CHAPTER 17

Tools of the trade: an introduction to psychiatric ethics

Chapter contents

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Outline

Following the use-before-definition approach of Austin's 'philosophical fieldwork', as developed in Part I, this chapter starts more or less straight in with practical case examples. We ask you to think about real situations, either from your general knowledge of mental health, or from your own experiences if you are a user or provider of services, and then to review the story of Mr AB, the man with depression treated on an involuntary basis introduced in Chapter 2.

Drawing on Mr AB's story:

- *Session 1* of the chapter outlines the scope of ethics in health care generally, focusing on the role of philosophy in ethics training and on what the objectives of such training should be.
- *Session 2* goes deeper into mental health territory, illustrating with two examples—capacity and confidentiality—the particular *conceptual* difficulties raised by ethical problems in mental health.

With these conceptual difficulties in mind, we then introduce a series of case vignettes, all of which, like the story of Mr AB, are about involuntary treatment. Our responses to these vignettes are then unpacked in:

- *Session 3*, which gives an introduction to the role of mental health law and how it connects with the role of bioethics.

Finally, in a brief *concluding session*, we review some of the reasons for the relative neglect of mental health by bioethics. Behind this neglect, we argue, is the influence of the traditional fact-centred medical model. Correspondingly, therefore, the more complete fact + value model to which we came at the end of Part I, provides a basis for developing the sharper set of tools required for mental health ethics. It is to these tools as provided by various kinds of ethical theory that we turn in Chapter 18. We return to mental health law in Chapter 19.

Session 1 Ethical and conceptual issues in psychiatry: aims and objectives

Getting started: the story of Mr AB

Ethics courses often start with an introduction to ethical theory. In this section we will be starting from the other end, as it were, from practical issues.

Starting from practical issues underlines the importance of ethics in everyday clinical care—even the most hard-nosed medical scientist recognizes the importance of ethical issues nowadays. However, starting from practice is also important for certain kinds of philosophical theory, notably linguistic analysis, as we saw in Part I, but also casuistry, as we will see later in this part, in Chapter 18.

EXERCISE 1 (30 minutes)

This first exercise is in three parts:

1. Think of a few examples of situations raising ethical issues in mental health. Try to think of (or imagine) one or more actual case examples rather than thinking abstractly in terms of general issues. Relevant case examples may be from your own experience, as a user or provider of services, or in both capacities; or they may be from your general knowledge of mental health. Then,
2. Write down a brief synopsis of the circumstances of your case(s) and of the ethical issues arising. Finally,
3. Think whether the issues can be grouped together or classified under more general headings.

After you have finished this for yourself, you may want to look at one or more of the overviews of ethical issues in mental health given in the Reading Guide. See how far your examples coincide with those of others. Do you think there is likely to be general agreement on what counts as an ethical issue in mental health?

Many people find that they struggle initially to think of ethics 'cases'. They can think of *issues* readily enough—after all, the newspapers, let alone professional journals, are nowadays full of them. When it comes to everyday experience, however, whether as providers or as users of services, for much of the time the ethical aspects of what we are doing are very much in the background.

The story of Mr AB

For our own example, we will give a rather more extended version of the story of Mr AB from Chapter 2[1]. We will be referring to Mr AB's story several times in this chapter and the next. This is how it ran.

> Mr AB, a 48-year old bank manager, came to the casualty department of his local hospital complaining of burning pains in his face and head. He had a letter from his general practitioner saying that she believed Mr AB had become seriously depressed.
>
> Mr AB admitted that he had had episodes of depression in the past, and that during one of these he had made a sudden and nearly fatal suicide attempt. Although appearing to be depressed, he denied any such feelings now. He refused to let the casualty officer call his wife. The casualty officer tried telephoning the GP but she was out 'on call'. He then got Mr AB's home number from 'directory enquiries' and telephoned his wife. Mrs AB was very concerned, being unaware that her husband had gone to see their GP. She confirmed what the GP's letter said, that over 3–4 weeks her husband had become gloomy and preoccupied and had lost interest in his work. But she added that on the last occasion, when he had complained similarly of head and facial pains, he had made a sudden and nearly fatal suicide attempt. Mrs AB was very

[1] As noted in Chapter 2, Mr AB's story is based on one described in chapter 10 (pp. 187–188) of Fulford (1989), which is in turn based on that of a real person, but with biographical and other details changed.

concerned that her husband should not be allowed to leave the hospital, at any rate before she could get there.

The casualty officer then called the duty psychiatrist to see Mr AB. Although initially guarded and suspicious, Mr AB eventually came out with what was really troubling him—he had 'advanced brain cancer'. After a careful neurological examination, the psychiatrist explained to Mr AB that there were no signs of this, but Mr AB remained adamant. All he wanted was something for the pains and to be allowed to go home.

Mrs AB (who had by now arrived) repeated to the psychiatrist that she was very much afraid her husband was planning to kill himself. He was behaving as he had done before his previous suicide attempt. For his part, however, Mr AB still insisted that he would not stay in hospital. It thus seemed to everyone that there was no option but to admit him as an involuntary patient. He accordingly came into the ward on a 'section', and, after further tests, made a full recovery on antidepressant therapy over a period of 8 weeks.

Mr AB's story: an ethical issue?

Mr AB's story is not unusual. It is not a high profile dramatic ethics 'case' of the kind that figures so often in the media. As already noted, most people find it is easier, first off, to think of 'big issues' than of individual stories like Mr AB's. The issue, in Mr AB's case, is involuntary treatment. But in this particular case, involuntary treatment (although always contestable in principle) appears to many people to be justified. This is why, in the terms of much ethics teaching, Mr AB's story is not an ethics 'case': on the face of it, there is nothing in Mr AB's story with which most people would want to take issue.

None the less, as a story of involuntary treatment, closer inspection will show that Mr AB's story does indeed raise ethical issues, issues that as we will see by the end of this part, run very deep: through the varieties of ethical theory in this chapter, to philosophical value theory in the next, to legal theory in Chapter 19 (including such contested areas as capacity, rationality, and best interests), and, in Chapters 20 and 21, to some of the worst abuses of psychiatry for purposes of political control, abuses arising (in part) from the (largely unrecognized) influence of a traditional medical model in which diagnosis is assumed to be a value-free area of medical science.

As with Mr AB's case, then, so with much else that happens in mental health, behind the everyday and the ordinary lie ethical issues many and deep.

Why, then, are we relatively blind to these issues? Why do so many people have such difficulty, first off, to think of particular 'ethics cases' from their own experience?

EXERCISE 2 (10 minutes)

What can we learn from this difficulty? What is the significance of the fact that we tend to be relatively blind to the ethical aspects of our day-to-day experience.

Write down your ideas on this before going on, thinking particularly about the work we did in Chapter 4 on 'definition and use'.

The main point of Exercise 1 was, straightforwardly, to *raise awareness* of the pervasiveness of ethical issues in mental health as a first step towards tackling them. We will be coming back to this in a moment. It is important to recognize, however, first, that our relative blindness to the ethical (and more broadly evaluative) aspects of everyday practice is closely similar to the relative blindness to conceptual issues that we looked at in Chapter 4 when we were thinking about philosophical methods.

Thus, recall that as with the concept of time, we remain largely unaware of the complex meanings of high-level organizing concepts, including (in medicine) the concepts of illness and disease, so long as we are able to *use* them (as by and large in bodily medicine we *have* been able to use them) without difficulty.

Much the same, then, is true of ethical aspects of practice: Mr AB's story, although raising a whole series of ethical issues, is not an obvious 'ethics case' because it is not, for most people, ethically contentious. As with conceptual issues in medicine, furthermore, so with ethical issues: it is appropriate that they should be ignored by practitioners so long as they are practically unproblematic. The danger, again with ethical as with conceptual issues, comes only when we are lulled into a sense of false security and fail to recognize the difficulties when they are there.

The two kinds of blindness, then, ethical and conceptual, are closely similar, and, as we will see by the end of this part, in mental health at least, they are indeed but two sides of the same 'use *versus* definition' coin.

Common kinds of ethical issue

For the moment, though, raising awareness of ethical issues is important primarily to get us started—unless we are at least aware of ethical issues, we cannot even get started on the task of finding ways of tackling them. And in mental health, once the process of raising awareness is started, the issues are not only evident but of familiar kinds.

The general issue raised by Mr AB is about *consent to treatment* and the highly contested role of compulsion. We will be considering this in detail later. Other issues that may have been raised by your own cases include *confidentiality, professional–client* (and *interprofessional*) relationships, and problems of *resource allocation*. Such topics are among the staples of bioethics and there is a voluminous literature on all of them (see Reading Guide at the end of this chapter).

This, however, raises a further question. If much that we do in mental health, and indeed in health care generally, although raising ethical issues in principle, is relatively uncontentious in practice, why is there this voluminous literature at all? After all, until the closing decades of the twentieth century, medicine got along fine with slimline codes, such as the Hippocratic Oath (to which we return later in this part). So why the disparity? Why the big literature when so much of practice is prima facie ethically straightforward?

We will return to this question in Chapter 18, with one kind of answer to it at the start of the chapter (an ethics-based answer)

and another (values-based) answer at the end. Here, though, rather than answering the question directly, we will take it as a prompt to think carefully about what role, if any, there is specifically for *philosophy* in relation to ethical skills in health care.

A role for philosophy?

So why *think*? Why, more particularly, think *philosophically*? Religion, politics, our parents, our community, may give us ethical standards. But what can philosophy, by its nature abstract and impersonal, contribute?

Philosophers manic and philosophers depressive

We looked at the outputs from philosophy in general in Chapter 6. Philosophers themselves, we found, have had very different takes on this, some depressive, others more manic. Bernard Williams, you will recall, was among the depressives: while noting the important contributions of history, psychology, sociology, and a wide range of other disciplines to ethics, he thought that philosophy, or at any rate analytic philosophy, had got too big for its boots (Williams, 1985). In respect of medical ethics, R.M. Hare, although very far from overplaying the role of philosophy, had a less jaundiced view than Williams: the discursive skills of the philosopher, he argued, may have a critically important contribution to make in medicine (Hare, 1993).

Still other philosophers, coming closer perhaps to the *ethos* of philosophy and mental health, have pointed out that bringing theory and practice together in ethics has been helpful for *both* sides. In an article that has rightly become a classic of the early medical ethics literature, the American philosopher Stephen Toulmin (1982), argued that ethical issues in medicine came in the nick of time for an ethical philosophy that had run itself into what at the time looked like a blind alley.

Toulmin has made a number of important contributions at the interface between philosophy and practice. Later in this chapter we will come back to his work on the importance of casuistry as a method of ethical reasoning. He was also one of the first (in recent philosophy) to emphasize the importance of abnormal mental states for work in general philosophy on the nature of mind (Toulmin, 1980).

A 'full-field' picture

We summed up the view we finally came to in Chapter 6, about the outputs from philosophy, in terms of Gilbert Ryle's metaphor of a 'logical geography'. Philosophy, we concluded, finding a middle ground between manic and depressive extremes, gives us a *more complete* picture of the complex meanings of the higher-level organizing concepts by which the logical geography of a subject is defined.

We called the more complete picture of the health-care concepts to which we had come by the end of Part I, a 'full-field' picture. This full-field picture, we suggested, could be regarded as a more complete picture of the logical geography at least of mental health, to the extent that it incorporated on an equal basis the values emphasized by antipsychiatry (left half-field) as well as the facts emphasized by psychiatry (right half-field). Similar full-field pictures were evident also in Part II, in the importance of meanings as well as causes in Jaspers' psychopathology; and in Part III, in the re-engagement, at various levels and in different ways, of observer with observed and the central importance of forms of non-algorithmic judgement in late twentieth century science. In Part V the objections to an easy reductionism of mind to brain and of the space of reasons to the realm of law make up another full-field picture.

Similarly, then, it is to a more complete, full-field, picture that we will arrive in this part. Medical ethics, as we will see, although developing in its modern form originally as a response to the challenges of scientific and technological advances in medicine, has, as one of has put it elsewhere (Fulford *et al.*, 2002, p. 5), "taken on the colours of its enemy." Medical ethics became *bio*ethics. And bioethics, as it is now called, like *bio*medicine and *bio*technology, has assumed (tacitly) what in the terminology of Chapter 6, is a right-field model of medicine, a model in which science is central and ethics peripheral. The tools of bioethics, correspondingly, have been largely right-field tools, helpful in responding to the problems arising in high-tech areas of medicine, but not always appropriately applied to the less dramatic if deeper and more pervasive issues arising in mental health.

Philosophy, then, in mental health ethics, could help to deliver a full-field set of ethical tools, not of course by abandoning the right-field tools of traditional bioethics, but by adding to them an equivalent set of left-field tools.

Four intermediate objectives for ethics training in health care

What does a 'full-field set of tools' amount to in practice? We hope to have developed at least a component of one kind of answer to this question by the end of this part of the book (with the theory and practice of Values-Based Practice (VBP)). This book is, however, first and foremost a textbook, a resource for learning and teaching. So, first things first: What, exactly, should the objectives of ethics *training* in health care be?

