Bringing Mental Health Ethics into the Mainstream

The history of mental health care is scattered with the remnants of many experiences by consumers and family members that have proven to be dissatisfying and ethically questionable. Whether this has come about as a result of the desire to understand human psychology, to advance the scientific study of the human brain, to undertake experiments on human subjects or to diminish the pain and suffering of the mentally ill is not important. As we reflect back it is clear that some of these experiences were bold but naïve science, some were societal initiatives in response to socioeconomic woes and some were enlightened attempts to save the poor, the disowned, the disenfranchised, the impoverished and the socially disadvantaged. What is crucial, however, is whether we take advantage of the shortcomings of the past to ensure that mental health care, treatment, education and research of the present and future embrace approaches that are steeped in sound ethical principles and values

The first issue of the Journal of Ethics in Mental Health (JEMH) shone a light on the role of ethics as it is understood and practiced in various parts of the world. Building on the success of the Journal's inaugural conference, you were introduced to mental health ethics from theoretical, conceptual and legal perspectives and you were made aware of how practitioners approach ethical issues on a daily basis in different clinical settings. This was a good start. But there are many other mental health ethical issues to explore and numerous perspectives yet to be heard from all corners of the globe. This was only the beginning and JEMH's commitment is to bring these to you for your consideration, reflection and comment. By doing so, we are convinced that the Journal will increasingly contribute value to mental health practice, to mental health research and to educational and training environments.

After the publication of the first issue of our Journal, we received numerous satisfying comments and reviews. For example, we heard statements such as: "fabulous issue"; "articles very well chosen"; "JEMH fills an important niche"; "quite impressive"; "I am pleased that you wish to provide a forum for consumers to voice concerns"; "great to see…refreshing, enjoyable and informative"; and more. Most important, the dialogues and debates of ethical issues in mental health have begun and the exchange of ideas has been most encouraging. So, please do not hesitate to contribute by offering your views or submitting an article.

We are pleased to announce that the guest editor for the November 2007 issue of JEMH will be Walter Glannon PhD, Canada Research Chair in Medical and Ethical Theory, at the University of Calgary, Canada. The theme of the issue will be neurodiversity. To quote Dr. Glannon, "The neurological and mental traits that regulate our thought and behaviour fall along a spectrum that extends from "normal" to "pathological." Yet many people have a constellation of both normal and pathological mental traits. Some even have traits associated with exceptional intellectual or artistic ability despite being diagnosed with a mental disorder. These cases raise ethical questions about which neurological and psychiatric conditions should be diagnosed as mental disorders or pathologies, and whether it is in one's best interests to be treated for these conditions. Recognition of neurodiversity may also have ethical implications in reducing the stigma attached to mental illness."

I trust you will enjoy the current edition of the Journal as we present new perspectives in ethics and mental health.

Ron Ballantyne MSW MBA
Managing Editor
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LETTERS

Dear Editors,

Congratulations on the Journal of Ethics in Mental Health. As someone who works extensively in this area, this new on-line journal is wonderful to see. I will be letting my students in my classes on ethics and my classes on working with people with serious mental illness all know about this journal. I will also inform my colleagues here at Loyola University. Best of luck.

James Marley PhD ACSW LCSW

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ARTICLE
PEER REVIEWED SUBMISSION

A Critical Reflection on Utilitarianism as the Basis for Psychiatric Ethics

Part I: Utilitarianism as an Ethical Theory

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ABSTRACT

Utilitarianism is one of the "grand Enlightenment" moral philosophies. It provides a means of evaluating the ethical implications of common and unusual situations faced by psychiatrists, and offers a logical and ostensibly scientific method of moral justification and action. In this first of our two papers, we trace the evolution of utilitarianism into a contemporary moral theory and review the main theoretical critiques. In the second paper we contextualize utilitarianism in psychiatry and consider its function within the realm of the professional ethics of psychiatrist as physician, before applying 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.

Introduction: Original Conceptions of Utilitarianism

The notion of maximizing pleasure, or avoiding pain, seems an intuitive raison d'être, and indeed forms the basis of a body of moral philosophies dating from antiquity. Ethical hedonism, first described by Epicurus (341 BC – 270 BC) (Epicurus, 1926), posits that the good life is one spent in pursuit of pleasure, defined simply as the avoidance of pain. A consequentialist philosophy holds that the rightness or wrongness of an action is determined solely by reference to the 'goodness' or 'badness' of the consequences of that action. Integrated, these two ideas give us the broad foundation of utilitarianism. Indeed in medicine, the injunction primum non-nocere ("first, do no harm") is one of the earliest utilitarian constructs.

These notions were formulated as a moral philosophy to provide an ethical framework for the political liberalism emerging in the post-Enlightenment West. Utilitarian ethics were to be the blueprints for social justice, and utilitarianism is habitually considered the starting point of contemporary moral philosophy (Kymlicka, 2002).

The original utilitarian ideas come from Jeremy Bentham (1748-1832), who constructed a hedonistic view of utilitarianism (Bentham, 1970/1823). To Bentham, man was at the mercy of 'the pleasures' and it was therefore preferable to be 'a contented pig' than 'unhappy human'. Bentham did not valorise the 'higher pleasures', arguing that happiness arising from the mindless game of "pushpin" was as good as that from reading poetry. John Stuart Mill (1806-1873), by contrast, argued that cultural, intellectual, and spiritual pleasures are of greater value than the physical pleasures in the eyes of a competent judge (Mill, 1968). Mill viewed the maximization of some form of eudemonic happiness as the source of the good. In an assertion slightly undermining the secular humanism of his project, Mill sought to endorse his utilitarianism by proclaiming, "In the golden rule of Jesus of Nazareth, we read the complete spirit of the ethics of utility" (Mill, 1968 p. 16). Mill's utilitarianism does not necessarily avoid the same difficulties as Bentham's version, particularly the so-called 'quantification problem', i.e. how to measure overall pleasure. GE Moore (1873-1958) averred that no true conception of the good could be formulated, and that an intuitive view of maximizing "ideals", like aestheticism, may be the ultimate goal of maximizing good (Moore, 1903/1988). Later, economist-driven formulations of the ultimate good of utilitarianism involved the satisfaction of preferences, allowing people to choose for themselves what has intrinsic value (Arrow, 1984)

Recent Conceptualisations of Utilitarianism

Utilitarians writing since Mill have elaborated the original ideas and modified utilitarianism to make it more workable. RM Hare (1919-2002) distinguished between two levels of utilitarian thinking (Hare, 1981;Hare, 1997). Hare asserted the existence of more lofty 'critical' level of thinking, applying the so-called 'Golden-Rule Argument', as against an 'intuitive' level, utilising simple consequentialist principles and integrating emotional responses. The intuitive level applies at the ethical coalface, and its deliberations must be acceptable at the critical level, whereas critical levels of moral reasoning are the domain of the 'archangels'. This latter kind of elitist moral philosophy, assuming that the common man is incapable of any form of reflective moral agency, was first described by Henry Sidgwick (1838-1900) (Sidgwick, 1907) and has been termed "government house utilitarianism" (Williams, 1973)

The distinction between intuitive and critical levels has evolved into 'Act' and 'Rule' utilitarianism (Hare, 1963). Hare argued that his utilitarianism may have been more what Kant had in mind in his moral philosophy, and saw 'The Kingdom of Ends' of Kant's Categorical Imperative (Kant, 1964) as being utilitarian in nature (Hare, 2000).

Hare advanced his version of utilitarianism as a workable basis for psychiatric ethics (Hare, 1993), arguing that utilitarian accounts of psychiatric ethics are often abandoned because of the perceived duties of psychiatrists to their patients. Hare suggested that psychiatrists:

> "need not think like utilitarians; they can cleave to principles expressed in terms of rights and duties and may, if they do this, achieve better the aims that an omniscient utilitarian would than if they themselves did any utilitarian calculation" (Hare 1993, p.30).

Rather than act automatically based on a simple calculation of maximized utility, the psychiatrist, as moral agent, acts on a utilitarian basis at the intuitive level, and reflects upon how rights and duties may be best served at a critical level.

Another formulation of utilitarianism is that of "negative utilitarianism", originally outlined by Karl Popper (1902-1994) in the aftermath of the political excesses of the 1930s and 40s (Popper, 1945). Negative utilitarianism argues that, as moral agents, we seek to prevent the greatest amount of harm or evil, as against maximizing preferences. An argument, reductio ad absurdum, against negative utilitarianism is the so-called 'pin-prick argument', which states it would be better to destroy humanity painlessly than allow one person to experience a pin-prick ("DP", 2006). Other, less straw-man arguments have also been made against negative utilitarianism (R. Smart, 1958).

The elaboration of utilitarianism by Peter Singer (1946-) follows on from Hare (Singer, 1993). Singer's principle of equality encompasses all beings with interests, and it requires equal consideration of those interests, whatever the species. This kind of universalization, Singer admits, is Kantian in spirit. Singer contends that suppressing individual need for that of the collective has a survival advantage, an argument for the naturalism of utilitarian ideas (Singer, 1981). All species may have an interest in avoiding pain but few have an interest in cultivating their unique individual abilities and Singer considers this as justifying different treatments for different interests. This is manifest in his concept of 'diminishing marginal utility', a form of hyper-consequentialism whereby the distinction between interests is as much about the need as the desire for the preference. For example, a starving person's preference for food has greater utility in its allocation than someone who is only slightly hungry. In expanding this idea, Singer takes a 'journey' model of life, which measures the wrongness of taking a life by the degree this thwarts a life journey's goals. To Singer, only a personal interest in continuing to live brings the journey model into play. Singer's utilitarianism has led to heated debate, in particular over the manner in which his philosophy appears to validate euthanasia and abortion (Singer & Kuhse, 1985). The core of his argument here relates to the perceived value of life being linked to sentience and the capacity to reach a life's journey goals, two issues highly relevant to severe mental illness.

Advantages of Utilitarianism

The advantages of utilitarianism as an ethical theory lie in its intuitive appeal, particularly in the case of act utilitarianism, and its apparent scientific approach to ethical reasoning. Beauchamp and Childress (2001) have devised a set of criteria by which a moral theory can be assessed (Beauchamp & Childress, 2001). These include clarity, coherence, comprehensiveness, simplicity, explanatory power, justificatory power, output power and practicality. On criteria such as output power, practicality and clarity, utilitarianism fares well. However, on issues such as justificatory power and comprehensiveness, there are problems. The ethical decision making process in utilitarianism may be quite straightforward. However, the justification and practicality of many utilitarian based decisions are limited, and its comprehensiveness as a moral philosophy is also a source of criticism.

