

**UNESCO CHAIR IN BIOETHICS**

**WPA STANDING COMMITTEE ON ETHICS**

**TEACHING ETHICS IN  
PSYCHIATRY:  
CASE-VIGNETTES**

Editors: A.Carmi, D. Moussaoui, J. Arboleda-Florez

*THE INTERNATIONAL CENTER FOR  
HEALTH, LAW AND ETHICS*

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CASE-VIGNETTES**

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## **Table of Contents**

Introduction	<b>i</b>
Foreword	<b>iii</b>
Case report no. 1 Informed consent	<b>1</b>
Case report no. 2 Informed consent	<b>3</b>
Case report no. 3 Patients' rights	<b>5</b>
Case report no. 4 Legal competency of the mentally ill persons	<b>7</b>
Case report no. 5 Double loyalty of the psychiatrist	<b>9</b>
Case report no. 6 Conflict of interests	<b>11</b>
Case report no. 7 Conflict of interests	<b>12</b>
Case report no. 8 Euthanasia	<b>14</b>
Case report no. 9 Euthanasia	<b>16</b>
Case report no. 10 Confidentiality	<b>19</b>
Case report no. 11 Confidentiality	<b>22</b>
Case report no. 12 Confidentiality	<b>25</b>
Case report no. 13 Confidentiality	<b>28</b>
Case report no. 14 Confidentiality	<b>31</b>
Case report no. 15 Confidentiality	<b>33</b>
Case report no. 16 Confidentiality	<b>35</b>
Case report no. 17 Confidentiality	<b>37</b>
Case report no. 18 Confidentiality	<b>39</b>
Case report no. 19 Scientific publication	<b>41</b>
Case report no. 20 Informing the patient	<b>43</b>

Case report no. 21 Forced treatment	<b>46</b>
Case report no. 22 Forced treatment	<b>49</b>
Case report no. 23 Forced treatment	<b>51</b>
Case report no. 24 Forced treatment	<b>54</b>
Case report no. 25 Forced treatment	<b>57</b>
Case report no. 26 Forced treatment	<b>60</b>
Case report no. 27 Forced treatment	<b>62</b>
Case report no. 28 Forced treatment	<b>64</b>
Case report no. 29 Unnecessary treatment	<b>66</b>
Case report no. 30 Forced hospitalization	<b>68</b>
Case report no. 31 Unnecessary hospitalization	<b>71</b>
Case report no. 32 Unnecessary hospitalization	<b>73</b>
Case report no. 33 Hospitalization	<b>74</b>
Case report no. 34 Hospitalization of prisoners	<b>76</b>
Case report no. 35 Hospitalization of prisoners	<b>78</b>
Case report no. 36 Expert testimony	<b>80</b>
Case report no. 37 Medical certificate	<b>83</b>
Case report no. 38 Expert testimony	<b>85</b>

# TEACHING ETHICS IN PSYCHIATRY: CASE-VIGNETTES

## Introduction

I am privileged to be asked to write an introduction to this unprecedented book on ethical dilemmas in psychiatry. I chaired the WPA Standing Committee on ethics for nine years and we produced the declaration of Madrid 1996. I am happy that the editors of this book were members of WPA ethics committee and also contributed to my book Ethics Culture and Psychiatry year 2000.

Attached to the declaration of Madrid, are specific guidelines dealing with new issues arising from the rapid changes and evolution of medical practice, and subsequently the psychiatrist may face many ethical dilemmas. Any codes of ethics can be a paradigm for the clinicians but it seems that the psychiatrist should sometimes tailor what he learnt about ethics to individual cases using his judgment, experience and sense of responsibility. Although ethical aspects of research have become a standard part of the agenda of research funding agencies and relevant governmental and non-governmental organizations, examination of ethical aspects of proposals for the purpose of reform of medical education or of restructuring medical or nursing curriculum is still a rare , even though changes in medical education have a profound impact on the ethical behavior of whole generation of students and doctors! There is generally little or no pressure to present evidence to the government and to the society that a particular reform will not only produce some gains in terms of more knowledge and skills but also contribute to the development of the propensity to act in accordance with ethical principles.

An ethical foundation is necessary in psychiatric practice so that patients are not left at the mercy of the good intent of the practitioner. However, ethical codes must be implemented with

tact and understanding of local constraints so that the image of the psychiatrist and psychiatry is not further jeopardized.

Currently according to WPA statutes and Bylaws no member society can be admitted to WPA unless they abide to our code of Ethics, the Declaration of Madrid.

I would like to congratulate the authors of this book as it fills a gap in our studies about ethics and it allows a thorough human mental exercise and gives insight to different dilemmas in the implementation of Ethics in Psychiatry.

Prof. Ahmed Okasha  
President WPA

## **Foreword**

A book directed to medical students and general psychiatrists on matters of ethics has to possess some special heuristics and pedagogical characteristics given the subject matter, which may be new, or may appear obscure to many, the problems in translating the concepts into an easy language and the technical props to be used to convey the message.

The editors have chosen vignettes as the tool to teach ethical concepts in this book. While as a teaching tool the use of vignettes may have its detractors, they are commonly used to convey in a few paragraphs the central elements of a case and to demonstrate in practice the application of concepts. Twenty colleagues from around the world have contributed their vignettes for this book. As such, they have a universal feeling, but also it is obvious that the problems they depict are very similar anywhere and that psychiatrists have to grapple with these issues no matter where they practice. The vignettes also cover large segments of issues and topics that most often bedevil the practice of psychiatry and, on occasions become a matter of public debate about the appropriateness of psychiatric interventions. Thus, the vignettes range from commitment to right to treatment and right to refuse treatment, to psychotherapeutic situations to legal and forensic psychiatry and on to informed consent and issues regarding confidentiality and privacy. Contributors were asked to mask much as possible any identifying elements in each vignette, this being a major ethical concern when writing about cases in regard to protection of confidentiality and privacy.

Some vignettes describe behaviours that are blatantly unethical and even border in legal wrongdoing. They have been kept as an indication that, at times, the dividing line between unethical behaviour and criminal lawbreaking is blurred and that unethical behaviour may carry legal consequences when that line is trespassed.

Following the presentation of each vignette a binary approach has been used to indicate the possibilities of at least two opposite

answers to the problem. While this approach may be considered too simplistic, the idea is to provide students with alternatives in thinking ethically, without encumbering them with deep ethical concepts for which texts and other books have been specifically written.

Teaching ethics via the use of vignettes is akin to teaching via cases in ground rounds. The danger of this approach would be to become too specific and to concentrate too closely to the issues of the case while forgetting the major socio-political implications underlying the case such as issues of distributive justice and resource allocation for mental health needs, criminalization of the mentally ill and a myriad of other legal entanglements in regard to commitment. As much as possible and in line with the principle of making the book basic and easy to use these issues have been mentioned in the hope of prompting the reader's interest otherwise. As such, this book can be considered as just a "primer" in ethics with no pretences to be a scholarly text.

A. Carmi  
D. Moussaoui  
J. Arboleda-Florez

## TEACHING ETHICS IN PSYCHIATRY: CASE-VIGNETTES

### **Case Report No. 1**

#### **Topic: Informed consent**

A 25 year old man goes to see a psychiatrist for the first time. He is accompanied by his father, who says that his son has been acting strangely for the last three weeks. He is seen on his own by the psychiatrist, and the young man describes the aural hallucinations that he has been having for three weeks. His discourse reveals an intense, invasive mystical delusion, with no signs of being dangerous. The psychiatrist diagnoses an acute psychotic episode and fears that it marks the beginning of schizophrenia. He wants to start neuroleptic treatment as soon as possible and tells the patient so. He explains the benefit of swift treatment and the possible side effects of the medicine. The patient refuses the treatment, fearing that his intellectual capacities will be harmed.

The psychiatrist then sees the patient again in the presence of his father, to explain the situation. At this point, the patient agrees to the treatment as he thinks that his father is the “emissary of God” and he must obey him.

G. Niveau,  
Switzerland

#### **Question: Should the psychiatrist treat the patient within these premises?**

1. YES, because the patient did express consent.
2. YES, because the patient has a good chance of recovery.
3. YES, because if the patient does not take antipsychotics, he might worsen clinically and even become dangerous for himself or for others.
4. NO, because consent was not given freely. The young man said that he was obliged to submit to his father’s wishes.

**Comments:**

Informed consent is defined as the willing and uncoerced acceptance of a medical intervention by a patient after adequate disclosure by the physician of the diagnostic assessment, the prognosis, the nature of the intervention, the risks and benefits, as well as of alternatives with their risks and benefits. The doctrine of informed consent can be seen as a special form of communication between a physician and patient. The therapist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions. For a patient's consent to be considered informed, it must adequately address three essential elements: Voluntariness, information and competency.

For a psychiatrist, one of the recurrent questions in daily practice is: "is it ethical to use a delusional content in the best interest of a patient?" In this case report, the psychiatrist did not comment on the change of decision made by the patient because of the presence of his father; he accepted the change without interfering, since this represented in the opinion of the psychiatrist the best possible decision by the patient.

The psychiatrist chose a consequentialist approach in its more common form of utilitarianism, rather than applying a strict understanding of informed consent respecting all aspects of autonomy, as would be the case if the patient, after a complete review of his situation, had come to this conclusion on his own regardless of the presence of his father. In his rather paternalistic clinical judgment, the psychiatrist considered that the decision for treatment, although vitiated by delusions, was the best for the patient at the time in order to prevent further deterioration of functioning and, possibly, need for hospitalization.

One of the functions of the psychiatrist is to tell the patient about delusions when they occur, following the principle that he should be, as much as possible, an ambassador of reality for mental patients in general and for the psychotic ones in particular.

**Case Report No. 2****Topic: Informed Consent**

42 year old Aboriginal woman with a diagnosis of residual schizophrenia, well functioning and symptom free for many years. She was admitted with suicidal ideation in the context of an unplanned and unwanted pregnancy. She has 2 adult children, both of whom were removed from her care at an early age. She considered termination of pregnancy, although with overwhelming feelings of guilt: the thought of a new baby was reprehensible for her. Pregnancy was the result of a casual encounter with her cousin who is regarded as an elder in the Aboriginal community. The father of the unborn baby was unaware of pregnancy. She continued to think about termination and time became critical. The patient's mental health deteriorated, initially with depression, then psychosis. Her capacity to give informed consent became impaired as her mental state deteriorated. Pharmacotherapy was required, but the issue of safety in pregnancy prevailed. Pressured by elders to give the baby to a childless, schizophrenic, younger sister (32),

As she had an idealized transference towards her consultant, she refused to speak with nursing staff or with registrar. She wanted the consultant to make decision for her: "I will do whatever you say".

S. Bloch,  
Australia

**Question: What should the consultant do?**

1. The consultant should refrain from telling her what to do. He will indicate to her the pros and cons of the alternative options, verify that she has fully understood his explanation, and ask her to make the relevant decision.
2. The consultant should regard her statement as a kind of authorization, and will tell her what to do, taking into consideration all relevant elements that will guarantee the fulfillment of the best interests of the patient.

**Comments:**

The patient is in a difficult situation, because she is divided between the wish to keep the pregnancy going, fearing the guilt generated by a termination of pregnancy, and the wish to keep her sexual relationship secret in her community (this is not quite clear from the narrative, though), which would become obvious if she delivers.

On the other hand, the situation of the doctor is also difficult. The status of doctors is high in traditional communities, which is the case here. This is why not satisfied by the proposal of the family to give the newborn away for adoption to her schizophrenic sister, not willing to take the responsibility to chooses termination of pregnancy, not happy with the possibility of informing the community about the identity of the father, and more than anything else, unable to take a clear decision because of her mental disorder, she chose not to choose and to let this responsibility to the doctor.

In this complex situation, it is clear that the doctor will not be able to take alone such a grave decision. A collective one is to be worked out, including members of the treating team, and some members of the community who are accepted by the patient, in order to help her contributing to the decision-making process. What ever decision is taken, it is definitely important to take into account the cultural background of this specific group. Western concepts of unfettered autonomy and individualism are not readily transferable to other cultural contexts where family and the immediate group, if not the whole community, have a saying on health decisions and act as collective ego, a sort of group consciousness in decision making. In these circumstances, despite the easy resolution of the problem if he accepts to make the decision alone, it would not be wise for the doctor to proceed this way. Assuming that the patient consents to the family consultation, and she would find it very difficult to cut off the cultural traditions, immediacy should not be a reason to circumvent an established process, especially if the family can mobilize and attend for a conference in short period of time.

**Case Report No. 3****Topic: Patients' rights**

Ms. Y., 32 years old, has a lengthy history of psychiatric problems. She was hospitalized on several occasions for paranoid schizophrenia. The last time she was hospitalized, she was diagnosed as actively delusional and hallucinating.

