that the legal system cannot reward people for their criminality, and so such a claim cannot even be raised in court. But is that the correct analysis? After all, the crime committed by C was one in which his responsibility was substantially diminished by his mental disorder and the failure to treat it: the legal system had already recognized that in the criminal trial.

That means that C was at most partly to blame for the crime: why would it not have been possible, for example, to determine what proportion of responsibility he bore rather than simply assert that he could not bring a claim at all, a rule that might be appropriate for someone bearing full responsibility?

And was reliance on the fact that C was partially responsible an unnecessarily technical device? It is possible for defendants to prove that they were suffering from insanity at the time of their offence, which in England has the impact that they are found Not Guilty by Reason of Insanity. But the practical outcome of such a finding is that the person is considered for detention in hospital in much the same way as C was. So it makes no difference to the outcome. At the time in English law, a verdict of Not Guilty by Reason of Insanity also required a trial and a verdict from a jury, whereas a finding of diminished responsibility could be accepted by the prosecution and the court: for practical rather than legal reasons, it was therefore entirely possible that persons whose mental state when they committed a homicide meant that they were in fact Not Guilty of Murder by Reason of Insanity would be adjudicated as Not Guilty of Murder but Guilty of Manslaughter on the grounds of Diminished Responsibility.

Moreover, is the payment of damages to C so problematic? In the first place, damages would only be paid if C could demonstrate that he had been caused loss: so there would be no question of any sort of bonus to C from his actions, merely the making good of any harm done to him. In the second place, when the question is about money, it is important not to focus just on C. His victim's survivors might well have a basis to bring an action for wrongful death against C, and this would be a liability: since it might be difficult for the victim's family to bring an action against the professionals who should have been more active in ensuring that C was treated, and since C might be able to pay any damage award only if he had won an award in a civil action taken against the same professionals. Thus, the issue of public policy takes on a different hue when the focus changes to view a wider picture. (In some jurisdictions, such as

the United Kingdom, there are provisions for the victims of violent crime to make an application to a statutory scheme for compensation.)

B. The failure to retain/prevent patient from leaving hospital

Case 5:

D had been committed to hospital for a short-term period to allow a further assessment of her mental condition in July. On the initial review, she was felt to pose a significant risk of self-harming and also of absconding, which would increase the risks of self-harm. At the outset, therefore, she was placed on continuous nursing observation. When this level of observation was reduced, D took the opportunity to abscond from the hospital; she did this on several occasions before being discharged from hospital to be treated at home in late August. Within a few days, her mental condition had deteriorated, apparently from her failure to take medication, and she was again committed for a longer-term period for treatment. Two days later, she absconded, but said that she would return at the end of the day, as she did. After another two days, she again absconded when refused permission to have leave to her family home: she went home. At that time, she was on a level of observation requiring nursing staff to check her every hour. Her sister informed the hospital, who indicated that the police would be called if D did not return to hospital. The hospital allowed her one hour before the police would be called. During that hour, D took an overdose of her mother's asthma medication, which caused severe and irremediable brain damage.

The hospital was sued for negligence in failing to prevent D from absconding and in failing to take quicker action to return her to the hospital. In the course of the proceedings, the hospital policy on how to deal with instances of patients who absconded was revealed, which indicated that police involvement should be kept to a minimum.

What happened in the court case:

The case was tried before a judge only: he found that the chosen regime of hourly observations was not negligent; and that in any event a more strict regime of observations – for example every quarter of an hour – would not have prevented D absconding. The Appeal Court felt that the judge's reasons had not been adequate but that his conclusion in this regard was

correct. The Court gave more extensive reasons. It was noted that the expert testimony presented by D had not indicated that she posed such an enhanced level of risk as would call for continuous observation, given that she had not self-harmed on previous occasions when she had absconded, that she had often returned of her own accord, and that she could be found at her home; moreover, continuous observation was invasive and made her cooperation with treatment less likely. Furthermore, calling the police more quickly would have given D the time to self-harm in the manner she chose; in addition, it was proper to have a policy of involving the police as the last resort, given the need to avoid antagonising patients whose cooperation was sought, and there was no suggestion of any need to treat this as an emergency situation requiring a swifter response. Therefore, the Court ruled, there was no negligence, and any failures did not cause the harm which D suffered.

Ethical issues arising:

Patients who are committed to hospital do not always wish to be there: indeed, it is open to argument that, certainly in relation to patients who have the capacity to make decisions, there should be no use of forced committal if a patient is willing to cooperate (and reliably so). Even if a patient's condition is such as to require hospitalisation, that does not compel the conclusion that they have to be there on a permanent basis or in locked conditions: that should depend on their particular needs and the risk they pose (which will more often be to themselves than to others). But risk is usually very difficult to assess: the simple fact is that most humans are unpredictable for much of the time. When the future is being assessed, there is little that one can do beyond reviewing the patient's history and forming a judgment on whether there are factors which indicate that the future will be different. There may be instances where patients express suicidal thoughts and appear without hope on account of a mental disorder: that may justify a very close level of observation. But patients do not always broadcast such obvious distress: indeed, that might be a very rare situation, and so the risks have to be predicted on the basis of much less

clear-cut factors. So, a patient who has made a determined suicide attempt in the past may be viewed as being at higher risk if he or she exhibits similar behaviour as that which was seen prior to a previous attempt. But D's actions on this occasion were out of line with her previous behavior.

The court mentioned the importance of having a regime which encouraged cooperation and avoided antagonizing patients, whether by having unnecessarily invasive levels of observation or having the police engaged too frequently. The language used by the court presents a somewhat paternalistic view of psychiatry, which entails patients having things done to them or done for them but in relation to which their tolerance and cooperation should be encouraged. (It is a long-standing view of the right of the state to intervene to secure treatment for those who are mentally disordered that the state is exercising a *parens patriae* jurisdiction, in other words acting as a parent does for a child.) A more patient-centered use of language leads to the same conclusion. Being placed in hospital against one's wishes entails a loss of power: but that loss should be the minimum required, which means that patients' actions that may be seen as an assertion of rights they retain must be permitted to the extent that it does not conflict with the hospital's right under the law to limit a patient's freedom.

In D's case, the law required her to have a base in the hospital for treatment and assessment of her compliance. Had her needs been for a hospital or an observation regime which made absconding more difficult, that could have been provided. Whether she in fact had such needs turns on the assessment of the risk posed by D, the difficulties of quantifying which are central to the ethical dilemma. A balance has to be drawn which weighs on the one hand the invasive nature of having patients in locked units or subject to continuous observation and the risks they pose: the latter must justify the former, but only if the risks are sufficiently serious.

But there is another element to this calculation, which is the difficulty of predicting human behavior and so assessing the risks posed to an objective standard. However foreseeability is

different from predictability. At times, risks can be foreseen and substantially reduced. In that context, the question raised is whether the regime should err on the side of caution and assume a higher risk (and so a more invasive set of measures to deal with it, even though the actual risk may well be lower); alternatively, should it require cogent reasons based on past experience and informed judgment as to the future? The former may result in more people being subject to restrictions which were never in fact necessary; the latter may mean that some people will slip through the protective net and self-harm. Constructing and operating a system which balances the various risks is difficult because it is based on the unpredictability of human behavior, yet clinically, foreseeability and risk reduction are part and parcel of dangerousness assessment which occurs prior to discharge from hospitalization.

When viewed from this practical standpoint, the fact that it would have been possible to have placed D on a locked unit and to have made absconding more difficult (by way of physical security) or to have placed her on continuous observation and so have made absconding impractical (by way of relationship security) and the further fact that her conduct in absconding was unlawful and a basis for having her arrested, all has to be judged against several relevant criteria. The first is that it is necessary to avoid looking with the benefit of hindsight and to assess what were the risks as they appeared at the time that the decision was taken to keep D on an open unit and to respond to her decision to abscond to home in the way that was done. Hindsight, however, can also lead to a false fatalism as to foreseeability and preventability. The second is that this risk has then to be weighed against the other features that are relevant, including the risks of patients withdrawing all cooperation if they perceive the regime to be too draconian or conversely, if their dangerousness is ignored and unacknowledged. Thirdly, the assessment of the risk has to be specific to the context, which was that D had gone to where it was expected that she would go and was with family members who also may have a duty, at least an ethical one, to ensure that a relative they know to be ill and who needs to be in hospital

is watched appropriately, if they are appropriately informed and educated prior to discharge.

C. Tort liability to victim for harm caused by patient

Case 6:

RP was aged 4 when she was murdered by A: he had developed significant problems as a result of an abusive childhood, including alcohol and drug misuse, and had attempted suicide on various occasions. A year before he murdered RP, whilst in hospital, A had indicated that he had sexual feelings towards children and that he expected that he would kill a child. There was a question of psychosis. He was discharged from hospital, but continued to be seen as an out-patient. RP lived on the same street as A.

RP's mother sued the hospital authorities, alleging that they negligently failed to recognize and deal with the danger posed by A.

Outcome of the court case:

RP's mother's case failed, as the court decided that the hospital did not owe her a duty of care and so no question of negligence arose. In particular, when the question is whether a hospital owes a duty of care towards the victim of a crime committed by a patient, this turns on whether there is a sufficient degree of proximity between the hospital and the victim. The practical way of offering protection is to be able to warn a potential victim so that protective measures can be taken (in light of the limitations on being able to detain a patient on grounds of mental disorder and the limited prospects of success in treatment for some groups of patients): but this cannot be done unless there is an identified victim or particular group at risk from the specific patient. Since A had not disclosed that anyone was specifically at risk of being harmed by him, there was no duty of care owed to RP on the basis that A lived on the same street. On that basis, her claim was dismissed on a ruling as to the law.

Ethical issues arising:

Although a relatively small proportion of persons with mental disabilities pose any risk to others, there are instances when there is such a risk. This sometimes involves factual situations which are

particularly heart-rending, such as the death of a child. This will produce a range of reactions, all of which are understandable, including anger and a desire to find someone to blame for the situation.

The outcome of the court case helps to elucidate the different strands that make up the concept of blame. Unpacking these strands helps to focus on the ethical questions which arise in explaining who is responsible for causing an unfortunate outcome. Of course, A was primarily responsible for killing RP in that he caused her death. If that was an exercise of a choice by him, he would be to blame for making such an unacceptable choice. But the bizarre nature of such an act raises the question of whether it was the product of a mind which was somehow disordered and so might be less than fully responsible for the outcome.

Psychiatry addresses different types of disorders. Some of them, under the general heading of personality disorder, involve people whose ability to live in society is compromised as a result of problems occurring during their formative years: since society (at the informal level, including in the form of families, local communities and social structures, and formally through social work mechanisms) is supposed to have protective mechanisms which intervene to prevent the ill-effects of poor parenting or abusive relationships, the actions of the personality disordered and psychotic individual are caused by those who played a part in the development of the disorder. So, at the same time as recognizing that the individual may pose a danger to society, an ethical viewpoint would conclude that this situation is not one for which the individual is necessarily wholly responsible.

A similar analysis may apply in other mental disorders which play a part in dangerous behavior. Some disorders may be caused by physical injury to the brain; others may be caused by genetic features; yet others may be triggered by exercises of choice (such as alcohol or drug-induced psychoses), but it may be that the trigger only occurs because of a genetic predisposition. The net effect of this complex causation is that the criminal action is not the responsibility of the mentally ill defendant alone.

An individual with a severe mental disability may (unlike A in this case) be judged to be legally insane: this provides a defense to criminal liability (at least in most jurisdictions), which reflects a view that the individual is not personally responsible for the offense. Many jurisdictions also allow a person whose actions were caused in part by a mental disorder to put forward their diminished responsibility as a partial defence to criminal liability (by, for example, leading to a conviction for a less serious offence) or as a basis for mitigating the sentence, or even as warranting an alternative to a criminal prosecution.

The fact that an assailant with a mental disability is sometimes not viewed as wholly responsible for the criminal action reflects the position taken by the parents of the dead girl in this case—namely, that someone else must bear part of the responsibility for the actions of A. Society ascribes responsibility for harmful events in different ways. One way is via criminal sanctions; another way is through damage awards in civil lawsuits. But a gut reaction that someone else must be to blame does not always translate to reality when sober reflection is applied to the facts, at least not in terms of legal liability. Part of the reason for this is that court actions such as the one on which this problem is based arise after a horrendous event has occurred, but the judgment that has to be made about the professional conduct is based on whether there was a failure to foresee that particular horrendous event: in other words, could it be predicted that A would attack RP? If not, then there was no reason to impose a legal duty between the professionals and RP and her family. So the court emphasizes the need for an identified victim.

Had there been an identified or identifiable victim, there would be further questions arising to inform the ethical debate and also the legal debate. It is desirable that those who pose risks because of mental disorder receive treatment, both for their benefit and also in the hope that the risks will not eventuate and society will thereby be protected. But there is a good reason why information provided to medical professionals is protected by confidentiality: if it is not, then those who need assistance because they pose a risk are less likely to reveal their problems (or even see clinical

professionals in the first place) if they have a good reason to fear that this information will be passed on to criminal justice agencies. So there is a tension there: the need to have effective treatment programs requires confidentiality, whereas the need to protect those at risk supports the need for information to be passed on so that people at risk can take protective steps. How to resolve this tension is difficult. If too much information about the risk of harm to others is passed on, then fewer dangerous people will seek treatment, which will raise the level of risk. On the other hand, if information about dangerousness is not properly sought, the risk of dangerousness may increase.

Different legal systems may draw the line differently, but a fairly common approach is to require professionals to pass on information when there is a specific victim who is identified as being at risk. A duty of care in negligence tends to arise when there is both a sufficient relationship and it is reasonable to impose a duty: these steps raise different questions, with the tension between the needs of confidentiality and the importance of passing on information feeding onto the question of the reasonableness of imposing a duty. But the fact that there is a specific person at risk provides an answer to both questions which commonly arise. In other words, the fact that a professional knows that there is a specific person at risk means that they have sufficient of a relationship to justify a duty of care. And the same fact means that it is reasonable to require that there be a duty despite the competing fact that it means that information obtained in confidence has to be used against the patient who supplied that information.⁷

D. Mistreatment in an institution: Treatment for a disorder which does not justify detention

Case 8:

B was convicted of homicide: his responsibility for the killing was found to be diminished in part by a psychosis. He was committed to a psychiatric hospital. After a significant period of treatment, B's clinical care team formed the view that he also suffered from a personality disorder in addition to the mental illness on the basis of which he was committed to hospital. An application was made to court to have the basis for detention changed to reflect both the mental illness and the personality disorder, but the court was not persuaded that the personality disorder was such as to justify detention. Nevertheless, he was transferred to a ward which specialized in the treatment of personality disorders. B challenged this transfer.

Outcome of the Court case:

The case went through three levels of court decision. The trial judge decided that it was lawful to place B on a ward and treat him for any form of mental disorder he was diagnosed as having; the Appeal Court overturned this, deciding that if the law allowed detention only if the particular category of mental disorder was sufficiently severe, then it was implicit that treatment was possible only for the categories of disorder that justified detention. But there was a further appeal, and the highest court determined that the trial judge was correct: the court's reasoning was that once the threshold had been passed at which the patient's mental condition justified detention, for whatever category of disorder, then the clinical team could (and indeed should) treat the patient for whatever additional categories of disorder were diagnosed to be present.

Ethical issues arising:

The first point arising is that there is a distinction between detention and treatment: they overlap, but they raise very different questions and involve different fundamental rights. The question of whether someone should be detained is a question

about their fundamental right to liberty. Questions which arise in this context can be many: for example, should detention be possible on the basis of risk posed to others (i.e., some form of police power) and should it extend to protecting people against the risks of self-harm arising from mental disorder? If the latter is a basis for detention, does the patient retain some capacity to make decisions about the consequences of their mental disorder?

The question of treatment is another matter: if it entails the use of medication, the fundamental right which is at stake is that of personal autonomy and the right to make choices about medical treatment.

But there is an obvious overlap. If the patient's mental disorder is such as to justify detention, should that be with a view to treatment to alleviate the condition (or the consequences of the condition)? If that is so, should the patient retain all their autonomy rights to make decisions as to treatment and so have the right to refuse to accept any treatment, thereby undermining the basis for detention? And should there be differential treatment criteria, depending on matters such as whether there is an urgent need for intervention, how invasive or irreversible the treatment is, and whether the consequence of not imposing treatment is that the patient will continue to pose a risk to other patients and to staff and so potentially have to be held in conditions of security which are themselves damaging to the patient in the long-term and leave forced treatment as the only practical way of allowing the patient to have any form of social life within the hospital (or any prospect of release from hospital).