Back to our cases

In much ethics training, whatever theoretical model is adopted (rights based, utilitarian, etc., as described below, in Session 2), the practical objectives are usually left implicit. It is assumed that in some general warm-hearted way ethics teaching must be 'good' for practice. So, again, what should our objectives be? We can ground our consideration of this question in the needs of practice by returning to the cases we considered in Exercise 1 above.

EXERCISE 3 (60 minutes)

This is a two-stage exercise:

Stage 1 (10 minutes)

Go back to your cases and select one of them to look at in more detail. The case in question may raise a dilemma, i.e. where you are torn about what to do; or it might be a disagreement, i.e. where there is a difference of opinion about what ought to be done.

- What contribution do you think training in ethics might make to resolving or at least tackling such dilemmas and disagreements?
- How might this improve clinical decision-making?

Stage 2 (50 minutes)

In developing a course in practice skills for medical students in Oxford (described more fully below), Tony Hope and Bill Fulford defined four key objectives for medical ethics teaching: (1) raising awareness; (2) changing attitudes; (3) increasing knowledge; and (4) developing thinking skills.

- To what extent are these objectives relevant to your own cases?
- More generally, if training in medical ethics achieves these objectives, how would this help to improve the way we deal with things in everyday practice, whether as users of services or as mental health professionals?

Intermediate objectives for ethics training

As indicated in Stage 2 of Exercise 3, in developing their course in 'Practice Skills' for medical students in Oxford, Hope and Fulford defined four practical objectives for medical ethics education. The Practice Skills course, which is described in Hope *et al.* (1996), was aimed at medical students who, typically, are overwhelmed with an enormous syllabus of technical skills and scientific knowledge. Ethics training for medical students thus has to have a very clearly defined practical rationale.

As Hope and Fulford (1994) describe elsewhere, the overall guiding aim of the 'practice skills' approach was to improve clinical practice by improving the skills of *application* of medical knowledge. This indeed is what 'practice skills' are, according to this model. They are the ethical, legal, and communication skills, which together with technical skills and clinical experience, support the application of medical knowledge in a clinical problem-solving approach to day-to-day practice. This guiding aim, however, is rather too general and long term to serve as an objective for ethics education. Hence, drawing on work in the philosophy of education, by John Wilson (1979), a colleague at the time in the Oxford Department of Education, Hope and Fulford developed the four more narrowly defined objectives listed in Exercise 3, as 'intermediate objectives'.

Awareness, attitudes, knowledge, and thinking skills, then, in medical ethics education, are four intermediate objectives on the road to the ultimate objective of improving practice. But how, and if so in what ways and to what extent, are these intermediate objectives helpful? We will consider each of Hope and Fulford's intermediate objectives for medical ethics education in turn, referring as appropriate to Mr AB. (Obviously you should be testing out what we say by reference to your own cases.)

Objective 1—raising awareness: the first word, not the last

We have already seen that raising awareness of ethical aspects of practice is important if only to get things underway. Increased awareness *per se*, however, is not always or inevitably a good thing—it could lead to indecisiveness, for example. So raising awareness of ethical issues, as Austin (in Chapter 4) said of linguistic analysis as a method for raising awareness of conceptual issues, although sometimes the first word is certainly not the last word. In ethics a whole range of further clinical skills besides raised awareness are certainly needed.

Becoming aware of an ethical issue, none the less, *is* a necessary first step to doing something about it. And ethical issues, once we reflect on them, are often more or less readily visible. Sometimes they are not, however. What about your own cases, then, in the exercise above? Were all the issues up front? In Mr AB's case, the most obvious ethical issue was to do with consent: he didn't want treatment (for depression); everyone else thought he needed it (we return to consent in detail later on). But what about confidentiality? Most people would say that the casualty officer was right to telephone Mr AB's wife; he might have been negligent if he had not; but this *is* a breach of confidentiality (albeit justified in the circumstances).

On a wider front, raising awareness is important in respect of the role of values generally in health care. We return to this towards the end of Chapter 18 when we move from ethics, traditionally understood, to Values-Based Practice (VBP). In the VBP model, raised awareness of values, particularly through greater attention to language use, is the first of four key areas of clinical skills supporting balanced clinical decision-making where different values are in play. (Raising awareness falls under Principle 6 of VBP, see Box 18.1, Chapter 18.). As we will see in Chapter 18, the training methods developed for raising awareness of values in clinical contexts draw directly on philosophers, such as J.L. Austin and R.M. Hare (see Part I) working in the awareness-raising tradition of linguistic analytic philosophy. There is thus a particularly close link here between analytic philosophical theory and everyday clinical practice.

Objective 2—changing attitudes: (a) cross-cultural perspectives

As an educational objective, changing attitudes is more contentious—which attitudes should be encouraged is itself an ethical issue! In most ethics teaching in health care it is assumed

that it is important to move people towards more open and patient-centred attitudes respectful of autonomy. This is not incompatible with holding strong personal views on matters such as abortion, for example. It is, however, not a value neutral attitude. It is a liberal ethic in its own right that requires a non-judgemental attitude to other peoples' values, even if, in some cases, respect for your own values may mean encouraging a patient to get help from someone else.

Dependency: a new 'top value'?

Yet even autonomy, although so widely taken for granted as a value in North America and western Europe, is very far from being a universally acknowledged principle of medical ethics. The theologian and philosopher, Alastair Campbell (1994), for example, in the next reading (linked with Exercise 4), argues for 'dependency' rather than 'autonomy' as the foundation value for medicine. He notes that autonomy fits fairly comfortably with the acute 'heroic' medical situations with which bioethics has been particularly preoccupied. He argues, though, that the scope of medical ethics should be widened to include the less dramatic but far more pervasive issues arising in chronic illness and disability, including the infirmities of old age. In the following extract Campbell starts to set out the conclusions that he believes we should draw from widening the scope of medical ethics in the way he proposes.

EXERCISE 4

Read the extract from:

Campbell A.V. (1994). Dependency: the foundational value in medical ethics. In *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press, p. 184

Link with Reading 17.1

Note that Campbell is not arguing for autonomy to be abandoned. His point is that in being set up as a foundational value, autonomy has become, and risks becoming further, unbalanced as a basis for health-care decision-making.

- However, do you think the answer to this is, as Campbell suggests, to set up a countervailing value as the foundation of medical ethics?

Campbell's concern in this article is that the dominance of autonomy in bioethics will result in unbalanced approaches to policy and practice in health care. Campbell's careful presentation of the case for making dependency the foundational value in medical ethics is anything but unbalanced. The danger, though, if Campbell's candidate for 'top value' (dependency) were to be successful, is of decision-making becoming unbalanced in the opposite direction. The danger here, indeed, as we will find later in this part, is a general one—making any one value the top value, risks unbalanced decision-making. Values-Based Practice (VBP), we will see in Chapter 18, is premised on the need for balanced decision-making were complex and conflicting values are in play.

Cross-cultural perspectives and a balanced view

The limitations of autonomy have been particularly emphasized in cross-cultural ethics. It is not only in cross-cultural contexts that clashes of values arise, of course: the rationale for VBP, as we will see in Chapter 18, is precisely that differences rather than agreement on values are the norm in health care. Individually, furthermore, as we noted above, even in respect of such widely recognized values as autonomy, there will come a point beyond which any one person will not be prepared to go, a point at which, as we say, we 'draw the line' in respecting someone else's wishes.

A cross-cultural perspective, however, gives a sharp reminder of just how parochial the 'givens' of any one society at any one period may be. Autonomy is a case in point. As a distinctively 'Western' value, autonomy sits uncomfortably with the values of societies in which family ties and the integrity of communities rate ahead of individual self-fulfilment. An authoritative expression of this concern is to be found in the work of the Egyptian psychiatrist, Ahmed Okasha. As a former Chair of the World Psychiatric Association's Ethics Committee (and subsequently WPA President), and also Head of the WHO Coordinating Center at Ain Shams University in Cairo, he is well placed to appreciate the tensions to which cross-cultural clashes of values give rise. He spells this out succinctly in the following reading (linked with Exercise 5). Note, by the way, that this reading is not from a specialist ethical or indeed cross-cultural journal, but from a core psychiatric update journal aimed at the needs of everyday practical psychiatry .

EXERCISE 5

Read the following extract from:

Okasha, A. (2000). Ethics of psychiatric practice: consent, compulsion and confidentiality. *Current Opinion in Psychiatry*, 13: 693–698. (Extract p. 694.)

Link with Reading 17.2

- Are there wider lessons here?
- Are there lessons from Okasha's cross-cultural reminder of the parochial nature of autonomy for your own cases?

In Mr AB's case, the importance of families, and of the interests of carers, are clearly evident in the casualty officer's decision to call Mr AB's wife. In an autonomy dominated ethic this has to be 'justified' (the term we used above) as a breach of confidentiality. In an ethic that seeks to balance autonomy against family and communitarian values, any need for justification runs the

other way. As the work of Okasha and others has shown, in cultures that value families and communities before individuals, it would be considered entirely natural and appropriate to make every effort to contact the relatives of Mr AB in circumstances of this kind.

Cross-cultural knowledge and understanding, which starts from mutual respect, can thus help to provide what we will argue in Chapter 18 is an essential balance of values in clinical decision making.

Objective 2—changing attitudes: (b) a role for virtue ethics

Changing attitudes as an educational objective is relevant particularly to what are called 'virtue ethics'. Credit for the late twentieth century renewal of interest in virtue ethics goes particularly to the British-born American philosopher, Alasdair MacIntyre, in his *After Virtue* (1982). The virtues are dispositions to act in certain ethically approved ways. Thus, William F. May, for example, of the Southern Methodist University at Galveston in the USA, has developed a detailed list of the virtues on which health-care ethics training should concentrate (May, 1994). Besides the more obvious virtues, such as respect, honesty, justice, and benevolence, May discusses fidelity, prudence, discretion, perseverance, and humility. The latter virtues may sound distinctly out of place as objectives of medical education. Drawing, however, on what again may seem an unlikely source, biblical scholarship, May shows how such virtues, properly interpreted and understood, may help to secure patterns of health-care decision making that are fully responsive to patients' real needs and concerns.

You can get a flavour of the rich mix of theoretical depth and practical relevance in May's approach from the following passage (linked with Exercise 6): this is concerned mainly with the virtue of prudence but finishes with a reference back to a related discussion of discretion.

EXERCISE 6

Read the extract from:

May, W.F. (1994). The virtues in a professional setting. ch 7 in *Medicine and Moral Reasoning* (ed. K.W.M. Fulford, G.R. Gillett, and J.M. Soskice). Cambridge: Cambridge University Press, (Extract pp. 85–86.)

Link with Reading 17.3

- What do you think of the three elements of prudence that May derives from the 'Medievalists'? Their unfamiliar Latin names aside, they read as rather precise learning outcomes!
- In the second extract, consider May's account of the virtues with Mr AB (or your own cases) particularly in mind.

Many of May's 'healthcare virtues' we nowadays take for granted, assuming that they will be acquired through apprenticeship learning as part of our training in the health-care professions—justice, beneficence, and so forth, might come within this category.

Other virtues proposed by May are less obvious, but, in mental health at least, they are clearly important. From May's list, perseverance and humility, for example, as characterized by him, were clearly important to the proper management of Mr AB's depression. The casualty officer concerned showed just these virtues in this case, but had he been less conscientious (showing less perseverance), or had he adopted a more high-handed attitude (showing less humility), things might have turned out very differently.

Objective 3: increasing knowledge—from fancy to fact

Knowledge is a neglected but increasingly important aspect of ethics, especially in mental health. Traditionally, ethicists have sometimes been openly cautious about the role of facts in ethics: what *ought* to be done, it is felt, should not be a function of what as a matter of fact *is* done (Gillon, 1996).

There is clearly much good sense in this. It is after all one consequence of the Humean 'no ought from an is' on which we drew so extensively in Part I. The downside, though, is that the facts have too often been ignored in ethical thinking in favour of fancies. Ethical reasoning, in particular, has too often been based on little more than taken-for-granted intuitions about what people want, feel, fear, and so forth, rather than on what they *actually* want, feel, fear, and so forth.

We can unpack the traditional intuition-led approach to facts in ethics into two closely related assumptions: the first assumption is that we can judge accurately what other people actually *want*; the second is that we can accurately judge what other people would regard as *satisfying* their wants. Neither of these assumptions are warranted. People in general and health-care practitioners in particular, perform rather badly on both counts (see, e.g. the reading below, linked with Exercise 8, from Peter Campbell, 1996). It is important, therefore, to use whatever means are available to find out what it is that people really *do* want.

This is not to say that, as a professional, it is always right to go along with what one's client or patient wants (we tackle the issues raised by this in the context of involuntary psychiatric treatment later). But at least we should try to be clear about the views of those concerned rather than just assuming that we know what they want.

From providers' fancies to users' facts

The readings in Exercises 7 and 8 illustrate two very different ways of getting information about the views of the users of mental health services. There are of course many other relevant methods for increasing knowledge of values, including a key role for good communication skills. We give further examples of the range of approaches that can be taken to increasing knowledge in the Reading Guides to chapters 4 and 18.