As she was afraid of being poisoned, she refused to accept medical treatment and her psychiatric problems remained unchanged.

At her last hospitalization, she met Mr. A., 30 years old, who had been diagnosed with mild mental retardation (IQ of 69), and was suffering from acute depression. They developed a close relationship, and as result, Ms. Y. became pregnant, and a baby boy was born: His name is H.

After the birth of the child, the parents were separately asked to sign forms certifying that they conceded their child custody rights and accepting adoption of the minor with no trial proceedings.

M. Zaki,  
Israel

**Question: Should the parents be asked to sign the adoption forms?**

1. YES, because in their condition they have no right to bring up children.
2. NO, because in view of their mental states their consent was not valid.
3. NO, because in view of their mental states a guardian should have been assigned to represent them.
4. NO, because problems of this nature should be dealt with by a judicial procedure.

**Comments:**

The conduct of the treating team is difficult to understand, unless other untold aspects of the case were not disclosed. We know nothing about the desire of each of the parents. We don't know either what is the position of their respective families. A number of mental patients, sometimes severely ill, raise their children in a manner which is not worse than for the majority of parents in the community, provided they obtain the help of their families. This reminds to some extent the highly unethical behavior of some doctors who sterilized for decades mental patients without their consent, especially the mentally retarded and the psychotic ones, in various European countries, until the 70's.

In highly controversial cases, the judiciary system must take the lead, with the help of experts, to find the best solution, or the least bad.

Paternalism and ascription of inadequacy and incompetence to mental patients or developmentally disabled persons, without having conducted an evaluation on the competence to parenting on these two patients, are common findings among some highly developed medical teams. Utilitarian principles in terms of expediency in rearing a child are proclaimed in order to override the autonomy of the patient in favour of social or political considerations.

**Case Report No. 4****Topic: Legal competency of the mentally ill persons**

A 35 year old single male, with secondary education, works at a house sale company. At the age of 20, he had an acute psychotic episode, which was diagnosed as schizophrenia. He was hospitalized for 2 months. After discharge, he complied with outpatient treatment plans. He was brought to the court for income tax evasion. Forensic psychiatric experts found him to be competent, as his behavior was not consistent with the symptoms of the illness previously mentioned in the medical records.

Naneishvili  
Georgia

**Question: Does the mental illness absolve a defendant from criminal responsibility?**

1. YES, mental illnesses deprive the patient of the ability to exercise judgment, comprehension, free will, and intent which are necessary conditions for finding a person responsible for his actions.
2. NO, mental illness may damage certain aspects of one's mentality and abilities without detracting from other aspects of one's mental ability. Every case should be examined with reference to its particular characteristics and motivations. In the current case the accused was indeed found responsible for his crime which had no relevance to his illness.

**Comments:**

Justice Cardozo stated (1914):" Every human being of adult years and sound mind has a right to determine what should be done with his own body".

The evaluation of a patient's sound mind requires consideration of various factors:

Can the patient take cognizance of the type of treatment? Can he appreciate the nature and the consequences of the

treatment? Can he form the desire to undergo the treatment? Generally, a person may be competent to make decisions regarding some aspects of life or health but not others. For instance, some patients are unable to make a reasoned decision concerning certain treatment options, but they may still be able to indicate their rejection of a specific intervention. From a clinical point of view, a diagnosis of schizophrenia in a 20 year-old person is often provisional. It might well change to other diagnoses such as bipolar disorder or even a non-psychotic one. It might also be an acute post-toxic psychotic episode which disappears without any mental aftereffect.

On the other hand, it is a classical tactics of offenders or criminals, to try to present to the court a psychiatric diagnosis in order to alleviate or exclude their legal responsibility, and escape sanctions.

The expert is asked by the court about mental status when the offence or the crime was committed. A person who presented an acute psychotic episode many years ago, and who lived a normal life during the committing of a crime will be sanctioned as any other normal person.

When an offender alleges a mental condition as a defense to a criminal offense, it is the duty of the Court to arrange for an evaluation of competence to proceed to trial (mental state at the time of the trial) and of criminal responsibility (mental state at the time of committing the offense). Only a thorough psychiatric evaluation of these two levels of competence could answer whether this accused acted in a state of mental incompetence at the time of the offense and whether some level of incompetence was present (due to a relapse of his condition or presence of chronic symptoms from his previous mental illness). If this is confirmed, then, the Court could entertain a plea of diminished responsibility or of insanity. On the other hand, the history of any previous mental condition would be irrelevant if the person is deemed to have acted in complete use of his mental faculties at the time of committing the offense. Autonomy and free-will in the commission or omission of any act are usually assumed unless proven the opposite.

**Case Report No. 5****Topic: Double loyalty of the psychiatrist**

A child psychiatrist agrees to provide an expert opinion with regard to allegations of sexual abuse made by a six-year-old child. He submits his report to the judge after 3 months. During this work he notices that the child is the victim of great physical suffering, and so agrees to continue seeing the child, at the mother's request, for psychotherapy sessions. Six months later, he is summoned to court to give testimony regarding the affair for which he provided an expert opinion. He then realizes that he is, at that point, both expert witness and consulting doctor.

G. Niveau,  
Switzerland

**Question: Should a doctor be allowed to function as an appointed expert and consulting physician at the same time?**

1. YES, technically he can be as good expert as treating doctor.
2. NO, the child had entrusted confidential information to the treating doctor. The doctor must not disclose this information to the judge.

**Comments:**

The trust is essential to the physician-patient relationship.

Dual loyalty exists when physicians have responsibilities and are accountable both to their patients and to a third party and when these responsibilities are incompatible. As a rule, a physician shall owe his patients complete loyalty, and only in exceptional situations he may place the interests of others above those of the patient.

Maintaining objectivity is an ethical obligation enjoining forensic experts, whether the opinion is helpful or not to the legal interests

of the person being evaluated. This objectivity is practically impossible if the expert is also the treating physician whose role would be to represent the best interest of the patients and to advocate for him. In the event that the situation is not helpful to the patient, either the doctor will perjure himself or at least coat the legal opinion in a favourable light, or he is honest and, by giving a negative opinion, risks damage to the doctor-patient relationship. Besides, there is also the risk of having to disclose in Court materials revealed in therapy under the assumption of confidentiality and privacy. Hence, forensic experts should abstain from giving evidence in any case in which they are also treating physicians.

However, and this is not the case in Switzerland, it may happen in some developing countries that there are very few psychiatrists for the entire country. It would be then very difficult to separate completely between the treating and the expert functions of the same doctor.

**Case Report No. 6****Topic: Conflict of Interests**

Seventy-six year old very wealthy woman affected with mild dementia whose children called on her doctor complaining of her spending habits of giving liberally to members of a church cult, whom they think, are scheming to alight her of her wealth. They are worried about their rights to her inheritance and request from the doctor to declare her incompetent to manage her own affairs. The doctor dutifully advises his patient about the visit from her children and told her that he did not think that a psychiatric consultation was in order. The doctor himself was a member of the same church cult.

J. Arboleda- Flórez,  
Canada

**Question: How should the doctor deal with the conflict of interests?**

1. He should refer the patient to another doctor.
2. He should continue to treat the patient and dismiss the children's request.

**Comments:**

There is here a case of conflict of interests. The treating doctor being in disagreement with the children about their assessment, should ask for a second opinion from a colleague who does not belong to the same church; this is to assess the mental state of the lady and to evaluate if her behaviour is or is not a consequence of her illness or of undue pressure from members of her church. The doctor is placing his patient's welfare at risk should she be experiencing a worsening of her dementia.

The best ethical solution on the long term for the treating doctor is to refer the patient to another doctor who has no relationship with her church.

**Case Report No. 7****Topic: Conflict of Interests**

Fifty year old psychiatrist hired a patient as a char woman to clean his apartment. He treated her for her phobias with hypnosis after returning home in the evenings. Working arrangements was in lieu of payment for treatment she could not afford otherwise.

J. Arboleda-Flórez,  
Canada

**Question: Was the psychiatrist right to have this working arrangement with his patient?**

1. YES, because the patient was able to benefit from the opportunity for treatment that she needed.
2. NO, because the psychiatrist should not mix the role of therapist and employer on account of future conflicts of interests.

**Comments:**

There is a principle which needs to be followed: no doctor, unless there is an emergency, should treat a family member, a friend, or a person working under one's responsibility.

The risk of conflict of interests in these situations, (including emotional issues), is very high. The main loser in such cases is almost always the patient, who needs a certain distance and neutrality for an optimal doctor-patient relationship.

Apart from the bad optics and the possibilities of other motivations impacting on the therapeutic alliance, the doctor has created a conflict of interests in which he cannot be both employer and treating physician. An optimal doctor-patient relationship demands certain distance between the parties. This is more so in psychiatry where issues of transference and countertransference tend to colour all aspects of the interaction. An optimal psychiatrist-patient relationship should

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be based on a level of equality where the psychiatrist is there to help the patient to find a better balance in life and how to manage his or her symptoms, but it is the patient who organizes and makes decisions on the course of the therapy. The idea is to help the patient to develop a better capacity to independent decision-making and to lessen dependencies. To the contrary, an employer-employee relationship is one of master and servant where contractual obligations enjoin the servant to carry out functions contemplated in the contract and that had been ordered by the master of the contract. A utilitarian arrangement of this nature mixes the roles and both parties will be the losers. A better solution would be for the doctor to appeal to his altruism and do the work "pro bono".

**Case Report No. 8****Topic: Euthanasia**

A 25 year old doctor's ailment was diagnosed as leukemia. He lived with a girl friend, with whom his relationship was excellent. Despite treatment at a reputable oncology center, his health deteriorated. After few months, he could swallow no liquids and was kept alive by perfusion. After struggling for another two to three weeks he requested, tentatively at first, but later with greater insistence, that his doctor help to put him out of pain by letting him die. After his request had been refused the doctor finally told him that since he himself had access to as much morphine as he wished, he had only to insert a large dose into his intravenous medication in order to terminate his life. He acted accordingly in the presence of his girl friend. However, instead of dying, he woke up in a happy mood and was able to enjoy his food and drink. He decided against further lethal action. His leukemia was the natural cause of his death a few months later.

Driss Moussaoui  
Morocco

**Question: Was the doctor allowed to advise the patient on the way to terminate his life?**

1. NO, mercy killing is forbidden in many countries in the world to medical practitioners.
2. NO, the consequences of the deed attest to its initiation.
3. YES, the case report deals with a terminal cancer patient. The patient is adult, sane, educated and is himself medically qualified. He was aware of his illness and its imminent outcome. He had sufficient reason and right to determine his own fate because of unbearable suffering.

**Comments:**

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient's own request, is unethical. A physician's duty, first and foremost, is the promotion of health, the reduction of suffering, and the protection of life.

Psychiatrists should be careful of actions that could lead to the death of those who cannot protect themselves because of their disability. The psychiatrist should be aware that the views of the patient may be distorted by mental illness such as depression. In such situations, the psychiatrist's role is to treat the illness.

This case shows that euthanasia is an extremely complex issue and can never be dealt with lightly. Even in desperate situations such as this one, with a patient in a terminal phase, the decision of life termination taken and acted upon by the patient himself gave the exact opposite result, since he woke up with a strong will to live.

This is why the doctor has to be extremely cautious towards wishes of death expressed by patients because of unbearable suffering. The clinical question to ask is whether the patient suffers from a depressive episode concomitantly with the physical illness. An antidepressant treatment might reverse the determination to die of some of these patients.

Euthanasia is not allowed in many countries and, as a form of assisted suicide, it is condemned in many religions. Assuming, however, that in this case there are no legal or religious injunctions, the issue to deal with, then, would not be euthanasia as such or its legality, but the fact that the doctor has taken a short route to euthanasia and has shirked off his moral duties and obligations. Apparently, he foisted the decision for an act of active euthanasia on his patient.

**Case Report No. 9****Topic: Euthanasia**

Ms. A.P. was a 45-year-old man who lived in an assisted residence because he was mentally retarded. He was sufficiently autonomous to go and do mechanical jobs in an office. A judge had declared him incapable twenty years ago and appointed an uncle as his guardian. He had a female friend in the institution. As a result of new treatment for epilepsy he suffered intestinal necrosis that required emergency surgery and a colostomy. In the post-operative period he developed various complications, starting with pneumonia treated by intravenous antibiotics. He became negative, did not want to eat and asked doctors and nurses to allow him to die, to go “to meet his mother”. The psychiatrist gave anti-depressive treatment and food was injected into him by nasogastric tube which he pulled out several times a week. He also fought with nurses who had to tie him to the bed in order to replace the tube. Three months after his admission to the hospital a new infection with pus collection appeared in his hips that required new surgery. He became aggressive to doctors and nurses, cried constantly and begged them to let him die. His guardian, an old man mentally limited and incapable of making any decision, signed an authorization for the operation.

