

# A Critical Reflection on Utilitarianism as the Basis for Psychiatric Ethics

## *Part II: Utilitarianism and Psychiatry*

**Michael Robertson MB BS FRANZCP**

Director of Psychiatry, Royal Prince Alfred Hospital and Sydney South West Area Health Service (Eastern Sector), and Clinical Lecturer, Discipline of Psychological Medicine, University of Sydney, Sydney, Australia.

**Garry Walter MB BS BMedSc PhD FRANZCP**

Professor of Child and Adolescent Psychiatry, University of Sydney, and Area Clinical Director, Child and Adolescent Mental Health Services, Northern Sydney Central Coast Health, NSW, Australia.

### ABSTRACT

In this second paper we contextualize utilitarianism to the craft of psychiatry and consider its function within the realm of the professional ethics of psychiatrists as physicians. We then apply it to two dilemmas faced by psychiatrists as individuals and as members of a profession. We conclude that psychiatry must search beyond utilitarianism in grappling with everyday clinical scenarios

### Utilitarianism and Psychiatry

Whilst many factors influence its craft, psychiatry is ultimately considered a profession. Any medical practitioner abides by a social contract as both a healer and professional (ABIM Foundation, ACP-ASIM Foundation, & EFIM, 2002). Physicians have reaffirmed the concept of medicine as a profession, in the face of commercialization of healthcare, globalization and advances in biotechnology. Cruess et al (2002) have argued:

“ In developed countries it (medicine) has changed in one or two generations from a cottage industry to one consuming a significant portion of each country’s gross domestic product (Cruess, Johnston, & Cruess, 2002)”

Professional ethics, arguably, have three core components: specialized training and the acquisition of specific skills; the provision of expert assistance to those in need and vulnerable; and the virtues of trustworthiness, efficacy and knowledge which ultimately enhance the common good and aggregate well being (Fullinwider, 1996). As a distinct professional entity, Radden (2002) has advocated that psychiatry has a unique

status and requires a specific ethical basis, predicated on the special virtues of compassion, humility, fidelity, trustworthiness, respect for confidentiality, veracity, prudence, warmth, sensitivity, humility and perseverance (Radden, 2002). This has been refuted, with one author positing that the ethical basis of the profession is best served by it possessing the core trait of “phronesis” (‘practical wisdom’ or ‘prudence’) - the ability to both decide how to act and reflect upon the desired end. (Crowden, 2002). Phronesis was championed by Aristotle and indeed the ethics of Aristotelian virtue have been proffered as the basis of psychiatric ethics (Fraser, 2000). Against such views is the contention that psychiatric ethics are meaningless, or even detrimental, if they lack a socio-cultural context and fail to acknowledge the embedded nature of the psychiatrist as moral agent (Dyer, 1988). Despite this, many physicians’ associations argue that there can be universal principles of ethics, despite socio-cultural differences (ABIM Foundation et al., 2002).

It is possible that the socio-cultural forces impacting upon medicine in the latter part of the twentieth century led to the dominance of utilitarianism and principlism as the ethical bases of medical practice (Pellegrino, 1993), perhaps because of their intuitive appeal in complex, evolving professional environments.

In recent times, two factors, extraneous to psychiatry, may have promoted utilitarianism’s position in psychiatric ethics. First, legislated responsibilities of psychiatrists, particularly in relation to issues of risk management, have effectively trumped any ethical code of conduct intrinsic to the psychiatric profession (Bloch & Pargiter, 2002). Such legal imperatives are invariably utilitarian in nature and have usually emerged in the context of social and political responses to issues such as public safety (Adshead, 2000; Welsh & Deahl, 2002). This has led to utilitarian justifications of the otherwise vexed ‘double agent role’ in regards to forensic patients (Halleck, 1984)

The other factor promoting utilitarian thinking in psychiatric ethics has been the profound changes to healthcare systems in the face of globalisation and financial pressures, particularly in the US and Australia. Indeed, as Dyer has stated, medicine has become a three way relationship between doctor, patient and third-party provider (Dyer, 1988). This issue was given close consideration by Green and Bloch (2001), who identified that when applied to mental health care decisions in a managed care setting in the US, there emerged the problem that “maximizing the common good encompasses a central limitation—the indifference to the uniqueness of the person” (Green & Bloch, 2001). Green and Bloch go as far as to suggest that the psychiatrist may be ethically compromised submitting to a market driven approach in the management of mental illness.