EXERCISE 7 (45 minutes)

Read the two extracts from:

Marshall, M. (1994). How should we measure need? Concept and practice in the development of a standardised assessment schedule. *Philosophy, Psychiatry, and Psychology*, 1: 29–31

Link with Reading 17.4

In these extracts Marshall shows that a standardized schedule developed by professionals to assess the needs of people with long-term mental health problems failed to take account of the perspectives of the client group (users and carers) concerned.

As you read these extracts, think about:

1. Why health-care professionals should be so bad at judging their clients' values and needs, and
2. Why, in particular, mental health-care professionals should be so bad at this.

We will be considering these two questions again in the next exercise. The 'values blindness' of professionals is a key observation under-pinning the move from traditional bioethics (in this chapter) to VBP (in Chapter 18).

Max Marshall's (1994) paper, which came out in the very first issue of *Philosophy, Psychiatry, and Psychology*, describes the conceptual work underpinning his research on the assessment of need in people with long-term mental health problems. At the time of writing his article, Marshall was a research psychiatrist working in the Department of Psychiatry in Oxford. He began by using the then current 'gold standard', the MRC Needs for Care Assessment Schedule. However, he soon found that, although claiming to replicate best clinical practice, the MRC schedule gave results that failed to match clinical assessments of need, and that, crucially, this was because it failed to incorporate the values of service users (as in the first extract, pp. 29–30) and carers (as in the second extract, pp. 30–31).

As Marshall describes in his paper, the MRC schedule failed in this respect essentially because it was guided by a flawed understanding of the *concept* of need. The MRC Schedule tacitly adopted, in the terminology of Chapter 6, a traditional right-field model (recall Aubrey Lewis on insight (chapter 3) as having a view that coincides with that of the physician). The MRC Schedule failed to recognize that in *best* clinical practice, professionals, contrary to the 'privileged access' model of professional knowledge implicit in the traditional medical model, were in practice taking close account of the views of their clients.

Combining empirical with philosophical methods

It is worth noting that Marshall's study began as a conventional empirical research project. It was in order to tackle the conceptual difficulties he ran into, that he had to turn to philosophy. In developing his new assessment schedule, therefore, he collaborated with an Oxford philosopher, James Griffin, who had worked on the concept of need (see for example, Griffin, 1990). This is why, although publishing his new schedule and empiricial research in main line journals, Marshall spelled out the key *conceptual* innovations guiding his work in his paper in *Philosophy, Psychiatry, and Psychology* (Marshall, 1994).

The commentaries to Marshall (1994), respectively by the philosopher Roger Crisp (1994) and by a consultant psychiatrist working in learning disability, John Morgan (1994), reflected the twin clinical and philosophical roots of his work.

Values blindness as a linguistic delusion

Returning, then, to the questions raised in Exercise 6 above, one reason for the values blindness of health-care professionals is a conceptual reason, namely, the influence of the traditional fact-centred medical model.

That it should take the brightest and best from both psychiatry and philosophy to break the stranglehold on our thinking of the traditional medical model, even in respect of an overtly evaluative concept such as that of 'need', is perhaps a sobering thought. Wittgenstein, you will recall from Part I (chapter 6), called similar strangleholds on thinking in philosophy, linguistic illusions, and aptly so, given that the strangleholds he had in mind arose from philosophers having an incomplete or otherwise distorted picture of the meanings of the concepts with which they were concerned. But the stranglehold of the traditional medical model is perhaps in some respects more like a *de*lusion, in that, judged at least by the growing volume of first-hand accounts from service users and carers, it has turned out to be so particularly hard to break.

User perspectives

Peter Campbell, whose work is illustrated in the next reading (linked with Exercise 8, Campbell, 1996), was an early contributor to the service user literature in mental health. He brings to this literature the perspective of someone who has experienced a series of manic-depressive episodes. While presenting well-balanced views on the role of medication and other contentious aspects of medical psychiatry, Campbell makes clear the extent to which professionals often simply fail to understand the real needs and wishes of the service users and carers who are their clients.

EXERCISE 8 (45 minutes)

Read the extract on what 'users' want from mental health crisis services from:

Campbell, P. (1996). What we want from crisis services. Pages 180–183 In *Speaking Our Minds: an anthology* (J. Read and J. Reynolds). Basingstoke: The Macmillan Press Ltd for The Open University, (Extract pages 182–183)

Link with Reading 17.5

In this article, Campbell describes some of the specific wishes and needs reported by people in crisis: to have more control of their own crisis situation, to gain understanding of and from their crisis situation, to be treated with respect and dignity, and to have access to 24-hour non-medical services.

Peter Campbell's work is very far from the polemics of the early 'antipsychiatry' movement. To the contrary, he is careful to point out that there is much (including as already noted the need sometimes for medication) on which professionals and service users can agree. All the same, far too often there are gaps between the values of service users and professionals, gaps of which professionals, for their part, seem all too often unaware.

Just how wide such gaps may be becomes clear particularly towards the end of the second extract when Peter Campbell records his own first mental health crisis. At this time, he says, none of the key issues from his point of view were in any conventional sense 'medical' issues at all.

User and provider perspectives: a resource

Is it really so surprising, though, that professionals should be relatively blind to the values of their clients? After all, to be a professional is (among other things) to have expert knowledge. But a professional's expert knowledge is, (1) *general* (where people's values are often highly individual), and (2) itself *driven by* particular values (i.e. of the individual professional, and of the profession as a whole). This combination means that professionals, just in being professionals, are at risk of drawing unwarranted conclusions about their client's values. And in the case of mental health, this risk is aggravated by the fact that, as we saw in Part I, mental health differs from other areas of health care precisely in that people's values in this area are *particularly* diverse. In mental health, then, the professional must become more aware, not only that the values of the client may be different from what he or she takes them to be, but that the values of any one client may be very different from the values of the next.

A particularly sharp difficulty, however, in the case of mental health, is the loss of insight by which some mental disorders are characterized (see Chapter 3). This is a particularly sharp difficulty, because, as the story of Mr AB illustrates, loss of insight is a characteristic particularly of psychotic disorders, which, as we saw in Chapter 3, may be among the most severe mental disorders. Hence it is just those who most *need* help who are most likely to *lack insight* into the fact that they need it. Peter Campbell, and many others, and not only in the user movement (e.g. Perkins and Moodley, 1993), have repeatedly warned of the hazards in the notion of insight; however, Mr AB illustrates the dilemma that 'loss of insight' raises. He lacked insight into his depression: what *he* wanted was pills, with which he was planning to kill himself before his (delusional) brain cancer got any worse; however, what *everyone else* thought he needed was treatment for depression.

In Mr AB's case, most people would agree that involuntary treatment was justified. The fact, however, that it may *sometimes* be right to act against patients' expressed wishes in situations in which their insight is psychotically disturbed, has led to a tendency among professionals to deny (usually tacitly) the validity of patients' values in the far more common situations in which their insight is *not* psychotically disturbed. As many of those with wide experience of training mental health professionals have often found, the most dangerous lack of insight in mental health is not service users' psychotic lack of insight but professionals' continuing lack of insight into service users' real needs (Perkins and Moodley, 1993)!

Again, we return to the practical implications of the differences between provider and user values, and indeed to the differences between the values of different health-care professions, in Chapter 18. As we will see, in a VBP model such differences of values cease to be merely a source of difficulty and become a positive resource for balanced health-care decision making.

Objective 4: improved thinking skills

We noted in chapter 6 of this book, and in our Preface, the role that philosophy may have in improving some of the generic thinking skills on which good practice depends. Yet the idea that it is possible to reason about ethical issues comes as a surprise to some people. They feel that 'ethics' is a matter of personal conviction. We could leave it at that, perhaps, if there were neither dilemmas nor disagreements for us to tackle; and it is certainly true that in reasoning about ethical issues we may eventually come to an impasse. Before we reach the point of impasse, however, there are a number of different ways in which we can try to think through ethical issues.

We start to examine some of the more important ways of reasoning about ethical issues in Session 2. First, though, we round off this session with a brief consideration of how training in ethics may contribute to clinical practice, starting with a word of warning!

Ethics training and ethical practice

The word of warning is that there are potential dangers even in the four eminently practical intermediate objectives for ethics education in health care outlined above.

The ethical downsides

Thus, increasing awareness could make practitioners *over*sensitive to ethical issues, paralysing action: changing attitudes can undermine peoples' established values and beliefs (this is especially important in cross-cultural work). Even knowledge can be misused if it is taken to imply that the expert necessarily 'knows best'.

Perhaps most important of all, too much discursive reasoning, 'thinking rather than doing', can come across in a situation demanding practical action at best as irrelevant 'waffling', at worst as yet a further exercise of professional power. The British social scientist, Patricia Alderson (1990), has described how the rise of ethical 'experts' in medicine has 'doubly disenfranchised' patients: they were already disenfranchised by specialist *technical* expertise; now they are disenfranchised by specialist *ethical* expertise.

Learning and doing

One way to minimize these dangers is to remind ourselves that, as with other areas of philosophy, ethics is as much a skill as a body of knowledge. We emphasised the skills acquisition objectives of this book in our Preface. It is with a view to skills acquisition that our materials are presented in an active rather than passive form, i.e. as a series of exercises linked by lines of argument with which the reader is encouraged to engage actively, disagreeing with, as well as sometimes being persuaded by, what is said.

With skills acquisition, then, in general as well as in ethics and philosophy, it is important to separate learning from doing, the development of a new skill from its deployment for real. If you come across a way of analysing ethical issues that you feel would be useful, whether in this book or elsewhere, try it out as an exercise when there is nothing practical hanging on the outcome and reflect on its success or failure. Repeating this process a couple of times will then allow you to use the new skill you have acquired in a natural and unselfconscious way when it is needed in practice. This is just like learning a new stroke in tennis by practising it before using it for real in a match.

Levels of ethical reasoning

R.M. Hare, to whose work we are indebted at several points in this book, has written about this aspect of the relationship between theory and practice in ethics in terms of different levels of moral reasoning. Hare (1981) distinguishes two levels of ethical reasoning. *Level 1* is the level of *everyday clinical practice*: at this level, we normally have to be decisive, and, to extend the above analogy with tennis, it is our ethical reflexes (or intuitions) by which we must be guided. *Level 2*, by contrast, is the level at which critical reflection on practice takes place. Level 2 thinking includes reflection both on the issues arising in particular practical situations and also on more abstract analyses of underlying concepts.

Hare's Level 1 (of more or less spontaneous responses in day-to-day practice) is closely related to the virtues (dispositions to act ethically); it is also the level at which training in ethics has a practical pay-off. Level 2 reasoning, on the other hand, as the level of reflection on practice, is the level at which practice skills and other practically oriented methods of ethics *training* operate. Training should not be on a 'one-off' basis, of course. It is essential to continue to reflect (sometimes) on practice if we are to continue to develop as practitioners.

Theoretical and applied ethics

Traditionally, applied ethics, concerned with the application of ethical theories to solving problems in practice, has been distinguished from theoretical ethics, concerned with the theories themselves. Theoretical ethics, in turn, has been divided into substantive theories, claiming to provide a theoretical basis for deriving answers to problems arising in practice, and analytic ethics, concerned with the meanings and implications of value terms and with other aspects of the conceptual structure of ethics.

Bioethics, as we will see in Chapter 18, has drawn particularly on substantive ethical theories (such as rights-based and utilitarian theories). With mental health, though, the particular *conceptual* difficulty of the subject means that in addition to substantive ethics, so defined, abstract analyses of concepts may also be crucial to Level 2 thinking. As we have seen in this chapter, and as we will be exploring in detail later in this part, a number of key ethical concepts (such as rationality, best interests, and so forth), which in many contexts in medicine and bioethics can be taken for granted, are often at the very heart of the ethical difficulties in mental health. As Dickenson and Fulford (2000) argue in their casebook, mental health ethics starts where general bioethics finishes.

Conceptual difficulties are at the heart of mental health ethics

It is in the analysis of concepts, therefore, drawing on the resources of general philosophy, that much of the work of mental health ethics must take place. This is why, as Fulford (1995) has argued, in mental health there is no real difference between pure and applied philosophy, pure and applied ethics. Certainly, we need to separate, as in tennis, learning from doing. Certainly, too, Hare's distinction between Level 1 (intuitive) and Level 2 (reflective) thinking is helpful in maintaining this separation. As to theoretical and applied ethics, though, it is analytic ethics, the least of theories in late twentieth century ethical theory, which as we will see, has the most direct practical applications in mental health ethics.

We return to analytic ethics as a resource for the toolkit of mental health ethics in Chapter 18. First, though, in Session 2 of this chapter, we need to look in more detail at some of the particular conceptual difficulties that are raised by mental health, and at how these are reflected in the special features of mental health ethics.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. Thinking about Mr AB's story, ethical issues are not always transparent in mental health. What does this remind you of from Chapter 2?

2. What are the implications of the relative invisibility of ethical issues for the role of philosophy in mental health ethics?
3. List four intermediate objectives for training in mental health ethics: which of these is particularly important for strengthening the 'user voice'?
4. What are Hare's two 'levels' of ethical reasoning and how do they relate to the links between training and practice?

Session 2 Conceptual difficulties and mental health ethics

All areas of health care raise particular ethical issues. Transplantation is different from assisted reproduction, for example, and both are different from terminal care. There are some important common themes: we noted consent and confidentiality, for example, in the last session. However, each area of health care requires a degree of attention in its own right.