Beauchamp and Childress (2001) believe that the principle of utility approximates their principle of "beneficence" and that it has tremendous output power. They also regard one of utilitarianism's strengths is its fitting well with approaches to public policy.

Critiques of Utilitarianism

Over time, there have been a number of cogent criticisms of utilitarianism as a moral philosophy. The more practical critiques have focussed upon the simple issue of the measurement of outcome of a utilitarian choice. Whilst this problem is more difficult with the Benthamite version of utilitarianism, the matter of how robustly one can measure gratification of preferences is problematic. The issue of adaptive preferences, whereby people accept less because of low expectations (such as the 'contented slave'), is one such area (Elster, 1982). The issues of unexperienced preferences (i.e., ones we will never know existed) and granting harmful preferences are also challenges to preference utilitarianism (Kymlicka, 2002). Some have argued that this potential limitation can be overcome by only applying preference utilitarianism to goods which are universally desired or provide basic necessity (Goodin, 1995), or for some form of utilitarian elite, like that described by Sidgwick (1907), to

oversee and exclude irrational preferences (Rawls, 1980). Ronald Dworkin (1931) has distinguished between 'personal preferences', referring to self, and 'external preferences', referring to a person's choices about others (Dworkin, 1977). We have seen recent examples of this in the vexed area of gay couples being restricted in access to assisted fertility treatments or entitlements to social welfare on the basis of their relationship. The capacity of utilitarian calculations to manifest latent prejudices prompted Dworkin and other writers to call for external preferences to be proscribed (Harsanyi, 1976; Kymlicka, 2002).

There have been a number of other logically based challenges to utilitarianism. Among these are the so-called 'replaceability problem' (Foot, 1967), based upon a thought experiment involving the utilitarian justification of one healthy person being killed to provide transplant organs for a half a dozen others in need – a utilitarian calculation. This is as confronting as the metaphor offered by Le Guin (2000) in her short story, The Ones Who Walk Away from the Omelas (Le Guin, 2000), in which a thriving population's prosperity is contingent upon the torture and imprisonment of an individual.

The above consideration relates to the so-called 'doctrine of double effect', first outlined by Thomas Aquinas (c.1225-1274), which seeks to explain the permissibility of an action that causes a serious harm as a side effect of promoting some good end (Cavanagh, 1997). The distinction here is between the direct or wilful creation of harm as a means, rather than a regrettable consequence of seeking a good. In medical ethics, this issue has been discussed primarily in terms of the intentions of the moral agent, and the proportionality of the harm in relation to the good (Boyle, 1991). Those who see this as the morally vacuous side of utilitarianism have called for a degree of 'deontic constraint', to this principle, rather than tolerating completely impersonal considerations of the positive and negative effects of actions (Nagel, 1986). In other words, rather than be purely beholden to utility in a vacuum, the moral agent should also reflect upon duties to other persons.

Bernard Williams (1929-2003), one of utilitarianism's most comprehensive critics, challenged us with his thought experiment 'Pedro and Jim', as to whether we would execute one man to save ten (Williams, 1973). The utilitarian decides to shoot one man; however according to Williams, being compelled to act on the basis of utility alienates us from our moral agency. In answer to these, somewhat 'straw-man' arguments, some have asserted that utilitarian arguments only evolved to fit common or mundane situations, and therefore cannot credibly apply to the kind of extraordinary situations cited by critics of utilitarianism (Sprigge, 1965) . Derek Parfit's "repugnant conclusion" argument (Parfit, 1984) also takes a logical knife to utilitarianism in that it is, according to the utilitarian calculation, better for the world to have 100 billion all living in marginal poverty than the current situation of wealth being concentrated in a comparatively small part of humanity. Bernard Williams argues that the utilitarian moral agent is both responsible for the consequences of the consequences of their actions, as well as failing to prevent the negative consequences of these. Williams charges that utilitarianism places the moral agent under the burden of unreasonable expectations (Williams, 1973), although others have taken the view that the responsibility for ongoing consequences of actions actually diminishes over time (J. Smart, 1973).

Williams has further charged that utilitarianism, like deontic ethics, alienates the moral agent from their moral agency (Williams, 1973). The idea of a 'U-Agent' (Brink, 1986), totally devoid of any personal morality and wedded to the utilitarian abacus, is clearly unrealistic, prompting some to soften the utilitarian stance to incorporate 'agent relative values' as against 'agent neutral values'. In the former, an act is considered morally wrong if its consequences have less overall value from the perspective of the agent; the latter where this is not a consideration (Sen, 1982). Indeed, any conceptualization of utilitarianism committed to our reneging on important personal commitments in order to promote the welfare of others, is unrealistic (Railton, 1984).

Kymlicka's criticism of utilitarianism (Kymlicka, 2000) is more historical than based on logic or thought experiments. Kymlicka argues that in Bentham's time utilitarianism was a progressive theory, but in modern liberal democracies it is a conservative one:

> "In short, when the question is whether to defend an oppressed majority against a small privileged elite, utilitarianism gives us a clear, progressive answer. But when the question is whether to defend an oppressed minority against a large, privileged majority, utilitarianism gives us vague and confusing answers (p. 48)"

Before applying these considerations to three scenarios commonly faced by psychiatrists, we will summarize the strengths and criticisms of utilitarianism as a basis of ethics. In terms of the strength of utilitarianism it has the veneer of scientific and rational method; it fits well with decision making at a macro-policy level; and appears to parallel decision procedures in daily life.

The negative features of utilitarianism based moral choices are that they: involve assessments of preferences which may be biased or flawed; expect too much of the moral agent in responsibility for consequences of consequences and negative responsibility; may require abandonment of emotional or filial bonds; potentially involve alienation from moral agency; may involve the active disadvantage or harm of individuals; and, are based on a political and moral philosophy that is arguably anachronistic.

Conclusion

In this paper, we have described the evolution of utilitarianism as an ethical theory and considered advantages and disadvantages. There have been a variety of critiques of utilitarianism varying from practical concerns to well constructed, logically based arguments. For those who face complex decisions affecting many people, utilitarianism offers a valuable technique of ethical reasoning. For psychiatrists whose craft is steeped in the Hippocratic tradition, the principle of utility presents a challenge to their ethical obligations as physicians. This is particularly the case where conclusions based on utilitarian calculations may have negative consequences for the patient. We will consider these criticisms in the context of psychiatric practice in the second of our papers on this topic

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References:

"DP". (2006). The pin-prick argument. Retrieved 14th October, 2006, from http://www.utilitarianism.com/pinprick-argument.html

Arrow, K. (1984). *Social Choice and Justice* (Vol. 1). Cambridge, MA: Bellknap.

Beauchamp, T., & Childress, J. (2001). *Principles of Biomedical Ethics (5th Edition)*. New York: Oxford University Press.

Bentham, J. (1970/1823). *An Introduction to the Principles of Morals and Legislation.* London: Althone Press.

Boyle, J. (1991). Who is Entitled to the Double Effect? *Journal of Medicine and Philosophy,* 16, 475-494.

Brink, D. (1986). Utilitarian morality and the personal point of view. *Journal of Philosophy*, 83, 417-438.

Cavanagh, T. (1997). Aquinas's Account of the Double Effect. *Thomist*, 61, 107-121.

Elster, J. (1982). Utilitarianism and the Genesis of Wants. In A. Sen & B. Williams (Eds.), *Utilitarianism and Beyond* (pp. 219-238). Cambridge: Cambridge University Press.

Epicurus. (1926). Letter to Menoeceus (C. Bailey, Trans.). In *The Extant Remains*. Oxford: The Clarendon Press.

Foot, P. (1967). Abortion and the doctrine of double effect. *Oxford Review,* 5, 28-41.

Goodin, R. (1995). *Utilitarianism as a Public Philosophy*. Cambridge: Cambridge University Press.

Hare, R. (1963). *Freedom and Reason*. London: Oxford University Press.

Hare, R. (1993). *The philosophical basis of psychiatric ethics*. New York: Oxford University Press.

Hare, R. (1997). A Philosophical Self Portrait. In *The Penguin Dictionary of Philosophy* (pp. 234-235). London: Penguin.

Hare, R. (2000). Could Kant have been a utilitarian? In *Sorting Out Ethics* (pp. 147-191). Oxford: Oxford University Press.

Harsanyi, J. (1976). *Rational Behaviour and Bargaining Equilibrium in Games and Social Situations*. Cambridge: Cambridge University Press.

Kant, I. (1964). *Groundwork of the Metaphysic of Morals.* . New York: Harper and Row.

Kymlicka, W. (2002). *Contemporary Political Philosophy*. New York: Oxford University Press.

Le Guin, U. (2000). The Ones who walk away from the Omelas. In *The Wind's Twelve Quarters*. London: Victor Gollancz.

Mill, J. (1968). *Utilitarianism, Liberty, Representative Government.* London: JM Dent and Sons.

Moore, G. (1903/1988). *Principia Ethica*. Amherst: Prometheus Books.

Nagel, T. (1986). *The View from Nowhere*. New York: Oxford University Press.

Parfit. (1984). *Reasons and Persons.* Oxford: Clarendon Press.

Popper, K. (1945). *The Open Society and its enemies.* Princeton: Princeton University Press.

Railton, P. (1984). Alienation, consequentialism, and the demands of morality. *Philosophy and Public Affairs*, 13, 134-171.

Rawls, J. (1980). Kantian constructivism in moral theory. *Journal of Philosophy*, 77, 515-572.

Sen, A. (1982). Rights and Agency. Philosophy and Public Affairs, 11, 3-39.

Sidgwick, H. (1907). *The Methods of Ethics (7th Ed)*. London: Macmiilan.

Singer, P. (1981). *The Expanding Circle: Ethics and Sociobiology*. New York: Farrar, Straus and Giroux.

Singer, P. (1993). *Practical Ethics (2nd Edition)*. Cambridge: Cambridge University Press.

Singer, P., & Kuhse, H. (1985). *Should the Baby Live? The Problem of Handicapped Infants* New York: Oxford University Press.

Smart, J. (1973). *Utilitarianism and the Future*. In J. Smart & B. Williams (Eds.), Utilitarianism: For and Against (pp. 62-67). Cambridge: Cambridge University Press.