Juan Vinas,  
Spain

**Question: Should the surgeon perform the operation?**

1. YES, there is informed consent from the legal guardian.
2. YES, not treating the patient would lead to his death.
3. NO, the legal guardian is mentally limited and incapable of making any decision. They should apply to the court for an alternative guardian.

**Comments:**

Obviously, the antidepressant treatment did not succeed in helping the patient get rid of his strong wish to die. The treating team is torn between the necessity of fighting the physical illness and its complications on the one hand, and his quality of life on the other.

The doctors in this case cannot stop treating the patient, despite the fact that he requested it. The action to take is a quality presence near the patient, calming his anger, prescribing anxiolytics and antidepressants in order to help the situation to become more serene.

Euthanasia is a highly controversial issue that becomes easily emotional as elements of personal morality, religious and legalities interface. Euthanasia may be passive or active. At the personal level, the obligation to preserve life is pitted against a proposed right to die with dignity. In some countries, it is against the law for a physician to assist a patient to die (active euthanasia), but the law may not be that clear if the patient is simply let to die naturally once it is determined that further treatments will not change the natural, final, outcome of the disease. Passive Euthanasia seems to be more acceptable on the assumption that a person has the right to refuse heroic treatments, once it is determined that probabilities of survival are limited even with the treatment, hence letting natural events take over. If the patient has come to that decision, then, other than some palliative care to manage pain, physicians should not intervene further. The question arises as to when or where to draw the line between heroic treatments and a proposed intervention with more than good probabilities of success so that death could be averted. An ethical physician will have to weigh all the imponderables so that the patient can be presented with all the alternatives and all probable outcomes of any intervention. In the instant case, the added complication relates to the doubtful competence of the guardian to make such life or death decisions. Presumably, the guardian has lived up to his or her duties up to now and nobody had objected. Only a Court will have the power to make a decision on

overriding the guardian's decision.

Patients have a right to qualified guardians when this is required to protect their personal well-beings and interests. Where judicial authorities find that a person with mental illness is unable to manage his own affairs, measures are taken, so far as is necessary and appropriate to the person's condition, to ensure the protection of his interests.

If the patient's representative forbids treatment which is, in the opinion of the psychiatrist, in the patient's best interest, the psychiatrist may challenge this decision in the relevant legal institution.

**Case Report No.10****Topic: Confidentiality**

A 45 year old rich, handsome, sociable and elegant man, a member of the jet society, had an amorous relationship with an equally elegant and beautiful 35-year old woman. Due to some bouts of jealousy on the part of the man (possibly of morbid dimensions), the young woman decided to put an end to the relationship. Following this, the man visited a psychiatrist, whom he had been seeing for some time, informed him that he was carrying a gun and that his next visit would be to his ex-girl-friend whom he had the intention of killing. He added that this information was confidential from patient to doctor and that any breach in confidentiality would not remain unnoticed.

The psychiatrist decided that a breach of confidentiality was necessary in this case and informed the lady and the police. When asked by the police, the man denied that he had bad intentions.

A heated discussion among professionals followed, which was re-fuelled by the fact that this man eventually managed to kill his ex-friend with the very gun he carried when he visited the psychiatrist's office.

G.Christodoulou  
Greece

**Question: Was the breach of confidentiality justified in this case?**

1. YES, in accordance with the "Tarasoff" case.
2. YES, in accordance with the Madrid Declaration.
3. YES, the doctor has a double loyalty obligation, i.e. not only to his patients but also to the wider community in case of danger.
4. YES, in order to protect the patient against his own violence.
5. NO, a precedent of this nature would tend to prevent violent criminals from presenting themselves to psychiatrists and obtaining treatment intended to help them to refrain from violence.

6. NO, the psychiatrist should have advised urgent treatment and at a later stage should have performed a further diagnosis and given consideration to any recommended further treatment.

**Comments:**

A first clinical question to be asked in this complex case is: why this man was seeing a psychiatrist before killing his girl-friend? If he presented a mental disorder, was the jealous behavior part of it? Would this have necessitated a compulsory hospitalization? It is clear that the psychiatrist had the right and the duty to inform both police and the ex-girl friend. Unfortunately, this did not prevent the murder of the lady.

A. Capron argues that the confidentiality doctrine can serve six functions: It can (1) protect individual autonomy, (2) protect the patient's status as a human being, (3) avoid fraud or duress, (4) encourage physicians to carefully consider their decisions, (5) foster rational decision making by the patient, and (6) involve public generally in medicine.

Confidentiality is not an all encompassing absolute. A careful balance must be maintained between preserving confidentiality and the need to breach it in order to promote the best interests of the patient or the safety and welfare of other persons or the public interest. Breaches are allowed in public health and in mental health. Law in many countries enjoin a psychiatrist to maintain confidentiality, but allow its breach when danger to others, especially an identified target, is at issue. In USA this is known as the Duty to Warn or the Tarasoff decision, for the case in which an infatuated young man killed his girlfriend who had manifested a desire to end the relationship. He had been released from a hospital emergency department where he had attended for assistance. The clinicians were found at fault for not warning the potential, identified, target. The situation is very similar to the instant case. The potential victim is an identified person and the psychiatrist will have to accept his duty to warn. However, he should have advised his patient

about his action, openness and honesty being essential within the psychotherapeutic relationship, and if necessary, should have proceeded to commit the patient (involuntary hospitalization) on the assumption that the patient either has a psychotic illness, or else, is proving incapable to control his actions given his present distress.

**Case Report No. 11****Topic: Confidentiality**

A 34 year old woman who has been pregnant for four months is admitted to the psychiatric ward of a local hospital after a suicide attempt. She belongs to an ethnic minority and she and her husband live with her parents-in-law. She informs the doctors that she immigrated under a scheme for the unification of families but is having difficulty in adjusting to her new environment. She is illiterate, cannot communicate in the language of her new country and through an interpreter states that she feels as if she is a prisoner exploited by her parents-in-law who force her to work hard. Her husband gives her little support. She has five small children and is expecting a sixth. In her desperation she has decided to end her life by throwing herself under a car, for which she has just been rescued and brought by the police to an emergency room. In the hospital she exhibits mild depression, but is no longer suicidal. She is very angry with her relatives and does not want any contact with them, stating that they will make her life even more miserable if they hear about her attempted suicide. Her family, not understanding why she is hospitalized among “crazy” people, wants to take her home. Her parents, feeling entitled to an explanation of her hospitalization in the psychiatric ward, wish to consult with the psychiatrist, who refuses their request for an interview without his patient’s consent. The woman feels that her situation would be even more difficult if her suicide attempt becomes known to her in-laws.

M. Kastrup  
Denmark

**Question: Should the psychiatrist advise the family about the patient suicide attempt?**

1. YES, disclosure of the information will ensure that the woman will be guarded by her family against further similar attempts thus promoting her safety and protecting her life.
2. YES, because the family will probably have the information from police.

3. YES, because the family might change its behavior in order to decrease the social pressure on the patient with the help of the treating team.

4. NO, the doctor is forbidden to disclose the information by the rules of confidentiality.

**Comments:**

In general, the psychiatrist is bound, legally as ethically, to hold in confidence all information that is revealed to him as a result of his relationship with his patient. Apparently, the psychiatrist's duty to keep patient's information confidential has been a cornerstone of medical ethics since the time of Hippocrates. The Hippocratic Oath states: "What I may hear or see in the course of the treatment or even outside the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about".

This is a typical case with transcultural issues; psychiatrists in developed countries are not always well prepared to deal with patients coming from countries with traditional culture. In such communities, the group is powerful and invades often the privacy of the individuals constituting it, especially when it comes to women, illiterate and dependent on the family.

Often, the clinician does not know the cultural nuances behind some kind of behaviour or chooses to ignore them out of dominant culture concerns about dilution of its own values or because of legalities. Clinicians are seldom exposed to cultural sensitivity training and, in multicultural societies, it would be impossible to know all cultural issues. On the assumption that clinicians have an obligation to look after their patients with the best of their abilities, any cultural issue that may interfere or colour an understanding of the pathology affecting the patient ought to be explored and understood before the clinician makes a decision to ignore its significance.

To tell or not to tell the family: both solutions are bad. To tell may

prevent another suicide attempt. Of course the family will be angry against the patient because of her suicidal attempt, but they would probably be even angrier not to be informed, especially if there is another one. They might even sue the doctor for hiding this element from them if she succeeds in killing herself. Not to mention that police would probably tell the family about the behavior of the patient in the street.

It is probable that a doctor in the country of origin of this patient would more easily tell the family than the doctor in Denmark. Both are right, depending on the context and the way they work with the patient and the family.

In as much as the therapeutic process is an opportunity for personal growth, in this case, the clinicians has a duty to discuss openly with the patient the meaning of her behaviour and the implications of her refusal to accept the dictates of her culture. On her part, the patient has a right to all information available including the positive or negative consequences of her own cultural dilemma so that she can make an informed decision about her future course of action. Involving the family in the therapeutic process will help in the transcultural divide on how the dominant culture sees the family role in the pathology and, this will be consonant to the values of the patient's culture.

**Case Report No. 12****Topic: Confidentiality**

Mr. Y., 51, presented to his GP in the company of his wife, Ms. X., 30.

Mr. Y. had been diagnosed with major depression, exacerbated by numerous social stressors. These included a recent diagnosis of AIDS, his wife's diagnosis of HIV, their inability to conceive a child, and escalating financial worries resulting from IVF (in vitro fertilization) costs, adoption agency reports, and his wife's surgical costs (recto-vaginal fistulae). He continually asked his GP, who was also Ms X.'s GP, for some explanation of where he might have gotten AIDS from as he had no previous IVDU (intravenous drug use), unprotected sex other than with his wife, or other risks. He also wanted more explanation about his wife's infertility, and was depressed by what he felt was doctors' collusion in not being forthcoming with him.

He would spend many hours ruminating about these issues; he felt guilty that he was not able to do more for his wife, and tearful and depressed about not being able to become a father. What distressed him most was his belief that he had infected Ms X. with HIV, and had thus in effect "killed her".

Unknown to Mr. Y., Ms. X. had been known as Mr. X. Mr. X. was born a man, but underwent a sex change in Brazil when he was 18 years old, financed by an older benefactor. After the surgery, Ms. X. worked in the sex trade, where she contracted HIV, and had known about this for many years. When she met Mr. Y., she did not disclose that she had once been a man, nor did she mention her HIV status, and presumably passed it on to Mr. Y. Ms. X. is unwilling to allow her surgeon and GP to tell Mr. Y. about her history as she feels it would "destroy him", worsen his depression and possibly drive him to suicide.

S. Bloch,  
Australia

**Question: Should the psychiatrist advise the husband about the story of his wife?**

1. NO, the rule of medical confidentiality deprives the doctor of any right to pass information obtained from the woman to the husband. The great damage that would be caused by giving this information to the husband including the danger that he might commit suicide outweighs any possible benefit of revealing the truth.

2. YES, there is a doctor/patient relationship between the doctor and the husband, the husband is requesting answers to his questions, the answers are obtainable from information given by the woman to the doctor and the doctor is therefore entitled to pass the information to the husband.

**Comments:**

This is obviously a difficult case from every single point of view. Medically, the depression of the husband will aggravate further the already deteriorated physical health of the husband and unprotected sex between husband and wife, when trying hard to have a baby, may have over-contaminated both by HIV, the husband not knowing that his wife cannot become pregnant.

From the ethical point of view, it is true that the situation of the GP is difficult, because he is the treating doctor of both husband and wife, entangled in a strange and complex situation. The best move of the doctor would be to refer one of the spouses to another doctor. This does not allow him to tell the truth to the husband, because he is or has been the treating doctor of the wife, the confidentiality obligation being valid during the entire life of the doctor, and even after.

Morally and probably legally, many societies would condemn the wife for having contaminated the husband, and for cheating him by hiding the past. On the other hand, from a psychodynamic point of view, the husband "knows without willing to know". When he asks the doctor from where he got

the HIV infection, he probably feels that his wife might have contaminated him; however, he does not dare confront such painful reality and denies. The prediction of his wife that he might commit suicide if he knows the truth is to be taken very seriously. Another possible move is to convince the wife to tell progressively the truth to the husband, with a strong psychotherapeutic support for both spouses.

Openness in communication is an essential component of any relationship. Unfortunately in this case, the wife has cheated on her husband, twice, once by not disclosing her past and twice by not confronting her present reality and she is cheating on the physician too by imposing constraints on his ability to help her husband. If the physician does not open up her issues with the husband he is colluding with her deceitfulness. Her motivation for her refusal to own up to her past and to her present circumstances will have to be fully explored for it may be that her motivation is not fear that he may commit suicide if he knows the truth, but a wish that he will commit suicide for not knowing what ails him. He has a right to know, regardless of the teleological consequences of the revelations. Applying a consequentialist analysis that only sees a negative outcome-suicide- fails to realize that positive outcomes to both parties could also flow from a decision to disclose.