## Utilitarianism as a Method of Ethical Reasoning in Psychiatry

Whilst it is reasonable to provide a theoretical critique of utilitarianism as applied to psychiatry, we suggest that the most useful method of evaluation is to apply Hare’s utilitarian basis of psychiatric ethics to two typical situations faced by psychiatrists.

### Vignette #1

A 45-year-old, unemployed single man suffers recurrent episodes of alcoholic hallucinosis, manifesting as florid paranoid psychosis. When abstinent from alcohol, his mental state is free of any psychotic symptoms and he regains full insight without antipsychotic treatment. He displays some level of impaired judgement and mental inflexibility, but is able to manage his finances and maintain a reasonable level of self-care. He can also comprehend the consequences of choosing to drink.

During one episode of alcoholic hallucinosis, he developed the belief that his neighbour was spying on him whilst he was in the shower. As a result, he attempted to stab his neighbour. He was arrested and convicted of attempted murder. He was found to be mentally ill by the court, and was released into the care of a psychiatrist. One condition of his release was that he was to abstain from drinking alcohol and attend ‘counseling’. The court had presented this to the psychiatrist as a fait accompli. In the light of his history of violent offending, the psychiatrist opted to treat the patient with regular depot antipsychotic medication.

The patient attended an appointment with the psychiatrist whilst intoxicated with alcohol and admitted he had not attended alcohol counselling sessions. He demonstrated evidence of recent physical trauma and admitted that he had been involved in a number of altercations. Although he was not floridly psychotic, probably due to the regular administration of depot antipsychotic medication, the patient was clearly in breach of his conditional release. The psychiatrist does not have a statutory duty to inform in this particular jurisdiction. How should s/he proceed?

## Discussion

Involuntary or coercive psychiatric treatment is justifiable in a variety of ethical theories, including utilitarianism and communitarianism (Munetz, Galon, & Frese, 2003). Applying a utilitarian approach to the present clinical dilemma, incarceration of the patient would seem to satisfy the greatest number of preferences – his alcohol use and its consequences are becoming a public menace and it is probable that the patient, and members of the community, may be harmed by his choice not to abide by the requirements of his conditional release. Few of these types of ethical decisions are based on therapeutic grounds, but rather grounds of risk (Szmukler & Holloway, 1998)

This kind of dilemma has certainly become a critical area of psychiatric ethics in the ‘post-Tarasoff’ era (Anfang & Appelbaum, 1996; Miller, 1990; Stone, 1984; Wexler, 1979). If the psychiatrist decided to breach confidentiality the patient will, in all probability, be incarcerated. The therapeutic relationship will be harmed and the likelihood of developing rapport in the future would be significantly compromised. The psychiatrist will find him or herself in the ‘double agent role’, in which their actions are more akin to law enforcement, rather than clinical care. Adhering to a duty to inform delivers the psychiatrist into the role of social agent, rather than healer (Guerwitz, 1977). Involuntary or coercive treatment of the mentally ill, particularly in the UK, is often asserted on the basis of utilitarian justice channelled through ‘knee-jerk’ populist reactions of governments in light of public safety (Welsh & Deahl, 2002); a process any physician schooled in the Hippocratic tradition would find anathema.