Smart, R. (1958). *Negative Utilitarianism*. Mind, 67, 542-543.

Sprigge, T. (1965). A Utilitarian reply to Dr McCloskey. *Inquiry*, 8, 264-291.

Williams, B. (1973). A Critique of Utilitarianism. In J. Smart & B. Williams (Eds.), *Utilitarianism: For and Against* (pp. 75-150). Cambridge: Cambridge University Press.

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ARTICLE
PEER REVIEWED SUBMISSION

A Critical Reflection on Utilitarianism as the Basis for Psychiatric Ethics

Part II: Utilitarianism and Psychiatry

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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 'counselling'. 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 attending 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 metamorphisis 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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ARTICLE
PEER REVIEWED SUBMISSION

Should Mental Health Professionals Refer Clients with Substance Use Disorders to 12-Step Programs?

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ABSTRACT

Attendance at 12-step programs has become part of the orthodoxy of treating clients with substance abuse disorders. However, concerns have been raised about the assumptions on which 12-step programs are based. I argue that antirepresentationalism is the moral principle that underpins such concerns. After clarifying the principle of antirepresentationalism, I explore strategies for reconciling antirepresentationalism with 12-step programs. However, all the strategies I try fail. Consequently, I adopt an alternative way of thinking about antirepresentationalism that leaves mental health professionals free to refer clients to 12-step programs. However, such referrals can continue only at the cost of accepting objectionable assumptions about motivation, spirituality and human agency. Therefore, it might well be time to find an alternative to 12-step programs.

Background

Twelve-step programs have become increasingly popular as substance abuse and dependence has increased. Alcoholics Anonymous (AA) alone can claim 1,867,212 members meeting in 106,202 groups worldwide (Alcoholics Anonymous, 2006b). Membership of similar groups has increased as substance of choice organizations have proliferated to assist recovery. Cocaine Anonymous, Marijuana Anonymous, Narcotics Anonymous, Nicotine Anonymous are just some of the 12-step programs available. Such groups provide much needed assistance to an increasing number of people and are generally well regarded by mental health professionals (psychiatrists, psychologists, nurses, social workers). As a result, attendance at 12-step programs is widely encouraged. However, there is at least one author who questions this orthodoxy? (Walters, 2002) directs his criticisms at AA, but his concerns apply to 12-step programs in general. Thus his argument, that it is time to find an alternative to AA, is to be taken seriously. The targets of Walters' criticisms are AA's assumptions about motivation, spirituality and human agency. According to Walters, AA assumes that alcohol abuse and dependence arise from denial and weak motivation. Walters also objects to the overly religious emphasis found in AA's conception of spirituality because God is invoked directly in 5 of the 12 steps. Moreover, Walters is concerned that Step 6 explicitly requires AA members to hold that they are "entirely ready to have God remove all […] defects of character" (Alcoholics Anonymous, 2006a) associated with alcohol abuse and dependence.

Walters' criticisms are relevant to 12-step programs in general because all such programs are predicated on a common philosophy. I want to take up Walters criticisms in this general sense. However, my terminology differs from his because I want to bring out a possible moral basis for Walters' concerns. From now on, I shall refer to Walters' criticisms of AA and, therefore, to his implied criticisms of 12-step programs in general, as an objection to representationalism. I shall explain.

Antirepresentationalism

According to May, (May, 1995, p.10) "The principle of antirepresentationalism is as follows: People ought not, other things being equal, to engage in practices whose effect, among others, is the representation or commendation of certain intentional lives as either intrinsically superior or intrinsically inferior to others."

Lack of space prevents me from tracing the philosophical antecedents of the principle of antirepresentationalism. Interested readers can assess the nuances May finds relevant in Lyotard, Deleuze, and Foucault by reading his book, The philosophy of post-structuralist anarchism (May, 1994).

May relies heavily on Foucault in his 1994 and 1995 books, and finds resonances for the antirepresentationalist principle he defends, not only in Foucault's work, but also in the way Foucault lived his life. Specifically, he remarks: "Throughout his life, Foucault avoided making recommendations either for action or for principles deciding which actions or practices should be promoted and which avoided." May (1995, p.11) However, as will become clear, Foucault's reticence cuts both ways because any argument against representationalism implies the practice it condemns.

May (1995) argues that representationalism is embedded in any and all practices that involve explicit or implicit claims to the intrinsic superiority or otherwise of intentional lives. If May is correct, then Walters' objection to AA, when generalized to all

12-step programs, is a moral objection to any practice that involves privileging one or more forms of intentional life over others. I shall explain why 12-step programs necessarily involve representationalism in the next section. For the moment, it is sufficient to mention that, other things being equal; any case against representationalism should deter mental health professionals from encouraging participation in 12-step programs, which of course is not the result that most clinicians want.

In other words, the Walters' article can be reduced to the following syllogism:

1. People ought not, other things being equal, to engage in practices that have the effect of recommending certain intentional lives.

2. 12-step programs necessarily have the effect of privileging certain intentional lives.

3. People ought not, other things being equal, refer people to 12-step programs.

Yet this result is likely to be contrary to the opinions of experienced mental health professionals because: it proscribes current practice; and equates the moral justification of 12-step programs with the ability to fill in open ended ceteris paribus clauses. How then can the principle of antirepresentationalism and participation in 12-step programs be reconciled?

One starting point is to look closely at the antirepresentationalist maxim. The first thing to notice about premise (1.) above is that antirepresentationalism entails no absolute ban on representationalism (May 1995). Therefore, it may be possible to justify the claim that forms of intentional life commended in 12-step programs are intrinsically superior to any intentional life that involves an addiction. However, any such argument may work for the substance use disorders, but cannot work for problems with sexual addiction or gambling. Why? For the reason that judgments about sexual addictions and gambling are more obviously normative than judgments about substance use disorders. That is, it is not clear that sexual addictions and problem gambling are illnesses in the way that Alcoholic Anonymous regards alcoholism as an illness. Therefore any objections to the sexual or gambling behaviors of others are likely to rest more obviously on moral grounds. Hence, qualified representationalism, the idea that there are circumstances in which it is acceptable to commend certain intentional lives as intrinsically superior, as in the case of treating an addiction regarded as an illness, cannot provide a general solution to the problem of reconciling the principle of antirepresentationalism with attendance at 12-step programs.

An alternative approach is to follow May (1995) in claiming that any ceteris paribus clause can accommodate the principle of antirepresentationalism on the basis of consequentialism. If May is correct, then representationalism is never wrong if more people are better off as a result of it, and nobody is left worse off. In other words, 12-step programs are immune to those of Walters' criticisms that involve his objection to antirepresentationalism to the degree that membership is associated with better rates of recovery and improvements in the lives of those who inhabit members' worlds. However, a recent Cochrane review found that no experimental studies have demonstrated the superiority of AA over other psychological interventions in reducing alcohol dependence or problems (Ferri et al., 2006). As a result, any argument in favor of AA that relies on consequentialism must fail if it is unsupported by scientific evidence of superior efficacy, or cannot otherwise be justified.

Accordingly, neither qualified representationalism, nor claims that exploit ceteris paribus clauses, nor any form of consequentialism that fails the test of evidence of superior efficacy over other interventions can reconcile antirepresentationalism with 12-step programs. Besides, even if one or more of these reconciliation strategies could succeed, they fall short in addressing what I take to be the most significant of Walters' criticisms.

Twelve-Step Programs

Walters objects to AA's assumptions about motivation on the grounds that 12-step proponents insist that a person "must hit rock bottom" before they are capable of finding the motivation to do "anything serious about a serious alcohol problem." (Walters' 2002, p.54) Such insistence is objectionable because it misidentifies motivation as a dispositional trait and ignores its interpersonal dimension (Walters 2002). In other words, Walters objects to the absence of an explicit commitment to enhancing a person's motivation by working with them in an interpersonal process of the kind associated with such interventions as motivational interviewing (Rollnick & Miller, 1995). Leaving aside the question of the relative efficacy of motivational interviewing and 12-step programs in motivating people with drinking problems toward recovery (Heather, 2005), Walters criticism, privileges interpersonal conceptions of motivation over the dispositional ones associated with 12-step programs on strictly ethical grounds. The intrinsic moral superiority of the former arises from a commitment to immediate assistance for the client, and the non-judgmental attitudes that enable the mental health professional to avoid confrontation in favor of supporting the client to consider disparities between a preferred level of functioning and his or her current level of functioning.

Walters criticizes AA for limiting spirituality to religious connotations associated specifically with non-denominational Christian theology. Five procedures originally borrowed by AA from the Oxford Group are integral to the 12-steps. AA membership involves: "…Giving in to God; Listening to God's direction; Checking for Guidance, Achieving Restitution; and Sharing." (Walters, 2002) Walters' objection to these and similar procedures is twofold: AA attendance is correlated with God-consciousness, thereby encouraging people without religious convictions to opt out; and transcendental beliefs of the kind associated with participation in 12-step programs encourage clients to surrender themselves to an external locus of control, thus denying the spirituality found within such religions as Taoism and Buddhism (Walters, 2002). Thus, the spirituality fostered by AA is incomplete and objectionable to the extent that it fosters denial of personal responsibly and human agency.

Walters' other telling criticism of AA is his objection to the assumption that loss of control is the primary explanation of problem drinking. According to Walters, AA operates on the assumption that all people with a drinking problem will lose control in the

presence of alcohol, thereby requiring total abstinence as the only reasonable and realistic goal in recovery. The effect of these related assumptions is that the AA member is dehumanized to the extent that he or she is regarded for all time as lacking in human agency sufficient to take a drink in moderation. Such absolutism reinforces the belief that for the person with a drinking problem the only safe amount of alcohol is none. Leaving aside evidence to the contrary (Walters, 2002), such an absolute commitment to abstinence reinforces the belief that any person with a drinking problem will forever lack self-control and, as a result, the only sensible solution is to deny him or her the self-agency taken for granted by everyone else.

But what precisely does the moral force of Walters' objections consist in? I should like to suggest that the moral force of Walters' arguments consists in antirepresentationalist sympathies of the kind associated with poststructuralist thought.