**Case Report No. 13****Topic: Confidentiality**

A 46 year old man, married and father of three children, is a bus driver on an inter-urban line on difficult roads across the mountains. In a consultation with a doctor, his main complaint is that he begun experiencing episodes of acute tachycardia during the past five months, following the death of his mother. It happened first when he was in the street, where he thought that he was taking leave of his senses and was about to die. In the emergency room of the hospital to which he was rushed he was diagnosed as having a heart that was in good shape, but owing to his stress, he was advised to take a holiday. Upon return from his vacation he began to suffer the same episodes especially when he was driving across the mountains. He also began to believe that his driving might become careless and cause him to drop into the ravine.

He insisted that this was exclusively a heart disease, refusing to consider that he was suffering from any kind of panic disorder which might be complicated by agoraphobia. Refusing to accept any psychotropic medication or psychotherapy, he demanded treatment by a cardiologist. He asserted that he would refuse to take “the same kind of medication as his mother”, who had been treated for years as a person with schizophrenia. At the same time he continued working on his arduous bus route, since he had contracted debts which he had to repay.

D. Moussaoui,  
Morocco

**Question: Should the physician advise the employer about the patient's state of health?**

1. YES, the driver's refusal to accept the professional opinion that he was (also) mentally ill is likely to cause an accident, injuring or killing not only himself but also the bus passengers. The danger to the lives of the driver and passengers outweighs the infringement of confidentiality.

2. NO, at this stage the doctor should preserve his relationship with the patient, cooperate with the cardiologist and the psychiatrist, and propose a treatment regime which will cover both the cardiologic and the psychiatric requirements.

3. NO, the confidentiality rule denies the doctor any right to infringe it. Advising the employer could result in the dismissal of the driver from his work.

### **Comments:**

Convincing the patient is the key solution to this case. It is not untrue to tell the patient, in collaboration with a cardiologist, that a serotonin uptake inhibitor would stop his cardiac symptoms. A panic disorder with probable agoraphobia, with or without depression (on which the case-report gives no hint) occurred after the death of a mentally ill mother. Taking into account the stigma this patient has towards psychiatry and psychotropic medications, it is wiser to refer him to a cardiologist for treatment. It is only if the patient refuses completely any kind of treatment and continues to deteriorate, that the alternative of informing the occupational doctor of the company, who would explain again the danger of driving the bus in such pathological condition. From the ethical point of view, most of the responsibility of the doctor is towards the suffering patient. However, if the illness could cause death or injuries of dozens of individuals, there is also a responsibility of the doctor towards the community.

Similar cases may happen with plane pilots or train drivers in case of epilepsy or substance abuse disorder for example.

A decision by this patient not to seek treatment for his panic attacks would, under ordinary circumstances, only affect him and those close to him. It is within the person's right to make decisions on whether to seek treatment or not. In fact, that should be the end of this matter, were it not for this person's occupation. Being affected by a serious case of panic attacks when the person has the security of the public in his hands, brings

up different series of complications to his management. A major panic attack in the middle of heavy traffic or on a busy highway could, conceivably, impact on this person's abilities to drive his bus in a safe and entirely conscious manner. Thus, the risk to the public, including his passengers and riders in other vehicles, will be high. In some countries, by law, regardless of confidentiality rules, a case of this nature will have to be reported and the person will have an option for treatment and proper control of the medical condition or relinquishing his driving privileges. A license to drive is not a right, but a privilege enjoining the owner to live up to some expectations and obligations. If he is not reported and anything happens the psychiatrist might be liable to penalties even under criminal law. A utilitarian argument can be made about the good of the majority v. the good to this single person. Given that the consequences could be disastrous to this patient, his passengers and the psychiatrist, the latter will have to make an act-deontological decision (as it applies to a case by case). As to the patient, his responsibilities flow from moral concepts, first in his role as a driver of public transportation, second on the liability and the causality should an accident happen, and finally on his own capacity (competency) as a driver.

**Case Report No. 14****Topic: Confidentiality**

The case occurred in a European country in which during the past thirty years, it has been repeatedly stated (sometime by representatives of psychiatric associations) that a psychiatrist working in the community should be seen as a “political activist”. It happened that a university professor of psychiatry in that country used electroconvulsive therapy in his department, for the first time after 27 years, in a patient with a very complex clinical picture resistant to pharmacotherapy. One of the assistants of the professor, a member of a political party, photocopied the clinical record of the patient and gave the photocopy to an officer of the party. The photocopy was then passed to a prominent newspaper, and on the following day a full page article appeared in the newspaper, attacking the professor for the barbaric treatment he had used. The article was accompanied by several interviews with psychiatrists, none of whom mentioned that electroconvulsive therapy is considered by several international clinical guidelines as an appropriate treatment in specific clinical conditions. The dean of the faculty did not take any disciplinary action against the assistant, but asked officially the professor to “provide an explanation” and promote “a public debate” in the faculty about the use of electroconvulsive therapy. The clinical picture of the patient improved significantly after the therapy, but no mention of this was made either in the newspaper or on any other public occasion.

M. Maj,  
Italy

**Question: Was the assistant entitled to distribute the information to the public?**

1. YES. The right of the society to know overrides the rule of confidentiality.
2. YES. The right of the medical men to control the use of medical methods overrides the rule of confidentiality.
3. NO. The assistant was not allowed to advance his ideological

interest on account of his duty to keep the rule of confidentiality.

**Comments:**

Anti-psychiatry movement, in its hard and its soft forms, exist every where in the world, including among psychiatrists. To go to the community with an academic controversy, such as the pros and cons of ECT is legitimate. To photocopy the file of a patient and to give it to non doctors and non-treating individuals is highly unethical. If the name of the patient is not hidden, and if the patient may be recognized through information contained in the photocopied file, the patient has the right to sue the assistant.

The assistant's supposedly "higher values" of the good of society and need to know arguments could have been achieved without infringing on the rights of others. The end does not justify the means in this case. Using somebody who could not protect himself/herself to advance a political point of view is amoral and reprehensible. In fact, in many countries it is also a criminal offense to reveal the content of medical records to anybody not authorized and when not consented by the patient.

The Dean shows moral turpitude by aligning himself with the majority. He decides to sacrifice the confidentiality of medical records entrusted to his hospital and to himself as the Chief Medical Officer in his Department. He also sacrifices the integrity of his Department and the interest of a member of his Faculty. In an analysis of responsibility he has failed in his duties.

**Case Report No. 15****Topic: Confidentiality**

Thirty-seven year old, married woman, attends her family doctor with complaints of vaginal discharges and itchiness around the vulva. After examinations and tests, the doctor gives her a second appointment and asks her to come with her husband. At this interview, he proceeds to advise them that she had a sexually transmitted an STD infection and advises them to abstain from further sexual interaction. He also asks the husband to submit to a laboratory investigation given the legal reporting requirement to the sanitary authorities. The information caused a major marital rift and the couple divorced. In the event, the husband was free of infection and, on subsequent appointment, the doctor apologized to the wife for he had discovered that she only had a minor case of monyliasis, but the laboratory had submitted him information belonging to another patient.

J. Arboleda-Flórez,  
Canada

**Question: Should the doctor have advised the husband that his wife had an STD infection?**

1. NO. The doctor is forbidden to disclose the information by the rules of confidentiality. The doctor should have asked the wife in advance whether she would agree to disclose the information to her husband.
2. YES. The doctor could assume that the wife consented to the disclosure of the information from the fact that she brought her husband to the second appointment.

**Comments:**

Confidentiality presupposes that something “secret” will be told by someone to a second party who will not repeat it to a third party. Confidentiality refers to the right of a patient not to have those communications imparted in confidence revealed to third

parties. It is derivative of the broader right to privacy that guards against a variety of intrusions on the patient's freedom from unwanted attention. Information obtained in the therapeutic relationship should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient.

Medical actions have sometimes a disastrous effect on the patients and their families. To announce a sexually transmitted infection, especially when it is an HIV infection, may be appalling, especially if it is a false result of the lab.

This is why it is essential to double check with the lab, and after giving the results to the concerned, to insist that they are provisional, until control testing from other labs are made.

It is also clear that ethically the diagnosis and its disclosure to the spouse must have been discussed before hand with her.

The doctor acted rashly and his motivations are not clear. In fact, he could be liable in tort law in that he caused major damages to a lawful interest of his patient. Even if the lady had agreed to bring her husband with her, the content of the meeting may have not been clear to her. The doctor has a duty to investigate thoroughly any extraordinary health event prior to informing the patient, let alone others. Not having counterchecked the results is tantamount to medical negligence. His rush to breach of confidentiality for purposes of applying a utilitarian rule is not justified given that the players are only two at this stage and such the decision to advise the husband could have waited until confirmation of the results with some other tests.

**Case Report No. 16****Topic: Confidentiality**

Sixty-eight year old powerful politician was affected with Lou Goerigh's disease and given no more than one year of life. She prohibited her doctor to ever mention her condition not even to her husband or her family because of the sensible political situation that such revelation might entail or to seek further consultations. As her condition worsened, pressures mount on her doctor to refer her to another physician or to hospitalize her. Following the expressed directions of his patient he refused, but her family insists on consultation and possible hospitalization.

J. Arboleda- Flórez,  
Canada

**Question: Should the doctor advise the family and the community about the patient's illness?**

1. NO. This information belongs to the patient and will be released only subject to the patient's consent.
2. NO. It might cause a political damage to the patient as well as to the community.
3. YES. The community has the right and the interest to know.

**Comments:**

The health of politicians, artists and other media exposed people, especially when they suffer from severe illnesses, makes easily front pages of media. It is understandable for a doctor to question the confidentiality principle when it comes to a head of state who suffers from say an Alzheimer's disease.

But when it is a deadly neurological disease such as this one, which does not affect the cognitive functioning until the end, there is no question that the confidentiality principle must be followed in a very strict manner.

The question is whether it is right or wrong to withhold the truth when it is not the interest of the person alone that is at play, but the interest of a large number of people as this person is a politician. Even the interests of her party are at stake. The party needs to come to terms with her condition and arrange for an orderly succession. Politicians are public people. Things that are private and confidential to many may not apply to them because the public good may be compromised. Deontologically, therefore, her decision to hide the truth is on shaky grounds. The doctor has a duty to keep in confidence his patient's condition, but he also has a duty to examine with her all the consequences of her decision. She has to understand that as her end nears, it would be impossible to hide the facts any longer and she will be in a worse position to take care of her personal and political affairs. Yet, for as long as she is competent, the physician will have to respect her decision.

**Case Report No. 17****Topic: Confidentiality**

A child aged 8 was referred to a mental health hospital by the social worker for family affairs who reported behavior disorders.

The child and his brother are caught in the midst of severe divorce disputes between their parents, and are in temporary custody of their father. In the first diagnostic session this boy's behavior could be described as hostile; he was furious and his answers were laconic. The moment the meeting was over, the father entered the room, and in front of his son demanded to see what I wrote in his file. He said "According to the Patients' Rights Law I'm entitled to see the notes you write in my son's file". He added that he deserved to know what his son thought about his mother and about him. It seems that the father perceived this son as being more attached to the mother, and as betraying him by loving his mother too. This child was probably aware of his father's intrusiveness and therefore he refused to cooperate in the psychiatric examination. Also, it was clear that the child was afraid to cooperate and reveal his feelings and thoughts, as his experience taught him that his father's anger could be very dangerous.

R. Finzi-Dottan,  
Israel

**Question: Should the doctor show the father the contents of the file?**

1. NO. The father's demand is an attempt to violate the child's right to privacy. The disclosure will not be in the best interest of the child.

2. YES. The parents are entitled as legal guardians to view their minor children's medical files.

**Comments:**

In general, information about health problems of the child should be disclosed to the parents, unless this may harm the child. This is less the case in child and adolescent psychiatry, because secrecy and privacy represent an essential ingredient in dealing with the users.

Often doctors are stuck in their choice between various solutions of an ethical problem. One of the facilitators to find the best solution is the following question: "Where is the best interest of the patient?" Obviously here, it is not in the interest of the child that the father knows what he possibly told the doctor.

The therapist has a duty to protect not only the confidentiality and privacy of the young patient, but also his/her future effectiveness in being of help to him, and to some extent the physical integrity of the patient should the father lose control as it seems to be happening already.

**Case Report No. 18****Topic: Confidentiality**

A 27-year-old, single female appeared for treatment complaining of severe bingeing and purging behavior for over ten years duration. The patient spent well over 12 hours a day gorging on food and then vomiting. As treatment progressed, it became clear that the patient's behavior was her attempt to prevent herself from acting on severe and continuous suicidal ideation and intent. The patient did not live with her family, but her parents were located in the same city and were not aware of the severity of her condition. The patient became engaged in long-term outpatient treatment, with intermittent hospitalizations when the suicidal intent became too intense. After several years of treatment, the family concluded that the patient had become overly dependent on the psychiatrist who was treating her, and attempted to have the psychiatrist's superiors remove him from treatment with the patient. Even when this occurred, the patient did not wish her family to know about the nature and severity of her condition.