Very frequently, and this was so on the facts of B's case, the legislative regime has certain criteria for detention and additional criteria as to when treatment may be compelled even if the patient does not consent. The legal regime in question at the time drew a distinction between different types of mental disorder (mental illness, personality disorders, and forms of learning disability) when it came to detention, but the legislative regime left open the question of whether the criteria

for treatment were to be applied to any category of mental disorder or only a disorder in the category used to justify detention (or categories if the patient suffered from different types of disorder). So the issue the court had to confront was whether the psychiatrists should treat the whole person (the legal regime allowing it to be done without the consent of the patient, but with a need for an independent second opinion if there was a long-term use of medication) or was only allowed to compel treatment for the category of disorder which allowed detention.

The view of the final court of appeal was that the deprivation of liberty required that as much freedom of judgment be allowed to the clinical team as possible so that they could meet the patient's needs. Indeed, the court phrased it as though detention brought with it a duty to provide such treatment.

But can this be right? Consider two different scenarios. In one, a personality disorder which by itself does not justify detention may mean that treatment for a mental illness is prevented (for example, because the ability of the patient to cooperate with treatment for the mental illness is compromised by the personality disorder). In such a case, treatment for the personality disorder may have to be seen as part and parcel of the treatment for the mental illness. But if there is no such link, why should the patient have to be subject to treatment for the personality disorder if his release depends only on the success of the treatment for mental illness?

Sometimes, the facts of a case do not illuminate the importance of the principle. The treatment to which B would be subject for his personality disorder was not in any sense invasive (being forms of psychological therapy with which he could easily choose not to cooperate), and there was no suggestion that this would get in the way of the treatment for the mental illness which was the basis for his detention. But change the facts slightly, and the importance of the principle becomes more clear. The basis for detention was learning disability, but there was also a mental illness which did not justify detention and which did not have any implications for the treatment regime

applicable to the learning disability: on the basis of the court judgment, an illness which would not itself justify detention is transformed into one which can be treated because there is another disorder which does justify detention.

E. The “duty to protect”

Case 9:

PP and TT briefly date, but Mr. P. becomes angry when Ms. T. begins to express interest in other men. P. sees his psychotherapist and discloses that he wants to kill T. The psychotherapist (a psychologist) discusses the case with colleagues (all psychiatrists) and decides to contact the police, who investigate P. and determine he is not a danger, but tell him to avoid T. P. does not follow-up treatment with his psychiatrist, and two months later fatally stabs T. T’s parents sue the therapist of P. for failure to warn T.

Question: Was a breach in patient confidentiality justified in this case?

YES, the psychiatrist has a dual obligation to both the interests and wellbeing of his patient as well as of society at large.

NO, a space exists between psychiatrist and patient that is immune from the influences of the laws of the nation in which that therapeutic relationship develops. Psychotherapeutic practice cannot be successful without absolute confidentiality; prioritizing the duty to public good over the duty to patient confidentiality may violate the ethics of psychiatric practice. This private space is recognized in Anglo-American law, and similar distinctions between “public” and “private” legal spaces apply in Islamic and Judaic law and elsewhere.

NO, abandoning an immune private space creates a dangerous precedent: it could inhibit patients from seeking care from a psychiatrist, or inhibit patients from being honest with their psychiatrists about violent tendencies or could incline psychiatrists not to explore topics that could reveal a patient’s violent thoughts or could change the way patient notes are written.

NO, because psychiatrists are not able to predict future dangerousness. The standards and criteria for potential harm that a psychiatrist could use to determine when to break confidentiality are difficult to establish, and leave open the

possibility of taking action too often or not often enough. The outer bounds of this responsibility are difficult to establish: does a duty to warn third parties also imply a duty to protect them from harm, for example, by notifying the police? Warning third parties may seem appropriate in the short term, but may backfire in the long term, decreasing prospects of public safety due to treatment non-compliance, loss of faith in caregivers, or greater use of involuntary care.

NO, the psychiatrist should have recommended acute treatment and potentially commitment in order to prevent immediate harm, and at a later date assess for continued dangerousness to others.

Discussion

The psychotherapist has at once an obligation to maintain patient confidentiality and an obligation to protect third parties from potential harm. The approaches to legal cases involving a duty to warn or protect third parties have found great influence and inspiration from the 1976 Supreme Court of California case that considered the fact pattern discussed here, the *Tarasoff* case. The Court ruled that a legal duty exists for psychotherapists to warn potential victims of violent acts by a patient. Famously, the court stated that “protective privilege ends where public peril begins.” Post-*Tarasoff* cases often include an additional obligation to prevent “foreseeable harm.” In the midst of a communicated threat, *Tarasoff*-like situations often arise in discharging inpatients or in outpatient settings. Numerous immediate questions confound any simplistic position that either endorses absolute patient confidentiality or total maximization of third party safety.

Concerns Addressed After Tarasoff

Since the *Tarasoff* decision, many have asserted that the many concerns that arose in the questions above have been overstated. Although an impenetrable private space between therapist and patient is an ideal in some notions of psychiatric practice, its reality is difficult to establish within a web of relations

external to this dyad within which both patient and provider find meaning and derive sustenance, as well as a social context whose very existence implies rights and obligations. These basic features seem non-controversial, as the *Tarasoff* ruling has been widely accepted in a large majority of American states, and has found much influence across the globe.

The weight of clinical evidence seems to demonstrate that psychotherapeutic practice can be successful without absolute confidentiality. One study on the effect of *Tarasoff*-like actions (including contacting law-enforcement officials as well as potential victims) taken by residents in psychiatry in inpatient environments demonstrated that patients do not, on the whole, seem to feel betrayed due to exceptional breaches of confidentiality. This would further suggest that patients would not be any more non-compliant, inhibited from seeking care in the future, or reluctant to disclose personal feelings.

Framing the issue at hand as a problem of dual obligation (duty to public good vs. to patient confidentiality) is itself suspect. The ethics of psychiatric practice should include an expansive notion of care that includes: both immediate and distant members of a community; both the patient and those without whom he or she could not be who they are (children, partners, siblings, etc), those upon whom he or she depends and derives sometimes pleasure and sometimes pain, but always meaning. Undoubtedly, potential violence harms "third parties," but also harms the psychiatrist's patient and the community in which the patient lives.

Considering such exceptional breaches of confidentiality in psychiatry within the larger context of similar breaches in psychiatry and medicine is instructive: we accept exceptional breaches of patient's rights to confidentiality in other matters, such as threats of suicide, child or elder abuse, domestic violence, mandatory reporting of communicable diseases such as AIDS, and when mental capacity is put at issue during litigation. A *Tarasoff*-like case is fully in line with these exceptional cases.

International Perspectives on *Tarasoff*

Although the major legal influence on issues relating to a duty to warn or protect has arisen from the *Tarasoff* decision in the United States, countries outside the United States have taken different perspectives on, and steps towards, implementing this duty. The duty to warn or protect has international legitimacy, especially in Europe, and the argument can readily be made that a necessary connection exists between international human rights law and private mental disability law. Internationally much less concern exists that a necessary breach of confidentiality would cause irreparable harm to the psychiatrist-patient relationship, an intuition supported by recent evidence even within the United States. Rather, European court systems have more integrated approaches to “public” and “private” legal matters and, under the influence of the European Convention on Human Rights, are more concerned with public agency liability.

Examples are available from other nations as well. In Hong Kong, for instance, questions of confidentiality are qualified in terms of patient interest and therapist duty towards such statements, and in India a cost-benefit social analysis is employed when determining whether such a privilege should obtain.¹⁰ Recent legal rulings in the United Kingdom suggest similar approaches to a duty to warn. By way of example, in one case, the Court of Appeal found that confidential information may be disclosed when risks to the public exist.¹⁰

Case 10:

H is a 21 year old male with a longstanding history of depressed mood, chronic suicidal ideations (without history of suicide attempts or hospitalizations), isolative behavior, psychotic symptoms (paranoid ideations, ideas of reference, auditory hallucinations, thought broadcasting), substantial polysubstance abuse (alcohol, LSD, marijuana), social anxiety, and increased depressed mood for two months since the break-up with his girlfriend of eight months whom he thought he would marry. Two weeks ago he used razors to carve into his right and left shoulders Norse mythological symbols with

deep personal meaning, but required no hospitalization. He presented to the hospital after another episode of cutting while under duress, but this time resulting in a deep 15cm self-injury to his left arm (in the shape of a Norse symbol) during an alcohol intoxication in which he saw a picture of his then ex-girlfriend online.

During his hospitalization, H shares his poetry with staff, which contains many violent themes. Included is a desire to rape an unidentified woman (“a plain straightforward date rape”), comments on his arm wound resembling a bleeding vagina (“where once was none/ but now a vaginal cleft”), subtle implications that this vagina may be that of his ex-girlfriend (“As she bleeds out/ I detest the mortal bond between/ death comes swiftly to bend the knee”), and a glorification of pain and suffering with joyous revenge in the bleeding rape of this woman (“caring not for her pain but only for mine/ united so we are/ the suffering is divine”).

He denies any active or conscious intent, desire or plans to harm her, and remarks that he wrote the poetry with no particular person in mind. With a forensic psychiatric consultation, the patient’s permission is obtained and his girlfriend is notified of the nature of the poetry he wrote, but that he has no active or conscious intent, desire or plans to harm her. The police are not notified.

After approximately four weeks, patient is discharged to partial hospitalization and follow up with private therapist. There are no known incidents of violence since his discharge.

Question: Did the psychiatry team have adequate evidence for considering the patient a danger to his girlfriend and therefore justifying a breach of confidentiality?

YES, his cutting behavior, alienation, anxiety, and bizarre activities combined with his recent history of breakup and present intimations of a desire for violence towards an unidentified woman are concerning enough to warrant an intervention even if this requires breaking patient confidentiality.

NO, we have no right to assume the patient is dangerous in the future just because he shows some signs of violent tendencies now. He is, after all, experiencing a difficult period of his life

and when better may have no residual tendencies for violence. Maintaining his trust and confidentiality now will allow him to remain close to the medical care giving system in the chronic phase of his illness, and thus further prevent any violent manifestations from manifesting.

Discussion

Psychiatrists' capacity for accurate intuitions about future dangerousness is an essential feature of *Tarasoff*-like cases. H's case exemplifies these complexities and suggests approaches to resolve problems of clinical assessment.

The assessment of violence includes an understanding of the type of harm, seriousness of harm, imminence of harm, and likelihood of harm. Risk factors for future violence include a history of violence, impulsiveness, reaction to violence, motivation to maintain self-control, and use of alcohol and drugs, which should be adequately documented.

The *Tarasoff* decisions include "imminent danger to identifiable persons" as a guideline of when a duty to warn obtains. In contrast to the *Tarasoff* case and others like it, no explicit threats are made in the present case, and H denies having thoughts of wanting to harm his girlfriend. Making problematic any clear "identifiable persons" standard, H's violent poetry entails graphic and disturbing imagery about killing an unidentified woman with characteristics similar to his girlfriend but without explicitly naming her. Neither can imminent danger be verified, as H denies any intent, plans or outward signs of anger towards his girlfriend. However, given these circumstances, his girlfriend can be considered naturally and foreseeable in the patient's zone of danger, and therefore warning her was appropriate. Fully accurate predictions of potential violence are not as central to *Tarasoff* as much as a basic threshold notion of duty to warn and public safety.

The professional judgment required in *Tarasoff*-like situations is difficult to attain alone. Seeking consultation from colleagues or forensic psychiatry specialists can only help provide clarity,

and was the best choice in Mr H's case. It is helpful to avoid categorical one-dimensional reasoning (for example, as Mr H's case demonstrates, making the utterance of the name of the potential victim an exclusive criterion for intervention) and approach the decision as a comprehensive multidimensional assessment of patient risk and public vulnerability.

The psychiatrist must understand the risk profile of the potentially dangerous patient and identify individual risk factors for dangerousness, such as capacity for communication under duress, which was diminished in Mr H. Similarly, it is critical to identify social risk factors for a potential victim, such as the capacity for avoidance of the patient upon release. Mr H's ex-girlfriend was conceivably able to avoid him, but they maintained online access to each other and shared mutual friends.

In the end, any potential intervention to warn or protect must be done on a case-by-case basis, and with an appreciation of the contingencies of each involved relationship. Situations of high risk for violence should have a low threshold for intervention, and vice-versa.

Case 11:

A, a 20-year-old single man, was admitted to the hospital 18 months after stabbing a stranger in the neck. He had attempted assaults on his mother and on numerous hospital staff members, demonstrating a range of behaviours consistent with the DSM-IV diagnoses of alcoholism and antisocial personality disorder. He often heard the voice of his deceased father saying, "Kill, kill!" and "Die, die!" Specifically, the voice commanded him to kill his mother. He refused to allow his family to be contacted or involved in his treatment, but he asked for help with the voices. He had no other sign of psychosis, and antipsychotic medication brought him little detectable relief.

With the command hallucinations, staff became concerned about a possible duty to third parties. The staff concluded that, in an "open ward" setting, a duty to warn did exist; transfer to a closed unit was rejected as too regressive. Staff proposed a draft of a letter that would inform A's mother of the danger to her while also serving to document

the staff response to her son's threats. It was decided to involve the patient maximally in the process. Mr A's therapist went over the letter and the attendant rationale with him. The letter stated that the patient "feared he might harm (his mother)." A agreed with the content of the letter and insisted on talking to his mother before staff mailed the letter, fearing the letter would cause his mother to wish never to speak to him again. His mother first responded to the letter by saying that he should be "locked up with the key thrown away." During the ensuing conversation, however, she stated openly, "I love you"; A responded, "I love you, too," and both began to cry.

Thereafter, A abided by a temporary agreement with the therapist not to see his mother outside the treatment setting; but he continued telephoning her and the family every day. Although his mother volunteered information to the staff by telephone, she otherwise refused to participate actively in her son's treatment. No civil commitment or further intervention was necessary for A.

Question: Should the psychiatrist team have involved the patient in the process of breaking confidentiality?

YES, an open process is the best way to maintain the trust of the patient in the long term and strengthen the therapeutic alliance.

NO, the patient's involvement can jeopardize the objectivity of an intervention directed at outside parties.

Discussion: Ethical Principles and Clinical Pragmatism

A's case demonstrates how, in clinical practice, many of the seeming conflicts of multiple duties of the psychiatrist can be reconciled, or at least mitigated.

First, it is essential to maintain the therapeutic alliance whenever possible. It is helpful to approach a breach of confidentiality in a manner similar to informed consent to treatment: maintain an open process of information gathering and sharing and avoid deception. This is not a simple process, and some creativity can go a long way. Trust and confidentiality can be maximally maintained by reviewing the breach *with* the patient. In A's case, a letter was the chosen as this vehicle of communication.

Here, active involvement of the patient in the process and providing the patient a dedicated period of time to symbolize and represent his threats were effective in reconceptualizing the meaning and source of such feelings, often diffusing them. Involving the patient in communicating warnings helps strengthen the therapeutic alliance by providing the patient with knowledge of the therapist's intent to protect both him and those close to him.

As we have seen in the study referenced in the discussion of the first case (above), breaches of confidentiality in extreme cases have not been found to shatter trust, and will be especially less likely to do so when we involve patients in a shared decision-making process. As with the establishment of the duty of confidentiality, arising from the therapeutic relationship, a necessary breach of confidentiality can be made a mutual process. This can include asking the patient's permission to speak with involved persons or police, even if refusal will necessitate going against the patient's wishes.

Much of the legal and ethical debates about individual privacy vs. public safety can be informed by pragmatic steps to help all involved parties avoid disastrous outcomes. The psychiatrist should identify and diminish as much as possible any exacerbating factors involving managed care and limited resources. Supporting more thorough evaluations, lengthened hospitalizations when necessary, and patient advocacy with third-party reviewers can help avoid premature hospital discharge or termination of care for a potentially dangerous patient, and obviate the need to breach confidentiality.

Within a family systems context, the *Tarasoff* decision may be turned to therapeutic advantage. As much as possible, incorporating involved loved-ones into a treatment plan can be effective in diffusing future threats of violence. Educating patients and families as to foreseeable risks of relapse and the creation of a comprehensive treatment plan to address the risk of relapse are critical components of this approach. On the other hand, knowing family concerns regarding their own safety by a patient who cannot be relied upon as a historian

can lead to a foreseeable unstable and dangerous patient at discharge.

If violent tendencies are feared in a patient, attention to his or her safety and wellbeing during a clinical session or admission may be one avenue to alleviating the source of these tendencies. Similarly, often neglected is securing the patient's safety after discharge, which may itself be a trigger for violence when planning for outpatient follow-up is lacking or insufficient. Any long-term or non-myopic management of *Tarasoff*-like decisions must include the patient among the potential victims of his or her own hand.