Poststructuralist Thought

In May's reading of poststructuralist thought it is morally wrong to represent to a person either what his or her intentional life actually is, or what his or her intentional life should be. Therefore, AA's 12-step programs are unethical to the extent that they undermine the intentional lives of people with drinking problems by encouraging them to understand themselves as powerless, irremediably dependent on alcohol without divine intervention and forever incapable of self-control in the presence of alcohol. Furthermore, 12-step programs in general go further than encouraging belief in such character defects by basing all hope for future alternative intentional lives on this deficit model of the self. To accept this reasoning is to admit that character deficits are the primary source of personal troubles. Such reasoning also entails privileging religious conviction over personal responsibility. Furthermore, it involves relying on external control rather than personal agency as the primary resource for solving problems.

The fault in such representations consists in the power implicit in representing the intentional lives of people to themselves. This power is oppressive in that it entails telling people what they have been, who they are, what they really want (May, 1995), and who they should strive to be. Yet, for me, such oppression is less a cause for concern than all the subtle processes in the 12-step process that encourage members to surrender human agency to first external controls and later to unquestioned internalized controls. Such subjugation of the self involves surrendering, not only to the beliefs and assumptions propagated by AA, but also to wider oppressive social relations that involve any and all aspects of what it means to be a citizen.

Discussion

Mental health professionals who accept Walters' antirepresentationalist position have choices. Either they can find a way of reconciling antirepresentationalism with participation in 12-step programs; or they can stop referring clients to AA and to similar programs. I neglect for convenience the possibility of referring clients to 12-step programs despite entertaining reservations. As many people find 12-step programs helpful if not effective, and Walters' paper seems to have been ignored, perhaps I am alone in thinking that representationalism is a problem. The crucial moral question is whether it is routinely permissible to represent certain intentional lives as intrinsically superior. I have sketched out a position that rules out justifying representationalism on the basis of qualified representationalism, ceteris parabus arguments, and consequentialism.

Perhaps I could have made more progress by distinguishing between strong and weak forms of representationalism. However, this line of reasoning would have thrust me into the kind of qualified representationalism that I have already ruled out. Conceivably, I could have saved myself worries by assuming that people share the same assumptions as AA before they become members of 12-step programs. Sadly I must reject this train of thought because all forms of the strong-weak distinction can be reduced to filling in the ceteris paribus clause. This is because the strong-weak distinction entails the claim that other things are not equal when a person pre-subscribes to the intrinsic superiority of the intentional lives valorized in 12-step programs. Even if this is not true, the strong-weak distinction runs into another problem. If I distinguish between explicit assumptions and implicit assumptions in the promulgation of intrinsically superior intentional lives, I come up against the problem of deciding which the weaker form is.

I could say that the weaker form consists in explicit assumptions about intrinsically superior intentional lives because the client can decide whether to reject these assumptions. But I could also say that the weaker form consists in implicit commendations of certain intentional lives because the client cannot reject anything of which he or she is unaware. The obvious objection to this way of thinking is to say that the strong-weak distinction is not so easily put out of play because it is always possible to predicate an alternative argument on the assumption of one or more unconscious mental processes. This amounts to the claim that everyone is subject to influences that affect them of which they are unaware, and raises the question of why members of 12-step programs should be any different. But this will not do, because post-modern thinking of the kind that raises representationalism to the level of a moral concern supersedes thinking about unconscious life. For example, the works by Foucault and others cited by May (1995) are specifically intended to avoid assumptions about unconscious processes and forms of power derived from psychoanalysis and Marxism. Consequently, no argument from the unconscious or from false consciousness can be used to justify, shore up, or otherwise save the strong-weak distinction.

What does all of this amount to? It amounts to good reasons to worry about any practice that involves representation of intrinsically superior intentional lives. The crucial question with respect to treatment of substance use disorders and disorders involving addiction and dependence in general, is why members of relevant self-help groups should accept what participation in 12-step programs obliges them to believe as a precondition for recovery. As the representation of intrinsically superior intentional lives, of the kind implicitly objected to by Walters, always involves the displacement, and by implication, the devaluing of an existing intentional life (May, 1995), it becomes a moral duty to ask what makes the recommended intentional life superior. May (1995) does not want

to rule out the justification of intrinsically superior intentional lives in principle. However, I am more deeply skeptical about the possibility of justifying any intentional life as intrinsically superior without falling into qualified representationalism, exploiting ceteris paribus clauses, relying on consequentialism, or invoking incoherent distinctions between strong representationalism and weak representationalism. If May (1995) is correct in thinking that it may be possible to justify representationalism, but cannot state precisely how this can be done, it is reasonable to conclude that nothing of value can be said about whether the representationalism entailed in 12-step programs is justified. In the absence of a defensible justification of representationalism, I am tempted to think that antirepresentationalism is the only sound option, but as will now become clear, this is not a sound conclusion.

Conclusion

I am unable to find a way to reconcile moral objections to representationalism of the kind implied by Walters with recommending people with substance use disorders and other problems to attend 12-step programs. Perhaps I should worry less about reconciling antirepresentationalism and attendance at 12-step programs and more about deflating arguments from antirepresentationalism. All this requires is to note that any argument form antirepresentationalism must be self-defeating. For in arguing against the promulgation of any candidate intrinsically superior intentional life, I must rely on the intrinsic superiority of the form of intentional life on which I base my objection. If this is correct, then mental health professionals need not worry about referring clients to 12-step programs because antirepresentationalism entails no less a commitment to intrinsically superior intentional lives than representationalism.

This is what was meant when I stated that Foucault's antirepresentationalist thoughts cut both ways. So what should mental health professionals do? My references to Foucault forbid me from making recommendations. All I can do is to clarify the choice that faces clinicians. Mental health professionals can either rule out Walter's objections to AA and other 12-step programs on the grounds that they involve the kind of representationalism to which he is opposed. Or they continue to refer clients to AA and to other 12-step programs in the knowledge that they are endorsing assumptions about motivation, spirituality and self control that are objectionable. Those who cannot support either approach are likely to agree with Walters that it is time to find an alternative to 12-step programs. However, if this is what happens, mental health ethicists will be challenged to defend the represenationalism on which an alternative approach is based, and to solve the problem of stating under what circumstances such representationalism is justified.

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References:

Alcoholics Anonymous. (2006a). The big book on line: Alcoholics Anonymous World Services, Inc. (http://www.aa.org/bigbookonline/).

Alcoholics Anonymous. (2006b). Membership.
(http://www.alcholics-anonymous.org/en_media_resources.cfm?PageID=74).

Ferri, M., Amato, L., & Davoli, M. Alcohol abuse and dependence: Psychosocial interventions, Cochrane Data Base of Systematic Reviews. The Cochrane Library 2006; issue 3 (http://dx.doi.org/10.1002/14651858.CD005032.pub2).

Heather, N. (2005). Motivational interviewing: Is it all our clients need? Addiction Research and Theory, 13(1), 1-18.

May, T. (1995). The moral theory of poststucturalism. Pennsylvania: Pennsylvania State University.

May, T. (1994) The philosophy of post-structuralist anarchism Pennsylvania: Pennsylvania State University.

Rollnick, S., & Miller, W. R. (1995). Motivational interviewing. Behavioural and Cognitive Psychotherapy, 23, 325-334.

Walters, G. D. (2002). Twelve reasons why we need to find alternatives to alcoholics anonymous. Addictive Disorders & Their Treatment, 1(2), 53-59.

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ARTICLE
An Invited Commentary

Consent or Coercion? Treatment Referrals to Alcoholics Anonymous

Commentary on Michael Clinton's: "Should Mental Health Professionals Refer Clients with Substance Use Disorders to 12-Step Programs?"

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> Who says 'hypothesis' renounces the ambition to be coercive in his arguments
>
> William James
> *The Varieties of Religious Experience*, p. 511

Introduction

Clinton is certainly correct that there can be serious ethical problems with mental health professionals referring clients with substance dependence and other addiction-related problems to 12-step programs. But the philosophical doctrine of representationalism he proposes is not a helpful way to address those issues. It seems more like red herring that only serves to detract attention from the real problem. This is the coercive nature of referrals to 12-step programs in many treatment and rehabilitation centres. Clinton's discussion is helpful because it invites us to consider this important ethical issue. But unfortunately his analysis fails to address the issue satisfactorily. At the same time, it seriously misconstrues the nature of 12-step programs, obscuring their own ethical stance on consent, eligibility and membership.

Walters' criticisms are relevant to 12-step programs in general beContrary to what Clinton argues, it is not so much the spiritual content of 12-step programs that is ethically objectionable here. Nor is it the fact that those programs might recommend a way of life that is allegedly superior to others, their so-called 'representationalism'. Both of these criticisms miss the point. Rather, what is ethically objectionable is the fact that referral to such programs by mental health professionals is often accompanied by coercion of some sort, subtle or explicit. This kind of coercion occurs whenever an in-patient or an out-patient at an addiction treatment centre or health care facility is forced to attend 12-step meetings as a condition of their program of care. Ironically, such a practice is actually ethically objectionable according to the stated goals and practices of 12-step programs themselves. For example, it violates both the spirit and the letter of the philosophy of Alcoholics Anonymous (henceforth, AA), which will be our primary example in this discussion. This is a point Clinton fails to mention. In the end, it is the current health care system and its referral practices that are guilty of a breach of ethics in this case, not AA or other 12-step programs like it.

Putting Representationalism Aside

Clinton defines representationalism as the view that 'people ought not, other things being equal, to engage in practices that have the effect of recommending certain intentional lives'. Various competing interpretations of this principle are explored. Indeed, so many competing versions are presented, with so many caveats, that the doctrine creates more problems than it solves. While it may be of philosophical interest to attempt to unravel these complexities, for the present reader, at least, the end result was the impression that representationalism is of doubtful practical utility when it comes to illuminating an ethical problem like the present one. It is a red herring that detracts attention from the real issue.

In fact, the situation is worse. For representationalism is not only a red herring. It also seems to be a very implausible doctrine. What, after all, is wrong with recommending one way of life or practice over another, if prospective participants are free to consent? It is hard to see what is ethically objectionable with this in the present context. No doubt, problems may arise when a way of life or practice is not simply recommended, but imposed. However, representationalism as defined by Clinton appears to conflate these two quite different alternatives, while it is only the second that is really ethically relevant.