So, how does mental health fare?

EXERCISE 9 (15 minutes)

In this exercise we are going to consider how mental health has fared in bioethics, not directly, but indirectly, by way of a piece of Austinian 'philosophical fieldwork'.

Most bioethicists, if asked directly, will deny that mental health has been (until recently) relatively neglected. But what does the actual literature, the outputs of bioethics, show?

Look through the index of any large medical ethics textbook. Also look at the chapter headings. Notice:

1. how far the subjects covered correspond with the issues raised by your cases in Exercise 1 of this chapter, and
2. the prominence or otherwise of mental health ethics.

If you are working with Beauchamp and Childress (1989), look finally at the examples in their extensive appendix. Do you see any discrepancy between the topics covered in the book and the examples given in the appendix?

You will probably find that most of the issues raised by your cases (consent and confidentiality, for example, as noted in the last session) are in the subject index. Some of the subject headings may well have triggered further thoughts about your cases.

Neglect of conceptual difficulties

At one level, then, the issues raised by mental health are indeed generic, similar issues being raised by other areas of medicine. Notice, however, that whereas other areas of medicine often get a section in their own right, mental health tends not to.

Neglect of mental health

The contrast is especially sharp between mental health and areas of bodily medicine that involve high-tech or other dramatic interventions. In the index to the third edition of Beauchamp and Childress (1989), for example, aside from entries on general ethical concepts (such as autonomy), many of the most prominent entries are of this kind: 'Abortion', 'AIDS', 'Blood', 'Cancer', 'dialysis', 'experimentation', etc., all have prominent entries. Mental health, although represented, is by contrast relatively hard to find: these are short entries under 'addiction', 'depression' and 'dementia', but none for such mental health hot topics as schizophrenia or personality disorder.

Beauchamp and Childress, it is important to say straight away, are unusual among bioethical textbooks of this period, in paying considerable attention to mental health: we return in Chapter 18 to the detailed analysis they provide of the issues raised by involuntary psychiatric treatment. And in their appendix of examples, in contrast to the subject headings in their index, no less than eight of 38 cases are concerned with mental disorder (including mental impairment). Even so, the message of the relative invisibility of mental health in the index, is that, in bioethics as in biomedicine, mental health is an also-ran, a Cinderella discipline, to other more high-tech areas of medicine.

Neglect of conceptual issues

There are good historical reasons, to which we return at the end of this chapter, why bioethics has mirrored biomedicine in neglecting mental health. For the moment, though, we are concerned with the consequences of this neglect.

EXERCISE 10

Think about this for yourself before going on. Given our conclusions in earlier parts of this book, particularly in Part I, what consequences would you expect from bioethics' tendency to mirror biomedicine?

Our main conclusion in Part I was that mental health, although stigmatized in the twentieth century medical model as being deficient scientifically, was in fact conceptually more *difficult* than high-tech areas of bodily medicine.

The greater conceptual difficulty of mental health, furthermore, although evident in a number of different areas, includes one area of particular relevance to ethics, namely its more complex value structure. Values, as we found in Part I, although present in all areas of health care, are particularly prominent in mental health. This is not because mental health is less scientific. It is because people's values differ more widely in the areas with which mental health is concerned (emotion, desire, volition, sexuality, etc.) than in those with which (high-tech) areas of bodily medicine are concerned (severe bodily pain, imminent death, etc.).

Bioethics, then, to the extent that it has mirrored biomedicine, has failed to recognize the greater conceptual difficulty of

mental health. Beauchamp and Childress (1989), as we will see in Chapter 18, are a partial exception to this: their detailed analysis of involuntary psychiatric treatment draws deeply on philosophical work on irrationality. All the same, even in Beauchamp and Childress, the relative neglect of conceptual difficulties is reflected in the absence of conceptual topics in their index: there are no entries for concepts of disorder, disease, dysfunction, illness, delusion, etc., nor even for values or value judgement.

We will see in Chapter 18, that this relative neglect of conceptual issues is a linguistic-analytic signal of the traditional medical model underlying Beauchamp and Childress' work, a model that is directly reflected in the conclusions they draw about involuntary psychiatric treatment.

But does it matter?

Bioethics, then, in neglecting mental health, has, like biomedicine, neglected conceptual issues, including those raised by diversity of values. In the case of biomedicine, its focus on empirical science is understandable, given medicine's huge successes in the twentieth century in meeting the challenge of major diseases. In respect of such diseases, values are present but unproblematic because they are largely shared (remember the example of a 'heart attack', in Chapter 6, which is a bad condition, in and of itself, in anyone's scale of values). In the case of bioethics, it is true, neglect of differences of values, and of related conceptual difficulties, is rather more surprising, ethics and values being closely related.

But does it matter than bioethics has mirrored biomedicine in neglecting conceptual issues? Anything approaching a full answer to this question will occupy us for the rest of this part of the book! In the remainder of this session, we will take a first step towards answering it by considering in more detail two examples of ethical difficulties, consent and confidentiality, generic in nature, but presenting particular problems in mental health. As we will see, in both cases, the particular difficulties arising in mental health are *conceptual* in nature. Our conclusion, then, will be that for mental health at least, it certainly *does* matter that bioethics has neglected conceptual issues.

Example 1: consent, capacity, and delusion

As before, we will start by considering actual case histories.

EXERCISE 11

This is another two-stage exercise. Again, it is important to do Stage 1, to think about the issues for yourself, before going on to the reading in Stage 2.

Stage 1 (45 minutes)

Consider any of your cases that involved consent (if none of them did, you might like to consider Mr AB). Consent is important in all areas of health care. But it can be especially problematic in mental health. Write short notes on:

1. what is required for genuine consent to a treatment, and
2. in what ways these requirements may be particularly difficult to fulfil in mental health.

Stage 2 (60 minutes)

Then look at any of the standard bioethical accounts of consent (for example Beauchamp and Childress). How far do your conclusions coincide with theirs?

Most authors agree with Beauchamp and Childress (1989) in defining two key conditions for consent: (1) *information*, and (2) *voluntariness (including freedom from coercion, which is sometimes treated as a distinct third condition*).

Both conditions, information and voluntariness, raise many difficulties in any situation in medicine: how much information is appropriate? Is an apparently free choice covertly coerced, for example through an unequal power relationship between doctor and patient? And so on.

Mental disorder and the conditions for consent

Mental disorder shares with other areas of health care such difficulties. In addition, however, it is among those conditions that, in and of themselves, may impair the very *capacity* for consent. Other capacity impairing conditions include mental impairment, unconsciousness, or being a young child. Mental disorder, however, to complicate matters further, covers many different ways in which consent may be impaired, corresponding with the many different kinds of psychopathology. Some of these affect particularly the first condition for consent, others particularly the second. Here are a couple of examples.

- *Condition 1 (information)*: anxiety blocks the ability to retain and recall new information (we tend not to register names when first introduced to people in a crowd—the 'cocktail party' effect). Hence people suffering from the often extreme anxiety engendered by anxiety disorders will be *especially* incapacitated in this respect.
- *Condition 2 (voluntariness)*: choice is only truly voluntary where there is an equal power relationship. Mental disorder is often associated with feeling demoralized and powerless (as in depression). Hence mental disorder itself may often leave people feeling disempowered.

A consent Catch-22

Yet despite difficulties of this kind, involuntary treatment is used in mental health for situations in which it would never be considered in other areas of medicine. In the case of bodily disorders (as we will see in Chapter 19), it is now a cardinal principle of health-care law in many legislations around the world, that an adult patient who has the capacity to make the requisite choice may refuse even life-saving treatment if they so wish, provided that (as with some infectious diseases, for example) their condition carries no immediate risk of danger

to others. A person may lack capacity in certain well defined circumstances—if they are unconscious, for example, as noted above, or are a minor (with different age thresholds being set for different kinds of decision), or have learning disability. In the absence of such capacity-impairing circumstances, however, consent to the treatment of bodily disorders is mandatory.

With a mental disorder, by contrast, and only with a mental disorder, treatment without consent may sometimes be considered appropriate for a *fully* conscious, *adult* patient of *normal* intelligence, not for the protection of others (though as we saw above involuntary psychiatric treatment is also used as in bodily medicine for the protection of others), but *in that person's own interests*. So here is a Catch-22 with a vengeance! In mental health, it may often be especially difficult to satisfy the *conditions* for consent (because of the effects of the mental disorder itself); yet it is also in mental health that the most radical *breaches* of consent occur!

The Catch-22 of involuntary psychiatric treatment is illustrated by Mr AB's case from the previous session. His treatment under the Mental Health Act was in direct conflict with his express wishes. Yet he was a fully conscious adult of normal intelligence. Further, treatment was needed (in the view of everyone except Mr AB) not to protect others but in his own interests. Mrs AB, among others, certainly did have an interest in her husband receiving treatment, just as she would have done if the threat to his life had been from a bodily illness (such as cancer). But the justification for involuntary treatment in Mr AB's case was the threat posed by his illness (depression) to, in the terms of condition 2 above, his own 'health or safety' (from suicide).

Capacity and mental disorder

The difference, of course, between Mr AB and someone with a bodily disorder (such as cancer), is that Mr AB's wishes were taken to be invalid: they were assumed to be, somehow, not his 'true wishes', a product rather of delusional beliefs arising in the context of a severe depressive illness; and Mr AB's refusal of treatment, correspondingly, was taken to be irrational. In other words Mr AB, consistently with health-care law generally, lacked the capacity to make decisions about his treatment. He lacked decision-making capacity, it is true, not for the reasons most often relevant to bodily disorders (impaired consciousness, for example, as immediately above), but he lacked capacity none the less. And he lacked capacity for a reason most often relevant to mental disorder, namely that he was suffering from delusions.

Delusions and the map of mental disorders

Delusions, you will recall from Chapter 2 in Part I, together with other functional psychotic symptoms, are at the centre of the map of psychopathology, our Rylean 'logical geography' of psychopathology, in part precisely because delusions represent the paradigm case of a mental disorder rendering the person concerned not responsible for their actions. It will be worth dwelling for a moment on just how well established is the ethical intuition that delusion and other functional psychotic symptoms invalidate choice.

Thus, the basis of the intuition is, at first glance, evident enough. In some forms of mental illness, notably with delusions, people are 'irrational', and hence, as with other legal excuses (accident, inadvertence, duress, etc.), they are held to be 'not responsible' for their actions. It was this property of mental disorders, as just noted, that we highlighted as Feature 3 of our Rylean 'map' of psychopathology in Chapter 2. So widely acknowledged is the intuition that mental disorders excuse, it has been built into legislation in many different countries and right back to classical times. Aristotle, for example, included the 'mad' among those who could not be 'bad' (see his *Nichomachean Ethics*, Bk.3, Section 3; 1112^{a}11–31, 2000); and most legal systems since then have included madness as one form of legal excuse. We noted in Part II, Daniel Robinson's (1996) remarkable review of two and a half thousand years of the insanity defence (and its cognates) across a wide range of diverse cultures. In forensic psychiatry, the legal intuition that delusions excuse continues to be important in respect of serious crimes: and in jurisdictions that retain capital punishment, 'important' means, quite literally, that life or death may hang on the distinction between mad and bad.

Excusing conditions and invalidating conditions

Historically, the intuition that people who are suffering from delusions are not responsible for their actions has been more in evidence in relation to excusing conditions in criminal law than to incapacity as a condition justifying involuntary treatment. This is because consent itself, the need for explicit consent as a condition for medical treatment, is a relatively recent development in medical ethics—like autonomy in bioethics (as noted above), consent is relatively 'late and local'. But it is essentially the same intuition, of loss of responsibility for one's actions, that lies behind the more everyday, if less high profile, cases of involuntary treatment, like that of Mr AB. The importance of delusion as an invalidating condition, as it is called in this context, is evident in day to day clinical work: despite the wide definition of mental disorder in most mental health legislation (as in the UK, see above), involuntary treatment is in practice largely (though by no means exclusively) confined to psychotic disorders (see e.g. Sensky *et al.*, 1991).

Deep intuitions and deep divisions

'Mad or sad', then, as in Mr AB's case, is equivalent in this respect to 'mad or bad' in the insanity defence. As with the insanity defence, though, so also with involuntary treatment, while the general principle may be well established, that people with psychotic disorders may not be responsible for their actions, there may still be deep difficulties in particular cases about where

to draw the line. There may be wide agreement, that is to say, on the principle that delusion is an excuse in law, and, correspondingly, an invalidating condition for treatment choice. There is, however, often considerable disagreement about whether the principle applies in a given case.

Even Mr AB's case, although introduced originally (by Fulford, 1989) as an example of a case in which all but the most radical of antipsychiatrists would agree involuntary treatment is justified, turned out, in a case vignette study (see below), to be a case over which opinion, for or against involuntary treatment, is split down the middle! In this case vignette study, as we will see, there were indeed other cases over which respondents were largely in agreement on whether or not involuntary treatment is justified. But Mr AB turned out not to be one of them! And the disagreement over cases such as Mr ABs, as we found when we first read Mr AB's story in Chapter 2, is not, or not primarily, as to the facts. The facts, as we saw in Chapter 2, may be all in, and yet there may still be disagreement as to how the facts should be interpreted. Such disagreements, then, as we concluded in Chapter 2, point to difficulties that are not empirical in nature but conceptual.