1. Note: this case study is based on the case of *Clunis v UK* [2001] Mental Health Law Reports 162.
2. The Homicide Act of 1957 provides that as a matter of English law, a killer cannot be convicted of murder but shall instead be convicted of manslaughter if he or she proves that "he was suffering from such abnormality of mind (whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury) as substantially impaired his mental responsibility for his acts and omissions in doing or being a party to the killing".
3. The specific human right in question was that under Article 6 of the European Convention on Human Rights, which provides that "(1) In the determination of his civil rights and obligations ..., everyone is entitled to a fair ... hearing ...".
4. The specific right invoked here was that under Article 8 of the European Convention. It is in two parts, the first setting out a right and the second setting out permissible restrictions on that right. The right is "(1) Everyone has the right to respect for his private and family life, ..." The permissible restrictions, which did not arise on the facts, are such as are proportionate to serve other legitimate interests.
5. This is based on the case of *Dunn v South Tyneside Health Care NHS Trust* [2004] Mental Health Law Reports 74
6. This is based on *Palmer v Tees Health Authority* [1999] Mental Health Law Reports 106.
7. See also, Chapter III, ... (discussing "duty to protect" cases).
8. This is based on the case of *R (B) v Ashworth Health Authority* [2005] Mental Health Law Reports 47
9. This case is *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976).
10. *W v Egdell* (1990) 1 All ER 855
11. See *Li Suk Han Hana v. Sun Tien Lun Catherine*, [2005] H.K.C. 758; *Sharda v. Dharmpal*, 2 LRI 173 (Ind. Sup. Ct. 2003).

Chapter IV. The criminal trial process

A. Incompetency to stand trial

1. Evaluations

Case.

ES was indicted for murder stemming from his participation in the armed robbery of a grocery store during which a cashier was fatally shot by S's accomplice.¹ The trial court then ordered the state to arrange a psychiatric evaluation to determine S's competency to stand trial, even though defense counsel had raised neither S's competency to stand trial nor his sanity at the time of the offense as an issue. Dr. Grigson² examined the defendant, concluded that he was competent, and, in his letter to the court, added that it was also his opinion that the defendant "knew right from wrong." Inexplicably, defense counsel was never notified that this examination was to take place.

After the jury convicted S of murder, the State called Dr. Grigson to testify at the penalty hearing. Following a *voir dire* hearing, he testified:

(a) that S. "is a very severe sociopath"; (b) that "he will continue his previous behavior"; (c) that his sociopathic condition will "only get worse"; (d) that he has no "regard for another human being's property or for their life, regardless of who it may be"; (e) that "[t]here is no treatment, no medicine that in any way at all modifies or changes this behavior"; (f) that he is "going to go ahead and commit other similar or same criminal acts if given the opportunity to do so"; and (g) that he "has no remorse or sorrow for what he has done."

The jury sentenced S. to death.

S eventually petitioned for habeas corpus in federal district court. That court vacated his death sentence, finding that it was constitutional error to admit Dr. Grigson's testimony at the penalty phase. The Fifth Circuit affirmed, holding that the "devastating" consequences of the "surprise" use of Dr. Grigson as a penalty phase witness denied S. due process.

Question: Was the psychiatric testimony as to future dangerousness unethical?

Yes. It forced the defendant to be a witness against himself without offering him constitutionally-required legal protection.

No. Once competency to stand trial was raised, the examining psychiatrist was free to question the defendant on all possible relevant matters.

What the Supreme Court said:

The U.S. Supreme Court granted *certiorari* and affirmed. Writing for the majority, the Chief Justice turned first to the Fifth Amendment question of whether Dr. Grigson's testimony violated S's privilege against self-incrimination, and rejected the state's contention of inapplicability on the theory that Dr. Grigson's testimony went to punishment, not to guilt. The Fifth Amendment, the Court found, extended to "any criminal case," and forbade the state from producing evidence "to convict and punish" an individual "by the simple, cruel expedient of forcing it from his own lips."

Because the privilege's availability turns on "the exposure it invites," just as it prevents a defendant from being made "the deluded instrument of his own conviction," so does it protect him "from being made the 'deluded instrument' of his own execution." There was thus "no basis to distinguish" between the guilt and penalty phases of a capital trial for Fifth Amendment privilege purposes," given the "gravity of the decision to be made at the penalty phase."

The Court ruled further that, when Dr. Grigson went beyond "simply reporting to the court on the issue of competency" and instead testified for the prosecution, "his role changed and became essentially like that of an agent of the State recounting unwarned statements made in a post-arrest custodial setting," thus violating the defendant's Fifth Amendment rights. Stressed the Court: "A criminal defendant, who neither initiates a psychiatric evaluation nor attempts to introduce any psychiatric evidence, may not be compelled to respond to a psychiatrist if

his statements can be used against him at a capital sentencing proceeding.”

If there has ever been a US Supreme Court case that reflected the underlying ethical standards, it is this one. *Declaration of Madrid Standard # 5* reads, “When psychiatrists are requested to assess a person, it is their duty to inform the person being assessed about the purpose of the intervention.” Dr. Grigson clearly (and, by any interpretation of the evidence, *intentionally*) violated this standard.

2. Restoration to competency

Case.

K.D. was charged with sexual exploitation of children, was found incompetent to stand trial, and was then committed to a forensic psychiatric hospital for a determination of the probability of his being restored to competence.³ While hospitalized, he was enrolled in the facility's "Competency Restoration Group," and a staff psychiatrist and psychologist certified that he had subsequently been restored to competence. At a subsequent hearing, the defendant's expert testified that defendant – who was moderately mentally retarded – was not competent, and stated, with regard to the program in which the defendant was "enrolled" while hospitalized: It is unlikely that this state of defect will be ameliorated via intervention strategies or treatment attempts. At best, intervention procedures may effect a rote repetition of conditioned verbalizations regarding the above requirements to reach competence, but these conditioned verbalizations will be hollow and without cognitive understanding or appreciation of content.

Question: Is the use of such restoration processes consistent with sound clinical practice?

Yes. The role of the mental health professional is to aid in restoration, and nothing that was done violates the law or ethical standards.

No. Such procedures avoid the important ethical issue of informed consent.

What the court said:

The court found that, while the defendant appeared to have a factual understanding of the proceedings, there was no reliable evidence that he could (1) consult with the lawyer with a reasonable degree of rational understanding; (2) otherwise assist in the defense, or (3) have a rational understanding of the criminal proceedings. It thus found him incompetent to stand trial. In the course of its opinion it made this finding:

Dr. Berger testified that to the best of his knowledge,

competency restoration programs are well-accepted in the medical and psychological community. However, he did not provide, and the government did not offer, any articles or peer review or other professional writing supporting the effectiveness of the practice. When questioned regarding whether Ms. Perry [the forensic psychologist] based her protocol on any accepted study or clinical approach, Dr. Berger testified that he didn't know.

In thinking about "competency restoration classes" in general, Dr. Debra Pinels, a prominent forensic psychiatrist, has said this:

The competence restoration literature has not addressed the informed consent process for participation in programming, the management of situations where defendants might raise incriminating information during an educational group, or the ramifications of refusal of a defendant to participate in restoration programming. These details could provide useful information for clinicians involved in restoration programming and for attorneys whose clients may be participants in these programs. Further review and discussion of these nuances would contribute to our understanding of the restoration process.

Certainly, the need to obtain informed consent is an essential predicate in all of the various standards that govern the behavior of forensic mental health professionals (see e.g., *Declaration of Madrid*, statement on "Ethics of Psychotherapy"; AAPL Guidelines, Standard 3 ("Consent is one of the core values of the ethical practice of medicine and psychiatry"); Specialty Guidelines, Forensic Psychology, Standard IV E 1). The fact that classes such as the one before the court in the Mr. D. case are conducted regularly, and without much apparent concern about the dilemma posed by Ronald Schouten, a lawyer-psychiatrist – that "superficial achievement rather than the defendants' acquisition of the complex skills needed to assist in their own defense" is the metric by which success in such classes is measured – raises yet another level of ethical concern about what transpires.

3. The right to refuse medication

Version 1:

One of the most persistent and contentious dilemmas in this area of law, psychiatry and public policy is the question of whether a defendant who is currently incompetent to stand trial can be medicated solely so as to make him competent to stand trial. Although this question was given some *legal* closure by the United States Supreme Court in *Sell v. United States*, that decision did not consider closely the underlying ethical arguments.⁴

C.S., formerly a practicing dentist, was charged with several counts of mail fraud, Medicaid fraud, and money laundering in connection with submitting fictitious insurance claims to the federal government for payment. He was found incompetent to stand trial and ordered hospitalized for up to four months to determine whether there was "substantial probability" that he would attain competency. Two months into the hospitalization, hospital staff recommended that S. take antipsychotic medication, and S. refused.

A magistrate found that S. was a danger to himself and others at the hospital, and that "the government has shown in as strong a manner as possible, that anti-psychotic medications are the only way to render the defendant not dangerous and competent to stand trial." The district court affirmed the magistrate's order, holding that the medication represented the "only viable hope of rendering defendant competent to stand trial" and appeared "necessary to serve the government's compelling interest in obtaining an adjudication of defendant's guilt or innocence of numerous and serious charges." The Eighth Circuit affirmed, and the Supreme Court granted the defendant's petition for *certiorari*.

The Supreme Court vacated the Eighth Circuit's decision and remanded the case for further proceedings. The Court recognized that S. had a liberty interest in avoiding the involuntary administration of antipsychotic drugs, and this interest was protected by the Fifth Amendment's due process

clause against all but “essential” or “overriding” state interests. The Court held:

[Our earlier] cases indicate that the Constitution permits the Government involuntarily to administer antipsychotic drugs to a mentally ill defendant facing serious criminal charges in order to render that defendant competent to stand trial, but only if the treatment is medically appropriate, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.

The Court considered these factors separately. First – using italics to stress the key words – it noted: a court “must find that *important* governmental interests are at stake”; bringing an individual to trial who is accused of a “serious crime” is “important”. Second, it added, the court must conclude that “involuntary medication will *significantly further* those concomitant state interests,” and must find that administration of the drugs is “substantially likely” to render the defendant competent to stand trial. At the same time, the Court warned, the trial court must find that administration of the drugs is “substantially unlikely to have side effects that will interfere significantly with the defendant’s ability to assist counsel in conducting a trial defense, thereby rendering the trial unfair.”

Third, the trial court must conclude that involuntary medication is “*necessary* to further those interests” and that “any alternative, less intrusive treatments are unlikely to achieve substantially the same results.” Finally, the trial court must conclude that “administration of the drugs is *medically appropriate, i.e.,* in the patient’s best medical interest in light of his medical condition.”

The Court emphasized that the governmental interest under this standard is the interest in rendering the defendant competent to stand trial:

A court need not consider whether to allow forced medication for that kind of purpose, if forced medication

is warranted for a *different* purpose, [e.g.], related to the individual's dangerousness, or purposes related to the individual's own interests where refusal to take drugs puts his health gravely at risk. There are often strong reasons for a court to determine whether forced administration of drugs can be justified on these alternative grounds *before* turning to the trial competence question.

Interestingly, the underlying ethical questions were *not* considered by the Supreme Court in *S*. They were, however, discussed in one of the forerunner cases – *United States v. Weston*,⁵ the so-called “Capitol Hill shooter” (Weston was charged with the murder of two Capitol Hill policemen).

There, the defendant's first argument posited that a doctor cannot ethically treat a defendant solely to make him competent to stand trial, since such action would make the psychiatrist an agent of the government rather than the patient. The Court rejected this argument, finding that it was “unaware of any legal authority to support this theory.” In supporting its position, the defense had relied on the testimony of Professor M. Gregg Bloche, who had relied on the United Nations Principles of Medical Ethics Relevant to the Role of Health Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (“the 1982 U.N. Principles”)⁶ and the Hippocratic Oath in support of his position. Professor Bloche had asserted that these ethical norms govern a psychiatrist's participation in the medication of a pretrial detainee.

The Court rejected this testimony, concluding it was “not persuaded” that the 1982 U.N. Principles, as interpreted by Professor Bloche, mandated a finding that it would be unethical for a psychiatrist to medicate a pretrial detainee involuntarily to restore competency. The 1982 U.N. Principles state that “[i]t is a contravention of medical ethics for health personnel, particularly psychiatrists, to be involved in any professional relationships with prisoners or detainees the purpose of which is not solely to evaluate, protect, or improve their physical and

mental health.” Noted the Court:

Those principles were available to the U.S. medical community when it established its ethical guidelines, which neither sanction nor prohibit involuntary medication for a pretrial detainee. The more recent guidelines and debates among the American Medical Association and other U.S. medical ethical societies have not embraced the argument advanced by the defense. The Court will not create medical ethical prohibitions where the medical community has not imposed such prohibitions. Similarly, the Court does not credit Professor Bloche’s interpretation of the Hippocratic Oath, which states, in part, that “into each house I come I will enter only for the good of my patients,” over that of numerous licensed medical psychiatrists who testified that medical ethics do not preclude medicating Weston.

Thus, while the Court concluded that an individual psychiatrist might object to involuntarily treating Weston with medication due to the psychiatrist’s own sense of ethics, no established ethical barrier to such treatment existed. On the other hand, it was persuaded by the opinions of Dr. Howard Zonana and Dr. Debra DePrato, both of whom at the time held positions on medical ethics panels, “that medical ethics does not preclude medicating a patient in Weston’s situation,” and concluded that “The controlling medical ethics authorities in this area, codified by the American Medical Association and its Council on Ethical and Judicial Affairs, do not bar treatment of a patient such as Weston.”

What is most interesting is that neither the *Declaration of Madrid* nor the AAPL Guidelines mention “drugs” or “medication” in any remotely-related context. This issue – and the related issue of whether a defendant can be medicated to make him competent to be executed – are among the most (if not *the* most) contentious ethical issues being “played out” before courts at the present time. Also, the 1982 UN Principles have not been cited in another US court decision in the six years since *Weston* was decided (and they were not discussed in *Sell*). This

suggests that the underlying ethical issues are *not* at the epicenter of the relevant legal debate.

Version 2:

[The facts are the same as in Version 1, above]

Question: Should the psychiatrist order the forcible administration of the antipsychotic medication?

Yes, because Dr. S should be restored to competency before the end of the court-ordered hospitalization so that he can stand trial.

Yes, if Dr. S is a danger to himself or to others.

No, because Dr. S should have an absolute right to refuse such medications.

Comments:

It is not within the realm of the psychiatrist's role to make treatment decisions – particularly regarding treatment which must be forcibly implemented – on the basis of anything but clinical considerations in the interest of his or her patient. Restoration to competency to stand trial is a legal issue, and any involuntary hospitalization and/or treatment to achieve this end must be ordered by the appropriate court under applicable law. The psychiatrist has both a legal and an ethical obligation to seek legal counsel regarding any forcible administration of medication.

Incompetency to stand trial limits the patient's actions and decision-making in the courtroom, but it does not indicate plenary incompetence. Competence should be presumed – and decision-making in other areas considered unimpaired – unless appropriately evaluated. Unless specific findings indicate that the patient is incompetent to make treatment decisions for him/herself, the patient retains the right to refuse treatment. *When the patient is incapacitated and/or unable to exercise proper judgment because of a mental disorder, or*

*gravely disabled or incompetent, the psychiatrists should consult with the family and, if appropriate, seek legal counsel to safeguard the human dignity and the legal rights of the patient.*⁷

However, despite the importance of personal autonomy and informed consent in a patient's decision-making, the right to refuse treatment (including medication) is not absolute. Both the expressed interest and the best interest of the patient – as well as the safety of others – must be considered. *No treatment should be provided against the patient's will, unless withholding treatment would endanger the life of the patient and/or those who surround him or her.*⁸

B. The insanity defense

1. The scope of expert testimony

Case. Inappropriate testimonial language

D.D. was convicted of first degree murder, notwithstanding his plea of not guilty by reason of insanity (based on mental illness and on mental retardation).⁹ At his trial, an expert witness defined psychosis as “a gross distortion of reality, when someone’s just out in left field,” apparently telling the jury that this definition came from “a manual of the American Psychiatric Association.” The witness also explained that defendants’ legal insanity could be determined by answering the question: “ were they so retarded that did they pick up a gun and think it was bananas”.

Question: Is it unethical for an expert to use lay terms not found in controlling statutes to define the defendant’s mental state?

Answer: Yes. Such terms distort the legal process and do not reflect fairness on the part of the expert.

No: The use of lay terminology simplifies complicated matters for the jurors.

What the court said:

In the course of its opinion reversing the defendant’s conviction and remanding for a new trial, the court stated:

The prosecution expert’s testimony was inadmissible since it impermissibly defined the meaning of legal terms the definition of which is the proper function of the court, [and] the definitions used by the expert were incorrect and excessively narrow. We further find that the testimony of the expert was excessively colloquial and imprecise. A colloquial expression such as “bananas” can signify a different degree of anti-social conduct to each juror and serves no purpose other than to create confusion. So too the expression used by the expert, “just out in left field”, as an alternative definition of psychosis, was a definition

certainly not found in the statute. Expert witnesses should testify expertly and should be required to define their terms by using words which do not cause the jurors to allow their individual imaginations to run free. We can no more allow such speculation based upon a prosecution expert's testimony than we could allow a defense expert to testify that a defendant is legally insane because he went "bananas" and was "out in left field". Counsel and the court have a responsibility to make certain that the language used by experts is professional, clear, and within the parameters of the standards set by the law.