Representationalism, therefore, is not the issue. As presented here, it is an implausible doctrine that merely serves to detract attention from the real ethical problem at hand. This is the imposition of one way of life over another in treatment contexts where individuals are referred to 12-step programs for addiction. In the language of consent, this imposition is tantamount to a form of coercion. Unfortunately, on this question, Clinton is not very helpful either. First, he overlooks the conditions for membership and entry into 12-step programs as they are stated by those programs themselves. And secondly, like many, he oversimplifies

the role and nature of spirituality and the concept of "God" in 12-step programs, which he appears to consider objectionable. This results in an inaccurate and misleading depiction of 12-step programs. And that, in turn, puts the responsibility for the ethical problem we are concerned with in the wrong place, namely, 12-step programs. In fact, the source of the problem lies elsewhere. It lies with the health care system.

If You Have Decided You Want What We Have…

Consider the case of Alcoholics Anonymous, the oldest and largest 12-step program. The AA literature makes it clears that entry into the AA program is meant to be fully voluntary and free of any coercion whatsoever. Indeed, AA is said to operate on a principle of 'attraction' rather than 'promotion' (Alcoholics Anonymous 1952, 180-184). Part of what this means is that AA members are not supposed to brazenly vaunt and publicize the merits of their way of life through organized means like the press and radio and television. In fact, individual members are encouraged to remain anonymous, avoid attention and publicity, and focus on the task of helping 'the alcoholic who still suffers' by attending and contributing to weekly local group meetings. Prospective members are invited to come to meetings to see the success of AA for themselves. Aggressive proselytizing is frowned upon.

In the AA program, prospective members are invited to consider whether they want to have the kind of sobriety and way of life AA claims to offer. The only requirement to join is 'a desire to stop drinking' and no effort is made to enlist or retain members who are uninterested (Alcoholics Anonymous 1952, 139-146). In fact, it is deemed a condition of success that interested individuals enter of their own free will and motivation. Prospective members are asked to consider: 'if you have decided you want what we have …'(Alcoholics Anonymous 1939/2007, 58; emphasis added). The implication here is clear. If somebody does not want the way of life that AA offers, then they should feel free to abstain.

In sum, the idea of forcing or coercing individuals to attend AA meetings is completely anathema to both the letter and the spirit of the AA Program. Unfortunately, Clinton seems to miss this point entirely. This gives an incorrect and misleading perspective of the ethics of the process governing attendance and membership in 12-step programs, most notably, AA According to it own literature, AA is against any form of coercion, subtle or explicit, and membership must be strictly voluntary. Forced attendance is actually deemed counterproductive to the aims of recovery.

Nonetheless, Clinton is certainly right to be concerned with referral to 12-step programs and he deserves credit for pointing us toward a genuine and very important ethical problem in this domain. This is the fact that, in practice, many individuals in treatment and rehabilitation centers are forcibly or subtly coerced to attend AA and other kinds of 12-step meetings. Indeed, sometimes attendance at AA meetings is even mandated by the courts. Such referral practices are ethically wrong. First, they are ethically wrong because they violate the requirement that informed consent must be voluntary and free of any coercion. Secondly, as we have just seen, they are ethically wrong according to the tenets of 12-step programs themselves.

In addition to being ethically wrong for the above two reasons, coerced referral to 12-step programs is also clinically objectionable. This is because the spiritual orientation 12-step programs like AA may not be for everyone. This last point is worth pondering. It is a matter on which Clinton errs seriously in his depiction of 12-step programs; at least ones like AA. He appears to finds the spiritual orientation of programs like AA objectionable, on representationist terms. But these worries are ill-founded.

Hypothesis of a Higher Power

The role of the concept of "God" in 12-step programs is exceedingly complex and varied and cannot possibly be successfully treated in a short commentary like the present one. At the same time, it is important to correct Clinton's misleading and philosophically impoverished discussion of the concept of "God" in such programs. A proper appreciation of this issue should help attenuate Clinton's worry that AA members aim to impose a morally superior way of life on prospective participants. Yet that, of course, does not mean that AA is for everyone.

To start, Clinton is correct that in its very early days, AA was largely inspired by a Christian sect called the Oxford Group. The early Oxford pioneers explicitly alluded to and recommended a dependence on God – in the Christian sense – as part as part of their treatment for alcoholism (Alcoholics Anonymous, 1957, 64-68, 74-77). But AA has 'come of age' since these early days, and the founding fathers of today's AA movement – Bill W. and Dr. Bob – quickly recognized that talk of 'God' could alienate and repulse many prospective members in dire need of help.

Inspired by the conception of spiritual experience outlined in William James' classic work, The Varieties of Religious Experience, the founders of AA opted to adopt an 'experimental' approach to the question of God (James 1902/1985). Rather than imposing a particular doctrine or dogmatic conception of God, they decided instead to ask prospective members to choose a God 'of their own understanding' (Alcoholics Anonymous 1952, 34-42; 1957, 262-267). This 'higher power' could be anything: a spouse, friend, AA group or member, a religious figure – whatever can be relied on for inspiration, strength, and support. In effect, by asking AA members to choose a higher power and God of their own understanding, prospective members are asked to treat belief in a higher power as an hypothesis: 'to act as if it were true and see if it works' (Alcoholics Anonymous, 1957, 264; see also James 1902/1985,) In practice, this often involves learning how 'to lean on another human being who seems to be finding the answer, and then lean on the higher power behind him' (Alcoholics Anonymous 1957, 264).

Clearly, the AA experimental approach to belief in a higher power of one's own choosing and understanding is unabashedly spiritual. But there is no religious dogma or particular conception of God imposed or even recommended here. Some AA members, including AA founder Dr. Bob, claim that they have

experienced sudden spiritual experiences that have launched their 'conversion' into sobriety. However, it is also stipulated in the AA literature that 'ordinarily, such occurrences are gradual and may take place over periods of months or even years (Alcoholics Anonymous, 1957, 63, Note 2). In practice, for many, the 'spiritual awakening' mentioned in step 12 of the program is tantamount to a new way of perceiving the world.

Thus, the concept of God in the AA program remains, like the AA program itself, highly open, flexible, and even slightly anarchic – as its founders intended. Clinton's discussion unfortunately seems to miss this crucial element, although he is right that, because of its spiritual orientation AA may not be for everyone. On this last point, however, he overlooks the fact that even AA admits its program of recovery may not be for everyone. As Bill W., one of AA's founders once wryly noted: 'It would be a sorry day for AA if ever we came to think that we had a monopoly on fixing drunks' (Alcoholics Anonymous 1957, 236).

Summary

To conclude, free and informed consent is the only ethically appropriate entry point to AA and other 12-step programs based on it. Any form of coercion or imposition is unacceptable and counter-productive to the aims of recovery. Therefore, mental health professionals should not forcibly refer clients to 12-step programs without first seeking informed consent. Such consent must be voluntary and based on an accurate understanding of the hypothetical and flexible employment of the concept of "God" in such programs. Unfortunately, Clinton's discussion obscures rather than clarifies most of these issues, although he deserves credit for drawing our attention to the problem of coercion. And on this question, it is our current health care system and its referral practices that are often guilty of a breach of ethics, not AA or other 12-step programs like it.

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References:

Alcoholics Anonymous (1939/2007). New York: Alcoholics Anonymous World Services Inc.

Alcoholics Anonymous (1952). Twelve Steps and Twelve Traditions. New York: Alcoholics Anonymous World Services Inc.

Alcoholics Anonymous (1957). Alcoholics Anonymous Comes of Age: A Brief History of A.A.. New York: Alcoholics Anonymous World Services Inc.

James, William. (1902/1985) The Varieties of Religious Experience. New York: Penguin American Library.

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ARTICLE
RESPONSE TO COMMENTARY

On the Colour of Herring: Response to Commentary

Response to Dr Charland's commentary on: "Should Mental Health Professionals Refer Clients with Substance Use Disorders to 12-Step Programs?"

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Introduction

I am grateful to Dr Charland for his commentary on my article. Although Dr Charland has found fault with much of what I have to say about 12-step programs, I am nevertheless grateful to him for his comments. The fact that much of Dr Charland's defence of 12-step programs distracts attention from my concerns, in no way devalues his contribution to the debate about the ethics of 12-step programs and addiction services.

Dr Charland has the following worries. He thinks that the philosophical doctrine of representationalism is a red herring that deflects attention from what he takes to be the "real" problem - the coercive nature of referrals to 12-step programs. Unlike me, he finds nothing objectionable in the spiritual context of 12-step programs. Furthermore, he believes that it is always alright to be given what you have decided you should have. Moreover, he pleads complexity in notions of God as a defence against my objection to the requirement that 12-step program members be entirely ready to have God remove all their defects of character. I hope that I have not misstated or misinterpreted Dr Charland's objections. If I have, I apologize to him without reservation. That said, I am pleased to address Dr Charland's objections in the hope that my response will encourage further debate about the ethics of 12-step programs.

Need Coercion Trump Representationalism?

Dr Charland argues that it is not so much the spiritual content of 12-step programs, nor anything that might be described as represenationalism that is ethically objectionable, but the fact that referral to such programs by mental health professionals is often accompanied by subtle or overt coercion to attend or forego treatment. Dr Charland then takes me to task for failing to mention that AA is not responsible for such ethical lapses because they are contrary to the spirit and letter of AA philosophy. So what Dr Charland's position on 12-step programs amounts to, when sufficiently generalized, is that it is alright to refer people to 12-step programs as long as the process does not involve coercion. Consequently, if ethical breaches are involved in 12-step programs, the fault lies on the side of mental health professionals because they coerce people to attend on pain of exclusion from treatment.

I agree with Dr Charland that coerced attendance at 12 step-programs is ethically objectionable. However, I part company with him when he identifies the "real" ethical problem with 12-step programs as the coercive behaviour of mental health professionals. This is because Dr Charland does not tell us how he decides whether an ethical problem is real. As Dr Charland's does not specify his criteria for separating out "real" ethical problems, we may be forgiven for thinking that an ethical problem is "real" only if Dr Charland is willing to acknowledge it as such. This is not a jibe but a serious point as we will see.