The patient may be harmed in gaol, or his mental state may deteriorate, which, despite the Thomasian ‘doctrine of double effect’, still violates the ancient injunction *primum non nocere*. The negative responsibility arising from harm to the therapeutic relationship is likely to mean the patient (assuming he is only briefly incarcerated) is unlikely to divulge further information. This may become an issue for the profession generally, as others may become less likely to see psychiatrists for fear of breaches of confidence, arguably increasing public peril (Stone, 1984). In the light of the Soviet era experience of psychiatry as a tool of repression by the state, the utilitarian grounds of involuntary treatment require a ‘self-critical and chastened paternalism’ (Chodoff, 1984).

### Vignette #2

A psychiatrist is the clinical director of a regional psychiatric service and has found her budget has been significantly reduced as the result of a widespread government austerity programme. She is required to maintain the current levels of acute treatment services, in order to meet performance indices of ‘patient flow’ from the emergency department and mental health admission centres of the region.

In order to meet these expectations the clinical director has to choose to cut either a vocational psychiatric rehabilitation service for people suffering chronic schizophrenia, or an early psychosis intervention programme, targeting young people with ‘high risk mental states’ or psychotic illnesses of duration less than six months. What should she decide?

## Discussion

This issue of distributive justice highlights even more clearly the value of utilitarian approaches to psychiatric ethics. This decision can be seen in terms of a triage approach to the allocation of limited resources. This kind of dilemma is not unique to psychiatry and normative analogies could be made between this type of decision and those related to the critical care of very premature infants or elderly patients.

A utilitarian approach to the dilemma would seem as follows. Mental health resources are finite and this strengthens the view that psychiatrists have a duty only to use effective treatments. In fact, "need" may be defined in terms of capacity to benefit from a treatment and it is therefore wrong to allocate resources to those who will not benefit through treatments that are not shown to work (Williams, 2004). In this situation, the choice appears to be between secondary and tertiary prevention, i.e., reducing the intensity and duration of an establishing illness, or reducing the disability of a well established illness. This is based on accepting the view that long duration of untreated psychosis imparts a poorer prognosis for the illness (Marshall et al., 2005). Secondary prevention is better than tertiary prevention in terms of measures of health economics such as Quality Adjusted Life Years (QALYs) (Harris, 1987; Williams, 1988), or Disability Adjusted Life Years (DALYs) (Murray & Lopez, 1996), particularly in regards to the concept of declining marginal utility applied to the chronically ill and disabled (Singer, McKie, Kuhse, & Richardson, 1995). The available evidence does not support vocational rehabilitation programs resulting in actual return to work, but rather limited improvement in measures of psychosocial functioning (Bond, 1992; Lehman, 1995). Allocating resources to the early psychosis program is arguably going to gratify the greatest number of preferences in the community, particularly given the reduction of consumption of future resources and the higher likelihood that the younger patients are more likely to enter the workforce. The humanitarian views, such as Singer's 'journey' view of life (Singer, 1993), also support the allocation of resources to the early intervention in psychosis program on the grounds of utility.

The counter position to this utilitarian approach does not dispute the logic of the target argument, but rather approaches the issue in a broader context. In general, utilitarian arguments have instrumental value in economic calculations, but are insensitive to clinical need (Morriem, 1988). One can directly argue against some of the facts used in the justification of the utilitarian position. For example, despite the hypothetical and intuitive appeal of the arguments of the 'early psychosis movement', there is still no firm evidence to support the efficacy and cost effectiveness of dedicated programs (Marshall & Rathbone, 2006). Moreover, the existing health economic methodologies are poorly studied in psychiatric disorder (Clark et al., 1994; Evers, Van Wijk, & Ament, 1997) and have been found to be insensitive in mental health (Chisholm, Healy, & Knapp, 1997).