To what extent do the various ethical standards speak to this issue? Nothing in the *Declaration of Madrid* speaks to this directly. The AAPL Guidelines require that forensic psychiatrists "adhere to the principle of honesty and [that] they strive for objectivity" (Guideline IV). Again, the forensic psychology guidelines are more detailed, and elaborate carefully on behavior that involves "public and professional communications." Here, forensic psychologists are admonished, when testifying, "to present their findings, conclusions, evidence or other professional products in a fair manner" (Standard VII, D), and to be able to "explain the relationship between their expert testimony and the legal issues and facts of an instant case" (Standard VII, F). It is clear that the witness here did neither.

Case. Potential coerciveness of state-appointed psychiatrist

After B.B. was arrested and charged with murder, he was transferred from the District of Columbia jail to St. Elizabeth's Hospital for examination both as to competency to stand trial and insanity at the time of the crime.¹⁰ After a report was submitted, stating that he "probably lacked substantial capacity to appreciate the wrongfulness of his conduct, [and] to conform his conduct to the requirements of the law," a government motion to transfer Mr. B. to a federal hospital in Missouri was granted. After a six-week observational period, that facility's doctors concluded that he was not insane under the then appropriate test in the District of Columbia.

On rebuttal, Dr. Kunev – a doctor from the Missouri facility – testified that, during an interview, Mr. B. had told him that his *wife* had suggested that perhaps he committed the crime in question because he was “under the influence of some magic, spells, or some influence of roots.” While the prosecution had not apprised defense counsel of this testimony prior to trial, the majority concluded that “there was every reason to believe ... that it came as a surprise to the prosecution.” Dr. Kunev had not recorded the substance of this particular exchange in his contemporaneous notes of the interview, and had destroyed all of his notes when he dictated his report (which made no mention of this conversation) to the court.

There was no question that this testimony was “very devastating,” and it was characterized by the prosecutor as the “critical thing” in the government’s case.

Question: Whether it is unethical for an expert witness to destroy the notes of an interview with a defendant asserting insanity?

Answer:

Yes. Such actions lessen the likelihood that the trial will be fair and reliable.

No: Once the defendant raised the issue of insanity, any testimony by psychiatrists retained by the government may be used to rebut the defendant’s assertions.

What the court said:

On appeal, a sharply split *en banc* United States Court of Appeals for the District of Columbia Circuit held that, “when a defendant raises the defense of insanity, he may constitutionally be subjected to compulsory examination by court-appointed or government psychiatrists without the necessity of recording; and when he introduces into evidence psychiatric evidence to support his insanity defense, testimony of those examining psychiatrists may be received (on that issue) as well.”

Writing for himself and three colleagues, Senior Circuit Judge Bazelon dissented, charging that, given the “grave potential

for abuse that inheres in the court-ordered psychiatric examination," and the court's obligation to "assure that compelled psychiatric examinations are administered fairly and that the results are reliable and susceptible to scrutiny," without a "full and objective record of every court-ordered insanity examination," he would rule that the defendant's examination and the subsequent admission of the examining psychiatrist's testimony "were in clear violation of [the defendant's] Fifth Amendment privilege against self-incrimination and his Sixth Amendment right to effective assistance of counsel." The privilege, he reasoned, "applies in a criminal trial on the issue of sanity, whether such a trial is conceived of as a determination of guilt or of sanction."

In great detail, Judge Bazelon argued that the court-ordered psychiatric evaluation posed a "grave threat" to each of the articulated values enunciated by the Supreme Court in its Fifth Amendment jurisprudence: defendant's privacy rights, society's fear of "inhumane treatment and abuses," the posing of a "cruel trauma" of "self-accusation, contempt or perjury," a distrust of "self-deprecatory statements," and the need to safeguard a fair state-individual balance. Similarly, he suggested that such examinations violated the Sixth Amendment right to counsel at a "critical stage" of the proceedings, since the evaluation was a "(1) pretrial 'confrontation' with the government (2) occurring at or after the start of 'adversary judicial proceedings,' (3) for which the assistance of counsel is necessary to prevent 'potential prejudice to the defendant's rights.'" Stressed Bazelon:

The government psychiatrist is armed with the same technical expertise as the private psychiatrist. He is trained to gain the confidence of a patient. As a medical doctor, the psychiatrist is conceived of as a healer, a participant in a voluntary therapeutic alliance directed to the patient's benefit. Unlike the policeman, whose goals and methods engender wariness in the defendant, the government psychiatrist in the state hospital engenders trust. But this trust is unwarranted. The psychiatrist's aim is

diagnosis, not therapy. His primary commitment is to his institution, not to his patient. Given these concerns, I must conclude that the court-ordered psychiatrist examination poses a threat of coercion similar to that in the interrogation deemed unconstitutional in *Miranda*.

Question: Is there anything in the ethical standards that govern psychiatry (or forensic psychiatry) that supports Judge Bazelon's dissent in this case?

The *Declaration of Madrid* clearly states, "When psychiatrists are requested to assess a person, it is their duty first to inform and advise the person being assessed about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment. This is particularly important when the psychiatrists are involved in third party situations." (Standard # 5). The question is thus posed: Did the government's actions here violate this standard?

Although a majority of the District of Columbia Court of Appeals (including, not insignificantly, current US Supreme Court Justice Antonin Scalia) rejected the defendant's legal arguments, it seems clear that Mr. B. was *not* so informed as to the "possible repercussions of the assessment." Looking at the more elaborate ethical standards of the American Academy of Psychiatry and Law, it appears that the actions here were equally violative. Under that formulation:

Special attention is paid to any limitations on the usual precepts of medical confidentiality. An evaluation for forensic purposes begins with notice to the evaluatee of any limitations on confidentiality. Information or reports derived from the forensic evaluation are subject to the rules of confidentiality as apply to the evaluation, and any disclosure is restricted accordingly.¹¹

Interestingly, one commentator has noted that the American Psychological Association and the American Psychiatric Association differed in their approach to this issue. Kathy Faulkner Yates, a prominent forensic psychologist, noted that both

organizations submitted *amicus curiae* briefs to the court in Mr. B. regarding informed consent, confidentiality, and possibilities for self-incrimination, but that "the briefs were quite different for these two organizations":

[T]he American Psychological Association argued that evidence obtained in the clinical interview *could* be used to establish appreciation of wrongfulness of the act or control of conduct. Thus, an opinion on criminal responsibility did incriminate the accused. In their brief, provision of additional safeguards were recommended regarding the role of the "government expert," both with respect to access to the patient and to nature of testimony. Conversely, the American Psychiatric Association held that there was no Constitutional need for the presence of counsel or for the provision of other safeguards because the principles of medical ethics dictated that the psychiatrist would carefully explain the limits of confidentiality to the defendant. If the limits of confidentiality were explained, procedural safeguards advocated by the American Psychological Association were unnecessary.

Yates speculated as to the possible reasons for the differences in these positions (perhaps a function of training differences "in how they conceptualize the fine line between an evaluative and therapeutic relationship, politics, or 'turf war'"). But she noted – persuasively, it seems to us – that "a defendant who is psychotic may be too compromised in terms of decision-making capacity to understand or appreciate the subtleties of confidentiality distinctions exemplified in *Byers*," and that "the potential for an antitherapeutic outcome for the mentally disabled defendant in this type of situation is clear."

2. Commitments following an insanity acquittal

At a homicide trial, H.F. was found not guilty by reason of insanity.¹² After he had been institutionalized for five years, six psychiatrists testified that he exhibited no abnormal or psychotic symptoms and had received no psychotropic medication of any kind. He had been a model patient, demonstrating good demeanor and grooming, and normal responsible actions and reactions. However, the judge concluded that the patient's model conduct demonstrated his mental illness and dangerousness, since it followed his faking sanity. A court-appointed psychiatrist declined to certify that Mr. F. would not be dangerous to himself or others. Later, he conceded that he had "hedged" in his testimony because he "did not want to be criticized should Mr. F. be released and then commit a criminal act." The judge ordered the commitment continued; subsequently, a habeas corpus petition was filed, and the patient was ordered released, over the state's opposition.

Question: Is it unethical for a mental health professional to testify with the explicitly purpose of seeking to avoid potential future criticism, depending on the court's decision in the case?

Yes. Such testimony violates all relevant ethical guidelines.

No. Such testimony is within the bounds of fair play, and may be cross-examined rigorously by the defendant's lawyer.

The question raised here is one that is rarely discussed, yet has enormous potential significance. First, consider Guideline VII F of the Specialty Guidelines for Forensic Psychologists:

Forensic psychologists are aware that their essential role as expert to the court is to assist the trier of fact to understand the evidence or to determine a fact in issue. In offering expert evidence, they are aware that their own professional observations, inferences and conclusions must be distinguished from legal facts, opinions and conclusions. Forensic psychologists are prepared to explain the relationship between their expert testimony and the legal issues and facts of an instant case.

Can there be any question that the court-appointed expert violated this Guideline?

The *Declaration of Madrid*, in its initial standard, states that "Psychiatry is a medical discipline concerned with: the provision of the best treatment for mental disorders, the rehabilitation of individuals suffering from mental illness and the promotion of mental health." (Standard #1). The testimony of the witness – designed solely to avoid personal criticism and not to promote the individual's mental health – violates this Standard as well.

Finally, Standard # 4 of the AAPL Guidelines posits, with regard to forensic psychiatrists:

Their clinical evaluation and the application of the data obtained to the legal criteria are performed in the spirit of such honesty and efforts to obtain objectivity. Their opinion reflects this honesty and efforts to attain objectivity.

Again, there can be no question that this witness failed – miserably – to adhere to this standard.

C. At trial

1. Issues of mitigation

Case.

C. McL. was charged with murder.¹³ As part of his report to the Court, the defense psychiatrist expressed concern about possible physical damage to the defendant's brain in "the areas ... involved in the primary control of and/or modulation of emotions," that might have been caused either by a childhood bullet wound, or by other "traumatic, chemical [or] vascular" means. Commenting on the lack of specificity in his report, the psychiatrist wrote, "I am sorry that I cannot be more specific, but my lack of present detailed knowledge concerning specific brain structures and the specific relationship to both emotions and behavior limits my ability to further specify."

Question: Is it a breach of professional ethics if an expert does not keep abreast of all scientific developments in areas related to the ones about which he is testifying?

Yes. When a mental health professional holds himself out to be an expert in court, he must be an expert on all matters relevant to the subject of his testimony.

No. The expert may limit his testimony to those aspects of forensic mental health about which he self-characterizes himself as an expert.

What the court said:

The trial court found the expert's actions to be a breach of professional behavior. "When [the psychiatrist] realized shortly after being appointed that issues relating to brain damage were likely to be relevant in this case, given his admitted lack of specific knowledge about the relationship of various brain structures to emotions and behavior he had an affirmative obligation to inform this Court and defense counsel of these limitations in his ability to provide the expert services needed in

this case. By continuing to proceed in this case, [he] accepted the responsibility to provide professional services that he knew or should have known he was not competent to perform, in violation [of state law]. In doing so, he seriously breached his obligations to defendant, to the Court and to the medical and psychiatric professions."

The state regulation referred to in the opinion defined unprofessional conduct by a physician as including, "accepting and performing professional responsibilities which the licensee knows or has reason to know that he or she is not competent to perform[.]" The court stressed that "the fact that the professional responsibilities involved in this case involve performance of a forensic psychiatric evaluation and rendering a psychiatric opinion for forensic rather than treatment purposes does not alter the applicability of this rule."

The question that is posed here is clear. Was the psychiatrist's behavior in contravention of Standard 2 of the *Declaration of Madrid*, that states: "It is the duty of psychiatrists to keep abreast of scientific developments of the specialty and to convey updated knowledge to others." Was the expert's "lack of present detailed knowledge concerning specific brain structures and the specific relationship to both emotions and behavior" a violation of this standard (as the trial judge concluded), or rather, was it consistent with the duty (expressed in the preface to the *Declaration*) that the psychiatrist "keep in mind the boundaries of the psychiatrist-patient relationship, and be guided primarily by the respect for patients and concern for their welfare and integrity"? If the specific issue was beyond the psychiatrist's self-described expertise, was his refusal to venture an expert opinion appropriate within this statement, or did it, as the trial judge found, violate a state administrative code? Strangely, this case (*People v. McLane*) has never been commented upon in the U.S. law review literature.

D. The death penalty

1. Testimony as to future dangerousness

Case.

After T.B. was convicted of murdering a police officer, two psychiatrists testified in response to hypothetical questions; neither had ever interviewed the defendant.¹⁴ They testified at the “penalty phase” of the proceedings – in accordance with state law – that the defendant “would probably commit further acts of violence and [thus] represent a continuing threat to society.” The jury accepted this testimony and imposed the death penalty (a sentence that was eventually upheld by the United States Supreme Court).

In his appeal to the Supreme Court, the defendant had made these arguments:

First, it is urged that psychiatrists, individually and as a group, are incompetent to predict with an acceptable degree of reliability that a particular criminal will commit other crimes in the future, and so represent a danger to the community. Second, it is said that in any event, psychiatrists should not be permitted to testify about future dangerousness in response to hypothetical questions and without having examined the defendant personally. Third, it is argued that in the particular circumstances in this case the testimony of the psychiatrists was so unreliable that the sentence should be set aside.

Question: Is it a violation of forensic ethics for a witness to testify about future dangerousness, especially in the context of a defendant whom he has never interviewed?

No. Such testimony is subject to vigorous cross-examination, and, also, is admissible on the part of lay witnesses who can offer non-expert opinions on this subject.

Yes. Such testimony is beyond the scope of acceptable expertise; psychiatrists cannot predict long-term dangerousness, especially in cases such as this in which the defendant was

never personally questioned.

What the court said:

The Court first rejected the argument that psychiatrists could not reliably predict future dangerousness in this context, noting that it made “little sense” to exclude *only* psychiatrists from the “entire universe of persons who might have an opinion on this issue,” and that the defendant’s argument would also “call into question those other contexts in which predictions of future behavior are constantly made.” In the course of this argument, the Court rejected the views presented by the American Psychiatric Association as *amicus* that: (1) such testimony was invalid due to “fundamentally low reliability,” and (2) long-term predictions of future dangerousness were essentially lay determinations that should be based on “predictive statistical or actuarial information that is fundamentally nonmedical in nature.” On the hypothetical issue, the Court simply held that expert testimony “is commonly admitted as evidence where it might help the fact finder do its assigned job,” and that the fact that the witnesses had not examined the defendant “went to the weight of their testimony, not to its admissibility.”

Dissenting, Justice Blackmun rejected the Court’s views on the psychiatric issue:

The Court holds that psychiatric testimony about a defendant’s future dangerousness is admissible, despite the fact that such testimony is wrong two times out of three. The Court reaches this result—even in a capital case—because, it is said, the testimony is subject to cross-examination and impeachment. In the present state of psychiatric knowledge, this is too much for me. One may accept this in a routine lawsuit for money damages, but when a person’s life is at stake—no matter how heinous his offense—a requirement of greater reliability should prevail. In a capital case, the specious testimony of a psychiatrist, colored in the eyes of an impressionable untouchability of a medical specialist’s words, equates with death itself.

Relying on the American Psychiatric Association's *amicus* brief, Justice Blackmun made four main points: (1) no "single, reputable source" was cited by the majority to contradict the proposition that psychiatric predictions of long-term violence "are wrong more often than they are right"; (2) laymen can do "at least as well and possibly better" than psychiatrists in predicting violence"; (3) it is "crystal-clear" from the literature that the state's witnesses "had no expertise whatever," and (4) such "baseless" testimony cannot be reconciled with the Constitution's "paramount concern for reliability in capital sentencing." He asserted:

Neither the Court nor the State of Texas has cited a single reputable scientific source contradicting the unanimous conclusion of professionals in this field that psychiatric predictions of long-term future violence are wrong more often than they are right.

Because such purportedly scientific testimony—"unreliable [and] prejudicial" —was imbued with an "'aura of scientific infallibility,'" it was capable of "shroud[ing] the evidence [, leading] the jury to accept it without critical scrutiny," Justice Blackmun charged: "When the court knows full well that psychiatrists' predictions of dangerousness are specious, there can be no excuse for imposing on the defendant, on pain of his life, the heavy burden of convincing a jury of laymen of the fraud."