Bioethics, as we will find when we return to this topic in Chapter 18, has generally failed to recognize the particular conceptual difficulties underpinning involuntary treatment in psychiatry. Consistently with its mirroring of biomedicine, therefore, it has assumed that the tools it has developed to support decision-making in relation to involuntary treatment in bodily medicine, can be used essentially unchanged in mental health. The failure of this assumption leads directly to the sharper set of tools that are required for ethical issues generally in mental health.

Example 2: confidentiality and the concept of mental disorder

Compared with consent, confidentiality, although important generally as an ethical issue, has not been widely recognized to raise distinctively *conceptual* issues in mental health. As with consent, then, the tools for handling ethical issues around confidentiality developed in bodily medicine, have generally been applied essentially unchanged to mental health. But is this right? We will look briefly at this question before moving on to the role of mental health law.

EXERCISE 12 (20 minutes)

- Is the special conceptual trickiness of ethical issues in mental health limited to consent?
- What about confidentiality?

Think about this in relation to your cases (or Mr AB).

- What conceptual issues could lie behind the problems of confidentiality they raise?

Confidentiality and consent

The casualty officer in Mr AB's case, you will recall, breached confidentiality by letting Mrs AB know that her husband had turned up in casualty. This breach of confidence, we said, was justified in the circumstances.

But exactly how was it justified? One justification for breaching confidentiality is a 'clear and present' danger to an identified third party, as in the oft-cited Tarasoff case, described by Beauchamp and Childress (1989), in case 1 in their appendix. However, there was no such clear and present danger to a third party in this case. The commonest justification for breaching confidentiality is that it is done with the patient's consent. But Mr AB, we have suggested, lacked capacity to consent. So the justification in this case seems to go back to the condition from which he was suffering, a form of depression that, just as it invalidated his refusal of treatment, invalidated his refusal of permission for the casualty officer to contact his wife.

True, capacity is decision specific. Loss of capacity for one kind of decision does not in itself involve loss of capacity for a different kind of decision. In this case, however, the two decisions—to refuse treatment and to refuse permission to contact his wife—were both driven by Mr AB's delusion that he was dying from brain cancer.

Confidentiality and disorder as a distributed concept

With confidentiality, then, as for involuntary treatment, there may be particular ethical difficulties in mental health arising from establishing the proper boundary of the concept of mental disorder as an invalidating condition.

Confidentiality illustrates a further difficulty with the concept of mental disorder, however, namely that disorder itself may not be neatly located within any one individual. We noted earlier that the bioethical principle of autonomy runs into difficulties in societies that value family and social networks above individualism. In mental health, the problem may be that disorder itself is understood in family or social terms. In child and adolescent psychiatry, in particular, it is often within the dynamics of family relationships that disorders are located rather than within any one individual.

Confidentiality and sharing

In Chapter 6 we found that the diversity of values, which is integral to the concept of mental illness (insofar as it is distinct from the concept of bodily illness), is integral to good practice in mental health; in particular, it underscored the importance of the multidisciplinary team. If this is right, however, then in mental health practice, confidences *have* to be shared.

Again, there are problems throughout health care about when it is right to share information given in confidence. Such difficulties, in the case of mental health, are made particularly acute by the diversity of values by which the concept of mental disorder is characterized. In some cases, one value may indeed

seem clearly to outweigh another: the lesson of the Tarasoff case, as noted above, is that where there is a 'clear and present' danger to an identified third party, the value of sharing information to protect that third party clearly outweighs the value of maintaining patient confidentiality. Even here, however, in Tarasoff-type cases, mental health presents particular difficulties. For one consequence of the value diversity of mental disorder is that balanced decision-making itself depends, *inter alia*, on a well-functioning multidisciplinary team. We return to this in Chapter 18, as a key feature of VBP. The problem here, however, in relation to confidentiality, is that it may not be possible to come to a balanced view about whether a third party is indeed in 'clear and present danger' without information being shared, not only within the members of a multidisciplinary team, but between a number of different agencies extending well beyond health and indeed social care (to include, e.g. the police). The British psychiatrist, George Szmukler, has estimated that over 30 different agencies are concerned with any one patient in community-based mental health services (Szmukler and Holloway, 2001).

With confidentiality, then, in mental health, the need for multidisciplinary and multi-agency working arising from the particular diversity of values by which the concept of mental disorder is characterized, leaves us with another Catch-22. A breach of confidentiality is justified if there is a clear and present danger to a third party. But establishing the presence of a clear and present danger depends on information being widely shared.

The conceptual depth dimension to mental health ethics

With confidentiality, therefore, as well as with consent, mental health ethics involves a depth dimension of conceptual difficulty that is lacking from the high-tech areas of bodily medicine on which bioethics has traditionally focused.

We should expect this, as we have seen, if the ideas about the concept of mental illness developed in Part I of this book are right. The bottom line of Part I was that mental health, contrary to the traditional medical model, is not a primitive or otherwise defective also-ran to bodily medicine, but an area of health care in which conceptual, as well as empirical, difficulties are writ large. We should expect particular conceptual difficulties in mental health ethics, then, and they are indeed there.

In Chapter 2, the conceptual difficulties embedded in Mr AB's case launched our discussion of the concept of mental illness, a discussion that, by the end of Chapter 6 led to our more complete or 'full-field' picture of the conceptual structure of health care. We pick up this discussion in Chapter 18, when we consider the implications of our 'full-field' picture for the sharper set of ethical tools required for mental health. First, though, in the final session of this chapter, we take a first look at the law as a resource for resolving ethical issues in mental health.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. In what respect is bioethics' attitude to mental health similar to that of biomedicine?
2. What are the conditions for consent (we noted two) and how are matters of consent made more difficult in mental health?
3. What particular kind of psychopathology is at the heart of the difficulties equally of consent and, in forensic contexts, of 'mad or bad'?
4. In addition to issues of consent, what further *conceptual* difficulties are involved with ethical problems of confidentiality in mental health?
5. What conflict of values is particularly associated with issues of confidentiality?

Session 3 Conceptual difficulties and mental health law

Thus far in this chapter, we have considered the nature of psychiatric ethics, its breadth, but also its conceptual depth. In Session 2, in particular, we noted how bioethics has tended to stop short just when things get interesting conceptually in mental health ethics. We considered two 'big issues' by way of illustration, consent and confidentiality, both generic issues, but both raising conceptual difficulties—about delusion and capacity, and about the wider concept of mental disorder, respectively. Difficulties of this kind, we argued, although legitimately left unspoken in other conceptually less complex areas of health care, are at the heart of the ethical difficulties in mental health.

In this session, we take a first look at medical law. As in Sessions 1 and 2 of this chapter, we start with some philosophical fieldwork, in this case by way of a series of case vignettes. In the next exercise, we will be asking you to respond to these case vignettes, not by way of philosophical analysis but as you would 'for real'. Unpacking our responses to these vignettes (initially in this session and then in more detail in Chapter 18), will show that health-care law, like bioethics, although providing a valuable general framework for the issues arising in mental health, needs to be combined with conceptually sharper tools for working with conflicting values if it is to be helpful to us practically, as users and providers of services, in mental health.

Philosophical fieldwork

We will start, then, with an exercise in 'philosophical fieldwork', in this case using a series of case vignettes (first published in Fulford and Hope, 1994).

Questionnaire

For instructions, please see Exercise13.

Time allowed: 5 MINUTES

CASES

	(tick one box per case) YES	?	NO
1. Miss AN, age 21 student. Four-year history of intermittent anorexia. Currently seriously under weight, exercising and using laxatives; amenorrhoeic. Refusing admission on the grounds that she is 'too fat'.	☐	☐	☐
2. Mr OC, aged 27. Bank clerk. Three-year history of progressive slowness at work. Referred with depression and anxiety following suspension from work. Shows severe and progressive obsessional checking which he agrees 'is something wrong with him'. However, he drops out of treatment.	☐	☐	☐
3. Mr SD, aged 48. Bank manager. Presents in casualty with biological symptoms of depression and hypochondriacal delusions. History of attempted suicide. Asking for something to 'help him sleep'. He refuses to stay in hospital when he is told that he may be suffering from depression.	☐	☐	☐
4. Miss HM, aged 25. Novice nun. Brought by superiors for urgent outpatient appointment as they are unable to contain her bizarre and sexually disinhibited behaviour. Shows pressure of speech, grandiose delusions, and auditory hallucinations. Refusing to stay.	☐	☐	☐
5. Mr B, aged 16. School boy. Seen by GP at parents' request with failing vision in one eye. Despite progressively impaired vision refuses to accept that he is unable to see with that eye. Diagnosis of optic atrophy but refuses investigation through fear of hospitals.	☐	☐	☐
6. Mr A, aged 50. Doctor. Developed thickening of lips, hoarse voice, and enlargement of skull over several years. Refused to accept that these changes were anything other than age-related and rejected his colleagues' diagnosis of acromegaly. Refusing investigations.	☐	☐	☐
7. Miss HP, aged 30. Secretary. Admitted to neurology ward and transferred to psychiatry under protest. Unable to use right hand (patient right-handed). Paralysis 'non-anatomical'. History of self-injury. Rejecting psychological diagnosis and planning to discharge herself.	☐	☐	☐
8. Mrs CR, aged 47. Housewife. Refusing investigation of breast lump discovered on routine screening. Understands that she does not have to accept treatment if the lesion is found to be malignant. Normal mental state.	☐	☐	☐
9. Mr S, aged 18. Student. Emergency psychiatric admission from his College. Behaving oddly. Showed thought insertion (Mike Yardwood 'using his brain'). Complaining that people were talking about him. Refusing medication and planning to leave hospital.	☐	☐	☐
10. Mrs HF, aged 51. Shop worker. Complained to general practitioner of hot flushes and irregular periods. Had developed backache and X-rays showed osteoporotic change. Refusing HRT despite full explanation of the implications.	☐	☐	☐
11. Mrs AGP, aged 25. Housewife. Progressively housebound over 2 years with agoraphobic symptoms. Refusing behavioural treatment despite threat to job and marriage.	☐	☐	☐
12. Mrs M, aged 46. Nurse. Withdrawing from marital therapy because she resents the implication that their 'problems' are in their relationship. Says her husband is 'sick'. Her husband has been violent in the past and is now threatening to kill her.	☐	☐	☐
13. Mr PP, aged 23. Unemployed man. Seen in casualty by the duty psychiatrist. Brought in by a girlfriend because he is angry and threatening to kill a rival. Has been drinking. History of criminal assault. No other symptoms. Refusing to stay.	☐	☐	☐
14. Mr SC, aged 60. Retired. Recent diagnosis of bronchial carcinoma. Normal mental state. Wants repeat prescription of sleeping tablets. GP knows him to be a supporter of euthanasia and suspects he intends to kill himself.	☐	☐	☐

Fig. 17.1 Case vignette questionnaire.

EXERCISE 13 (4 minutes only!)

In this exercise you are asked to decide for yourself about involuntary treatment for a number of cases including bodily as well as mental disorders.

The cases are given in the questionnaire in Figure 17.1. As this shows, you have to decide for yourself what you would do in each case. If you are a health-care professional, imagine that the people described are your clients or patients; if not, imagine what you would want to happen if the person concerned were a close relative, your son, or your partner, say.

The time allowed for this exercise really is 4 minutes! The reason for this is that it is not a 'test' of theory but a way of bringing out what you would do, or want done, in practice. In J.L. Austin's terms, this is an exercise in using our concepts for real in the spirit of his 'philosophical fieldwork'. In R.M. Hare's terms (as in the last session), it is Level 1 moral thinking, acting on your intuitions in the heat of the moment.

Level 1 thinking, as Hare pointed out is how we all have to work if we are to remain effective. In practice, we simply do not have much time to think. We have to decide what to do and get on with it. Similarly, we often have to act on limited information, again as with these case vignettes.

Time yourself, then, and run quickly down the list of cases in Figure 17.1, relying on your intuitions to guide you. If you are working in a group, compare your responses (but don't change them!) before reading on.

Having done the case vignettes, we will be moving to Level 2 thinking, reflecting on what lies behind our intuitions as reflected in the 'real-life' choices we have made.

Well, how did you get on? Remember, there are no *definitive* right or wrong answers here. There are rules about involuntary treatment (we come to the legal rules in a moment). But the purpose of the exercise is to get your reactions as guided by your intuitions in the heat of the moment over choices of the kind that have to be made in everyday practice.

The responses people give to these cases are remarkably consistent. Table 17.1 shows the results from a typical group of respondents to the questionnaire. As this indicates, responses to the cases fall into three broad categories: for most cases, most people feel that involuntary treatment is *not* justified; but for two cases (4 and 9) almost everyone feels that involuntary treatment *is* justified; while for two further cases (1 and 3), opinion is sharply *divided*. Case 3, by the way, is of course based on Mr AB. As noted above, it was a surprise (for Fulford) to find (when he started using Mr AB's story in this questionnaire) that involuntary treatment in Mr AB's case was very far from being a foregone conclusion!