Dr Charland goes wrong in his consistent preference for the conjunction "or" over the conjunction "and". That is, for Dr Charland, either 12-step programs or mental health professionals commit ethical breaches, but not both. Whereas, I prefer the conjunction "and" because both 12-step programs and mental health professionals are implicated in ethical breaches; the former for the reasons I have stated in my article, the latter to the extent that Dr Charland is correct to assert that referral to 12-step programs often involves coercion. So if we replace Dr Charland's implicit "or" with my explicit "and", it cannot be the case that coercion must trump represenationalism as a "real" moral concern. This is because as we have seen, Dr Charland offers no guidance on when an ethical problem is "real". Therefore, Dr Charland is wrong to insist as he does that the ethical problem we are concerned with, referral to 12-step programs, has its source not in anything to do with 12-step programs, but in the health care system. The fact of the matter is that both 12-step programs and the health care system are implicated in ethical breaches if the thoughts I offer in my article are correct. Hence, much turns on whether representationalism can

be dismissed as easily as Dr Charland supposes.

In Defence of Representationalism

Dr Charland does not like my treatment of representationalism. While he concedes that it might be of philosophical interest to unravel the complexities of antirepresentationalism, he finds the process a distraction from what he takes to be the real moral issue – coercing people to attend 12-step programs. But Dr Charland misses what is wrong with recommending one way of life or practice over another. This is because while he concedes that representationalism is wrong if it is imposed, he believes that there can be nothing wrong if 12-step members consent.

Dr Charland falls into error here in the same way as he did before. He just cannot see beyond the conjuction 'or". As a result, Dr Charland cannot conceive of the possibility that representationalism could be wrong even in the absence of coercion. Why? Because coercion is a concept that Dr Charland uses in a way that relies on a dated view of power. That is, Dr Charland seems to think that power is something that is distributed among individuals. Hence the notion of coercion, the thought that power is something that one can have over another person, rather than something that is constituted in the forms of subjectivity that shape how we think and what we take for granted. While it is true that representationalism is wrong when mental health professionals coerce people to attend 12-step programs on pain of being excluded from treatment, power remains even in the absence of coercion. This is the whole point of Foucault's (1980) conception of power/knowledge, which is central to my worries about representationalism. Power operates not only in the sense of one person, the mental health professional, having power over another, the person living with a problem of addiction, but also in the inner most thoughts that shape how we behave towards ourselves as well as to others. Hence representationalism matters because all moral lives are contingent and can be other than they are, and other things being equal, there is no reason to regard one form of mental life as intrinsically superior to another. Readers will note that Dr Charland asserts rather than defends his acceptance of representationalism.

In the absence of defensible reasons, Dr Charland is just plain wrong to suppose that no ethical breach occurs in the absence of coercion. Yes, coercion is wrong and, usually indefensible, but it is also wrong to represent any form of moral life as intrinsically superior to another as occurs in 12-step programs in the way that I claim in my article.

It should be noted that Dr Charland does not take up the challenge of specifying what makes intrinsically superior mental lives superior. Rather, he prefers to substitute consent for any such justification. Consequently, the question is not whether there is anything wrong with representing superior mental lives to 12-step program members, but whether concerns about representationalism enable us to bring out distinctively moral issues that are pertinent to deciding whether mental health professionals should refer clients with substance abuse disorders to 12-step programs. In my article I draw attention to the following concerns from my reading of Walters:

1. 12-step programs rely on the erroneous assumption that a person "must hit rock bottom" before he or she can be motivated to do anything serious about his or her addiction.
2. 12-step programs regard defects of character as the root cause of addictions.
3. 12-step programs rob people of the possibility of self-control by presuming that the only answer to addictive behaviours is total abstinence.
4. The correlation of 12-step programs with God consciousness encourages members to surrender themselves to an external locus of control, whether this is the God mentioned in the steps themselves, or the God hypothesis defended by Dr Charland.

These concerns are important because, as I point out in my article, there is no reason to suppose that 12-step programs are superior in effectiveness to other psychological interventions. Hence any ethical breaches that occur as a result of attendance at 12-step programs occur for no defensible reason. Note this objection is consistent with Dr Charland's views on coercion as well as my views on representationalism.

Submission to a Higher Power

I agree with Dr Charland that the concept of God is "exceedingly complex" and varied and cannot be treated in a short article. At the same time, it is possible, even in limited space, to point out moral objections to the notion of God expressed explicitly in the 12-steps. Whereas I am willing to grant, for the sake of argument, that AA has come of age in the way that Dr Charland claims, and even that the 12-step approach relies on a hypothetical rather than an absolute conception of God, I cannot concede that the latter is satisfactory as a reply to my objection about the explicit reference to God in the 12 steps. One cannot simply ignore that which is stated in the 12-steps. Neither can one avoid, dismiss, or otherwise put out of play, the moral objections I have expressed about the pernicious, unsatisfactory, and to many unacceptable connotations of the stated relationship between the 12-step program member and even a hypothetical Higher Power.

Like my own, Dr Charland's discussion of the nature of God, or a Higher Power, as conceived in 12-step programs, is necessarily short, over simplified and in need of more clarification then either of us has the space in which to elaborate. However, it is possible to offer thoughts based on objections to representationalism that bring out the difference between us.

In my article I refer to Foucault as a basis for May's critique of representationalism. Foucault's thought is wide ranging and open to many different interpretations. But one consistent interpretation of his work in the context of reflection on the notion of God is the question of the possibility of theologies of "dissolution" Tilley (1995). Dissolution is used here to refer to the idea of the new possibilities for theology that are opened up as existing stabilities are broken down. Dr Charland's reference to the hypothesis of a Higher Power in AA philosophy is consistent with dissolution theology, in that he claims that the God of AA is no longer a God on which one can be dependent, but a God chosen on the basis of one's own understanding. However, such

notions of a Higher Power are completely at variance with the notion of God as stated in the 12 steps themselves. Hence, Dr Charland's argument can be reduced to saying that we should not worry about the ethical import of the 12 steps as the notion of representationalism would encourage us to do because the Higher Power in AA is not the God of the 12-steps. Thus Dr Charland creates a paradox for AA by maintaining that the 12-steps mark the journey to recovery, while at the same time claiming that at least some of the 12-steps should not be taken seriously because they do not mean what the say.

Even on the grounds of what I shall call the dissolution hypothesis, Dr Charland's argument fails because any form of spirituality that recognizes the importance of antirepresentationalism must leave open space for freedom of the human spirit. The Foucauldian basis of May's antirepresentationalism is resistance to all forms of subordination of the human spirit. Especially anathema to Foucault was the notion of the "obedient subject" in any form (Fillion, 2005). What more powerful means to creating the "obedient" subject can there be than the confessional of a 12-step program? "Hi! My name is Tom, and I'm an alcoholic." Rather than opening a space for the irrepressibility of the human spirit as is needed to live with the challenge of alcohol or drug dependence, the 12-steps of AA and similar programs encourage members to subordinate themselves to a Higher Power, to abandon themselves to either an outmoded conception of an all powerful God, or to take on the attributes, strivings or characteristics of others. All of which, rather than releasing the member from a self-imposed situation of dependence, substitutes one form of dependence for another. Such constraints limit autonomy and the right to be self-legislating in the sense of giving a shape to the self that can only be recognized as admirable and worthy if it is truly one's own, rather than derived from the representation of supposedly superior moral lives Fillion (2005). Therefore, Dr Charland errs in relying on a conception of theology with respect to the God of AA in a way that embodies, uses, relies on, and otherwise takes for granted the representationalism in which he does not believe.

Summary

Despite our differences, I am grateful to Dr Charland for his commentary on my article. I cannot accept his distinction between "real" and other ethical problems and concerns, either about 12-step programs or about any other moral issue. The ethical concerns I have raised are real enough, in the ordinary sense of the word, for the people who need help with problems of drinking or other addictions. In that sense, I am entitled to worry about such ethical problems as those I bring to light in my article.

My article offers readers the choice between rejecting representationalism and endorsing assumptions about motivation, spirituality, and self control that are objectionable, or finding an alternative to 12-step programs. What a pity Dr Charland's rejection of antirepresentationalism, seems to commit him to the objectionable assumptions to which I refer, and to the implication that an alternative to 12-step programs is neither relevant nor necessary.

For Dr Charland, I look at 12-step programs with too much of a jaundiced eye, whereas he looks at the issue of referral as through spectacles with different lens, one plain, the other rose tinted. Through the plain lens, Dr Charland sees the ethical breach of coercion in referrals by mental health professionals to 12-step programs; through the other, he sees AA, and by implication, other 12-step programs. If Dr Charland was to remove his hypothetical spectacles, he would be able to see that the herring he writes about are completely devoid of even the slightest pinkish hue. There was only an illusion of red because Dr Charland is concerned to find no moral fault with AA or other 12-step programs. But of course, as Dr Charland's spectacles are hypothetical, he cannot remove them, which is the point of my argument from antirepresenationalism. This is the irony, perhaps even the "real" irony that Dr Charland misses.

References:

Réal Fillion, (2005) *Freedom, Truth, and Possibility in Foucault's Ethics*. Foucault Studies: 3, 50-64.

Michel Foucault (1980) *Power/Knowledge: Selected Interviews & Other Writings* 1972-1977. Edited by. Colin Gordon. Pantheon Books: New York.

Terrance Tilley (1995) *Postmodern Theologies: The Challenge of Religious Diversity*. Orbis: Maryknoll, New York.

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ANALYSIS
CONFERENCE PROCEEDINGS

Ethical Crossroads along the Way: Short Stories about Medical Training

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WHY TELL STORIES?

"Insofar as ethics occurs in the context of human relationships, our ability to discern right from wrong and good from bad depends to a significant extent on how open we allow ourselves to be to others. By sharing and comparing stories we learn to better appreciate where our lives and experiences intersect with the lives and experiences of others. Ethics takes place at this intersection. In a very real and important sense, the ethical landscape of each clinical encounter is subtly negotiated through shared understanding. Through sharing we cultivate empathy, and from empathy we internalize the motivation to behave toward others as we ought. Empathy is the impetus to respect, and respect is the core of ethics. Narrative is the mechanism that brings it all together."

(Workman 2006)

Introduction

The stories below were shared as part of the presentation I made at the 2006 JEMH Conference on Ethics in Mental Health. The intent of the presentation was to highlight some of the ethical flashpoints that I encountered in medical school and early on in my psychiatry career.

My hope is that these stories might foster some discussion amongst clinicians or students who are reflecting on power relationships and the evolution of medical sub-culture norms.

Ethical crossroads may be marked by a sense of malaise or discomfort that bubbles up and is not easily diffused, assuaged, or rationalized away through all of our usual strategies. Of course, we also often know we are at an ethical crossroad because the unfairness of a situation slaps us hard in the face.