Question: By any interpretation, is the testimony at the heart of this case consistent with psychiatric ethics?

No. The testimony in this case is violative of a broad array of ethical principles and standards, and, in part, led to Dr. Grigson – the state's key witness – being expelled from both the American Psychiatric Association (APA) and Texas Psychiatric Association. Notwithstanding these expulsions, Texas District Attorneys continued to call Dr. Grigson as an expert witness in numerous subsequent death penalty cases.

The APA censured Dr. Grigson, charging that he violated the

group's ethics code by "arriving at a psychiatric diagnosis without first having examined the individuals in question, and for indicating, while testifying in court as an expert witness, that he could predict with 100 percent certainty that the individuals would engage in future violent acts." Yet, these ethical lapses are not the sum total of Grigson's ethical violations.

By way of example, The Declaration of Madrid states that "It is the duty of psychiatrists to keep abreast of scientific developments of the specialty and to convey updated knowledge to others." On the witness stand, Grigson rejected what was then the state-of-the-art valid and reliable finding that predictions of future dangerousness were inherently unreliable, and testified – incorrectly – that only a small minority of psychiatrists accepted these studies and that these studies did not represent the view of the APA. Clearly, Dr. Grigson's testimony violated this standard.

Three years before the decision in the *Barefoot* case, Dr. Richard Bonnie, one of the pre-eminent legal scholars in this field, set out these ethical principles to guide forensic witnesses:

1. An expert witness should decline to offer any opinion on the dangerousness issue unless he has conducted a comprehensive examination of the defendant, with extensive attention to developmental and behavioral history, directed specifically at the probability of future violence.
2. An expert witness should not express an opinion on a defendant's dangerousness unless he has special training and experience in conducting such evaluations, unless he is fully familiar with the developing clinical literature on this subject, and unless he qualifies his opinions with the observation that clinical predictions of future violence currently lack empirical validation.
3. An expert witness asked to express an opinion on a defendant's dangerousness should do so only if the opinion derives from a generally accepted diagnostic

or psychodynamic framework.

It is clear that Dr. Grigson's testimony violated each of these principles as well.

What is most interesting about this case is the pretextuality of the United States Supreme Court in its acceptance of this testimony, so as to serve the teleological purpose of allowing it to affirm the underlying criminal conviction. One of the editors of this volume wrote the following commentary soon after the case was decided, and nothing that has happened in the intervening two decades-plus suggests that this assessment is in need of any substantial revision:

Barefoot appears to be indefensible on evidentiary grounds, on constitutional grounds and on common sense grounds. It flies in the face of virtually all of the relevant scientific literature. It is inconsistent with the development of evidence law doctrine, and it makes a mockery of earlier Supreme Court decisions cautioning that *extra* reliability is needed in capital cases.

2. The need for additional testing

Case.

H.P.S. was convicted of murder and sentenced to death.¹⁵ As part of his application for a writ of habeas corpus, he alleged that he was entitled to an evidentiary hearing at which he could assert that his two court-appointed psychiatrists failed to conduct competent and appropriate evaluations. A third psychiatrist evaluated him, considered his past medical history (this was not done by the two court-appointed witnesses), and determined that he “suffered from a form of organic brain damage.” Because the original evaluations were “so grossly insufficient” (for ignoring “clear indications” of such brain damage), a new hearing was ordered.

Question: Are such evaluations violative of forensic ethics?

Yes. Such evaluations fail to meet the minimum standards as to competence demanded by specialty standards.

No. The testimony was adequate and within the scope of acceptability.

To what extent does this sort of “gross” error violate ethical standards? Remarkably, the *Declaration of Madrid* does not speak directly to this question (perhaps because it might have appeared to the drafters that it was a “given” that examiners would minimally do what was not done by the two court-appointed psychiatrists in the case of H.P.S.), but it does articulate that “Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles” (Standard #1). This, of course, was not therapy, but an evaluation for court. Does that come within the *Madrid* guidelines?

The Specialty Guidelines for Forensic Psychologists (certainly the most comprehensive U.S.-based document of its kind) includes a lengthy section on “Competence” (of evaluators/examiners), and demand, inter alia:

1. Forensic psychologists provide services only in areas of

psychology in which they have specialized knowledge, skill, experience, and education.

2. Forensic psychologists have an obligation to present to the court, regarding the specific matters to which they will testify, the boundaries of their competence, the factual bases (knowledge, skill, experience, training, and education) for their qualification as an expert, and the relevance of those factual bases to their qualification as an expert on the specific matters at issue.
3. Forensic psychologists are responsible for a fundamental and reasonable level of knowledge and understanding of the legal and professional standards which govern their participation as experts in legal proceedings.

(Standards III A-C).

Although, again, these standards do not speak directly to the behavior in this case, they appear to support potential allegations of an ethical violation. The intersection between examination and court evaluation is not always spelled out in ethical guidelines, and this missing synapse may be critical in a case such as this. There can be little question that what was done here falls below any bar of competent or ethical evaluation practice.

3. The use of medication to make a death row inmate competent to be executed¹⁶

Case.

Dr. Lutz works on death row. One of his prisoners suffers from schizophrenia. Fifteen years ago, the prisoner was convicted of horrific crimes. The prisoner tortured, beat, and killed several families. Even though he had a history of psychosis, he was found legally sane at the time of the acts. Dr. Lutz has been treating the prisoner with an antipsychotic medication but the prisoner's condition has worsened. The prisoner was determined not competent to be executed.

Dr. Lutz was given the task of restoring the competence of the patient to be executed. Dr. Lutz knows that once the patient is restored, he will be shortly thereafter be executed. However, Dr. Lutz feels that his job is to treat the patient and that his role is separate and distinct from the government's interest in executing the patient.

Questions:

- 1. What is the conflict of interest?**
- 2. Can Dr. Lutz balance his desire to treat his patient with his knowledge that, if he is successful, the government will then execute his patient?**
- 3. Is Dr. Lutz's treating the patient authentically fulfilling a treatment role?**

Answers:

1. The U.S. Supreme Court has ruled, on more than one occasion, that execution of persons who are "insane" (or who have mental retardation) may not have retributive or deterrence value, may not serve as an example to others, and may be offensive to humanity.

However, a controversy exists as to whether psychiatrists should be involved in restoring to competency a prisoner who will shortly be executed. Some psychiatrists believe that such restorations are a method of participating in a prisoner's

execution and therefore the doctor is not participating in a treatment role but in the hastening of the patient's death. Other psychiatrists believe that the prisoner has a right to be treated and that such restorations to competency will allow the patient to continue to actively participate in their defense until the time they are executed. Those who oppose participation in this process draw on sources such as the findings of the *Final Report of the Amnesty International Conference for the Abolition of Torture* (Paris, France), Dec. 10-11, 1973, and the 29th World Medical Assembly of the World Medical Association (the so-called Declaration of Tokyo).

Most recently, the Supreme Court ruled that it was unconstitutional to prevent a prisoner from making a showing that his mental illness "obstruct[ed] a *rational understanding* of the State's reason for his execution."¹⁷ This 2007 ruling clarified the underlying issues for lawyers, but did not resolve the dilemma for psychiatrists. It can be expected, however, that this decision will lead to heightened awareness of this issue (and additional subsequent litigation). As a result, it is likely that the ethical implications of this dilemma and the relationship between the medical and legal questions will be scrutinized more carefully, and that this added scrutiny may provide direct guidance for practitioners.

2. Although the Declaration of Tokyo appears to prohibit psychiatric participation in this process, there is no unanimity as to whether such participation is legally permissible. Dr. Lutz must understand that his perception of what his job is may conflict with this Declaration, and, of course, may lead to the ultimate death of his patient.

3. Ethicists and other scholars have carefully separated out the forensic and treating roles of psychiatrists in settings that involve the legal process. Prison doctors — who are only treating their patients because the patients are incarcerated — stand in a unique relationship to those they treat (who, ordinarily, have no freedom of choice with regard to choice of their doctor). Doctors such as Dr. Lutz must acknowledge this as they balance their roles in this sort of case.

1. This case is reported at *Estelle v. Smith*, 451 U.S. 454 (1981).
2. Dr. Grigson was the same witness who testified in the future dangerousness case, discussed *infra*, Chapter 4, at ...
3. This case is reported as *State v. Duhon*, 109 P.3d 1282 (Kan. App. 2005).
4. This case is reported at 539 U.S. 166 (2003).
5. This case is reported at 134 F.Supp.2d 115 (D.D.C. 2001), *aff'd*, 255 F.3d 873 (D.C. Cir. 2001).
6. U.N.G.A. Res., New York, December 18, 1982, U.N. Doc. A/REX/37/94.
7. *Madrid Declaration On Ethical Standards for Psychiatric Practice* (Ethical Standard 4), Approved by the General Assembly of the World Psychiatric Association on August 25, 1996 and amended by the General Assembly in Yokohama, Japan, in August 2002.
8. *Id.*
9. The case is reported as *People v. Doan*, 366 N.W.2d 593 (Mich.App. 1985).
10. The case is reported as *United States v. Byers*, 740 F.2d 1104 (D.C. Cir. 1984).
11. American Academy of Psychiatry & the Law Ethical Guidelines for the Practice of Forensic Psychiatry, Standard II.
12. This case is reported as *Francois v. Henderson*, 850 F.2d 231 (5th Cir. 1988).
13. This case is reported as *People v. McLane*, 631 N.Y.S.2d 976 (N.Y. Sup. 1995).
14. The case is reported as *Barefoot v. Estelle*, 463 U.S. 880 (1983).
15. The case is reported as *State v. Sireci*, 536 So.2d 231 (Fla. 1988).
16. Unlike the other cases in this chapter, this case is a hypothetical, combining aspects of *Ford v. Wainwright*, 477 U.S. 399 (1986), *Panetti v. Quarterman*, 127 S. Ct. 2842 (2007), and unreported cases known to the authors.
17. *Panetti*, 127 S. Ct. at 2860.

Part II. From Informed Consent to Conflicts of Interest to Informed Consent

Chapter 1: Relationships with drug companies, hospitals, supervisors, employees, professional colleagues and patients

Case.

Dr. Carter is a first-year resident who has become interested in going to dinners sponsored by pharmaceutical companies. He enjoys going out to nice restaurants and notices that some of the speakers at these dinners are prominent doctors in his department. The chair of the department is among the featured speakers at one of the pharmaceutical company dinners. The topics of the dinners are both new medications that have come to market and popular medications that are still on patent.

At one of the dinners, Dr. Carter learns about a new medication that has been on the market for two years. The medication is a metabolite of another medication that has gone off patent at the same time the new drug came to market. Both drugs are manufactured by the same pharmaceutical company. Clinicians who have used the new medication have found little difference between the newer medication and the older medication. However, the pharmaceutical company insists that there are significant differences between the two medications based upon the data it has collected. Dr. Carter notices that some of his attending supervisors are prescribing more of the newer medication to inpatients and speak about the advantages of the medication at dinners sponsored by the pharmaceutical company.

He also attended one of the pharmaceutically sponsored grand rounds and was quite impressed by the information and the guest speaker; a nationally recognized expert in the field presented clear data that supported the therapeutic superiority of the new medication. Neither the expert in the field nor his supervisors provided much information about alternative treatments to the new medication. The information that was provided highlighted negative features of the alternative medications. Last week, Dr. Carter read an article in a prestigious journal that showed that several alternative generic treatments were equally effective for similar patient populations.

While doing an outpatient rotation, Dr. Carter noticed that patients who were discharged from the inpatient service were started on the newer medication while in hospital but later found out that their insurance company was not going to cover the newer medication because generic alternatives were available. Dr. Carter had to call the insurance company to attempt to pre-certify use of the newer, more expensive medication. Some of Dr. Carter's patients were furious at the suggestion that they would have to be switched off the newer medication that had helped them in the hospital, either to the generic alternative or to other alternatives on the insurance company's formulary. Dr. Carter knew of a patient assistance program that would pay the entire cost of the medication for some of his patients and part of the cost for other patients. Some of Dr. Carter's patients did not qualify for the patient assistance program.

Few of Dr. Carter's patients were pre-certified by their insurance company to start the newer medication because they had tried several medication alternatives in the past that were not helpful. To Dr. Carter's delight, some of the patients on the new medication continued to get better. Several patients now wanted to work because they were feeling better. Dr. Carter became concerned because these patients would be earning too much money to be eligible for their current insurance coverage or the available patient assistance program. Furthermore, these patients did not want to try a generic alternative that was a fraction of the cost because they did not want to risk feeling worse.

Question: Are there any conflicts of interest in this case? What are some arguments for and against there being a conflict of interest?

YES. Dr. Carter has a duty to treat his patients by considering various treatment alternatives. However, the pharmaceutical industry and Dr. Carter's department chair and supervisors who speak on behalf of the pharmaceutical industry want Dr. Carter to think more about using the patented medication and less about generic alternatives.

YES. The pharmaceutical industry has an interest in having its new patented medication used rather than the medication that has just become generic. On the other hand, the insurance company wants the generic medication and other less costly alternatives to treatment to be employed first.

YES. Dr. Carter wants to learn more about newer medication alternatives to treat patients, and also enjoys free meals at nice restaurants. The residency program wants Dr. Carter to learn about all alternatives to treatment and to consider the influence of pharmaceutical companies as an impediment towards achieving this goal.

YES. The insurance company wants to use a less costly alternative to treatment than the name-brand medication. Some patients want the newest and possibly the most expensive treatments available because they believe the treatment is a better alternative than medications that have gone off patent.

YES. The chair and Dr. Carter's supervisors have a conflict in evaluating Dr. Carter. If Dr. Carter fails to attend the dinners sponsored by the pharmaceutical company and there is a low turnout, will their pride and perhaps even their pocketbooks eventually be hurt?

NO. Dr. Carter and the other medical professionals have training and experience that will allow them to make good decisions about patient care. Their choices to advocate on behalf of the pharmaceutical company or to attend events sponsored by pharmaceutical companies are their professional decisions

and others should not impose their moral values on them.

Question: Should clinicians inform patients about their roles with pharmaceutical companies.

YES. A clinician's informing patients about his role with a pharmaceutical company can help to create trust between the clinician and his patients. Alternatively, this information can help patients decide if they want to go to another practitioner who may not have this potential conflict of interest.

YES. Arguably, if a clinician is a member of the American Psychiatric Association, an organization to which this company provides substantial funds, this fact also may be relevant for some patients to be aware of when they consider the choice between brand and generic medication.

NO. In the case presented, disclosure may damage Dr. Carter's relationship with his patients and cause them to have a negative feeling about what otherwise might be good patient care.

NO. If a malpractice claim were to occur, a plaintiff's attorney might use this disclosure to create a perception in the jury that Dr. Carter was a tool of the pharmaceutical industry, whether or not this was true and whether Dr. Carter's relationship with the pharmaceutical company was or was not relevant to the case at hand.

Discussion

This case illustrates the growing concern that the pharmaceutical industry has too much influence on the practice of medicine. When the influence of pharmaceutical companies negatively impacts patient care, then a conflict of interest is created. In this case, there is little or no difference between the generic medication and the name-brand medication. Practitioners should take all factors into consideration, but all else being equal, they should choose the medication that will cost the patient and insurers less.

The nationally renowned expert in this case talked about the

advantages of the pharmaceutical company's medication and the disadvantages of other medications. For a dinner of this sort to be truly educational and not viewed as a marketing event, the speaker should talk about important points practitioners will need to consider when obtaining informed consent. Namely, the expert should talk about the risks, benefits, and alternatives to the medication, including no medication at all. Benefits of alternative treatments should also be discussed. Such information can be used by practitioners to obtain truly informed consent and not give patients a biased view of medications based on a biased talk they heard at a pharmaceutically-sponsored dinner.

In this case, Dr. Carter started inpatients on brand-name medications that the patient's insurance company did not want to pay for on an outpatient basis. Starting a patient on the more expensive brand-name medication as an inpatient is acceptable as long as the patient provides informed consent for the medication and is able and willing to assume the financial responsibility if the insurance company will not pay for the medication, or if the inpatient team obtains assurance from the insurance company that the medication will be covered in outpatient care. It is not acceptable for a patient to be started on a new medication only to find out that his or her insurance company will no longer cover the medication after the patient leaves the hospital. Patients in this situation may, unacceptably, be out of medication for a period of time. Moreover, trust, a key feature of a therapeutic alliance, can be at risk.

In addition to any direct conflicts of interest there may also be indirect ones. That is, in order to protect the therapeutic alliance and provide genuine informed consent, Dr. Carter should also disclose any indirect ties that may pose potential conflicts. For example, if his department, chair, or program receives pharmaceutical funding, especially monies which may pay his salary in whole or in part, this fact should be disclosed to his patients when prescribing. Also, evidence-based practice is compromised when the information disseminated is imbalanced, incomplete, or biased. For example, if Dr. Carter's

sole or primary source of information about patented vs. generic medications is industry-sponsored, this should also be shared with his patients. This problem is perhaps most obvious when prescribing providers receive their information from CMEs or Grand Rounds that are industry-funded, but it may also be a problem if Dr. Carter is receiving his information from peer-reviewed medical journals if the journal editors and reviewers were not careful in their screening of potential conflicts of interest.