A. Tasman,  
USA

**Question: Should the family be advised about the nature or severity of the patient's condition?**

1. NO. The medical team should respect the rule of confidentiality.
2. YES. The risk of the patient's putting end to her life justified the interference on behalf of her close relatives

**Comments:**

It is clear that in the context of this therapeutic relationship the wish of the patient should be respected, meaning that the doctor has no right to disclose neither the diagnosis nor the prognosis to the parents. Even if disclosed, this will be of no

help to the patient, because of the gap existing between the patient and her parents.

The patient is an adult and it appears that she is competent. Competent adults can make irrational decisions for as long as they are reasoned decisions. The argument that it will be good for her to obtain the support of her family is paternalistic and utilitarian. It may be that, existentially, she will be better off fending for her own survival on her own than becoming dependent on the help of her parents. Freedom has its costs and, sometimes, the worst slavery is that coated in goodness. This case shows how important is the cultural background from the medical and from the ethical points of view. It would be impossible to imagine an ill single young girl living alone in a different home than her parents' in a traditional society. This is why the concept of autonomy is essential in many countries from North America and Western Europe, and this is why it is weaker in many traditional societies from Asia, Africa and Latin America.

**Case Report No. 19****Topic: Scientific Publication**

Dr. X. published a paper based on two dreams from psychotherapeutic treatments (without any identifying clues), making detailed diagnostic and prognostic comments. A brief version was published in a magazine dedicated to Human Sciences Updating.

As Dr. X. was a prestigious colleague, I used to include his name in my list of professional references.

When my hospital workmate asked me for a therapist, I gave her three names, including Dr. X. She categorically rejected him because she considered that he badly harmed her sister, when she was his patient.

The problem originated from the above mentioned paper. The patient had bought the Human Sciences magazine at a newspaper and magazine stand, precisely because she saw her therapist's name as an author. She was deeply upset when she recognized her own dream printed in the magazine, and when she realized (even if nobody else could recognize her as the patient), that the theoretical comments were about her personality and her psychological conflicts.

She interrupted her treatment and rejected any meeting with her former therapist.

Y.B.  
Uruguay

**Question: Was the psychiatrist entitled to publish the article in this case?**

1. YES, because the article did not include any identifying details.
2. YES, the patient's right to privacy is opposed by the right of the public for the improvement of its health. Publication of scientific research contributes to the advancement of science and medicine.
3. NO, because the right to privacy overrides any other right.

4. NO, the doctor should have shown the article to the patient and requested her permission to publish it, either as it is or with corrections requested by the patient.

**Comments:**

To whom belongs the medical file of a patient? The trend worldwide is to make it the property of the patient. This is also true for any production of the patient, artistic or otherwise.

This is why the public use of a case without the agreement of the patient is not ethically acceptable. Even the direct or indirect use of a clinical case for didactic purposes needs the green light of the patient. This does not apply to small pieces of actual case-vignettes when they do not describe the whole case in detail (e.g. content of hallucinations, description of the behavior of a jealous person).

The main problem remains with the publication of a case, knowing that second-hand use of the scientific article may happen if it is of interest to the media. An informed consent from the patient is a clear necessity, even if the person cannot be recognized through the information contained in the article. Apart from breaching ownership rules, the therapist also violates rules of confidentiality and privacy even if the patient cannot be so easily recognized (she did recognize herself, which is enough!). Utilizing her materials helps the therapist in his reputation, but it is of no gain to his patient. For centuries, social good or the benefit of science has been advanced as utilitarian argument to justify the use of humans as subjects of research (especially prisoners), often without their consent and to no personal gain for them.

Psychiatrists are prohibited from making use of confidential information for academic benefits. Psychiatrists are obliged to disguise their clinical data, even though it is detrimental to the scientific value of the material, in order to avoid the recognition of the patient. Sometimes material may be so impossible to camouflage that it should not be published at all, in spite of its scientific value.

**Case Report No. 20****Topic: Informing the patient**

D. was a 43 year old man who suffered from a chronic and severe bipolar affective disorder for which he was undergoing a prolonged hospitalization. One day, the nurse in charge of the ward where he was hospitalized, received a phone call from D.'s sister informing her of the sudden death of their father. The sister also gave the nurse details of the father's funeral which was to take place the following day. The nurse contacted D.s psychotherapist, who happened to be on vacation, asking her what to do. The therapist instructed the nurse to withhold the information from D. until her return from vacation. This was so that she could inform D. personally about the loss and could offer him the therapeutic support necessary in order to avoid any major decompensation of his mental condition and also to provide an opportunity to elaborate in depth the relationship between D. and his father.

The decision of the psychotherapist was reported to the Department director, who immediately rescinded the therapist's decision and ordered that the patient be permitted to attend his father's funeral and to take part in the Shiva (the traditional seven days' mourning period in the Jewish religion), even providing him with an accompanying staff member. The Director's reasons for the decision were twofold:

1. Patients have the right to know and the right to experience events of great personal significance at the time when these occur and not when it is convenient for the therapist to inform them. (In this case the therapist was not prepared to interrupt her vacation in order to be with the patient in his hour of distress.)
2. It is the duty of the staff working in the hospital to take direct care of patients of those therapists who are temporarily absent from the hospital because of illness, holidays or sabbaticals etc. It is their duty to provide those patients with all the necessary treatment and emotional support, especially when the patients are confronted with distressing personal events.

Epilogue: The patient participated in the funeral and the Shiva, and

behaved in a fairly well-adjusted manner. When his therapist returned to the hospital she was able to elaborate the different reactions of the patient to those difficult events.

R. Mester,  
Israel

**Question: Should the patient have been advised about the death of his father and permitted to attend the funeral?**

1. NO, it was better to protect the patient from the grief entailed in disclosure of the information and participation in his father's funeral.
2. YES, the patient has the right to be respected and to receive truthful information.

**Comments:**

Patients have the right of self-determination, to make free decisions regarding themselves. One of the most perplexing moral dilemmas in health care results when the moral principles of benefiting the patient and of respecting the patient's autonomy cross each other. Not sharing the truth with patients is to deprive them of their freedom to choose whichever course of therapy they wish to take and to reduce their status as moral persons. The conclusion that honesty is the best policy in medicine raises the question of just how the truth is to be told. Full and frank disclosure does not necessarily mean a painful detailing of every possible facet of the decision.

The medical power is a reality. This is why it should go hand in hand with a deep sense of responsibility. Even though the patient suffers from a severe form of bipolar disorder, and may be particularly sensitive to loss and separation, it would have been a significant trauma not to be informed about the death of his father and not to attend his funeral. The ceremonial surrounding it, with all the social support that goes with it, are

probably at least as efficacious as the help of a psychotherapist in lowering the trauma impact on the patient.

In case of absence of the treating doctor, and in case of emergency, other doctors of the medical team usually take the responsibility to change the treatment, even if it is of a psychotherapeutic nature. The decision of the head of the department, after discussion with the other members of the staff, was the right one.

Within the psychotherapeutic process however, it is important for the psychotherapist to clarify her position to the patient, and to explain why she suggested not to inform the patient about his father's death while she was away for vacation.

The therapist's reasoning to substantiate her decision to withhold the news and to deprive the patient from participating in a social and religious ritual of high significance to her could be seen as paternalistic and heavy handed and to be of benefit to her alone, not her patient. While the therapist analyses the risk of revealing the bad news to the patient, she does not analyze the risks of not revealing the news, which could be more devastating than the reverse. Her self-serving decision is of no good to the patient.

**Case Report No. 21****Topic: Forced treatment**

A 50 year old man had served a five year term for raping a young woman who had previously conducted a sexual relationship with him, although he was HIV positive. He had previous convictions for rape, the last sentence being relatively mild because experts expected him to die from AIDS while still in prison.

The psychiatric expert had testified during the previous trial that he had an antisocial personality disorder but that his responsibility for the criminal act was not diminished. During his prison term the available treatments for AIDS improved substantially. He profited from this so that his health was better at the time when he was to be released than at the time of the previous trial.

HIV specialists, who had treated him while in prison, the public and politicians were concerned that he could be dangerous after release from prison and pressed for a psychiatric examination in order to have him civilly committed to a psychiatric hospital.

N. Nedopil,  
Germany

**Question: Should a psychiatric examination be required for purposes of protection of public health?**

1. YES, a forced examination is justified for the public good since we are concerned with a criminal with an antisocial personality and a criminal history who is likely to harm the general community.
2. NO, there is no point in an examination because there is no way to hospitalize him.
3. NO, because mental health resources should not be used to enforce legal protection against criminality in the absence of mental illness.

**Comments:**

This is an issue of major importance on health policy. It pertains to social policy and the justice correctional management of serious criminals. Many of these persons have criminal pathology that requires criminological management, not clinical management for which there would not be any treatment available other than custodial holding. This very fact, that there could be utilization of mental health resources that are already scarce on holding criminals instead of providing beds for mental patients touches on matters of equity and fair distribution of health care resources and resource allocation to mental patients and whether resource allocation is a legitimate and fair process in society. A peripheral issue on this case is public health for which a vigorous debate will be necessary on whether society has the right to incarcerate individuals preventatively as a means to protect the health of the population from potential transmissible hazards of some of the members. What *quid pro quo* is society willing to enter into between protection of public health and curtailment to individual freedoms?

The problem of people with anti-social personality is that they are rejected by both systems: the psychiatric and the judicial ones. When they commit a crime, forensic psychiatrists recommend usually to the court the full responsibility of their acts. On the other hand, the judge sees well that these people "are not normal", especially when they have depressive, anxiety disorders associated to their personality disorder, as well as other behavioral disturbances, e.g. substance abuse, alcohol dependence, suicide attempts.

It is probably this hesitation which allowed the recurrence of the raping behavior. It is clear that such person needs a psychiatric assessment from time to time, but if the person does not accept to be seen by a psychiatrist regularly in order to get rid of his behavior (which is the most probable), he would never show up, and would rather be driven towards anti-social behaviors, including rape. The only answer to that specific behavior remains judicial, in order to protect the society, with

the secondary help of psychiatrists.

Another issue in this case is to be sure that this person does not present a dementia due to his HIV infection.

**Case Report No. 22****Topic: Forced treatment**

A 46-year old engineer with acute relapse of paranoid schizophrenia calls at the emergency room of the local psychiatric hospital politely requesting admission to the closed ward. He is reporting vivid delusions of persecution (e.g. being attacked by cosmic rays sent from satellites driven by extraterrestrial creatures } which bring him to a state of “mental and physical paralysis”) and hallucinations (e.g. hearing the warning voices of those creatures, feeling the painful penetration of his body with the rays). After entering the ward the patient rejects the proposition of psychopharmacology stating he feels safe and comfortable staying in the closed ward, behind the bared and handleless windows, as his persecutors are not able to get at him there.

K. Orzechowska Juzwenko  
Poland

**Question: What should the psychiatrist do in this case?**

1. Provide the patient with comprehensive information regarding his condition, possible methods of treatment (including psychotherapy, sociotherapy and pharmacotherapy), and the consequences of refusing treatment. He should throughout be patiently trying to convince him to accept the therapy.
2. Initiate competency proceedings with a view to seeking authority to treat the patient involuntarily.
3. Treat the patient immediately and attempt to achieve mitigation of his psychosis.

**Comments:**

Generally, a patient has a right to refuse or stop treatment, subject to a few exceptions.

Firstly, if domestic legislation provides that, having regard to the patient’s own safety or the safety of others, the patient unreasonably withholds consent to treatment.

Secondly, in case of emergency. An emergency is an acute medical condition liable to cause death, disability, or serious illness if not immediately attended to. The rationale for this exception is that since a reasonable man would consent to treatment in an emergency if able to do so, it is presumed that any patient would give consent under such circumstances.

Thirdly, when the patient is incompetent. A person is deemed competent if he can understand the nature and consequences of the proposed medical procedure.

In case of disagreement with the patient, it is important to know if he or she is competent to take the right decision for one's own interest. Is there anybody in the family or the environment of the patient who could convince him to take medications? Another option, in some European and North American countries, is the possibility to go to court, asking for the permission to force the treatment on the patient.

The best solution remains negotiation with the patient trying to convince him about the benefit he may get from neuroleptics, such as a better sleep and less anxiety.

In many countries where the beds are organized on a population basis and hospitals have to provide evidence of good management of resources, occupying a bed when it is not necessary increases the costs and deprives others from a needed resource. Resource allocation and their good management dictate that unless a patient is fully benefiting from the investment this should be stopped. In this case, the patient seems oblivious to this need so that clinicians have to take action. Although utilitarian, issues of fairness to the payer and to the population demand that the patient be confronted with his refusal and either be declared healthy and discharged, or incompetent and be treated.