What I knew before medical school...

My ethical radar was shaped by substantial formal training and experience in philosophy, medical ethics, health services, and health policy before going to medical school. My medical training and early clinical experiences were thus processed primarily through an ethicist's eye.

A culture unto itself

By and large I was taught and inspired by noble and selfless role models; these residents, physicians, and allied health workers were passionately committed to their vocations and honourable traditions. However, some of what I encountered along the way was so egregiously unethical that not only was I shocked by what actually transpired, but I was stunned by colleagues so stressed, vulnerable, fearful, or acclimatized within the hierarchical world of medicine that they were silenced or blind to the transgressions.

A remarkable thing about the culture surrounding medical training was how much behaviour is driven by fear. Fear of judgment by colleagues, fear of complaints by patients, fear of a bad evaluation by a supervisor, fear of being found out as incompetent, fear of being held to unrealistic standards, fear of administration or bosses who arbitrarily or unpredictably reprimand, fear due to the lack of effective recourse to address systemic unfairness, fear of co-workers too burnt out or angry to care about me or anyone, fear of narcissistic over-controlling bullies who run roughshod over the kind people, fear of oversight by a professional college dedicated to protecting the public's interest but not mine, fear of a hospital that will hang you out in the wind if anything goes wrong, fear of speaking up when something isn't right, fear of being labeled as a trouble maker or whistle blower if you try to challenge the status quo however perverse it is…

Against that backdrop…

1994-95 - Clerkship

Clerkship is the last year of medical school; it is an intensely busy time during which you rotate through the many areas of medicine (surgery, internal medicine, ob/gyn, psychiatry, emergency, family medicine, etc) for a couple of weeks or a month at a time. The hours are long and it represents the start of your exhausting life of being "on-call" (staying up all night every few days and working 24-36 hour shifts). You operate under the supervision of residents (recent MD graduates doing specialized training) and staff physicians.

1) "Stat to surgery"

I was paged at 3:00 in the morning stat to surgery in the large teaching hospital where I was on-call. As I ran through the family waiting area toward the operating rooms I noticed a man with two young children sitting there. He looked scared. It was his wife in the operating room. She had a disease that made her blood vessels spring leaks from time to time. I scrubbed and gowned and joined the emergency surgery that was already in progress. The surgeon needed more hands to hold instruments and push organs out of the way; that was my job. He was furiously looking for a source of bleeding and he finally found it in a large vessel deep in the liver. His efforts to stem the blood loss were hampered by the fact that the blood vessel was so fragile that it couldn't easily be repaired; the vessel wall was like paper falling apart. He worked with a focused intensity and finally looked up at me and said that there was nothing more he could do. He started packing the open abdominal cavity with towels.

I asked him what happens next as I was uncertain about her status. With frustration in his voice the surgeon said that she was going to die because her vessels were beyond repair. I asked what that meant…will she die within minutes or slowly bleed out? It was the anesthetist who answered; he said that the packing will slow the bleeding and that it would take a few days for her to die. He added that blood transfusions could keep her alive for an even longer period but that that was a waste of a precious resource given that she was going to die anyway. I then asked the surgeon whether I was to accompany him as he broke the news to her when she was awakened from the anesthetic. He looked surprised by the question and stated that it would be "cruel" to wake her up just to tell her she is going to die soon. The anesthetist then added that he would use medications to keep her unconscious until she died.

My immediate reaction was one of confusion. I asked a few more questions. No, she was not being kept unconscious because her pain would be unmanageable if she were awakened. No, her husband would not be told that she could simply be awakened at any time; he would be led to believe that her physical condition rendered her unconscious.

I followed along over the next couple of days and everything unfolded as the surgical team planned. She slowly bled to death and her husband and children never saw her conscious again.

I felt tremendous anguish over these circumstances. While I understood the rationale, my firm beliefs about autonomy and choice for her and her husband made acceptance of the events profoundly emotionally difficult for me.

I believed that the choice to keep her unconscious was about the surgeon's discomfort and had little to do with her best interests. I did not believe it was right to deny her a couple of days in which to do whatever she might have wished (Make her peace with God? Say goodbye to her children…). I did not believe that her husband and children should be denied the opportunity to speak with her…

In the days that followed I discussed the events with several other surgeons and anesthetists and they uniformly endorsed what had happened as the right thing to do, and explained to me that this is the norm in these types of cases. It couldn't have been clearer to me that the "norm" was wrong. And yet, I never did reveal the true state of affairs to the husband after the surgery. I was certain that to have done so would have lead to my being failed on the surgery rotation and possibly being kicked out of medical school. You simply don't defy a staff surgeon's directions.

As far as I know, this practice remains the "norm" on many surgical services.

2) "Jump on him!"

I was doing my psychiatry rotation on a general adult psychiatry service at a large provincial psychiatric hospital. While I had done my reading, I was really completely naïve about psychiatric care in a real clinical setting like this.

One day, early on in my rotation the staff psychiatrist who supervised me told me that we were going into a patient's room to give him an injection. I did not know that the patient did not want the injection, or that he was in a "bubble room" (a locked room with only a mattress on the floor) because he was so agitated. As we approached the room we were joined by about 5 of the nurses from the floor, including one burley male nurse. The door was opened, and when we went in we were immediately confronted by a large, clearly furious man. Without advance discussion or preparation the psychiatrist directed me to "Jump on him". I hesitated, confused by the direction I was being given. The male nurse, on the other hand, immediately leapt upon the man and a wild skirmish ensued. When the male nurse got the patient to the floor, the other female nurses quickly converged to secure his limbs. I too joined in at that juncture and helped to hold down a leg. The injection was given and we all ran out of the room with the enraged patient screaming after us.

The whole spectacle was simply shocking to me. I felt that this was traumatic for the patient and that I had no right to hold someone down. At that initial stage in my medical training I had not thought through issues related to isolation rooms, the merits of physical versus chemical restraints, or the legitimate use of force with patients. I also had no appreciation for how relatively humane our modern Canadian psychiatric care was relative to some of the abuses extant around the world (e.g. patients kept in small cages or tied down for weeks at a time).

I wish I had been better prepared for what we were going to do and what was expected of me. However, I offer this story not by way of claiming that what happened was unethical but rather as an illustration of an initial moment of transformational learning that informed my subsequent clinical experiences and practice. The injunction to "do no harm" should actually be, "do as little harm as possible".

Over the years since I have had many patients tell me that these institutional episodes of aggressive restraint were profoundly traumatic for them, and it is the possibility of it happening again that makes them most fearful of future readmission. The thought of being tied down for days on end is unbearable.

I have also had patients thank me for treating them using all appropriate means when they were too ill to exercise their own judgment. Even knowing this, I cannot be unaffected by a human being suffering so much, or at such great risk of harm, that the only humane response is the counter-intuitive action of aggressive restraint. Doing what is right can sometimes feel very wrong.

What has particularly disturbed me in the years since are those occasions that I have witnessed restraints seemingly used punitively or to coerce treatment compliance. And as we are numbed to our "code whites" (aggressive patient code) and it becomes easier or common to use restraints because of short staffing or because a facility is ill equipped to handle too many aggressive patients at once, we can forget that even one minute of unnecessary restraint is a gross violation of human rights and dignity.

1995-96 - Year 1: Rotating Internship

Like clerkship, during the rotating internship year you move from one area of medicine to another every month. Unlike clerkship you are now a doctor with an extraordinary amount of responsibility and a paucity of clinical experience to guide you. My internship year was without doubt the most stressful and exhausting year of my life.

3) The abortion clinic

During my obstetrics & gynecology rotation I was assigned to work in the abortion clinic at a general university hospital. I was told I would not be doing the abortions directly ("the ob/gyn residents do them"), but that I would be doing the same day pre-op physical examinations required before the abortion procedures could be performed. No one asked me whether this represented a moral conflict for me, and there was no indication that I could refuse and request another placement. This lack of discussion astonished me given the civic, religious, and moral divides that make abortion the ongoing minefield that it is. It seemed clear to me that there was an assumption that no one would object to being part of the process if they didn't actually have to do the abortions themselves. A questionable moral assumption akin to assuming someone won't mind building bombs as long as they don't have to drop the bombs themselves.

Interestingly, the Royal College of Canada specialty certification process for Obstetrics & Gynecology does not require that residents in this field have actually done abortions as part of their residency training but that they simply know how to do them.

4) "You'll be fine"

One early morning during my surgery rotation I was on hospital rounds going from room to room with the staff surgeon to whose team I had been assigned. Other team members in the gaggle trailing along were the senior surgical resident, the junior surgical resident, some clerks, and medical students. Before entering one room the surgeon told us that the woman we were about to see had been found, during exploratory surgery the day before, to have widespread abdominal cancer. We were also told the cancer was well advanced and beyond treatment and that she would likely die within a few weeks. We then entered the patient's room and the surgeon cheerily told her that the surgery had gone well, that nothing significant had been discovered and that she would go home soon and be fine.

I was shocked. When we returned to the hall I asked the surgeon what his plan or strategy was for disclosure of the terminal cancer diagnosis. He told me he had no intention of telling her the truth as this would be harmful. I asked about what happens as she gets sicker and wants an explanation for her lack of improvement. He responded that by then it wouldn't matter what she knows and that she will have had a nice period without worry.

Given my thorough knowledge of the literature and ethics of truth telling I cautiously challenged his position. The days of withholding information under the guise of 'therapeutic privilege' and 'best interests' were long past in Canada. The conversation, however, was dismissively shut down by him. The senior resident quickly gave me a clear message that she and I could discuss it further later.

When I spoke with the senior resident alone after rounds she made it clear that the surgeon lied to patients regularly, and she told me that when she herself had challenged him on this early in her assignment to his team, he simply revoked her operating privileges for a month. For a surgical resident to be denied operating time is a dire consequence, so she remained silent on this matter from that point on. She also told me that other staff in the surgery department were fully aware of this surgeon's communication patterns but that he was free to practice as he wished as a self regulated independent practitioner.

His exercise of power was remarkable and his certainty about his actions was stunning. Short of patients complaining themselves, there seemed truly to be little systemic recourse. And he was modeling his behaviour for clerks and medical students who took at face value that what he was doing was morally acceptable.