Question: What are some relevant questions that the speaker who asserted the new medication's superiority could have been asked?

1. What data demonstrate that the two populations were truly comparable?
2. Were the trials conducted for a sufficient length of time and with sufficient medical monitoring so that unanticipated side effects of the new medications could be identified?
3. Were any studies available, but not published, which showed no difference in outcomes between the treatments tested?
4. What was the dropout rate and why did patients drop out?
5. Beyond any honorarium that the speaker receives, are there any indirect sources of support such as so-called unrestricted funds contributed to the speaker's home department or institution's salary or overhead pool?

Discussion

The first of these questions is important because another source of bias in pharmaceutically sponsored research includes violations of equipoise or the uncertainty principle. This principle has been defined in terms of "substantial uncertainty about the relative value of one treatment over another." When non-

equivalent or sub-standard comparisons are made (e.g., using only placebos as comparative controls rather than comparing the new drug with standard psychotropic medication) the conclusions about the efficacy of the new medication are suspect. Also, the study may be conducted for a short time, during which known benefits may become manifest before more subtle, yet substantial risks emerge. A high dropout rate may also be indicative of side effects which produce unanticipated, nameless, and thus clinically unrecognized suffering. Such nameless suffering, unobserved by researchers, may nonetheless result in patients voting with their feet by dropping out of studies.

Case:

Dr. Reddy was hired by a large academic center to provide outpatient clinical services. He was hired under a productivity contract; the more patients he saw, the greater his salary. The “no show” rate of the clinic was 50%; therefore, in order to reach his goal, Dr. Reddy had to “double book” patients in order to reach his productivity target. There were days when 50% of the patients did not show up for their appointments. Dr. Reddy was happy to have days like these. This meant that he was able to meet his productivity target and not feel overworked. On other days, however, Dr. Reddy had almost all of his patients show up. These days were extremely busy and Dr. Reddy was lucky to get any of his notes done during the day. At the end of each week, Dr. Reddy was calculating whether or not he met his productivity target and adjusted the following weeks’ schedule accordingly. Nonetheless, Dr. Reddy began to become aware that he was being directed to see more patients than he could provide with quality care.

Dr. Reddy’s contract included a bonus if his notes included the documentation of specific factors that were required by a regulatory agency that oversaw the quality of the academic center’s outpatient services. These factors included documentation of the patient’s current status, changes in medications, any thoughts the patient might have of harming themselves or others, laboratory results, coordination with other providers, diagnostic summary, assessment, plan of care, etc.

Furthermore, Dr. Reddy was required by the insurance companies to document specific factors in order for the clinic to be reimbursed. After three months on the job, Dr. Reddy began to standardize the questions he asked patients so that he could see patients quickly and efficiently. Dr. Reddy was able to maintain his productivity level and had met all of the documentation requirements set forth by the insurance companies and the regulatory agency. Dr. Reddy also began to give patients in the waiting room self-report questionnaires as an alternative to spending time with them.

Dr. Reddy was satisfied by the salary he was receiving but was not happy with the amount of time he had to spend at the clinic and away from his family. His practice grew and after several months he was seeing hundreds of patients. Dr. Reddy felt that he did not get to know his patients; conversely, for their part, many of Dr. Reddy's patients felt that he was not listening to their concerns.

One day Dr. Reddy found out that one of his patients had committed suicide. Dr. Reddy last saw the patient two weeks before. Following each visit, he documented that the patient denied suicidal ideation. However, Dr. Reddy never went through a complete suicide risk assessment because of time constraints; nor did he ask probing or indirect questions. Dr. Reddy did know that the patient had attempted to overdose on pills 5 years previously.

Dr. Reddy did not know until after the suicide that the patient was under significant work stress, had been traumatized as a child, and saw work as a lifeline to autonomy. This was the causal nexus of the suicide. Even though Dr. Reddy felt horrible about the patient's suicide, he also felt relieved that he was not going to get sued because he had documented what was required by the regulatory agency and the insurance company.

Question: Was there a conflict of interest in this case?

YES. The most important conflict of interest in this case is between Dr. Reddy's duty to his patients and his financial interests as motivated by his productivity contract. Dr. Reddy has a special obligation, as a mental health provider, to assess static and dynamic risk factors for suicide in his patients. Simply

documenting that any particular patient does not have suicidal ideation may meet minimal documentation requirements set forth by regulatory agencies and institutional policies; however, Dr. Reddy must make assessments in accord with the standard of care that any prudent practitioner would meet under similar circumstances.

YES. Another important conflict is between the need of the insurance company to make a profit and the academic center's mission to be a leader in education, clinical care, and research.

NO. Many large academic and private hospitals and clinics use productivity contracts. Given lower reimbursement rates by insurers, patient care demands, the need to support overhead including malpractice insurance, and the need to support their salaries, clinicians have been placed on these contracts to help their institutions grow and serve more of the needs of the community.

NO. Many providers, in attempting to be time- and cost-effective, are now using standardized assessment tools for assessing and diagnosing patients. Such tools can provide valuable adjunctive information that, when used appropriately with a clinical interview, can guide the interviewer's questions and more effectively elicit the most important problems to target. One example in which use of standardized assessment tools is better than clinical judgment is the area of violence risk assessments using actuarial instruments. These instruments have been shown to be somewhat better than unaided clinical judgment. However, again, they should be used as tools as part of a comprehensive approach to patient care.

Discussion

Over-reliance on standardized assessment tools may compromise patient care. When a practitioner such as Dr. Reddy is in a time-pressured situation, there is a temptation to supplant portions of the clinical interview with the data gathered from the assessment tool. Patients may not be able to

express themselves fully, understand the questions asked on the assessment tools, or (for various reasons including social approval response bias) incompletely fill out the assessment tool. The result can be an inadequate or improper assessment of the patient's diagnosis and psychosocial factors affecting the patient, as well as inadequate or improper treatment that may be detrimental to the patient.

Indeed, there is an increasing reliance on obtaining a psychiatric diagnosis by checklist. Although such checklists have many advantages, especially in terms of enhancing reliability and efficiency, they should be used as supplement, not as the primary means by which to obtain a diagnosis. When symptom checklists are used as the primary means to develop a diagnosis, not only do they interfere with the important practice of building rapport, but they also obscure the individual variability of patient suffering and undermine an appreciation for the context in which symptoms are manifest.

Diagnosis by checklist is fostered by the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual (DSM)*. This manual was constructed for inter-rater reliability. However, under time pressure what is often remembered are its bullet points. Thus, while the manual enables reliability it also enables "diagnosis by checklist" at the expense of validity and diagnosis by narrative. The APA's DSM checklist structure facilitates the most common and profitable varieties of pharmaceutical research. However, it may limit other forms of research that depend on narratives for discovering promising biopsychosocial approaches to treatment. The checklist approach also limits the clinical opportunity for formulating individualized, patient-narrative-dependent diagnostic formulations that themselves can have clinical value for building a therapeutic alliance. There is little room in the course of filling out a checklist for an authentic therapeutic dialogue. Moreover, as much as they save time, checklists also tend to enable a *pro forma* approach not only to the diagnostic process but also to the therapeutic process, including those aspects of the process by which patients can be engaged in a meaningful

informed-consent dialogue. Finally, to quote Hamlet's retort to Horatio, "There are more things in heaven and earth than are dreamt of in your philosophy." The fact that a patient's suffering does not fit a DSM category does not extinguish the reality of the pain.

Question: Does Dr. Reddy risk being sued for malpractice?

YES. Under prevailing malpractice law, there are multiple legal factors to consider. First, there must be a duty to the patient. Dr. Reddy had a duty to treat the patient. Then there must be a dereliction of duty. The dereliction of duty in this case is Dr. Reddy's failure to do a proper suicide risk assessment. The dereliction of duty must then be a direct cause of damages. It is arguable whether Dr. Reddy's failure to do a suicide risk assessment or to form an effective therapeutic alliance with the patient — i.e., the dereliction of duty — directly led to this patient's suicide. Evidence gathered by both the plaintiff and defence will be used either in settlement procedures or at trial.

NO. Dr. Reddy may be practicing according to the prevailing standard of care. He is seeing his patients, documenting important factors related to quality of care, and using standardized questions to provide care for his patients. If a malpractice case goes to trial, a jury will have to decide whether Dr. Reddy fell below the standard of care and whether this led to the patient's death. Even if he is found liable for malpractice, this does not make his care unethical.

Discussion

Malpractice is an anxiety-provoking issue facing all practitioners. Some medical practitioners can expect to be involved in malpractice litigation one or more times during the course of their career. Even if practitioners did not do anything to cause the patient's adverse outcome, they may be forced to settle by their malpractice insurance company for financial reasons. In the event of an adverse verdict or even a settlement, the practitioner's name goes to the National Practitioner Data Bank. Practitioners who do not follow their

malpractice insurance company's advice may be required to bear the cost of litigation and the losses they incur if juries decide against them. Over the years, malpractice insurance rates have increased, and this has compelled many practitioners to leave private practice. Some states have faced a shortage of practitioners in certain subspecialties such as obstetrics and gynaecology. Texas, which has placed a cap on malpractice awards, has seen an influx of practitioners wanting to get medical licenses in that state. Of course, such an influx may also attract some clinicians whose practice is relatively low-standard and high-risk.

Given this malpractice climate, institutions' need to meet their budgets, low insurance reimbursements, and the desire of the practitioner to earn money, practitioners are forced to make difficult choices. One choice they may make is to be part of a large institution with a risk management division that will require certain documentation standards to practice at the institution. These documentation standards may be incorporated as part of the practitioner's contract. Practitioners who sign productivity contracts may then double-book patients to earn more money, mitigate their risks of malpractice by using documentation standards, and look for ways of providing quality care in as little time as possible.

In this system, there are significant risks for malpractice. For example, the plaintiff's lawyers may ask why the doctor could not spend 5 more minutes with the patient to obtain additional information or do further risk assessment. The lawyer may also ask the practitioner why they did not see the patient within one week instead of two weeks if there was cause for concern. It is easy for a practitioner to be viewed as someone interested in profits over patient care, when in fact, there may be many factors outside of the practitioner's control which have led to the current conditions in which care is delivered.

Case.

Dr. Gonzalez is a psychiatrist who works in a small community in a Northern state. She is one of two psychiatrists in town who speak

Spanish. In addition, as the only qualified medical examiner in town, she does evaluations of industrial-related mental health injuries. One day, Sarah, an immigrant from Mexico whom Dr. Gonzalez has been treating, claimed that she had been sexually harassed at the workplace. Sarah said that she became depressed and subsequently filed for Workers' Compensation. Dr. Gonzalez was asked to do the evaluation because although Sarah speaks English, she (the patient) is more fluent in Spanish, her native language.

Dr. Gonzalez agreed to do the evaluation. Two weeks later (prior to the evaluation), Dr. Gonzalez obtained other medical records and collateral information. Dr. Gonzalez then met with Sarah and told her that, although a treatment relationship existed, the information obtained for purposes of the evaluation was not confidential and that during the evaluation Dr. Gonzalez would not be acting as her doctor. Sarah agreed to proceed. At the completion of her examination, Dr. Gonzalez submitted a report that concluded that Sarah's depression was not related to events at the workplace but to pre-existing factors related to her dysfunctional marriage and an alcoholic husband.

When Sarah learned about the denial of the Workers' Compensation claim based upon Dr. Gonzalez's report, she became furious and terminated her relationship with Dr. Gonzalez. Sarah felt betrayed and accused Dr. Gonzalez of using information that was confidential in their therapeutic relationship in a non-confidential report.

Question: Is there a conflict of interest in this case?

YES. Dr. Gonzalez is acting both as a forensic evaluator and as Sarah's treating psychiatrist. The role of a forensic evaluator is to be "objective" and use the weight of the evidence in formulating an opinion. The role of a treating psychiatrist involves several "subjective" elements and involves being an advocate for the patient. Treating psychiatrists are in a therapeutic relationship that involves building trust with the patient. In that relationship, the patient may reveal information to the psychiatrist that he or she would not otherwise reveal. Forensic evaluators, on the other hand, are not in a therapeutic relationship with the patient, and information that is ascertained

by the psychiatrist in a forensic evaluation may be incorporated into a report that will be presented to a party that is contesting the patient's claims.

NO. In states such as California, the primary treating physician is asked to be an evaluator on Workers' Compensation claims. The rationale for doing so is that the primary treating physician knows the patient best and will be in the best position to do a disability evaluation.

Question: Can the conflict of roles be detrimental to the patient?

YES. Before Dr. Gonzalez was the forensic evaluator, she was the patient's treating psychiatrist. The patient and Dr. Gonzalez formed a relationship based upon the understanding that the information provided by the patient would be confidential within certain parameters. Once Dr. Gonzalez became the patient's forensic evaluator, Dr. Gonzalez was no longer working within the scope of a doctor-patient relationship but as a "neutral" evaluator with a duty to strive for objectivity. It is possible that information the patient thought was confidential would be placed into Dr. Gonzalez's report. Regardless of the decision made by the agency requesting the forensic evaluation, there will be an adverse impact on the treating relationship with the patient.

NO. Again, Dr. Gonzalez is Sarah's psychiatrist prior to the Workers' Compensation evaluation and may be in the best position to evaluate Sarah. Dr. Gonzalez has an advantage over the forensic evaluator in that she has seen Sarah on numerous occasions and in different situations and therefore will be able to provide valuable insight into Sarah's claim of psychological injury at the workplace. Moreover, Sarah had consented to the release of the information.

Discussion

This case raises the issue of the dual roles of treatment provider and forensic evaluator. In this case, Dr. Gonzalez is the patient's treating psychiatrist and forensic evaluator. Doctors in states

such as California may be asked to take on these two roles because it saves money for the Workers' Compensation system. One argument is that the treatment provider is in the best position to be the patient's medical evaluator because they have a relationship with the patient and know the patient well.

However, in any system that requires the treatment provider to be a medical-legal evaluator, there are potential role conflicts. The treatment provider will want to advocate for their patient. In an adversarial system, this advocacy is a potential bias against the opposing party. In addition, if the patient does not obtain a favorable outcome, the treating provider can be blamed. This can tear apart the therapeutic relationship. At the very least, patients should be informed of the benefits, risks, and alternatives to a treating clinician's acting as a forensic evaluator and their consent obtained prior to release of otherwise confidential information in non-emergency settings.

In the United States there is an ongoing debate as to the extent to which even unidentified but potentially identifiable patient-related information can be collected without a patient's consent. The current version of the governing federal regulation, the Health Insurance Portability and Accountability Act (HIPAA), is in conflict with more stringent state privacy laws. When it comes to sensitive information ranging from psychiatric to genetic, loss of privacy can undermine the therapeutic alliance, doctor-patient communication, and the reliability of the clinical history.

Case.

Dr. James works for a managed care company as a medical reviewer. His role with the company is to review appeals of denials of pre-certifications of coverage of inpatient hospitalizations. Among medical reviewers, there is a bonus structure in place such that the "top 10%" of reviewers who denied appeals will get a 30% bonus on top of their base salary. Over the past five years, Dr. James received the bonus four times. Dr. James reviewed the denied claims that were appealed and, for the most part, "rubber-stamped" the denials. Dr. James figured that he was not practicing medicine by denying the claims

because doctors who worked at hospital had the ultimate responsibility for keeping the patient in hospital if medically necessary. Furthermore, the inpatient doctors could appeal the decision to the chief medical officer of the insurance company, and this made Dr. James feel comfortable that if he made an incorrect decision to deny coverage, it would be corrected.

On one occasion, Dr. James denied a pre-certification for inpatient stay, but the hospital nonetheless decided to admit the patient and absorb the cost. The patient did well and was eventually discharged. The doctors who treated the patient at the hospital felt that the inpatient stay saved the patient's life. The hospital later filed another appeal with the managed care company, and the utilization review doctors noted that the doctors employed by the managed care organization were "notorious" for denying claims. They accused the doctors who worked at the managed care company of being "heartless" and "inhuman." Later that year, the hospital terminated its contract with the managed care company.

Dr. James continued to do well at the managed care company, and the next year was offered the position of chief medical officer. He enjoyed his success but was concerned about running into colleagues at the local psychiatric society who resented his company's track record for denying claims. He addressed this problem by encouraging the managed care company to make a contribution to the psychiatric society's continuing risk management programs. He became active in the society and was eventually appointed chairperson of its ethics committee by members of its executive council, to whose treatment decision appeals he always gave special consideration.