When any treatment is authorized without the patient's informed consent, every effort should be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practical in the development of the treatment plan.

**Case Report No. 23****Topic: Forced treatment**

B. was a robust woman of 57, married and the mother of three adult children. She was admitted to a psychiatric hospital due to a severe retarded depression disorder.

The physical examination on admission revealed a large tumor in the left breast with clear clinical signs of malignancy, such as invasion of the skin and a pustulous purulent crater. The consultant surgeon advised immediate surgical intervention.

B. refused surgery claiming that she was examined by a surgeon before admission and was informed that she was in good physical condition and did not require any physical treatment.

The Director of the department to which she was admitted discussed the situation with B.'s family and explained to them that he felt that she was not competent to decide for herself on matters relating to her health. Consequently, he arranged with them to provide the husband with a medical report recommending to the court that he be appointed her legal guardian in relation to her medical treatment.

The husband subsequently gave his informed consent to the operation. B. refused verbally to be operated but did not show any physical opposition to being transferred to a surgical unit where she underwent the appropriate operation. The histological report revealed that she was suffering from a malignant cancer. On recovering from the operation, B. was returned to the psychiatric ward.

After the operation, B.'s depression cleared up, she became active again and was discharged from the hospital a few weeks later. A follow-up five years later showed that B. was in fine mental condition, and had been functioning well without any relapses or recidivism of her cancer.

However, during all the years she continued to claim that the Director of the psychiatric department where she was hospitalized was wrong, since she had never had a cancer in her breast.

R. Mester,  
Israel

**Question: Was the surgeon entitled to operate on the patient in this case?**

1. YES, the patient denied her illness and the need for surgery. The patient's husband was appointed guardian in accordance with the recommendations of two psychiatrists and he gave his consent for the operation.
2. NO, the patient opposed the operation. Every person has the right to disagree with an evaluation of his medical state and should not be deprived of his personal independence.

**Comments:**

In this case, the doctors did exactly what they had to do, and the course of the illness showed clearly that they were right. The behavior of this lady is a clear case of denial. Oncologists know well about such cases, when despite all scientific evidence of the existence of a cancer, the patient continues to think that nothing is wrong with his/her health. There are cases of experienced radiologists with a lung cancer, with obvious images of cancer on the X-rays, who interpret the signs in favour of a much more benign illness.

Other cases of patients with cancer, who in an oncology ward, talk with other patients and telling others how glad they were, because they were operated just before having a "real cancer".

Denial is a way to fight death anxiety, and should be dealt with in a soft manner, unless it is a matter of life or death, as it was the case here, and urgent action is required, with the help of the judicial system if necessary. Moreover, this lady had a severe form of depression which made her probably incompetent to choose the right solution for her health problem.

It is likely that this patient was incompetent out of her depression plus unspecified mental symptoms of the cancer itself. The cancer was operable and possibly had a good prognosis if intervened immediately. Declaring the patient incompetent to make such very important decision on account of her mental

illness may appear heavy handed and contrary to principles of autonomous decision making. Yet, this principle is not an absolute and can be overridden if proper legal procedures are followed, the best interest of the patient and her family are safeguarded, treatments are available, and the intervention is expected to have a good probability of success and prolongation of life. These principles were all present in this case. Her subsequent continuous denial is inconsequential and harmless.

**Case Report No. 24****Topic: Forced treatment**

Ruth, an 80 year-old holocaust survivor living alone in her home, was born in Poland and was in a concentration camp until the age of 22. She lost her entire family during the war. She moved to Australia with her husband and was happily married, but had no children and only a few friends. Her only relative is an 84 year old sister who suffers from dementia and lives in a nursing home. Ruth became depressed after the death of her husband from a stroke two years previously. She is also experiencing significant anxiety and difficulty in coping on her own. She has no previous mental history, but suffers from hypertension.

While on treatment at home, she experienced severe nausea and vomiting to the antidepressants making it necessary to admit her, involuntarily, to a psycho-geriatric unit. A case manager was appointed with a view to organizing support at home. She was considered to be seriously depressed with persistent low mood, lack of energy and motivation, poor self-esteem, obsessive rumination, but no suicidal thoughts or psychotic symptoms were elicited. Minimal state was assessed at 27/30. The organic work-up was unremarkable. Neuro-psychology report showed a borderline to low-average range for executive function and memory. Although she reacted better to new medications and responded well to the support in the clinic, even participating in group activities, she continued to experience significant anxiety and suffered a relapse with deterioration of her mental state when advised that a guardian had been appointed. Although she accepted this decision, she objected to being placed in a nursing home, wishing to return home on her own and, yet, acknowledging that she would not be able to manage. Worsening depressive symptoms, severe agitation, expression of suicidal thoughts and deterioration in self-care occurred despite the current treatment with medications.

On consultation, two psychiatrists recommended electroshock therapy (ECT), or adding another anti-depressant medication. She reluctantly accepted to take the new medication, but refused consent for ECT. Her guardian agreed that her doctor should go ahead and

treat her with ECT.

S. Bloch,  
Australia

**Question: Should the patient be treated by ECT against her will?**

1. YES, two psychiatrists have found that the treatment will benefit the patient.
2. YES, her guardian agreed to the proposed treatment.
3. NO. The psychiatrist should explore alternative treatment that will probably be more acceptable by the patient.

**Comments:**

In principle, a major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent. Electroconvulsive therapy may not be performed unless informed consent has been given by the patient or his guardian.

Social support is an essential part of the management of mental disorders, especially when patients are old and isolated. Loss for this patient is multiple: a demented sister, a deceased husband, poor health and finally the designation of a guardian meaning to her loss of liberty, all happening in a relatively short period of time. No wonder that her depression worsened, and that ECT was indicated.

Her direct participation to the decision making should however be sought, explaining with patience the necessity of a medical treatment to overcome her depression. It would be better to try other antidepressants before ECT because she does not agree. This is a way to give her again a certain sense of ownership of her own life, the very last thing that she still have,

if doctors allow it.

As age advances, a sense of loss of controls on our lives sets in, others make decisions, and those on whom one has relied upon in the past are gone or are as incapable as ourselves. Social death creeps in and makes us irrelevant. Alone in our own surroundings, at least we still have some memories and the objects we have collected remind us of our past and where we belong. Thus, the final dislocation comes when we have to leave the last vestige of ourselves and be moved to a nursing home at the mercy of strangers be they staff or other residents. Depression is practically inevitable and this may be made worse by medications we require for our many ailments. It may be that heavy treatment like ECT are required in a case like this, but a good case will have to be made after balancing benefits and risks on a patient at this age, alone in the world and bereft of anything or anybody that gave meaning to her life.

**Case Report No. 25****Topic: Forced treatment**

Victor is a 78 year old retired man who has a history of schizophrenia that went untreated for many years. His compliance with medication has been erratic. There are concerns about whether he also suffers from dementia (Alzheimer). He has several medical problems, especially arthritic pain. He does not have a regular family doctor, but attends to several doctors in different parts of the city. One doctor placed him on multiple testosterone injections and he was using dangerous quantities of other medications. This led to an acute urinary obstruction that required emergency prostate surgery, the seriousness of which was not understood by the patient or his family. He was further transferred to the psycho-geriatric unit.

Victor lives at home with his wife and adult son. Two other children live independently. His relationship with his wife is strained on account of his abusive verbal behavior towards her and his accusations that she is a prostitute and that she has liaisons with other men. He has become violent. Recently he put paint thinner in her denture cup and placed steel wool in her food. He also pulled a kitchen knife on his son and has, on numerous occasions, left the gas stove on after cooking. More recently, he left the emergency room of a hospital when advised that he needed surgery for acute urinary retention.

His wife is scared of him and she feels that she can no longer look after him at home. She believes that he is unsafe and dangerous and in need of placement. His son supports her, but other members of the family are opposed and believe that she and the son have their own reasons so they are pressuring his son to protest against any intervention from the psycho-geriatric team. The team considers that Victor is unable to take care of himself due to declining cognition, especially executive decision-making. Victor feels that he has been unduly incarcerated against his will. He constantly contacts his immediate and wider family to help “rescue” him. On the other hand, other than his wife and his son, the rest of the family does not think that he is at risk. They do not seem to understand the severity of his illness and his impaired capacity to make rational decisions. The team’s decision is that Victor needs placement and they have

successfully applied for a guardian.

S. Bloch,  
Australia

**Question: Should the patient be committed to the hospital?**

1. NO, firstly, it is proper to give as much consideration as possible to the wish of the patient. Secondly, there is no evidence that the patient might injure himself. Thirdly we should not rule out the possibility that the patient's wife and young son are requesting hospitalization for their own personal convenience; and finally, insufficient consideration has been given to the question as to whether either of the families of the elder son and daughter would be prepared to take him in.

2. YES, treatment of the patient justifies his commitment to hospital, especially as the team is maintaining contact with the guardian who had been appointed for the patient.

**Comments:**

This patient suffers from schizophrenia and from a probable Alzheimer's disease. His dangerous behavioral disturbances, as reported by the wife and the son, make it necessary to treat him in the hospital for a certain duration of time, and to designate a guardian.

However, the fact that some other members of the family do not believe that he might be dangerous for himself or for the others (gas stove on after cooking, threatening with a knife for example), should put forward the question: is there a specific conflict with his wife and the son living with him? This will not change essentially the decisions taken, but would help better manage the discharge of the patient from the hospital after treatment.

The patient has an acute medico-surgical condition, urinary retention, that if untreated will have major complications and

even death over a period of days. Furthermore, he has an undiagnosed mental condition that, regardless of its nature or diagnosis, is serious enough because of behaviours that pose a danger to himself or others. Under these circumstances, in many countries, he would be committable (involuntary hospitalization). Personal autonomy and freedom will have to be sacrificed for his good or the protection of others.

Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission. "Involuntary admission" means the admission and detention for treatment of a person suffering from mental disorder in a hospital or similar establishment, the placement not being at his own request. A patient may be placed in such an establishment only when, by reason of his mental disorder, he represents a serious danger to himself or to other persons. An important element is the qualification that the patient is not competent to decide for himself about psychiatric treatment.

**Case Report No. 26****Topic: Forced Treatment**

Tim is a 63-year-old man, living with his wife. He has no children and is being treated with palliative chemotherapy for his metastatic bowel cancer. He seems to be responding well, but he had to be admitted to psychiatry four months earlier because of severe depression characterized by lowered mood, anhedonia, poor sleep, anxiety, and overvalued ideas bordering on delusions. He has shown some improvement, but takes medications reluctantly needing much persuasion, claiming that “there is no point”, despite evidence and medical opinions to the contrary. His refusal is clearly associated with his depressive episodes, but his wife appears to be colluding with him as she is a devotee of alternative medicine. It is suspected that she is not giving him the medication.

S.Bloch,  
Australia

**Question: Should the psychiatrist use physical or mental treatment against the will of the patient?**

1. YES, the patient has melancholic depression which is preventing him from consenting to treatment that would prolong his life.
2. NO, the patient is not mentally incapacitated and can take responsibility for his own life.

**Comments:**

Cancer is often associated with depression, which does not help compliance with the anti-cancer treatment.

If the patient was currently presenting a severe depressive episode, a forced treatment may have been envisaged.

However, the patient is complying and taking his medication albeit reluctantly and despite his wife’s misgivings. His own

doubts may be related to his depression, but nothing seems to indicate that he is incompetent. As such, he cannot be forced to adhere better to the treatment although he could be urged and the medical team should do its best to enrol the help of his wife and other members of his family. He is still capable of autonomous decision making and this will have to be respected.

**Case Report No. 27****Topic: Forced Treatment**

Arnold is a 24 year old unemployed man, who used to live independently in a home adjacent to his parents' large property. He associated largely with "alternative" and "greenie" groups. He was referred to psychiatric services by the community outreach workers who had concerns about his physical and mental state. He had been eating minimal amounts and appeared malnourished and emaciated. He could barely walk and had collapsed several times. He had been subsisting on a skimpy vegetarian diet. At 184 cm and a weight of 44kg, his body mass index was only 13. His mother reported that he began to lose weight approximately four years before when he became interested in alternative medicine and dieting. He had read alternative nutrition materials and was convinced that fruitarians were happier people. He believed that non-organic foods were toxic to the vital organs and manufactured as part of food and drug "conspiracies". He claimed that dairy products were "mucous forming" around the throat, which interfered with absorption. He also believed that eating root vegetables meant "killing" the vegetable and that his fasting would make him live longer. Three years earlier he had moved into a van and isolated himself, was disheveled, and walked around town with only a blanket on, becoming verbally aggressive when confronted. Eventually he began to suffer from urinary incontinence. On admission, despite his life threatening physiological changes, he insisted that his weight was adequate and maintained that if he had survived on his diet thus far, his food intake must have been adequate. He felt that people come in different shapes and sizes and commented that people who are obese are not locked up. He did not accept the abnormal results of his X-rays, blood tests, electrocardiogram, etc. He had no interest in contact with psychiatric services and he was generally mistrusting of doctors.