These alone do not make for a particularly compelling critique of the utilitarian position, in that they merely 'argue the toss' on a few premises. In a broader context of psychiatrist as ethical agent, the counterargument against the utilitarian position considers the issue of the professional ethics of being a physician, particularly in

regards to the duties of advocacy for justice and the patient's best interests. Indeed, the chronically ill group may have no advocacy at all, whereas the younger population may have families who also impart the deleterious effects of external preferences, which have no place in such a decision. This kind of dilemma was considered broadly by Green and Bloch, who averred, inter alia, that participation in utilitarian calculations affecting a "flawed health system" diminished the psychiatrist as ethical agent, particularly in the way the fidelity of the therapeutic relationship is eroded (Green & Bloch, 2001). In partaking in utilitarian (and indeed deontic) approaches to clinical dilemmas, the physician is alienated from his or her moral agency (Morriem, 1988). Moreover, population based choices about healthcare resources always convey harm to someone (Harris, 1987), so the process does violate the injunctions of the Hippocratic tradition, even allowing for the comfortable moratoria offered by the 'double-effect' doctrine. Applying some of Bernard Williams's (1973) critiques of negative responsibility, the 'U-psychiatrist' is arguably responsible for the adverse consequences of those patients disadvantaged by the decision to fund the early psychosis group.

## Conclusion

This critique of utilitarianism as the moral basis of psychiatry may be recast as a question of whether a functional, intuitive and practical moral philosophy is compatible with the profession of psychiatry. As we have argued, utilitarianism in its more evolved forms has become the starting point of all moral philosophy and therefore the default position in most ethical dilemmas faced in the practice of medicine generally. Our consideration of the genealogical and practical critiques of utilitarianism, in both their theoretical form and applied to common dilemmas facing psychiatrists, highlight that there are significant problems in psychiatrists basing their moral deliberations on utilitarianism. It seems that any moral philosophy which marginalizes the virtues required of a physician, particularly in situations where the tenets of professional ethics and the Hippocratic tradition are compromised, cannot be reasonably endorsed by the psychiatric profession.

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## References:

- ABIM Foundation, ACP-ASIM Foundation, & EFIM. (2002). Medical Professionalism in the New Millennium: A Physician Charter *Annals of Internal Medicine*, 136, 243-246.
- Adshead, G. (2000). Care or Custody? Ethical dilemmas in forensic psychiatry. *Journal of Medical Ethics*, 26, 302-304.
- Anfang, S., & Appelbaum, P. (1996). Twenty years after Tarasoff: reviewing duty to protect. *Harvard Review of Psychiatry*, 4, 67-76.