Question: Are there conflicts of interest in this case?

YES. Dr. James is working as both as a medical practitioner and as a medical reviewer for an insurance company. His role as a doctor is to promote the care of patients, whereas his role at the insurance company is to save the insurance company money by allowing pre-certification of claims based on insurance company criteria and personal judgment. The conflict becomes more obvious when there is a bonus attached to denying claims. Even though Dr. James may want to promote

the care of patients as well as help his company make a profit, the added incentive of denying claims may lead to the denial of legitimate claims. Furthermore, the fact that a patient has the right to appeal the denial of a claim makes it easier for Dr. James to deny debatable claims while making it more difficult for the patient to obtain care.

YES. Not so readily apparent is the potential conflict between the hospital's responsibility to provide care and its need to be profitable. Hospital administrators understand that a certain proportion of care will be denied by insurance companies and will dedicate a proportion of their resources to appeal claim denials. Hospitals will also be motivated to discharge patients early in order to avoid claim denials or to earn more money under a capitated system. In either case, there is an increased risk that patients will be discharged earlier, and especially when doctors' performance ratings can be tied into how quickly they discharge patients in relation to their peers.

NO. Insurance companies can argue that they are not practicing medicine but merely administering benefits when they approve or deny claims, and that they are using medical expertise in approving and denying benefits. With this reasoning, there is no provider-patient relationship.

Discussion

The US Congress created the Employee Retirement Income Security Act (ERISA) in order to have uniformity across the nation in the way employee pensions were treated, but the unintended consequence was that health care benefits fell under ERISA. Plaintiffs whose claims fall under ERISA and who sue their insurance company can be compensated only for the value of the benefit that was denied them. There is no remedy for pain and suffering or punitive damages. Therefore, insurance companies will try to move plaintiffs' cases to federal courts because the ERISA remedies are favourable to the insurance company. Professional medical organizations have not commented on whether doctors who are medical reviewers have a doctor-patient relationship with those whose claims they review.

The ultimate responsibility for patient care is with the treating physician. If a practitioner believes it is necessary for a patient to stay in the hospital for a longer period of time, then they should keep the patient in the hospital regardless of the status of payment. Practitioners who prematurely discharge a patient risk an adverse event happening to the patient and a subsequent malpractice claim. Patients can be billed for what their insurance companies did not pay for and can sue their insurance company for the value of the benefit denied for claims that fall under ERISA.

Case.

Dr. Harper is one of the most revered doctors in America for his research into various brain disorders and is the chair of one of the most prestigious medical school and hospital departments of psychiatry. He is also a speaker at dinners and various symposia sponsored by Zombor*, a national pharmaceutical company. Last year, Dr. Harper's department earned \$150,000 from work he had done for the Zombor Corporation. He himself did not receive any funds directly, but the funds went into a pooled salary fund at the hospital.

Dr. Harper prides himself on being "objective" in his research. His research findings have supported his prescribing one of Zombor's newest medications. Whenever he sees patients, he discusses Zombor's medication first and then alternatives from other pharmaceutical companies. When he speaks about Zombor's medication with patients, Dr. Harper speaks mainly about the benefits and risks associated with Zombor's medication. He discusses other alternatives but does not spend as much time talking about those. Dr. Harper is aware that the pharmaceutical company has data on his prescribing patterns. Twice a month, a pharmaceutical representative from Zombor visits Dr. Harper to talk about new speaking engagements.

Three months ago, one of Dr. Harper's meta-analyses found that Zombor's medication was associated with increased heart attacks.

* This drug is imaginary.

Dr. Harper discussed this side effect with the pharmaceutical company. Zombor asked Dr. Harper to minimize the significance of the finding in his communications with the public. Dr. Harper agreed not to highlight his new finding in the study which bore his name and in the press releases accompanying the study which were written on his hospital and medical school letterhead.

However, after three patients filed a lawsuit against the pharmaceutical company, the stock price of Zombor dropped by 8%. Dr. Harper was questioned about why he was not more forthright about the potential rate of side effects. To the media, Dr. Harper made it appear that he did give the public adequate warnings once his meta-analysis came out. However, those who worked with Dr. Harper felt that he did not go far enough to warn the public as early as he could about the association between use of the medication and heart attacks.

Question: Is there a conflict of interest in this case?

YES. Dr. Harper is a researcher, chair of a hospital and medical school department of psychiatry, a clinician, and is affiliated with a pharmaceutical company. That in and of itself may not be controversial today, as a significant percentage of pharmaceutical research is now funded by pharmaceutical companies. However, some may argue that Dr. Harper's affiliation with the pharmaceutical company will bias the results of his research and his clinical care. Indeed, there are data that demonstrate that industry-supported research tends to draw pro-industry conclusions. For example, researchers who have compared non-profit and industry-funded clinical trials (e.g., of antidepressants and antipsychotics) have shown an alarming connection between sponsorship and positive outcomes. A second problem is that Dr. Harper has the use of the hospital and medical school logo and letterhead to send out news releases regarding research sponsored by the pharmaceutical company. Critics of the company, clinicians who do not draw their salaries from a pooled salary fund contributed to by the pharmaceutical company but who are in private practice and donate their time to the department,

are not allowed to use the departmental letterhead bearing the hospital and medical school logo to promote their public work.

NO. Dr. Harper is working with a pharmaceutical company whose mission is to help develop medications to treat potentially disabling and fatal illnesses. Toward that end, the company needs to make money in order to take risks on new ventures. The success of pharmaceutical companies in developing medications has saved countless lives and has been a significant component of the economy. The philanthropy of pharmaceutical companies has allowed patients with low income to access medications and care and has allowed medications to be provided at a low cost to persons in developing countries.

Question: Is there anything unethical about Dr. Harper's conduct?

YES. Dr. Harper did publish the meta-analysis which discussed the new side effect. However, Dr. Harper effectively agreed to "tone down" the result of his meta-analysis. The pharmaceutical company knew that the sale of Zombor's medication would decrease dramatically and the company would be under greater scrutiny if the information was a significant topic of conversation in the public arena. On the other hand, Dr. Harper knew or should have known that suppressing information could have potentially fatal consequences for many patients. Dr. Harper's role as a doctor and researcher conflicted with his role as an employee of the pharmaceutical company. Dr. Harper wrote press releases and correspondence with the drug company using the hospital's and medical school's logo and letterhead. His critics are effectively excluded from doing so unless they allow their earnings to be assimilated into a salary pool contributed to by the pharmaceutical company.

Discussion

There has been much controversy over the past several years about the influence of pharmaceutical companies on research

and the roles doctors play in this relationship. One argument has been that research funded by pharmaceutical companies is biased in favour of their medications. Also, there are studies that have demonstrated that pharmaceutical company sponsorship is associated with inconsistent and selective reporting of adverse side effects and other unfavourable results as well as with misleading research design.

Doctors have been implicated in “ghost writing” controversies. These are situations where research design and papers that bear the doctor’s name have actually been controlled by another party, and often the third party is an employee of, or is affiliated with, a pharmaceutical company. Doctors are accused of benefiting from this by gaining fame, notoriety, prestige, academic positions, and money for research that is biased towards pharmaceutical companies.

Case.

Dr. Riggins opened a private psychiatric practice in a large metropolitan city. He was new to the city and needed to build his practice quickly in order to support his salary and overhead, including the salaries of the people who worked for him. Dr. Riggins, being a savvy business person, came up with what appeared to be a profitable business model. The model was based upon patient referrals from general practitioners. For every patient who was referred to Dr. Riggins from the general practitioner’s office, the general practitioner would receive \$100. Dr. Riggins viewed this as a “win-win” situation because patients would get care, Dr. Riggins would get patients, and general practitioners would get mental health care for their patients and an extra \$100 dollars per referral.

In a matter of 6 months, Dr. Riggins’ practice was operating at full capacity. However, Dr. Riggins noted that many of his referrals from general practitioners were inappropriate. Some of the patients did not have mental health needs. Some of the patients asked why they were not referred to providers who were located closer to where they lived or who were in their insurance company’s network.

Question: Is there conflict of interest in this case?

YES. Physicians are motivated to build their practices and earn money whereas patients are motivated to get care that is in their best interest.

NO. One view may be that a physician who refers patients to a better system of care is looking out for the best interest of the patient and that payment for the referral is a “reward” for doing something good for their patients.

Discussion

Patient referrals should be based on the patient’s best interest. Professional organizations have recognized that paying for referral of patients compromises this interest and can be illegal. Health care agents that induce doctors to provide them with referrals may be seen as offering “kickbacks” to physicians. Physicians who accept payments may be motivated to refer patients to providers for additional income. There is less motivation on the part of the physician who is receiving the payment to consider other providers who may better serve the patient in the long term. Similar issues arise when clinicians are offered financial rewards for referring patients for studies sponsored by pharmaceutical companies. At the very least the patient should be informed as to what financial inducements for referral exist within physician networks or between physicians and pharmaceutical companies. By contrast, it is worth noting that among attorneys’ client referrals, fee splitting is a common practice.

Case.

Mrs. Smith is a patient of Dr. Belmont. They have been engaged in a psychotherapeutic relationship for twenty years. Mrs. Smith has been suffering from major depressive disorder since she was a teenager. At the start of their therapeutic relationship, Dr. Belmont discussed with Mrs. Smith that what was said during the course of Mrs. Smith’s treatment would remain confidential. Over the years, her husband encouraged Mrs. Smith to consider antidepressant medications.

However, Mrs. Smith indicated that Dr. Belmont recommended “talk therapy” and no medications.

One year ago, Mrs. Smith initiated a divorce from her husband of thirty years. The divorce proceedings have been bitter. Three months ago, Mrs. Smith attempted suicide and was placed in a psychiatric hospital. Mr. Smith retained an attorney and filed a complaint with the state medical board complaining that Dr. Belmont fell below the standard of care in his treatment of Mrs. Smith. Mr. Smith’s basis for his claim was that Dr. Belmont breached his duty as a psychiatrist by promoting psychotherapy as the sole method of treatment of Mrs. Smith, and that if Dr. Belmont had treated his wife with antidepressant medications earlier during the course of her treatment, their relationship would not have deteriorated and she would not have attempted suicide.

The state medical board requested Mrs. Smith’s medical records from Dr. Belmont. However, Mrs. Smith refused to sign a release of information for the records to be released to the board. Dr. Belmont, citing patient confidentiality, refused the request of the medical board. The medical board fined Dr. Belmont for failing to comply with its request.

Question: Is there a conflict of interest in this case?

YES. Dr. Belmont wants to protect the confidentiality of Mrs. Smith’s records, whereas the state medical board wants to investigate Dr. Belmont for an unethical practice complaint.

NO. One can argue that if the medical board has subpoena power, providing them with the medical records will be in the best interests of all parties and that patient confidentiality would be protected to the greatest extent possible. Any wrongdoing on the part of Dr. Belmont could then be explored and addressed.

Discussion:

Dr. Belmont may have had a potential conflict of interest between protecting patient confidentiality and avoiding punishment for withholding the records from the

board. However, since Ms. Smith is an independent agent, he ultimately had to respect her wishes regarding her records. Therefore, it was ethical for him to comply with her wish to withhold her psychiatric treatment records from a third party, in this instance a medical board.

Question: Did Dr. Belmont obtain meaningful informed consent to treat Ms. Smith?

NO. Dr. Belmont recommended only psychotherapy and did not explore medications either as an alternative or complementary form of treatment. While such a strategy was common until the early seventies, today all too often the situation is one where medication is offered as the only alternative and therapy is not offered either as an alternative or as complementary.

Discussion:

In order for a medical provider to obtain informed consent, alternatives to treatment must be discussed. This allows the patient to consider various choices of treatment, including the risks and benefits of each. Conversely, it is ethically questionable to inform the patient only of medications and not of psychotherapy as an alternative or complementary form of treatment. A key component of any meaningful informed consent process is that the risks and benefits of alternative or complementary treatment approaches be explored with the patient in a manner which the patient can appreciate. This includes the option of no treatment. Such an exploration is not only ethically but clinically indicated by way of reducing potential complications of treatment and strengthening the therapeutic alliance, which is especially vital in the treatment of patients suffering from the varieties of physical and mental pain treated by psychiatrists. In this context a meaningful informed consent process is the key to a vital therapeutic alliance and trust.

Question: What if Dr. Belmont were a psychologist who could not prescribe medications? Would he have to inform Mrs. Smith about medication alternatives?

YES. Informed consent involves discussing the benefits, risks, and alternatives to treatment, including no treatment at all. If Dr. Belmont offers one form of treatment, he must be able to educate the patient about other standard treatments so that the patient can make an informed choice.

NO. A counter-argument is that psychologists who do not prescribe medications do not have enough knowledge about medications to educate their patients about these alternatives so that their patients can make an informed choice of treatment.

Discussion

Even if Dr. Belmont is a psychologist without prescribing privileges, he must be able to discuss that medication alternatives exist and the potential benefits and risks of taking medications. If Dr. Belmont does not have enough knowledge about medications to discuss the benefits and risks of treatment or to know whether and when to refer for a psychiatric evaluation, he will need to seek consultation from a psychiatrist who can prescribe medications or educate Mrs. Smith about medication alternatives so that Mrs. Smith can make an informed choice. Similarly, a practitioner who prescribes medications must be able to inform patients about psychotherapy as an option or as a complement.

Intoxicating all-knowingness, intolerance of uncertainty, indoctrination by the flow of marketing, anchoring on initial marketing misinformation, and financial self-interest can each be significant countertransference factors which produce conflicts of interest. This is illustrated by the apocryphal "drunk looking for the key underneath the lamppost because that is where the light is" phenomenon, whereby clinicians consider only those diagnoses they are familiar with and inform the patient only of those treatment modalities they are capable of undertaking themselves.

What complicates the informed consent process when informing patients about the risks and benefits of psychotropic medications and the risks and benefits of alternatives to medications is the fact that prescribing providers may not be receiving accurate and balanced information. That is, studies have demonstrated that industry supported research tends to draw pro-industry conclusions. Similarly, numerous studies have shown that pharmaceutically sponsored research is less likely to report adverse side effects. For example, if Dr. Belmont is receiving his information from CME workshops that are (directly or indirectly) industry-sponsored, or from industry-supported research published in journals, he may be receiving biased information. Dr. Belmont should also look at other available sources of information such as published articles both for and against the proposed treatment and discuss treatment options with colleagues in order to ensure that he has a balanced perspective. In today's pharmaceutically influenced environment, individual, group, family and milieu therapies are as often overlooked as pharmacotherapy was in the late sixties and early seventies.

Case.

Dr. Ford is an attending psychiatrist at a large hospital affiliated with a major academic institution. Currently, he is rotating through a major hospital on his consultation-liaison rotation. Yesterday, he was called to see a patient for "suicidal ideas." When Dr. Ford arrived, he talked with the patient for one hour. The patient, hospitalized for a hip replacement, stated that he did not have suicidal ideation and that he had said that he "felt like killing myself [himself]" solely as a result of his frustration with the primary service-provision team. Apparently, the primary team would come into his room early in the morning, look under his wound dressing, talk among themselves and leave. The patient felt frustrated that he did not know how long he was going to stay in the hospital and that he did not know whether he was getting any better. After Dr. Ford listened to the patient and took other factors into consideration (e.g., psychiatric history, suicide attempts, social supports, someone to live for, etc.), he did not diagnose the patient with a mental illness.

Today, Dr. Ford's medical director called Dr. Ford to his office. He told Dr. Ford that "there always needs to be a diagnosis listed" in order to be reimbursed by insurance companies. The medical director asked Dr. Ford to document in the patient's chart that the patient had an *Adjustment Disorder*.

Question: Is there a conflict of interest?

YES. Dr. Ford has a duty to use his knowledge to diagnose patients accurately. All hospitals have an interest to generate revenue or, at the very least, minimize losses. Because Dr. Ford did not diagnose the patient with a mental illness, the hospital risked not getting paid for the service Dr. Ford performed. The medical director views diagnosing the patient with an adjustment disorder as a trivial matter that will not affect the patient's long-term outcome and will allow for reimbursement. However, a reliable but invalid diagnosis may be stigmatizing, constricting, pigeon-holing, and a barrier to a formulation which, while lacking a DSM diagnosis, can be both valid and helpful (e.g., a patient-staff relational problem).

Question: Did Dr. Ford fail to address anything?

YES. Dr. Ford failed to address that there was a communication error between the primary team and the patient. Often, the primary team is busy and does not have time for long conversations with patients. However, when patients feel that their concerns are not being listened to or they are not properly informed about what is happening to them, they can become anxious and fearful. Patients may express their frustration by making dramatic statements which, in turn, generate consultation with a psychiatrist.

Question: Are there any potential long-term consequences for the patient?