Table 17.1 Responses to the case vignette questionnaire

Cases	Respondents opting for involuntary treatment (%)
1 Anorexia	25
2 Obsessional disorder	10
3 Depression	50
4 Hypomania	≤100
5 Optic atrophy	1
6 Acromegaly	0
7 Hysteria	3
8 Breast lump	0
9 Schizophrenia	≤100
10 Osteoporosis	0
11 Agoraphobia	0
12 Marital problems	1
13 Personality disorder	1
14 Bronchial carcinoma	1

A consistent three-part pattern . . .

This overall three-part pattern, with responses falling into the three groups of a 'split vote' on involuntary treatment (cases 1 and 3), 'mainly yes' (cases 4 and 9), and 'mainly no' (the rest), has been replicated in teaching sessions with different groups of mental health-care professionals (psychiatric nurses, psychiatrists, social workers, etc.), with patient advocacy groups, and with groups in many different countries. It was even found with a group of former dissidents from one of the old Soviet block countries who had suffered politically motivated abusive uses of psychiatry (we return to this in Chapters 20 and 21).

There *are* differences, of course, in how people respond to the case vignette questionnaire. Between individuals the differences may be quite large. Your own responses may not have coincided with the three part pattern! We will see later (when we get to VBP in Chapter 18) that there are good reasons for such individual variation, reasons to do (in part) with the variation in human values. But the *overall* pattern of responses is none the less remarkably stable.

The pattern, furthermore, has a degree of face validity (see Part I, Chapter 2) to the extent that the cases actually picked out are all to a greater or lesser extent psychotic: the two clear 'yes' cases are overtly psychotic (case 4, with hypomania, and case 9, with schizophrenia), case 3 (one of the two with a split vote) has delusions, and case 1 (the other split vote) has anorexia, a condition that, although not among the classical psychotic disorders, may be associated in its more severe forms with psychotic disturbances of insight. Selecting these particular cases, then, is consistent with the literature cited above, showing the

historically and cross-culturally stable association of psychosis with loss of responsibility for one's actions. It is also, as we noted in Session 1 above, consistent with current clinical practice.

. . . with differences

As a matter of Level 1 thinking, in Hare's terminology, these results thus indicate a high degree of consistency over our ethical intuitions about consent. The questionnaire, though, also, and crucially, shows inherent *differences* of view. This is shown in part by the (admittedly low) level of disagreement about all the cases. It is unusual with any group to get complete agreement on any of the cases.

The importance of differences of view, however, is also shown, more dramatically, by the split vote on cases 1 and 3. The fact that, even in the somewhat artificial context of a case vignette questionnaire, no less than two of 14 cases should regularly attract a vote that is split down the middle, shows clearly the depth of disagreement that there may be over issues of compulsion in mental health.

Such differences, with opinion split down the middle, are indeed clearly evident also in practice. In the polarized psychiatry versus antipsychiatry debate in the 1960s and 1970s that we explored in Part I, Szasz' antipsychiatry argument against the concept of mental illness was driven largely by his rejection of involuntary treatment. Pro-psychiatry arguments, on the other hand, are often driven equally strongly by endorsement of involuntary treatment, at least in cases like Mr AB's. John Wing, for example, the British social psychiatrist, whose foundational work in modern descriptive psychopathology we introduced in Chapter 3, described as 'morally repellent' the attitude of those (like Szasz) who would reject involuntary treatment for people (like Mr AB) who are suicidally depressed (Wing, 1978, p. 244). So we need to move to Hare's Level 2 thinking, to reflect on and to try to understand what lies behind our intuitive responses to cases such as these.

Interpreting the three-part pattern

Level 2 thinking about involuntary treatment, as illustrated by our case vignette questionnaire, could involve direct ethical debate about the contested cases: neither Szasz nor Wing, for example, would have been satisfied with the split vote over case 3 (see their contrasting views above about the ethics of involuntary treatment for suicidally depressed people noted immediately above). Direct ethical debate is important in health care. We will be introducing in Chapter 18 a range of ideas both from bioethics and from ethical theory that may contribute particularly to the thinking skills that are needed for ethical debate in health care.

Here, though, our approach, guided as it is by the observation that ethical problems in psychiatry are a product of deeper conceptual difficulties, has to be more circumspect. Our aim has to be, not to dispute but to explain. Drawing on the methods outlined in Part I, we will thus treat the three-part pattern of responses to the case vignette questionnaire as (in Gilbert Ryle's vivid metaphor) a 'logical geography' of consent, as a pattern reflecting the features of our ordinary (i.e. unreflective or intuitive) use of concepts in relation to consent, and as a pattern therefore for which philosophical analysis has to account.

Linguistic analysis, you will recall from Part I, is not premissed on the correctness of this or that use of concepts: in the terms of Part I, therefore, interpreting the three part pattern of our responses to the case vignettes, means that we have either to *explain* or to explain it *away*. Either outcome will do. Either outcome, that is to say, will help to give us a more complete picture of the concepts guiding our intuitive responses to involuntary treatment as reflected in the three-part pattern.

Interpretation: (1) too much law, and too little

What, then, lies behind the three-part pattern of responses to our case vignette questionnaire. What account can we give of this pattern, and, hence, of the logical geography of consent?

EXERCISE 14 (10 minutes)

Think about this question yourself before going on. The idea at this stage is not so much to start thinking philosophically as simply to reflect on your own decisions, to consider what was influencing you for or against involuntary treatment in each of the cases.

Faced with this question, many people start by talking about the legal framework of health-care practice. If you are a mental health professional, and/or have had direct experience of mental illness, your understanding specifically of mental health law will probably have figured strongly in your decisions about the cases in the questionnaire.

A role for mental health law

The law is clearly relevant. Mental health law, indeed, as we noted earlier, directly reflects historically long-standing and cross-culturally stable intuitions about the loss of responsibility that goes with some kinds of mental disorder. Thus, modern mental health legislation requires (in one form or another) two conditions to be fulfilled for involuntary psychiatric treatment.

- *Condition 1 (mental disorder)*—the patient must be suffering from a mental disorder.
- *Condition 2 (risk)*—there must be a risk to the patient or others arising from the disorder.

These conditions vary in the detail of how they are defined in different legislations but they are always there in one form or another. In the UK, for example, Section 2 (Admission for Assessment) of the Mental Health Act 1983 (applicable in England and Wales), specifies (*Condition 1*) that the person concerned must be '. . . suffering from mental disorder . . . ', mental disorder being defined earlier, in Section 1 of the Act, as 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'; and (*Condition 2*) that the patient '. . . ought to be so detained in the

interests of his own health or safety or with a view to the protection of other persons'. So defined, then, these two conditions do indeed cover many of our cases. Many of our cases were suffering from a mental disorder (*Condition 1*) and they were also a risk to themselves or others (*Condition 2*).

To this extent, therefore, if you were thinking of mental health legislation in responding to the case vignette questionnaire, this would have been entirely in order. Indeed, if you are a mental health professional and had *not* been thinking of it, you would have been at risk of a negligence claim!

Too much law

So mental health law is relevant. Is it, however, sufficient to explain our responses (and thus to give us the required account of the logical geography of consent)? In other words, does applying the two legal criteria for consent to our cases reproduce the three-part pattern of our responses to them in the exercise above?

The answer, essentially, is 'no', because the two conditions, taken together, are considerably overinclusive. As defined in the legislation, the two conditions, although covering the cases in the vignette exercise for which involuntary treatment is widely felt to be justified, also covers many cases for which involuntary treatment is *not* widely felt to be justified.

This is illustrated by Table 17.2 (adapted from Fulford, 1992, p. 358), which shows what happens when we apply the two legal criteria for consent to the cases in our vignette questionnaire. The figure lists the vignette cases in the left-hand column with approximate percentage 'yes' votes next to them. The next column then gives a + sign for any case for which involuntary treatment would be allowed under mental health legislation incorporating the two conditions, of mental disorder and of risk.

Table 17.2 Responses to the case vignette questionnaire using the two key conditions for compulsion in the Mental Health Act 1983

Case vignettes	Respondents opting for involuntary treatment (%)	Possible basis of response Mental Health legislation—mental disorder + risk (self or others)
1 Anorexia	25	+
2 Obsessional disorder	10	+
3 Depression	50	+
4 Hypomania	≤100	+
5 Optic atrophy	1	
6 Acromegaly	0	
7 Hysteria	3	+
8 Breast lump	0	
9 Schizophrenia	≤100	+
10 Osteoporosis	0	
11 Agoraphobia	0	+
12 Marital problems	1	
13 Personality disorder	1	?
14 Bronchial carcinoma	1	

As the figure illustrates, the cases where many or most people's intuitions said 'yes' to involuntary treatment (cases 1, 3, 4, and 9) are well covered. But a great many more cases are covered as well!

There is room to argue about the details here. But the message is clear, that as a basis for explaining our intuitive ethical responses to these cases, mental health law, at least of this broadly drawn kind, is too inclusive.

Narrow excuses, wide invalidating conditions

Similar very wide criteria for involuntary psychiatric treatment are to be found in many other legislations (see Fulford and Hope, 1996). Such criteria, it is worth noting, stand in marked contrast with the corresponding legal criteria generally adopted for mental disorder as a legal excuse. As noted above, the 'insanity defence' has been based, centrally, on delusion. Other mental disorders may be put forward to a court in mitigation, in hope of a reduction in the severity of sentencing; but other mental disorders are not generally accepted as an excuse, i.e. as a condition removing the accused's responsibility for the crime altogether. In England and Wales, for example, a successful plea of 'insanity' must satisfy the very narrow constraints of the McNaughten rules, namely that the person concerned did not understand either the nature of the act (of killing someone) or that it was wrong. These rules are derived from a famous nineteenth century case in which Daniel McNaughton, after shooting and mortally wounding the Prime Minister, Sir Robert Peele's, private secretary, Edward Drummond (McNaughton thought his victim was the Prime Minister), was held to be not responsible for his actions because he was suffering from delusions (West and Walk, 1977).

Legislators, then, while restricting the insanity defence rather narrowly, and usually to delusion or other psychotic disorders, have tended to take a much more open-handed approach to involuntary treatment. This discrepancy points ahead to the bottom line of Chapter 19, namely that in law as in medicine, values, although not always recognized for what they are, may be crucially important not only to the way the law is interpreted but also to how it is drafted in the first place. With the insanity defence the primary concern (or value) of legislators is that the law should not be used inappropriately as an 'escape route' for those who have committed serious crimes (such as murder). With involuntary treatment, on the other hand, the primary concern (or value) of legislators is to ensure that the law is used appropriately to ensure that those who are in need of treatment receive it.

Too little law

The natural reaction to the overinclusiveness of the legal conditions for involuntary treatment, is to say: 'Ah, but it's not "mental disorder + risk" as such that explains our responses to the vignettes; it is "*serious* mental disorder and/or *serious* risk".' Take such legislation literally, this line of thought goes, and, yes, it is overinclusive with a vengeance; however, interpret it in a 'common sense' way, as being intended to be used only for serious cases, and it comes closer to our intuitive responses, surely.

The idea, then, is that legislation should be drawn widely, leaving professionals the room they need to apply it in appropriate, i.e. serious, cases. There are many points—legal, ethical, and practical—for and against such an approach. For our purposes, though, of explaining the logical geography of consent, the effectiveness or otherwise of stiffening up the legal criteria for consent with an implicit criterion of seriousness, depends on what meaning is given to 'serious'.

Interpretation: (2) law plus seriousness

What, then, is meant by 'serious' in the context of mental health legislation on consent? We will briefly consider two meanings of 'serious', a legal meaning attached to Criterion 1 (i.e. a legal definition of 'serious mental disorder'), and a bioethical meaning attached to Criterion 2 (i.e. a bioethical definition of 'serious risk'). Neither criterion, as we will see, and as is illustrated in Tables 17.3 and 17.4, sufficiently explains the three-part pattern of our responses to the case vignette questionnaire.

Psychopathology, by contrast, to anticipate the final part of this session, *does* provide an appropriate criterion of seriousness, in the concept of psychosis (introduced in Chapter 3). Psychosis, indeed, and the concept of psychosis furthermore as defined specifically for use in legal contexts by a group of lawyers and doctors (the 'Butler Committee') in the run up to the 1983 Act, fits the three-part pattern like a glove. If, then, use is indeed a guide to meaning (as Austin showed us in Part I), psychosis is closely relevant to the grounds of involuntary psychiatric treatment. The conceptual 'fit' between psychosis and involuntary treatment, however, begs the theoretical question of why some cases, at least, are controversial. It thus also begs the bottom line practical questions about how to improve decision-making in this area.

Legal 'serious' = 'warrants admission'

First, then, a legal criterion of seriousness. There is a measure of 'serious' built into the Mental Health Act 1983 in the notion that, in the words of Section 2 of the Act (Admission for Assessment), the required mental disorder should be '. . . of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period'.

There is much to commend this approach. First, it places the burden of decision firmly on those directly involved. It is not for lawyers to say who needs to be admitted to hospital. As a criterion of 'seriousness', furthermore, 'warrants admission' is responsive to changes in professional best practice. Since the 1983 Act was drafted, in the late 1970s and early 1980s, we have witnessed a radical shift in mental health from hospital-based to community-based services. This shift has been reflected in successive editions of the Code of Practice, a comprehensive guide to the use of the Act (in England and Wales, see chapter 19).