- Bloch, S., & Pargiter, R. (2002). A history of psychiatric ethics. *Psychiatric Clinics of North America*, 25, 509-524.
- Bond, G. (1992). Vocational rehabilitation. In R. Liberman (Ed.), *Handbook of Psychiatric Rehabilitation* (pp. 244-263). New York: Macmillan Press.
- Chisholm, D., Healy, A., & Knapp, M. (1997). QALYs and mental health care. *Social psychiatry and psychiatric epidemiology*, 32, 68-75.
- Chodoff, P. (1984). Involuntary hospitalization of the mentally ill as a moral issue. *American Journal of Psychiatry*, 141, 384-389.
- Clark, R., Teague, G., Ricketts, S., Bush, P., Keller, A., Zubkoff, M., et al. (1994). Measuring resource use in economic evaluations: determining the social costs of mental illness. *Journal of Mental Health Administration*, 21, 32-41.
- Crowden, A. (2002). Ethically sensitive mental health care: is there a need for a unique ethics for psychiatry? *Australian and New Zealand Journal of Psychiatry*, 36, 52-59.
- Cruess, S., Johnston, S., & Cruess, R. (2002). Professionalism for medicine: opportunities and obligations. *Medical Journal of Australia*(177), 208- 211.
- Dyer, A. (1988). *Ethics and Psychiatry: Toward a Professional Definition*. New York: American Psychiatric Press.
- Evers, S., Van Wijk, A., & Ament, A. (1997). Economic evaluation of mental health care interventions. A review. *Health Economics*, 6, 161-177.
- Fraser, A. (2000). *Ethics for psychiatrists derived from virtue theory*. Paper presented at the 4th International Conference on Philosophy and Psychiatry. Firenze.
- Fullinwider, R. (1996). Professional codes and moral understanding. In M. Coady & S. Bloch (Eds.), *Codes of Ethics and the professions*. Melbourne: Melbourne University Press.
- Green, S., & Bloch, S. (2001). Working in a flawed mental healthcare system: an ethical challenge. *American Journal of Psychiatry*, 158, 1378-1383.
- Guerwitz, H. (1977). Tarasoff: protective privilege versus public peril. *American Journal of Psychiatry*, 134, 289-292.
- Halleck, S. (1984). The ethical dilemmas of forensic psychiatry: a utilitarian approach. *Bulletin of the American Academy of Psychiatry and the Law*, 12, 279-288.
- Harris, J. (1987). QALYfying the value of life. *Journal of Medical Ethics*, 13, 117-123.
- Lehman, A. (1995). Vocational rehabilitation in schizophrenia. *Schizophrenia Bulletin*, 21, 645-656.
- Marshall, M., Lewis, S., Lockwood, A., Drake, R., Jones, P., & Croudace, T. (2005). Association Between Duration of Untreated Psychosis and Outcome in Cohorts of First-Episode Patients. *Archives of General Psychiatry*, 62, 975-983.
- Marshall, M., & Rathbone, J. (2006). Early Intervention for psychosis. *Cochrane Database of Systematic Reviews* (4), Art. No.: CD004718.
- Miller, R. (1990). Ethical issues involved in the dual role of treater and evaluator. In R. Rosner & R. Weinstock (Eds.), *Ethical Practice in Psychiatry and the Law* (pp. 129-150). New York: Plenum Press.
- Morriem, E. (1988). Cost containment: challenging fidelity and justice. *Hastings Center Report*, 18, 20-25.
- Munetz, M., Galon, P., & Frese, F. (2003). The ethics of mandatory community treatment. *Journal of the American Academy of Psychiatry and the Law*, 31, 173-183.
- Murray, C., & Lopez, A. (1996). *The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Washington DC Harvard School of Public Health on behalf of the World Health Organization and the World Bank.
- Pellegrino, E. (1993). The metamorphosis of medical ethics. *Journal of the American Medical Association*, 269, 1158-1162.
- Radden, J. (2002). Notes towards a professional ethics for psychiatry. *Australian and New Zealand Journal of Psychiatry*, 36, 52-59.
- Singer, P. (1993). *Practical Ethics (2nd Edition)*. Cambridge: Cambridge University Press.
- Singer, P., McKie, J., Kuhse, H., & Richardson, J. (1995). Double jeopardy and the use of QALYs in health care allocation. *Journal of Medical Ethics*, 21, 144-150.
- Stone, A. (1984). The Tarasoff case and some of its progeny: suing psychotherapists to safeguard society. In *Law, Psychiatry and Society* (pp. 161- 190). Washington DC: American Psychiatric Press.
- Szmukler, G., & Holloway, F. (1998). Ethics in community psychiatry. *Current Opinion in Psychiatry*, 11(5), 549-553.
- Welsh, S., & Deahl, M. (2002). Modern Psychiatric Ethics. *The Lancet*, 359, 253-255.
- Wexler, D. (1979). Patients, therapist, and third parties: The victimological virtues of Tarasoff. *International Journal of Law and Psychiatry*, 2, 1-28.
- Williams, A. (1988). Ethics and efficiency in the provision of health care. In J. Bell & S. Mendus (Eds.), *Philosophy and medical welfare* (pp. 111-126). New York: Cambridge University Press.
- Williams, A. (2004). Economics, Society and Health Care Ethics. In R. Gillon (Ed.), *Principles of Health Care Ethics* (pp. 829-843). Chichester: John Wiley and Sons.

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**Address for Correspondence:**

**e-mail:** [mrobertson@med.usyd.edu.au](mailto:mrobertson@med.usyd.edu.au)