Arnold proved a difficult diagnostic and management problem. He required urgent nasogastric re-nutrition against his will as an involuntary patient. In undergoing such treatment, he felt that doctors were "fascist" and that, as a free citizen, he had the right to eat what he wanted and not have to adhere to conventional westernized ideals. He did not view himself as a mental patient, and accused the system

of being intolerant to alternative lifestyles and beliefs.

S. Bloch,  
Australia

**Question: Should the patient be fed against his will?**

1. YES, the physical state of the patient has deteriorated to an extent that constitutes an actual danger to his life. For the benefit of the patient and the preservation of his health and life it is permitted to force feeding him.

2. NO, the patient has the right to determine his own philosophy of life and to behave accordingly. He has not lost his sanity and he deserves to enjoy the respect of society for his wishes, as long as he does not infringe the rights of others.

**Comments:**

A number of delusional beliefs are clouding this patient's judgment so that his autonomous decision making is seriously compromised.

The patient was clearly in danger of dying sooner than later if nothing was done by the doctors. His delusional way of managing his food intake and his general isolated way of life are probably part of a schizophrenic disorder. Leaving the patient without care would have certainly led him to death.

Some less serious cases of this kind are much more problematic, when there is a clear delusional way of dealing with food intake, a serious loss of weight, endangering the health of the patient (e.g. proneness to infections, avitaminosis) without a direct and immediate threat for one's life. The intervention of the doctors is much more difficult then.

**Case Report No. 28****Topic: Forced treatment**

A 43-year-old patient has suffered from schizophrenia since he was 20. At the moment it is a chronic form of schizophrenia with chronic deficits, domination of negative symptoms, and constant presence of delusions. This is known from the patient's mother because he refuses to contact a doctor. He has never been aggressive to others and never fulfilled the criteria for compulsory hospitalization. Recently, his mother has noticed a worsening of his health with intensified positive symptoms which impair his social functioning. She asked for a compulsory treatment, but in the best interests of the patient, the psychiatrist prescribed risperidone in liquid form to be added to a soup by the mother. This gave a good result - the patient started to walk his dog for the first time in six years.

C. Hoschl,  
Czech Republic

**Question:** Was the psychiatrist allowed to collaborate with the mother by assisting her to provide the medicament to the patient without the latter's knowledge?

1. YES, the benefit to the health of the patient justified this action.
2. YES, it was permissible for the psychiatrist to supply the prescription for the patient. The subsequent actions of the mother need not concern the doctor.
3. NO, the patient and only the patient is being treated by the psychiatrist who has sole operative responsibility. The doctor is not permitted to cooperate in depriving the patient of his independence.

**Comments:**

In principle, a patient shall be entitled to have access to the information concerning his health. Treating a patient without

his knowledge is not considered usually to be ethical.

Moreover, prescribing a medication to a patient without examining her or him is not acceptable and implies legal responsibility in case of serious side effects.

Treatment without examination and full knowledge of the patient is already a wrong premise, providing it without the patient having given the benefit to know of his condition and to be an active participant in his treatment violates his autonomy, no matter how well-meaning the doctor and the patient's mother are. The utilitarian argument that improvement has taken place does not modify the fact that deontologically speaking, deceitfulness is never a good base for action.

However, there might be a number of situations where this solution can be considered: if the patient is not competent, or if the patient lives for example in a very remote area and no doctor is around, as it happens in many regions in developing countries. The right of the patient to be informed may be subject to restrictions in order to prevent serious harm to his health. However, this privilege is open to great abuse, and psychiatrists should make use of it only in extreme circumstances.

**Case Report No. 29****Topic: Unnecessary treatment**

A 26 year old woman contacts a psychiatrist because she is perplexed by a situation which she does not know how to handle.

She was born of Turkish immigrant parents, and has been brought up in a Western European country. With respect to norms and values in the sphere of women's behavior she feels that her personality has been split by two cultures. She has had sexual relations without the knowledge of her parents who are arranging for her marriage to a young man from Turkey. She knows that her prospective bridegroom's parents are traditional and will accept only a virgin as their daughter-in-law.

She reluctantly contacts her family doctor for advice with reference to the restoration of her virginity. She is met with a refusal since he cannot recommend that a tradition be upheld that does not provide a woman with freedom to choose her sexual partner.

The young woman is distressed by the fact that the date of the marriage is approaching and she believes that her family will be disgraced and she will become the object of contempt.

**Question: Was the doctor's refusal to operate on the patient justified?**

1. YES, patients cannot dictate their medical treatment to their doctors, especially in the case of medically unnecessary surgery.
2. YES, the result of considering the interest of the patient would be against the cultural beliefs of her community.
3. NO, giving the requested treatment would benefit the woman and improve her mental health.
4. NO. If the treatment is denied, the expected damage to the woman would be immeasurably greater than an arbitrary insult to the intended bridegroom or his family. In any case the treatment should be given secretly.

**Comments:**

Many medical or surgical interventions are unnecessary. Witness the dieting prescriptions and most cosmetic surgeries. Vanity is not a disease, but millions of persons seek treatment to maintain it intact. This request for hymeneal restoration could be construed as vanity maintenance albeit coloured by cultural traditions and, if not done, some potentially dire consequences. This is a typical case of lack of cultural sensitivity. The doctor should have, at least, consulted with a doctor from the same nationality or the same region of the patient. The information would have been then that this kind of surgical operation is very frequently done, in order to save the face of the girl and of the family.

It is hypocritical, but it may save the life of a non-virgin girl, even when she lives in a Western European country. The weight of traditions is so heavy, the presence of the family and relatives is so important, and the dependence of the individuals, especially women, towards their community is so crucial, that a transgression such as this one would lead to the exclusion from the community for ever, and sometimes to her murder. But if the girl is willing to acquire more autonomy towards her family and her tradition, the duty of the doctor is to help in this hard and difficult endeavor.

**Case Report No. 30****Topic: Forced Hospitalization**

A 37 year old married female, mother of 4 year old twins, with medical education, received an assignment at a governmental organization. From the very first days she distanced herself from the staff. She obeyed the orders of the administration, but frequently seemed to be distracted from her duties. After four weeks, colleagues noticed her bizarre behavior: speaking loudly, criticizing others, demonstratively varnishing fingers and continually drinking coffee. They tried to communicate with her, but she moved close to the window of the office at the thirteenth floor. She claimed that unknown fingerprints surrounded her and she was trying to transmit the information directly to the chief security officer of the country. The manager contacted the husband, who told him that he had known her for five years and had no knowledge of her ever consulting a psychiatrist, but there was a “non-significant mental problem” after the birth of the twins. The husband came to the office, but the woman did not permit him to approach her. She attempted to throw herself from the window, and the police with support of an ambulance crew took her to the psychiatric hospital. At the reception, the woman, her husband and her brother refused to stay at the hospital. The reception ward psychiatrists let her go home under the supervision of the family.

G. Naneishvili  
Georgia

**Question: Should the patient have been released from the hospital?**

1. YES, everybody, including the mentally ill, is entitled to personal independence and to have his wishes respected. It was obligatory to respect the woman’s wish to return home especially as she was accompanied by members of her family.
2. NO, the hospital emergency room received information regarding the pathological behavior of the woman at work. They were also aware of the recent suicide attempt. It was

therefore obligatory to advise and/or persuade the woman to undergo a short period of hospitalization for the purposes of diagnosis and treatment. Otherwise they should have applied to the appropriate authority for a hearing regarding this option.

**Comments:**

It is important to remember that many women develop a post-natal depression after delivery. This seems to have been the case for this lady four years ago. Another pathological episode, probably of affective nature (delusional depression, manic episode or mixed state), was may have been triggered by the new governmental assignment.

The important issue here is to know whether the patient could be treated at home or not. The answer to this question depends on the quality of family and community ties. The only problem is the probable minimization of the husband towards the episode of post-natal depression of the patient, which may lead to lack of compliance of the treatment in case the pathological status remains sub-acute for a long period of time.

The case report implies that this person had a mental problem previously and her behaviour at work is clearly abnormal, if not psychotic. To refuse to look into determinants of her behaviour and, then, to threaten to commit suicide by defenestration in front of her husband and coworkers requiring police and paramedical intervention, are clear signs that this person needs help. Every person not admitted involuntarily shall have the right to leave the mental health facility at any time. However, personal autonomy to make treatment decisions does not impose a duty on others to put up with disruptive behaviour or on an employer to accept labour disruptions that may create a climate of insecurity in the workplace. Much as the patient can make her decision about accepting treatment, so the employer can make a decision to terminate her employment given that she had just joined and was likely on a probationary period. The other issue pertains to the responsibility of the emergency doctors on releasing her. If her behaviour is

disruptive enough at work to be considered psychotic, it is unlikely that she will be different at home where there is the added complication of taking care of the children who, then, could be exposed to risk. Great as the family system could be, psychotic and disruptive behaviour without treatment would be exceptional and impossible burden of care to impose on a family. The State represented by the health system is not living up to its responsibilities towards this person and her family and is placing her and others, at least the children, at risk.

**Case Report No. 31****Topic: Unnecessary hospitalization**

A 58 year old male, diagnosed with paranoid schizophrenia in full remission, is placed in a psychiatric hospital for 8 months, as he has no private place to reside in. The patient has no official guardian. His brother, who sold the patient's home without permission, refuses to take him from the hospital and take care of him. The patient has to stay in the hospital, where he has only the minimal basic needs for existence.

G. Naneishvili  
Georgia

**Question: Should the patient be discharged from the hospital?**

1. NO, the psychiatric establishment is supposed to be concerned with mental health, regardless of whether the patient resides in or out of an institution. In this case, removing the patient from the institution would result in returning him to a seriously ill condition.
2. YES, the function of the institution is to recommend treatment only for patients who need treatment in a closed environment.
3. YES, but only after the management of the institution will have verified that qualified external authorities will accept continuing responsibility for the patient.

**Comments:**

Too often, and this is a worldwide problem, psychiatric wards play the role of shelters for social problems. It is clear that, often, the people who have great social difficulties have similarly psychiatric disturbances. A vicious circle aggravates each of the problems by the other.

In developing countries, where the family is the main social support element, its disappearance results in fragile people in

cutting all kinds of social ties and leads to homelessness. The dilemma resides in the fact that discharging the patient would leave him dying in the street after a few weeks or months. On the other hand, filling all the beds with such social cases does not permit the hospitalization of those really in need of institutional care, especially psychiatric emergencies.

The solution, if at all possible, is to convince the local authorities to create social centers for such cases, and to send a psychiatrist once or twice a week to see those in need of psychiatric help.

In this specific case, it is strange that the brother sold the patient's house without his permission; on the other hand, the patient was not helped by a social worker of the psychiatric institution. A judicial solution may be sought for this specific problem.

At the core of this problem is the matter of human rights. Does the state have a right to imprison a mental patient on the guise of treatment when the patient does not need to be in a hospital? Hospitalization in a mental institution is a form of deprivation of liberty, hence incarceration by another name. Apart from loss of freedom and opportunities in society, this patient is also exposed to other restriction in his life as is usual in mental institutions, even possibilities of abuse as is also common in them. Thus, his human and civil rights are being abused and the case is a clear example of stigmatization and discrimination. The patient is in need of support services and the state ought to have an obligation to provide these at different levels and venues according to need. Allocation of health resources should include a proportionate share for this type of need. Every patient has a right to economic security and to decent standard of living. He has the right to be treated, cared for and work in the community in which he lives.

**Case Report No. 32****Topic: Unnecessary hospitalization**

A 47 years old, unemployed female, diagnosed with schizophrenia several times was treated at a psychiatric hospital. She had lived with her husband and all contacts with other relatives were lost. During remissions she used to do laundering at a country house. For the last few years, she lived alone, as her husband left her.

For two years she heard voices which issued commands to her. Under their influence she destroyed her own house by fire and was arrested by police and hospitalized. After a few years her mental status was stabilized; she now sincerely regrets what she had done. At the same time, she has no place to live after discharge. There is no assisted residency in the country, which is why she is still kept at the hospital. She has no prospects of improving her domiciliary status in the foreseeable future.

G. Naneishvili  
Georgia

**Question: Should the patient be discharged from the hospital?**

1. NO, the psychiatric establishment is supposed to be concerned with mental health, regardless of whether the patient resides in or out of an institution. In this case, removing the patient from the institution would result in returning her to a seriously ill condition.
2. YES, the function of the institution is to recommend treatment only for patients who need treatment in a closed environment.
3. YES, but only after the management of the institution will have verified that qualified external authorities will accept continuing responsibility for the patient.