'Warrants admission' is thus a flexible criterion of seriousness, which, in principle, allows for relevant discretion in using what would otherwise be the very wide criteria for admission defined

Table 17.3 Responses to the case vignette questionnaire using the two legal criteria plus a further legal criterion of 'warrants admission' as a measure of seriousness

Case vignettes	Responses to vignettes—% 'yes' for involuntary treatment	Possible basis of response			
		Mental health legislation—mental disorder + risk (self or others)	Mental health legislation + criteria of seriousness		Severe mental disorder—by Butler criteria (= psychotic symptoms)
			Mental disorder warrants admission	Mental disorder + risk is life threatening	
1 Anorexia	25	+	?		
2 Obsessional disorder	10	+	?		
3 Depression	50	+	?		
4 Hypomania	≤100	+	?		
5 Optic atrophy	1				
6 Acromegaly	0				
7 Hysteria	3	+	?		
8 Breast lump	0				
9 Schizophrenia	≤100	+	?		
10 Osteoporosis	0				
11 Agoraphobia	0	+			
12 Marital problems	1				
13 Personality disorder	1	?	?		
14 Bronchial carcinoma	1				

Table 17.4 Response to the case vignette questionnaire using the two legal criteria plus a bioethical criterion of 'immediately life threatening' as a 'measure of seriousness'

Case vignettes	Responses to vignettes—% 'yes' for involuntary treatment	Possible basis of response			
		Mental health legislation—mental disorder + risk (self or others)	Mental health legislation + criteria of seriousness		Severe mental disorder—by Butler criteria (= psychotic symptoms)
			Mental disorder warrants admission	Mental disorder + risk is life threatening	
1 Anorexia	25	+		?	
2 Obsessional disorder	10	+			
3 Depression	50	+		+	
4 Hypomania	≤100	+			
5 Optic atrophy	1				
6 Acromegaly	0				
7 Hysteria	3	+			
8 Breast lump	0				
9 Schizophrenia	≤100	+			
10 Osteoporosis	0				
11 Agoraphobia	0	+			
12 Marital problems	1				
13 Personality disorder	1	?		+	
14 Bronchial carcinoma	1				

in the Act. If it is a helpful criterion, however, it is not (in itself) sufficient to focus the use of the Act appropriately. There are two reasons for this. First, as Table 17.3 shows, it begs the question. The '?' responses in Table 17.3 reflect the fact that 'warrants admission' is precisely what is at issue. Thus, mental disorders like obsessive-compulsive disorder (case 2) and agoraphobia (case 11) might well be treated on an out-patient basis nowadays. In the late 1970s and early 1980s, however, when the 1983 Act was in preparation, they were often thought to 'warrant admission' to hospital. Other cases on the list are actually described as already being in hospital (e.g. case 7, hysteria). The criterion of 'warrants admission' thus tracks, and tracks faithfully, our intuitive use of involuntary (hospital) treatment, but by the same token fails to provide guidance where it is the appropriateness of admission itself that is at issue.

The second reason why 'warrants admission' is not sufficient to focus the use of the Act, is that it has failed in practice. Thus, over the life of the 1983 Act, despite its in principle sensitivity to changes in clinical practice, it has failed to reflect the shift away from hospital-based services. The shift from hospital- to community-based services since 1983 means that, if 'warrants admission' were an effective constraint on the use of the Act, involuntary admissions should have fallen sharply. In fact, they have gone steadily up (MHAC, 2003).

There are many possible reasons for this, of course. It may be that, absent a criterion of 'warrants admission', use of the Act would have increased over this period even more. The negative correlation between the use of the Act and the use of hospital admissions, however, is at least prima facie evidence that as a legal constraint, 'warrants admission' is not sufficient to guide decisions about the use of involuntary treatment in practice.

Bioethical 'serious' = 'immediately life-threatening'

In the bioethical literature, a general medical condition normally has to be immediately life-threatening before involuntary treatment is considered justifiable. This criterion, used as a criterion of 'seriousness' to strengthen the Mental Health Act Criterion 2, of risk to self or others, would certainly restrict the use of the Act. But if we apply *this* sense of 'serious' to our cases, we move from an overinclusive result to a result which is not inclusive enough! As Table 17.4 shows (adapted from Fulford, 1992), the criterion of 'immediately life threatening' excludes cases (e.g. cases 4 and 9) that most people *would* intuitively treat, and includes other cases (e.g. case 13) that most would *not* treat.

The Butler problem

The problem of finding an appropriate criterion of seriousness was very much in the minds of those involved in drafting the Mental Health Act 1983. In the run up to the Act, a government committee of enquiry was set up under Lord Butler to review the whole question of the treatment of the mentally disordered in law (Butler, 1975). Among many other issues, they considered in

depth just how to provide a narrower criterion for mental illness as a legal excuse, and, correspondingly, for involuntary treatment. This is covered in Sections 18.26–18.36 of their report.

EXERCISE 15 (60 minutes)

Read the extract from:

Butler, Rt. Hon., the Lord. (1975). Chairman, Report of the Committee on Mentally Abnormal Offenders, Cmnd 6244. London: Her Majesty's Stationery Office. (Extract pp. 228–229)

Link with Reading 17.6

Although individual parts of the report are not attributed to particular members of the Committee, this section was written mainly by the British psychiatrist, Sir Denis Hill, at the time Professor of Psychiatry at the Institute of Psychiatry in London, and it provides an authoritative discussion of the issues.

How does the Butler Committee seek to define the particular kind of mental disorder which impairs rationality to the point that people are not responsible for their actions? Note the criteria they offer and then try applying these to our cases.

The Butler solution

The Butler Committee solution, then, as set out in the reading (linked with Exercise 15), was to define a category of 'severe mental disorder' corresponding broadly with the traditional psychopathological categories of 'psychotic disorder'. As the Committee noted, psychosis is difficult to define (we touched on this in Chapter 3, for example; see also Fulford, 1992) but at least we can identify certain particular psychotic symptoms. Hence, the Butler Committee concluded, 'severe mental disorder', for purposes of future mental health legislation, should be defined by reference to a number of widely recognized groups of psychotic symptoms of organic and functional disorders, specifically:

1. Lasting impairment of intellectual functions shown by failure of memory, orientation, comprehension, or learning capacity.
2. Lasting alteration of mood of such degree as to give rise to delusional appraisal of the patient's situation, his past or his future, or that of others, or to lack of any appraisal.
3. Delusional beliefs, persecutory, jealous, or grandiose.
4. Abnormal perceptions associated with delusional misinterpretation of events.
5. Thinking so disordered as to prevent reasonable appraisal of the patient's situation or reasonable communication with others.

This is a clear and distinct list. Each of the symptoms can be looked up in any medical textbook. Each of these symptoms, moreover, can be identified with a high degree of reliability (see Chapter 3). Moreover, applying the Butler definition of 'severe mental disorder' to our cases fits the pattern of our responses like a glove. As Table 17.5 shows, the Butler definition picks out strongly cases 4 and 9, which had a more or less 100% 'vote' (both of these cases have two Butler symptoms each); case 3, with a 50% vote, less strongly (and case 3 has only one Butler symptom); and case 1, with only a 25% vote, rather weakly (anorexia nervosa displays Butler symptoms only to the extent that the extreme disorders of body image and beliefs about nutrition with which it is associated are regarded as psychotic). The remainder of the cases are firmly excluded by the Butler criteria.

Butler begs the question

So, problem solved? Well, at one level certainly. The Butler criteria 'fit' practice, not only with the case vignette exercise, but also in the empirical studies noted above, on the kind of cases actually treated on an involuntary basis, or regarded as legally not responsible (see, e.g. Sensky *et al.*, 1991, noted above; and Walker, 1967).

In the event, however, this was one of the few sections of the Butler report that failed to make it into the 1983 Act, the legislators employing instead the very wide definition of mental disorder cited above. In this the 1983 Act was following the norm. In Fulford and Hope's survey of European legislation, noted earlier, only Denmark defined its mental disorder criterion explicitly in terms of psychotic disorder—and even Denmark added a 'let out' rider to the effect that compulsion could also be used for 'any other similar condition' (Fulford and Hope, 1996).

The concern remained, therefore, at the time of the 1983 Act, that even though 'psychosis' might in general come near the mark as an appropriate criterion of 'serious mental disorder', as a definition it would prove too insensitive to the subtle judgements required of practitioners in particular cases.

The validity of this concern is reflected in the results of our case vignette questionnaire, in which, ironically, the very success of the Butler proposals in mirroring what we do in practice, also shows its limitations. The point is this: even in the artificially constrained circumstances of a questionnaire study, there were two cases (1 and 3) over which opinion was fundamentally divided. The Butler 'solution', as noted above, accurately reflects this division of opinion. But in itself the Butler Solution fails to explain just *why* opinion on these cases should be so divided. And if this is so under these ideal conditions, how much more so will it be 'in the field'?

Back to conceptual difficulties

The core difficulty, therefore, although indeed tracked by the Butler criteria for defining severe mental disorder, remains unresolved. The *nature* of the difficulty, on the other hand, is now clear. It is, as everything we have said in this chapter would lead you to anticipate, a *conceptual* difficulty, a difficulty, in this case, about the concept of irrationality.

Table 17.5 Responses to the case vignette questionnaire using the Butler criteria for defining serious mental disorder

Case vignettes	Responses to vignettes—% 'yes' for involuntary treatment	Possible basis of response			
		Mental health legislation—mental disorder + risk (self or others)	Mental health legislation + criteria of seriousness		Severe mental disorder—by Butler criteria (= psychotic symptoms)
			Mental disorder warrants admission	Mental disorder + risk is life threatening	
1 Anorexia	25	+	+	?	?
2 Obsessional disorder	10	+	+ (in 1983)		
3 Depression	50	+	+	+	+
4 Hypomania	≤100	+	+		++
5 Optic atrophy	1				
6 Acromegaly	0				
7 Hysteria	3	+	+		
8 Breast lump	0				
9 Schizophrenia	≤100	+	+		++
10 Osteoporosis	0				
11 Agoraphobia	0	+	+ (in 1983)		
12 Marital problems	1				
13 Personality disorder	1	?		+	
14 Bronchial carcinoma	1				

Thus, in our responses to the case vignette questionnaire we were picking out, if the analysis offered here is correct, serious mental disorders. The relevant sense of 'serious', however, the specific sense of 'serious' that guided our choices, was that the cases in question were 'psychotic'. The choices we made in Exercise 13, as we have several times noted, are consistent with a long historical and cross-culturally stable intuition that people with severe mental disorders are irrational in some particularly radical way that renders them not responsible for their actions. It is this intuition, traditionally reflected in the insanity defence, that re-emerges in a modern context in relation to involuntary psychiatric treatment. It is this same intuition that is reflected in our responses to the case vignette questionnaire in Exercise 13.

Back to the need for sharper conceptual tools

To identify the origin of the particular ethical difficulties associated with involuntary psychiatric treatment in this way, as being associated centrally with the concept of psychosis, is to focus attention appropriately on the key conceptual difficulties. As a step towards resolving the difficulties, this could be helpful. However, it is not, as such, to resolve them.

Our initial consideration of mental health law, then, in this session, like our initial consideration of bioethics in the last, leads back to the need for a sharper set of conceptual tools for tackling ethical and value issues in mental health. We return to the task of building the required tool kit in Chapter 18 when we look at one detailed account of irrationality in the bioethical literature, and again in Chapter 19 when we consider the current front-runner in the UK for a legal criterion of seriousness, namely, incapacity.

Before coming directly to bioethics, though, we will take 'time out' to reflect briefly on why it is that, if the ethical problems raised by mental health are indeed deeper than in other areas of health care, they should have been relatively neglected in the bioethical literature.

Reflection on the session and self-test questions

Write down your own reflections on the materials in this session drawing out any points that are particularly significant for you. Then write brief notes about the following:

1. What was the 'philosophical fieldwork' on consent with which we started this session; and what was the overall result?
2. How consistent are the results of this fieldwork across different groups.
3. Are the results sufficiently explained by mental health law?
4. Are the results sufficiently explained by mental health law liberally interpreted to imply a standard bioethical criterion of 'seriousness', i.e. where a serious condition is one that is 'immediately life threatening'?
5. What are the 'Butler' criteria; and do they explain the pattern of responses in our philosophical fieldwork?

Conclusions: seven reasons for the neglect of mental health by bioethics

In this chapter, we have seen that the ethical issues arising in mental health, such as confidentiality and consent, although much the same kind of issues as those arising in other areas of health care, are conceptually trickier. This is why, we have argued, neither general bioethics nor law, although providing helpful guidance, has proven sufficient for tackling the conceptual difficulties at the heart of mental health ethics. This is why, we have further argued, a conceptually sharper set of tools may be needed to tackle them.

Given, however, the particularly acute challenges of mental health ethics, both practical and intellectual, its neglect by bioethics requires some explanation. Not, of course, by way of apology. Some explanation, however, *is* required here, if only as a basis for understanding how bioethics might now evolve to encompass, on an equal basis, mental health with other areas of health care.