YES. Even when a patient is diagnosed with an adjustment disorder, this can have long-term consequences. If the patient were to apply for long-term disability insurance that covered both physical and mental health injuries, the insurance company

might require that the patient pay a higher premium because of the existence of a pre-existing mental health condition.

Discussion

Diagnoses of mental illness can have long-term sequelae including stigmatization, inappropriate treatment, and an impact on the patient's finances. In psychiatry the informed consent process is fundamental for a therapeutic alliance. Diagnoses without a patient's participation and consent are disempowering and can foreseeable increase a patient's suffering.

Hospital systems may place financial pressures on physicians to label patients with mental illnesses when there are none present or to label the patient with a more severe mental illness in order to be reimbursed by third-party payers. Physicians caught in this situation need to consider the consequences of directly addressing the situation versus iatrogenically creating unnecessary suffering.

Chapter 2. Other ethical dilemmas

Case.

Dr. Amro is a famous psychoanalyst in New York. She has clients who are employed by hedge funds and by some of the top investment banks in the world. During the psychoanalytic sessions, the investment bankers often talk about companies that will be making initial public offerings, while the hedge fund clients talk about stocks they will be “shorting” (a term of art in the hedge fund business). Dr. Amro has little knowledge about business. She discusses some of her cases with a group of other psychoanalysts who get together weekly. In one of the sessions, she discloses that one of the hedge fund clients has learned that “bad” information about a company will come out in the next three days and that her patient is concerned that many people in that company will lose their jobs while his fund will profit from “shorting” the stock. One of Dr. Amro’s colleagues, realizing that 10% of his personal portfolio is with the company, proceeds to call his broker to sell off all of the company’s stock. The colleague never mentions to Dr. Amro what he did, but feels that what he did was not wrong because “no one was hurt in the process.”

Question: Is there a conflict of interest?

YES. This case illustrates a classical conflict of interest with a twist. The classic case is that of a psychiatrist using confidential information learned within a session to make a profit – essentially, taking advantage of the therapeutic relationship by using insider information learned in that setting. In this case, it is one of Dr. Amro’s colleagues who uses this information to prevent financial loss.

NO. The colleague may argue that he does not have a doctor-patient relationship or other relationship with the patient and therefore can act on information learned indirectly from the patient. Another argument the colleague may make is that if he did not act on the information, then he would suffer a huge financial loss.

Discussion

This case illustrates the need to carefully consider various aspects of confidentiality even during case presentations to colleagues. Dr. Amro should have omitted the name of the company from the case presentation. Especially given the potentially incendiary nature of this information, a strong argument can be made that it was her duty not to disclose any more confidential information than was necessary to present the clinical case.

The ethical principles that apply to Dr. Amro also apply to the colleague. In this case, the colleague feels that no one was "hurt" in the process because he acted before the bad news about the company was made public. Nevertheless, the colleague violated the trust of Dr. Amro and the patient by using the information for personal gain. Furthermore, he contributed to other people losing their jobs by helping to drive down the price of the company's stock.

Case.

Mr. Lewis serves as an active duty member of the military. One year ago, he was engaged in an intense battle and developed symptoms consistent with posttraumatic stress disorder. A military psychiatrist started to evaluate Mr. Lewis. During one of the sessions, Mr. Lewis disclosed that, as a result of the anxiety, he did not feel that he would be able to shoot his gun straight and did not feel that he would be effective in engaging "the enemy" in battle. After the evaluation, the military psychiatrist diagnosed Mr. Lewis with posttraumatic stress disorder and recommended starting him on medications. However, the psychiatrist also reported that he would have to report Mr. Lewis to military officials because Mr. Lewis was placing his fellow soldiers "at risk."

Question: Is there a conflict of interest in this case?

YES. The military psychiatrist has two roles. One role is as a treating psychiatrist and the other is as a member of the military. The goal of the military psychiatrist is not only to treat mental

illnesses but also to make sure that the soldier is fit to carry out his military duties and obligations. This includes having the capacity and ability to kill other persons if engaged in combat. It also means that, the more effective the treatment is (in allowing the patient to return to duty), the higher the likelihood of the patient being placed in a situation where there is a higher risk of injury or death to others as a result of the patient's residual impairment.

Joseph Heller, in *Catch-22*, described the paradoxical ambience which can pervade psychiatric decision making in the midst of the fog of war. The following Gedanken experiment is instructive: Freud's Rat Man, cured by Freud of his obsession, became sufficiently unimpaired to serve in the Austrian Army, where he was to be killed in World War I. Had Freud foreseen this, would he have cured the Rat Man?

NO. One may argue that a soldier knows ahead of time the mental and physical requirements of being a soldier. A physician in the military may view that reporting soldiers who are not mentally fit for duty helps to protect their country, other soldiers, and the soldier in question.

Discussion

One aspect of the military psychiatrist's job is to ensure that soldiers are fit for duty, which includes being able to engage in combat situations. The military psychiatrist has a duty to the military and to the protection of the country, but as a doctor, the military psychiatrist is treating someone for the purpose of inflicting death upon an enemy fighter, protecting fellow soldiers, and dealing with the stresses of combat.

Psychiatrists may find themselves in the uncomfortable role of evaluating whether a soldier is fit to fight and potentially kill the enemy. Doctors are trained to extend life and relieve suffering. Doctors are also trained to maintain patient confidentiality, yet in this case there is a duty to report soldiers who are not fit for duty. So doctors must balance these conflicting responsibilities. One way to address this dual role conflict would be to warn

the soldier ahead of time about the limits of confidentiality and to explore with the soldier the catch-22 potential of being “cured” so as to be fit for a duty which places the soldier at high risk of being killed.

Case.

A European country legalized doctor-assisted suicide. Over the prior two decades, that nation over several decades had become more open to what was seen as a compassionate way of ending suffering. Strict criteria were enacted as to which patients would qualify for consideration. A two-year waiting period was stipulated in the enacting legislation. The government of the nation had run a large budget deficit for several years and had been working on cutting healthcare costs. One healthcare minister thought that a way to save the government money and end suffering of severely ill patients was to promote doctor-assisted suicide as an alternative to care. The minister felt that the budget for hospice care would be reduced by 30% if the government more aggressively pushed for doctor-assisted suicide. Furthermore, the minister thought that those who were gravely disabled with no hope of leading a “quality” life would find doctor-assisted suicide a viable alternative.

Question: Is there conflict of interest in this case?

YES. Doctors are trained to extend life and to relieve suffering. Euthanasia involves active participation on the part of a doctor to hasten a patient’s death. There needs to be a bright line between doctors as healers and doctors as killers.

YES. There is a monetary interest in advocating for euthanasia. This monetary interest may be an intrusion on the doctor-patient relationship. No matter the safeguards, patients who are already fearful will have their fears amplified by reasonable distrust.

NO. Some may argue that euthanasia, when chosen by the patient in a genuine informed-consent process, is a humane method of addressing the patient’s suffering and that doctors are in the best position to euthanize patients. Government

sponsorship of such a program can help to legitimize the practice.

Discussion

Throughout the world, there are different views on doctor-assisted suicide. It is common to hear about the withdrawal of life support, but the act of hastening the death of a patient is viewed by many medical professionals as contrary to the core ethical purpose of the medical profession. In this case, the view of this nation's society towards doctor-assisted suicide has changed. The government believes it can save money and end suffering at the same time, in essence a "win-win" situation.

Even if this position reflects the will of the majority of the nation's citizens, it may discriminate against those minority groups that wish to have more intensive treatment even in end-of-life care. Research is limited on the question of whether there are major cultural differences in the assessment of the value (and continuation in all cases) of end-of-life care, but what research exists indicates that minority groups are more likely to prefer intense, and thus expensive, care, even so-called "heroic measures" at the end of life. The conflict is that a monetary incentive to end life infringes upon a personal decision made among family members, medical providers, and the patient. Ending life essentially goes from being a purely medical decision to being a medical and financial decision.

Certain disability rights groups have raised the concern that if doctor-assisted suicide were to be legalized, there would be a financial motivation on the part of insurers to withhold costly care until the disabled person chooses to end his life.

Countries that legalize doctor-assisted suicide and have a managed-care model of care will need to look at the issues involved in preserving life and ending life. These countries will need to decide how best to implement safeguards to preserve – both for minority groups and for the individual – the choice of ending or not ending one's life in the face of financial pressures from third-party entities.

Case.

Mr. Lee is a patient who has been diagnosed as having chronic paranoid schizophrenia. He is currently participating in a state-sponsored benefits program that has paid for his mental health treatment for the past five years. Mr. Lee has now improved to the point that he wants to resume working. He saw a job opening at a local coffee shop and thought about applying. The job pays minimum wage and would accommodate Mr. Lee's treatment programming during the week. Mr. Lee's psychiatrist thought that working would be a great idea because it would give Mr. Lee basic responsibilities and would help improve his self-esteem.

After thinking about recommending Mr. Lee to work, Mr. Lee's psychiatrist then has second thoughts. If Mr. Lee were to work, his state-sponsored insurance company would no longer pay for treatment because Mr. Lee would be earning too much money. The money that Mr. Lee made would not cover his treatment, nor would it cover his day to day expenses. Mr. Lee's psychiatrist then decided that when Mr. Lee came to his next appointment, he would recommend that Mr. Lee go to a psychiatric rehabilitation program instead of pursuing the coffee-shop job.

Question: Is there a conflict of interest in this case?

YES. Mr. Lee wants to work. He suffers from a chronic, severe mental illness, and working may help provide some improvement in his mental illness and may help improve his self-esteem. The state-sponsored program wants to save money and make sure that the patients with the most need are supported by the program.

However, the state-sponsored program's goal is paradoxical in nature. If a patient gets better, it is not in his best interest to work, because he will then not receive the state-sponsored coverage. If the patient were to work, he would not be able to pay his treatment bills, which could become overwhelming. Patients in this situation have an incentive not to work. Only by not being able to work will they remain eligible for the state-sponsored program.

NO. The state may argue that they have a finite level of resources and have preserved most of their resources to treat persons with the most serious illnesses. Although there are faults in the system, the state may argue that there are no better alternatives.

Discussion

This case illustrates an ethical dilemma caused by misaligned incentives. The state wants to treat patients with the most serious illnesses; arguably, these patients need the most resources. Some patients will get better, but instead of additional support being provided for those who express a desire and ability to work, the system takes away benefits, in effect providing an incentive for patients to stay sick. Doctors are then placed in a catch-22 situation where the patient will remain sick if they do not work or may become sick if they work because they will be denied benefits for treatment. One ethical and effective option is to develop a system that provides motivation and support for patients who are able to get better while placing appropriate supports along each step of improvement.

Case.

A high-ranking residency program in the United States prides itself on not having graduates of foreign medical schools. For the past several years, it has accepted graduates only from within this country.

Dr. Manning, a graduate of an Indian medical school, was an excellent student. He won many awards and was noted to be an excellent practitioner. Dr. Manning moved his family to the United States, hoping eventually to obtain U.S. citizenship. Dr. Manning looked at the two local hospital residency programs. One was a high-ranking program while the other was a lower ranking program. Because of all of his accomplishments, Dr. Manning thought that he would be better suited for the higher ranking program. He felt that he knew as much as if not more than the residents of the high-ranking program because of his experience as an independent practitioner in India. Dr. Manning went to several websites for medical students and found

out that the high-ranking program was not “foreign friendly.” Despite this, Dr. Manning applied for residency to the two local programs. The lower-ranked program offered him a position (but not in the specialty area in which he was most interested), and Dr. Manning decided to take this position based upon his perception that he would not have a chance at gaining acceptance to the high-ranking program.

Question: Is there conflict of interest in this case?

YES. The residency program wants the best candidates for its program, but the prestige of the program is based on having most or all of its candidates from the host country and few if any doctors with foreign credentials.

NO. The residency program may argue that it wants to provide an education to doctors from the host country because the educators in the program have a better understanding of the quality of the medical schools the host country's graduates come from. Furthermore, the residency program may argue that candidates from the host country deserve the best training spots because they will stay in the host country to provide care for its citizens.

Discussion

The medical profession prides itself on being a meritocracy that seeks out well-trained medical providers. Many countries depend upon foreign-trained doctors in order to support their healthcare systems. When access to foreign nationals is denied to training programs because of the trainees' foreign credentials, the training program suffers because it does not have the best candidates. Another consideration is that many of the foreign nationals obtain positions in areas that are underserved and in need of doctors. Moreover, excluding foreign-trained nationals may in effect recreate quota systems which in earlier years were used to exclude indigenous minority groups. In the United States, for example, for many years there were quotas in medical schools and hospitals for African-Americans, ethnic Americans, and Jewish doctors.

Foreign nationals are often dissuaded from applying to the most prestigious training programs because some of these programs have a reputation of not being “foreign-friendly.” Some programs have prided themselves on not admitting foreign nationals. This can create an atmosphere of real or perceived discrimination based on national origin, which is as insidious as earlier varieties of racial, ethnic, and religious discrimination. This can also lead to the host country’s believing that medical training in other parts of the world is inferior to that of the host country whereas the opposite may be true.

Case.

Amy has been charged with one count of felonious assault of a police officer. She has a history of chronic paranoid schizophrenia and at the time of the act did not know the wrongfulness of her act. In the state she lives in, in order to raise an affirmative insanity defense, a defendant must show by clear and convincing evidence that he or she had a severe mental illness and, as a result of her mental illness, did not know the wrongfulness of her act.

Amy’s treating psychiatrist is exploring with Amy what plea she should enter. The reasoning Amy’s attorney gave was that if Amy pleaded not guilty by reason of insanity, then there was a likelihood that Amy would spend more time in a state mental hospital. Amy’s attorney thought that, if she were to plead guilty, the prosecutor would likely offer a plea bargain and Amy would get probation. On the other hand, Amy is not likely to get effective treatment if she pleads guilty. Amy asks her psychiatrist to advise her. What should the psychiatrist advise?

Question: Is there a conflict of interest in this case?

YES. Some would simply state that the psychiatrist should not give any advice or should tell Amy to listen to her attorney. However, the psychiatrist wants to support the patient’s needs for both freedom and treatment. Thus the conflict.

YES. A successful “not guilty by reason of insanity” (NGRI) defense may lead to civil commitment procedures to a state

hospital for psychiatric treatment. However, the duration of treatment in a state institution will most likely be far longer than the amount of time a defendant would have served in prison had she pled guilty.

Discussion

In this case, the potential for a plea bargain was more appealing than raising a “not guilty by reason of insanity” (NGRI) defense. An NGRI verdict may be doubly stigmatizing in that the defendant, in addition to admitting that she committed the underlying act (as an insanity plea cannot be entered unless the defendant makes that admission), is now also labeled as mentally ill. Such individuals may find the conditions of their confinement more onerous, with actually fewer civil rights (privacy, conjugal visits, and others), in a maximum security forensic hospital than in some prisons. On the other hand, prisons are particularly dangerous places for persons with mental illness, who can fall prey to the sociopathic predators who dominate jailhouse social structure. The fact that the victim in Amy’s case was a police officer might make her imprisonment even more difficult for her.

Chapter 3. Informed Consent

A local hospital has been grappling with how best to obtain informed consent for its treatments. One idea has been to develop informed-consent forms. One form states: "I discussed the benefits, risks, and alternatives of treatment with the patient," and the patient is asked to sign the form. However, a member of the risk management staff found that simple statement to be inadequate. They suggested that, once a patient chooses a treatment, she should sign forms that would list every potential side effect and adverse reaction. Doctors and other healthcare providers wanted a less time-consuming way to obtain informed consent. Patients did not understand medical jargon and wanted more time to discuss the options for treatment in detail so that they could feel that they made an informed choice.

Question: Is there a conflict of interest in this case?

YES. Each party wants the patient to make an informed choice when choosing among various treatment options. However, the hospital is concerned that, when an adverse outcome occurs, a lawsuit against the medical provider and hospital will ensue. Risk-management staff believe that the best form of protection is an exhaustive list of risks. Doctors under time-pressure want a simple, easily understood form that will inform the patients and protect the doctors against malpractice suits.

Discussion

The hospital's position in this case is: "If you did not document it, it did not occur." This quote refers to situations in which doctors claim that they discussed particular considerations with the patient, but because they did not document this in the medical record a jury will believe that the doctor did not warn the patient of relevant adverse events. However, this is not categorically true.

Informed consent is an ongoing process, not a "one-time event"

that involves simply signing a form (whether short or long). Medical providers should discuss the benefits, risks, and alternatives to treatment, including no treatment at all. Furthermore, medical providers should engage the patient's family or others in her social support systems whenever possible when making medical decisions. Medical providers should document these discussions in as much detail as possible. Forms should be used only when the patient has met with the medical provider and has had options explained to them. Only after the patient's questions have been answered and the medical provider is satisfied that the patient is able to provide informed consent should a form be signed as adjunctive documentation of the informed consent process.