**Comments:**

*Comments similar to those in the previous case apply here.*

**Case Report no. 33****Topic: Hospitalization**

Late at night, a 26 year old woman was brought by police to the admission ward of a big psychiatric hospital. During the previous day, she was arrested under suspicion of robbery and put into custody. In custody, she suddenly became agitated, although she never had mental problems before. Police considered her as a psychiatric patient whom they cannot handle and referred her to the psychiatric hospital, which is the only psychiatric institution that works 24 hours a day and mostly treats severely psychotic patients. The psychiatrist on duty learned that the woman was from another town and that she was 3 months pregnant for which she had regular medical documentation written by an obstetrician. However, gynecological clinic previously refused to admit her because of acute mental problem, explaining that it is out of their professional area and there are no gynecological indications for admission. During the interview, the woman did not show any psychiatric symptom or disorder, except mild situational anxiety. Still, she wanted to stay in hospital because she did not have money or a place to spend a night over. Police also insisted that she could not be sent back to custody. According to propositions of psychiatric hospital, only psychotic patients and those dangerous for themselves or others could have been admitted into emergency psychiatric ward. In addition, environment of psychotics could be unfavorable for a pregnant woman.

T.Cavic, D.Lecic-Tosevski  
Serbia and Montenegro

**Question: Should the woman be discharged from the hospital?**

1. NO. Sending her out in the middle of night will increase her agitation and anxiety as she did not have money or a place to spend her night over.
2. YES, as only psychotic patients and those dangerous for themselves or others were entitled to stay in emergency psychiatric ward.

**Comments:**

It is obvious that this person has basic needs to be taken care of: food, shelter, management of pregnancy and delivery. Hospitalization in a locked psychiatric ward, where patients may be agitated and sometimes violent is not humanly acceptable in absence of mental disorder, especially for a pregnant woman. This case is a social one and does not belong to psychiatry.

Basically, the problem is lack of an adequate social net that could provide help on an immediate, emergency, basis for a short period of time until other matters are sorted out. Definitely, the state cannot send this person to the street in the middle of the night especially in her pregnant condition.

**Case Report No. 34****Topic: Hospitalization of prisoners**

A 52 year old inmate of a prison, after suffering for several weeks from anxiety, depression and suicidal ideas was sent to the psychiatric ward of a hospital for treatment. Convicted of fraud he had been given a two-year prison sentence and had completed half his term.

After a few days in hospital he improved dramatically. He behaved well in the ward and was constantly visited by members of his family and friends. After a month of hospitalization it was decided that he should be discharged from hospital and returned to prison. Upon hearing the decision, he suffered a relapse and became suicidal. During a further fortnight of hospitalization, his health improved very quickly but he suffered a further relapse two days before he was due to return to prison.

M. El Yazaji  
Morocco

**Question: What should the decision be with regard to the prisoner in this case?**

1. The prisoner should be returned immediately to prison. The part of the therapeutic process is to help this person mature and assume responsibility to society.
2. Hospitalization should be continued because we know that prisons are pathogenic environments and this person does not have the personality resources to survive in the prison.

**Comments:**

Unfortunately, prisons have become repositories of mental patients anywhere in the world. It is an obligation of the state to provide treatment for them in prisons in the form of a psychiatric annex or regular psychiatric clinics in the same way that other prisoners with other medical conditions are managed.

Many prisoners suffer from some kind of mental disorders, mostly of anxious and depressive type. Others suffer from schizophrenia, bipolar disorders, and substance abuse disorders. The problem here is that depression and suicidal ideas were genuine at first. Then, he discovered that his psychopathology was the key to escape the prison sanction, and used it more or less as a way to gain a benefit from his illness. This was mixed with an authentic suffering generated by the idea of returning to the prison environment. The question is how much manipulation is there in the symptoms he presents to the doctor. The patient has to accept his responsibility for his criminal action and the hospital cannot keep him for the remaining of his imprisonment, nor convey the message that it is alright for prisoners to sojourn in the mental hospital at will.

The concern of the treating team is the occurrence of an effective suicide of this patient if he returns to prison. A possible solution might be for the treating doctor to organize regular consultations for the patient in prison.

Professional and moral obligations for clinicians include a thorough and dispassionate analysis of diagnostic elements based on which they make management and treatment decisions.

**Case Report No. 35****Topic: Hospitalization of prisoners**

A 45 year old patient, 10 years ago committed a financial crime and as a consequence he will be committed to prison in the next few months. He asked to be committed to a psychiatric hospital. He leads a big company. According to his wife he has mentally changed, during the last six years. He has developed persecution delusions and his employees in fact run the company. Last year during a worsening of his symptoms, a paranoid syndrome was diagnosed and he made a serious suicide attempt. He was treated in a psychiatric hospital with risperidone with good results. During psychiatric examination, a depressive disorder and questionable diagnosis of schizophrenia was entered. There is no strict necessity for hospitalization. However, the patient is demanding a referral to a hospital, but is refusing to assent to pharmacological treatment. He claims that he is not ill; he merely wants to avoid imprisonment.

C.Hoschl,  
Czech Republic

**Question: Should the defendant be admitted to a psychiatric hospital?**

1. YES, the defendant is a mentally ill patient who has been hospitalized in the past, and on clinical grounds, should be hospitalized now. His claim that he is not ill, and that his request stems from his desire to avoid imprisonment, may be considered as part of his psychiatric disorder. It is to be hoped that on hospitalization he will agree to receive medical treatment similar to the successful treatment which was previously given. The admission should be for psychiatric evaluation.

2. NO, the defendant was sentenced to imprisonment, and according to his own words his request to be hospitalized was not made in order to obtain curative treatment, but in order to avoid his punishment.

**Comments :**

Personal responsibility and acceptance of the consequences of one's actions is part of being mature and able to form part of any social group.

This patient cannot on the one hand ask to be hospitalized because of illness instead of being in jail, and refuse to be treated on the other. This discrepancy may be due to his illness and hence advocates for him to be hospitalized, at least for a psychiatric assessment.

The usual question asked by the court to an expert is: "was the defendant mentally ill and incompetent when he committed the offence or the crime?" If not, the court tries the person, even if he becomes mentally ill afterwards.

Being a prisoner with a paranoid schizophrenia or a depression is not unusual. The treatment could be started in the hospital and continued in prison.

Mental illness can be used at times as excuse for some actions and every country has parameters to regulate these exceptions. That is not the case here as that mental illness was not at play at the time of the crime or at sentencing. Considerations on resource allocation demand that resources be used for those in need, not for those in want. Only a thorough evaluation of the person can determine the need for services. The ethical obligation of the clinician in this case is to conduct such evaluation and to make decisions according to the findings.

**Case Report No. 36****Topic: Expert testimony**

A 29 year old Turkish worker, who had come to Germany four years before, stabbed his wife and wounded her severely. Her life was saved only because he rushed her to the hospital for emergency surgery.

In court both claimed that they had a quarrel before the stabbing in their car. She accused him of adultery and told him that she was going to make love to his best friend and that his friend would do a better job than the husband. Her concluding words were: "I will be fucked by a better lover and I hope those who fucked you did a good job too".

The defendant remembered that he stabbed once, although the victim was wounded twice, and he had a blurred memory which could be a sign of profound disturbances of consciousness, a reason to mitigate punishment according to German law. The couple had meanwhile been reconciled and wanted to continue their marriage.

After the psychiatric examination, which did not reveal any disturbances, the defendant wanted to talk to the psychiatrist under the privilege of confidentiality, which was denied. At that moment the defendant started to tremble, cry, and sweat and almost collapsed. He then claimed that he had been the victim of sexual abuse in Turkey and had seen a doctor at that time but had not told him about his victimization. The only persons who knew about it were his brother who had prevented the defendant from shooting his molester, and now the psychiatrist. If anyone in the Turkish community were to learn about it, he would lose all self respect; and his wife would leave him because he could not be master of his own house.

This opinion was supported by an expert on oriental culture. The defendant preferred a harsher sentence over the disclosure of his secret to the court.

N. Nedopil,  
Germany

**Question: Was the psychiatrist expected to advise the court about the story of the patient in this case?**

1. YES, the function of the expert witness is to assist the court to research and determine the truth and to correctly determine the degree of responsibility of the accused for his deeds. The right of the community for a correct verdict overrides the interests of the accused.

2. YES, the accused did not have the status of patient of the psychiatrist. He was examined in order to establish his mental status in order to guide the conduct of his trial, and not in order to establish a doctor/patient relationship. Moreover when he requested the permission of the psychiatrist to inform him regarding his past the latter refused to give the permission and heard the account of the accused as a casual listener and not as part of his duty as a doctor.

3. NO, when the accused told his secret to the psychiatrist he was relying on the rule of medical secrecy. It is a fact that he never revealed this information to anybody except his brother and the doctor.

4. NO, the accused as a sane adult has the right to conduct his actions as he sees fit and the doctor has no right to interfere.

**Comments:**

It is an ambivalent move of the defendant to speak about his sexually abuse to the expert, although this one denied him confidentiality in clear terms. There is a legal aspect and a psychological one to this confession. From the legal point of view, the expert is hired by the court and has to report every single detail to enlighten it in order to reach a just decision for each case,

From the psychological point of view, one may ask if the fact that the husband reported in an emotional catharsis what happened to him in the past to a doctor who is not tied by the obligation of confidentiality is not a way of asking him to let

others know, despite his opposite request.

A technical solution could be to inform the judge privately “in camera” about all the material assembled, especially the blurred memory and the profound disturbance of consciousness that fit with the rape experience this man had in the past.

Experts are not the physician in care of persons sent to them for an evaluation. Experts are engaged by the Court to provide an opinion and are under duty to reveal all findings of the evaluation that pertain to the case, be it for findings of guilt or for purposes of sentencing. An expert fails in his duty if he conceals pertinent information to the Court.

**Case Report No. 37****Topic: Medical certificate**

A patient dies in a psychiatric hospital as a result of a complication of HIV/AIDS. He has been unable to give his informed consent to the revelation of his primary diagnosis.

It is common practice for members of his ethnic group to contribute to a “Burial Insurance Plan” from an early age. This provides for the elaborate funeral which family tradition obligates and for which the family would otherwise make considerable financial sacrifices.

However, the “Burial Insurance Plan” disqualifies a person from any benefits if the demise is related to HIV/AIDS. Normal policy and procedure were observed by the doctor. The death certificate issued to the family was not required to expose the dead man’s immuno-compromised status.

In a questionnaire delivered to the doctor for completion, the need for disclosure is broached since he must certify the cause of death. If he fails to complete the questionnaire, no benefits will accrue to the deceased’s family from the policy. Refusal to complete will indicate that the required diagnosis is being withheld deliberately. The family will not benefit and the diagnosis will be obvious.

T. Zabow ,  
South Africa

**Question: Should the doctor indicate the cause of the death in this case?**

1. NO, the patient did not authorize him to reveal his secret.
2. NO, the doctor does not have to provide for the economic interests of the insurance company.
3. YES, a doctor’s medical opinion should always be complete, accurate and true.

**Comments:**

The doctor has no other solution than to tell the truth about the illness of the deceased person. The larger utilitarian need to have good records ought to override the personal distress in this case. The dilemma is not an deontological one, but one of compliance and accuracy of information to be provided.

**Case Report No. 38****Topic: Expert testimony**

A prostitute is murdered in extremely violent circumstances. Nobody witnessed the crime but, a month later, the police arrest a 25-year-old man who admits responsibility. He confirms that he took 4 ecstasy tablets an hour before the crime and cannot explain the reason for his acts. No biological testing was carried out at the time, and no more tests can be conducted at the time of the arrest.

The young man had already been committed to a psychiatric ward a year earlier following an acute psychotic incident after consuming narcotics. The enquiry shows that he had indeed purchased ecstasy a week before the murder, and had no objective motive for committing the crime. If the expert considers that he acted under the influence of the drug, then the young man could be sentenced to a short prison term and an obligation to seek treatment. However, if the expert does not acknowledge the role of the narcotic, then the young man could be sentenced to life imprisonment.

G. Niveau,  
Switzerland

**Question: Should the expert witness be influenced by the expected critical outcome in regard to the medical state of the accused?**

1. NO, all the expert witness is required to do is to answer the medical or scientific question that is put to him in the court of law. The consequences, regardless as to whether they are critical or trivial are immaterial.

2. YES, the more important the consequence of the expert opinion which is presented to the court, the heavier is the responsibility placed on the shoulders of the expert to work harder and more carefully.

**Comments:**

The expert has the duty to report on every single aspect of his findings to the court. As a technical witness, he should not pre-judge the defendant one way or another. It is clear that every expert has his opinion about the case, but this should not interfere with the technical work he must report to the court in the most objective and complete way.