Why, then, have these issues been relatively neglected until recently?

EXERCISE 16 (10 minutes)

- Given that ethical problems in mental health are both more pervasive and more difficult than in other areas of health care, why should they been relatively neglected?
- Why should mental health have been treated in this respect as a footnote to technological medicine?

If you are working in a group, discuss this together. Write down a few suggestions before going on.

This is a complex question, worthy of several good PhDs in the history of ideas! Here are a few possible answers:

1. *Mental health only appears ethically more problematic.* This is the kind of answer that is generated by the traditional medical model, as in Chapter 4, for example, with those who think that the concept of mental illness can be cleaned up evaluatively, and made to look more 'scientific', like the concept of bodily illness. Those who remain un-persuaded by the arguments of Part I will find this answer sufficient!
2. *Even if mental health is more ethically problematic, the problems are all solvable in a straightforwardly practical way without philosophical reflection.* We have argued in Session 1 of this chapter that, to the contrary, philosophical reflection is necessary. Philosophical reflection may not have been necessary in the past when there was little that medicine could do about *most* problems. But increasingly wide options about what *can* be done, opened up through scientific advances, have brought with them increasingly difficult problems about what *ought* to be done (see Fulford, 1989). Scientific advance, therefore, means a conceptually trickier medicine, and hence a conceptually trickier medical ethics. We return to the science-led nature of the need for philosophy in medicine specifically in relation to philosophical value theory in the final session of Chapter 18 (on VBP).
3. *As a discipline, bioethics was started by philosophers who, being experts on rationality, were afraid of irrationality*. This is the point, made by the British philosopher Anthony Quinton in relation to philosophical work on rationality, with which we opened Chapter 2 (see Quinton, 1985). Again, though, this cannot be a sufficient explanation for the neglect of mental health by traditional bioethics, for key figures in the early bioethics movement were experienced in mental health issues. Will Galen, for example, one of the founders of the Hastings Centre, the first centre of excellence for bioethics in the USA, was actually a psychiatrist. So the subject was not neglected through ignorance.
4. *There is little money for research into the ethics of mental health*. This has certainly been a factor. Mental health, along with other areas of primary care, has been relatively starved of funding. Dan Callaghan, the founder of the Hastings Centre, has commented that of four projects for which they sought start-up funding for the centre, it was only the psychiatry project that failed to attract a grant (personal communication).
5. *The dominant medical model focused attention on high-tech areas of medicine*. Historically, this has been an important factor and we return to it at the start of Chapter 18. Bioethics came into existence as a response to the ethical problems raised by high-tech medicine and it was thus inevitable that its initial focus should have been on this area of health care. With this, however, came the standard 'medical model' according to which the 'high tech' of natural science is the hallmark of the medical. Even today, when in many countries the balance has shifted sharply towards primary care, issues raised by technological advance continue to dominate much of bioethics.
6. *The conceptual 'tools of the trade' developed by early bioethics worked straightforwardly with ethical problems in high-tech medicine, but were more difficult to apply in mental health.* This has probably been an important if largely unacknowledged reason for the relative neglect of mental health. In its early days, bioethics had to get results to survive and results were much harder to come by in mental health. Concentrating on the more straightforward (though still difficult enough) ethical problems of high-tech medicine was thus a legitimate strategy at this stage.

As an intellectual strategy, however, concentrating on the high-tech only worked because the *conceptual* problems implicit in ethical issues in technological medicine are relatively straightforward. In the ethics of euthanasia, for example, the rationality of the patient is assumed for bodily disorders, but is at the heart

of the ethical issues raised by euthanasia for mental disorders (see Special Issue of *Philosophy, Psychiatry, and Psychology on Psychiatric Euthanasia*, 1998).

We will find later in this part that the utility of bioethics' early simplifications even in technological medicine is growing less all the time. Developing a conceptually sharper set of ethical tools will thus be important not only for mental health but for health care generally.

7. *We already have satisfactory bioethical tools that can be applied as required to mental health*. This implies that the ethical problems raised by involuntary *psychiatric* treatment, for example, notwithstanding the underlying conceptual issues explored in this chapter, are really no different from those raised by involuntary treatment in any other area of health care. In other words, to return to our case vignette examples, we really *do* have a satisfactory bioethical model of consent to which involuntary psychiatric treatment can be subsumed.

The idea that involuntary *psychiatric* treatment is a marginal note to an otherwise sound body of theory and practice about involuntary treatment generally, is implicit in many bioethics texts, in which, as we will see in Chapter 18, mental health is subsumed under a general topic of consent.

One conclusion from this part as a whole, however, will be that subsuming mental health ethics to other areas of healthcare ethics, is putting the cart before the horse. There is, certainly, no satisfactory bioethical account of consent in mental health. This is not, however, the result of a failure to apply a satisfactory general account of consent to an aberrant area of health care. To the contrary, the failure of bioethics to provide an adequate account of consent in mental health, we will argue, marks fault lines in bioethics' account of consent as a whole (Fulford, 1993). So this will turn out to be yet another example of the truth of what J.L. Austin (in Part I) called the negative concept wearing the trousers, i.e. of problems in mental health turning out to highlight and illuminate problems in healthcare generally.

Reading guide

Ethics teaching and ethics training

Resources for teaching psychiatric ethics

Bioethics is a growth industry and now offers a huge resource of books, journals, and electronic databases. As noted in the chapter, much of this is not specific to mental health ethics. None the less, these resources if searched carefully provide much useful material. Searchable literature databases useful for ethics training include those operated by the Kennedy Center, Bioethicsline, Medline, and Knowledge Finder. Philosophical literature (including books as well as peer-reviewed journals) are listed by Philosopher's Index. There are also on-line discussion groups and list subscriber services such as that run by the Feminist Association of Bioethics. Among journals as resources for teaching and training, the *Bulletin of Medical Ethics* is a punchy newsletter-style update journal that covers developments internationally as well as in the UK. The journal *Philosophy, Psychiatry, & Psychology* focuses particularly on mental health and combines case studies with in-depth analysis of underlying conceptual and philosophical problems. Thematic issues, for example on psychiatric euthanasia (1998, Vol. 5(2)), are available to support training in particular topic areas. We list illustrative examples below and in later Reading Guides. *Philosophy, Psychiatry, & Psychology* is available on-line and these are also on-line versions of journals such as the Hastings Center Report.

A practical manual, including sample seminars, outlines of ethical theory, and a detailed Appendix covering literature sources, databases, and courses, all aimed at ethics education in medicine, is *The Oxford Practice Skills Course* (Hope, Fulford, and Yates, 1996). The development of this approach, and the main features of 'practice skills' as they apply to mental health, are described in a pair of chapters in Gillon and Lloyd's (1993) *Principles of Health Care Ethics* (Fulford and Hope, 1994, chapter 58; Hope and Fulford, 1994, chapter 59). Resources aimed specifically at psychiatry are less readily available. But Robert Michels and Kevin Kelly (1999), chapter 24 in Bloch, Chodoff, and Green's (1994) *Psychiatric Ethics*, describe a valuable topic-based approach.

Case books

Consistently with the 'philosophical fieldwork' approach of this book, case studies are particularly important in opening up the conceptual depth dimensions of mental health ethics.

An early case study drawing out the perspectives of all those involved in a vivid and highly readable way is *In That Case* (1982) by Alistair Campbell (a philosopher) and Roger Higgs (a general practitioner). The introductory chapter to Mike Parker and Donna Dickenson's (2000) *The Cambridge Workbook in Medical Ethics* includes a comparison of various approaches to reading cases in medical ethics. The workbook includes many mental health issues.

An early but still valuable source of cases in psychiatric ethics was published in America by the Group for the Advancement of Psychiatry (1990) *A Casebook for Psychiatric Ethics*. As the sister volume to Bloch, Chodoff, and Green's edited collection, *Psychiatric Ethics* (see above), Dickenson and Fulford's (2000) *In Two Minds: a casebook of psychiatric ethics* is a casebook with philosophical clout! The distinctive feature of 'In Two Minds' is the combination of detailed case histories illustrating a range of clinical-ethical problems in psychiatry, with in-depth philosophical treatment. *In Two*

Minds also includes detailed reading guides on many of the main topics in general medical ethics (as indicated below and in later Reading Guides in this part).

Involuntary psychiatric treatment, autonomy and consent

Roger Peele and Paul Chodoff (1999), chapter 20 in Bloch, Chodoff, and Green's (1999) *Psychiatric Ethics,* give a comprehensive overview of the ethical issues raised by involuntary psychiatric treatment particularly in the context of deinstitutionalization. The philosopher, Tom Beauchamp gives a clear account of autonomy, setting it in its philosophical-ethical context, in *The Philosophical Basis of Psychiatric Ethics* (see chapter 3 in Bloch *et al*.'s (1999) *Psychiatric Ethics*). Although not dealing specifically with psychiatry, Agich (1993) provides a highly relevant discussion of autonomy in *Autonomy and Long-term Care*. For an outline treatment of the ethical and conceptual issues underlying involuntary treatment in psychiatry, see Fulford (1995). Consent to psychiatric treatment in relation to children and young people is discussed from a legal, ethical, and practical viewpoint by Dickenson (1994) in a review article, 'Children's informed consent'. An analysis of the justification for involuntary treatment in terms of risk to others and self is given in the philosopher, Joel Feinberg's (1986) *Harm to Self: the moral limits of the criminal law*. Agich (1994) gives a succinct summary in a *Philosophy, Psychiatry, & Psychology* Key Concepts article on Autonomy. An early statement of the need for balanced decision making in involuntary treatment is Eastman and Hope (1988). Grisso and Appelbaum (1998) describe an influential and well validated model for assessing competence to consent to treatment. Culver and Gert (2004) provide an authoritative update and overview on competence.

Articles, with cross-disciplinary commentaries, exploring the conceptual underpinnings of consent and related ethical issues in psychiatry appear regularly in *Philosophy, Psychiatry, & Psychology*: see e.g. Moore, Hope, and Fulford (1994) on mania; Dickenson and Jones (1995) on children and developmental issues; Braude (1996) on multiple personality and moral responsibility; Charland (1998a) on the importance of emotion; Hinshelwood (1997a and b), with commentaries by Mace, 1997, Sturdee, 1997, and Thornton, 1997, on consent in psychotherapy; and Savulescu and Dickenson (1998) on advance directives. Other examples of the conceptually enriched nature of psychiatric ethics include Radden (1996) on multiple personality and other dissociative states; Charland (2004) on personality disorder, and Hinshelwood (1997c) on the distinction between psychotherapy and brainwashing. The special issue of *Philosophy, Psychiatry, & Psychology* on psychiatric euthanasia (see Reading guide in Chapter 19) directly challenges the limitations of traditional bioethics when transferred from bodily health to mental health. As noted above, Dickenson and Fulford's (2000) *In Two Minds* combines detailed case histories with in-depth analysis of the conceptual and philosophical issues.

A growing number of authors (e.g. Okasha, 2000; Adshead, 2000), have pointed out that bioethicists have often conflated the very different approaches to issues of autonomy and consent that are taken by people in different parts of the world with different cultural traditions. Alternatives to the dominant principles-based approach include feminist ethics (e.g. Gilligan, 1993), narrative or hermeneutic ethics (Widdershoven, 2002), communitarian ethics (Parker, 1999), and Hegelian ethics (e.g. Dickenson, 1997). These approaches emphasize aspects of consent, such as relationship, emotion, and the social context, which are likely to be particularly important in psychiatry. Emotional aspects of competence to consent are explored in *Philosophy, Psychiatry, & Psychology* by Charland (1998a) in his article 'Is Mr Spock mentally competent? Competence to consent and emotion', with commentaries by Chadwick (1998), Elliott (1998), and Youngner (1998), and a response by Charland (1998b).

A more detailed reading guide on involuntary psychiatric treatment is given in chapter 2 of Dickenson and Fulford's (2000) *In Two Minds*. Reading guides on related topics in *In Two Minds*, include 'Abusive uses of psychiatry' (chapter 3), 'Responsibility and rationality' (chapter 4), 'Autonomy, capacity, competence and consent (chapter 6). Note also, 'Confidentiality' (chapter 7).

Confidentiality

All the large textbooks of medical ethics include sections on confidentiality: see for example, chapter 7 of Beauchamp and Childress' (1989) *Principles of Biomedical Ethics*. A recent collection of articles reviewing many important aspects of confidentiality in mental health is the forensic psychiatrist, Chris Cordess' (2001) *Confidentiality and Mental Health*. The ethical aspects of confidentiality in psychiatry are also reviewed by David Joseph and Joseph Orek (1999) in chapter 7 of *Psychiatric Ethics* (ed. Bloch, Chodoff, and Green).

Illustrative of the guidance issued by professional organizations is The Royal College of Psychiatrists' 'CR85', which covers issues raised by confidentiality in all areas of psychiatry, including research (Royal College of Psychiatrists, 2000).

Confidentiality is a growing issue in relation to publication. A valuable review of the practical, ethical and legal aspects of confidentiality in respect of case reports is provided by Wilkinson *et al*.'s (1995) in 'Case reports and confidentiality: opinion is sought, medical and legal'.

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