1996- 2000 Years 2 to 5: Psychiatric Residency

There are so many stories to be told. Some represent violations that are nuanced, subtle, innocent, of little real consequence, and sometimes occur in plain sight of colleagues. Others, interestingly, are really not about ethical issues in the sense that those involved in a situation struggled with uncertainty over the best moral course; rather they are simply stories about blunt abuses of power, authority, and privilege that go unanswered.

The years in residency produce a remarkable transformation wrought through intense clinical exposure. If you took the number of hours you work in the five years of residency and divide that number into a more typical 40 hour work week, it turns out that in five years you have worked what would be an equivalent of nine years at a regular job.

In residency you develop clinical competence, hone communication skills, sift through the biases, learn about your own huge blind spots and prejudices, feel a growing sense of professional autonomy, and you work to find the balance as you behave more and more authoritatively and paternalistically in moments of crisis. You struggle with certifying someone ("civil commitment") against their will. You deal with your vulnerability and the high probability (over 70%) of being assaulted by a patient sometime during your training. And you experience the recurrent and vicarious micro-traumas that accompany such emotionally demanding work.

5) "In my country"

During my psychiatry residency I had the privilege of working with a number of Saudi Arabian residents who were training in Canada. I enjoyed the discussions with them that challenged my world views, and forced me to think about culture bound symptoms and disease interpretations in a much broader and richer light.

As residents we regularly observed each other doing interviews and assessments, and then provided formal feedback. In the discussion following an observed interview with a homosexual patient, one of my Saudi colleagues commented that he thought the man should be put to death. He explained that in his country he had on many occasions gone to witness public executions of gay men on Sunday afternoons in the marketplace. Not surprisingly, his comments provoked a strong reaction among the discussants present. He was accused of homophobia, ignorance about the biological nature of the determination of sexual orientation, crass insensitivity, and bigotry. He, in response, clearly and simply explained his beliefs, his culture, and his values, and he wondered at the intensity of our responses.

My personal experience of this fellow resident was that he was very caring, and very kind and respectful with patients. Paradoxically, as much as I found his posture in relation to homosexual patients abhorrent, his challenge to me to try and see the world through his eyes was a remarkable lesson in cultural sensitivity.

6) Attitudes towards patients with Borderline Personality Disorder

Difficult patients can evoke intense responses. What makes them difficult? Among other things: threats of violence, suicidal threats to manipulate an outcome, intense and unpredictable emotional responses, threats of legal action, and pressured boundary violations.

On any given psychiatry service you quickly hear about some of the most difficult patients. "She is a PD" (personality disorder) is both the catchphrase and warning that a patient is difficult. Interestingly, the person "is a PD" rather than someone "living with a personality disorder illness". The implicit and explicit message is often that these patients are intentionally problematic and that their "acting out" behaviours should be responded to with autocratic redirection and rebuff rather than a nuanced clinical appreciation of what the behaviour represents in terms of an attempt to elicit help.

Make no mistake about what I am saying. The appropriate care of patients with personality disorders represents some of the hardest and most skilled work a psychiatrist can do. The therapeutic challenges related to abandonment and maintenance of boundaries are huge, as evidenced by a voluminous literature and case reports on these very topics. To say that some of these patients are a challenge is an astonishing understatement.

As you move through residency, developing a positive attitude of care towards this group of patients can mean having to swim against the affective undercurrent of resentment, frustration, and helplessness that some staff psychiatrists exude.

Hospital admission is therapeutically counterproductive in some patients with personality disorders (they get sicker or more distressed in hospital inpatient milieus). As a resident I frequently found myself in the awkward and distressing position of seeing a patient in the Emergency Room whom the staff psychiatrists at that hospital had agreed (following years of experience with the patient) should never be admitted to hospital because it makes matters worse. Obviously, good clinical judgment is still called for with each new encounter in the Emergency Room. And certainly, sometimes a brief crisis admission is warranted. Nevertheless, the history and records available to you are key guiding information as you make a decision about whether it is safe to let a suicidal patient with borderline personality disorder illness go home.

Being denied admission can be very difficult for a desperate and suicidal patient to accept, even when all the evidence is that in the past they clearly became more distressed on admission. On one occasion, I informed a patient that she would not be admitted and, unbeknownst to me, rather than leaving the ER she went into a nearby examination room and attempted to hang herself off a short, thin chain dangling under a gurney. This required that she put all her weight on her neck as she lay prone on the floor (like doing a push-up and lifting her hands up with her head through the chain). The chain cut into her neck and she was bleeding a lot. She kicked and fought off staff trying to help her. As the ER physician and I stood in the doorway and watched the mayhem, he turned to me and said, "Well, I guess you'll admit her now". And

so I did. But on team rounds the next morning where admissions from the night before are reviewed, I was grilled for 10 minutes over the folly of my decision to admit. In the end, the staff psychiatrists finally let it go with my defense that if I hadn't admitted her she would have left the ER and once again made a near lethal suicide attempt, as was commonplace with her (e.g. overdoses, swallowing razor blades), and that she would then be admitted anyway but that she would be taking up a scarce ICU bed.

So what is the ethical essence that I wish to highlight in all of this? I believe the shaping of attitudes towards difficult patients that occurs within a teaching centre has a ripple effect across the broad domain of psychiatric culture and that it is at the root of some of the paternalism and disrespect that is both tolerated and fostered in some clinical settings. Such bias and prejudice gives us mutually reinforced license to haughtily dismiss and discount the needs of "annoying" "non-compliant" and "difficult" patients.

And the stories continue...

Benjy Freedman, an old medical ethics professor of mine asked, "Where are the heroes of bioethics?" When we see something that is wrong we may pay a great price for saying so. However, if we don't speak up, we all pay a price. History has taught us the savage toll that silence takes when we abrogate our moral duty to each other…

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Endnote:

Workman S, Hubert J, Byers R, Jaggi R, Jantz A; CMAJ, May 9, 2006; 174(10), p. 1453 .

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Billing for Missed Appointments

Andrea Kenney

There's a bee in my bonnet… I was pleased to be introduced to the first issue of the Journal of Ethics and Mental Health and to learn that it will provide an opportunity for consumers to voice their concerns. The following is mine…

I've been chronically ill since the age of six and now live with multiple conditions and see numerous specialists to manage my illnesses. Over the years, I've had extensive contact with specialist physicians, including psychiatrists and also psychologists. I succeeded, despite my illness, to make it half way through a Ph.D. in Clinical and Experimental Psychology only to have to abandon my pursuits due to new illnesses. While studying, I operated a small private practice as a psychologist for six years. I also was President of a Users' Committee for a number of years in Montreal. In Quebec, these committees are legal entities which operate with budgets supplied by the provincial government. My point is, I consider myself a consumer expert of a sort from numerous angles.

The bee in my bonnet is the increasingly prevalent practice I see in Mississauga where I now live for physicians to bill clients for missed appointments. The position of l'Ordre des psychologies du Québec on this problem is that such a practice is unethical-- one ought not receive income from a service never rendered and any "administration fees" recovered for missed appointments should involve written pre-consent by the client to agreed-upon terms. But physicians all over post announcements they will bill either a penalty (e.g., $5 to $20) or a "replacement" fee based on an average billing for appointments missed or not cancelled within 24 to 48 hours. I recently was referred to a clinic that offers psychotherapeutic services delivered by family physicians and they have the audacity to charge in the neighbourhood of $90 for a missed appointment. These announcements contain no mention of patient options or perspective.

I can confidently say I'm never a no-show for appointments. But just knowing that I'd be billed for getting too sick to leave my house at the last minute deeply offends me. And putting the less powerful, more vulnerable patient in the position of potentially arguing with my potentially unsympathetic healthcare provider to justify my refusal to pay their bill tacitly communicates to me that my provider has no idea how inherently disempowering it is to have to depend on them in the first place. Nor does my healthcare provider realize how arrogant, insulting and disgraceful this practice is to me, that is, to be grabbing more income above the income they already earn off the misfortune of my illness. My relationship with these doctors is by definition damaged to some degree despite the good service they may provide.

My more constructive point is that I think many terrific, "ethical" doctors have no idea that there's an issue of ethics here. Is there not some way to educate physicians so they can make more informed choices about how they decide to manage delinquent patients?

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Thoughts on the Ethics of Compassion

Submitted by: Maureen Foy

Family Member, Toronto, Canada

I would like to talk about some of my experiences in the mental health system using the language of compassion and reflection. I thought, at first, that this would be straightforward. In some obvious way, I think the stories that I will share say everything that needs to be said.

But nothing is simple. As humans, we make the most uncomplicated gesture of kindness or the most outrageous act of violence a topic for debate and analysis. These debates sometimes go on indefinitely and are too often used as excuses for doing nothing. Nevertheless, debates and analysis must occur. They are ways of reflecting on our practice and pondering over the rightness or the wrongness of our actions. In some fundamental way, reflecting on our ethical behaviour is tantamount to being human.

So, I was happy to accept the invitation to write this piece because I want you to hear that families want and need to experience your compassion. I also hope that sharing memories from past years and my very current stories will contribute to a reflection on practice. I know, as a mother of a person who is often completely vulnerable, the importance of reflecting on my own power and my compassion or lack of compassion. In this regard, and in many ways, service providers and families are in this together.

What is compassion anyway? I would like to say first what compassion is not. Compassion is not sentiment. Compassion is to suffer with, to undergo with and to share solidarity with another. Compassion leads to action – feeding, clothing, sheltering, providing treatment, or comforting, and without action it is sentiment or pity. Compassion requires one sometimes to take risks. Or it may be as simple as an instance of active or deep listening. This leads to the fundamental point of my piece – compassion is so important to alleviating suffering, and a lack of compassion so potent in exacerbating it, that compassion is an ethical issue.

For nearly 30 years I have been my daughter's main support person. I know, first hand, when someone is compassionate. There was an instance of it, during a painful time of my life and my daughter's illness that was so appreciated I'll never forget it. It made it possible for me, literally, to keep going. I will say more about this later.

Unfortunately, more often than not, compassion seems to be absent. Pills are given, information is taken, but compassion is missing. This is not easy or pleasant for me to say, but it is my experience and I know it is the experience of other family members. My most painful, compassionless experience happened very recently. Over the Easter weekend my daughter was admitted to a crisis unit in a general hospital. When I arrived she was sitting alone, looking lost and scared. My daughter thought she was waiting to see a doctor. There were three staff members in the unit. Over a period of two to three hours of waiting the staff did not speak to us or look at us once. It was as though we were not there. We were invisible. There were no words of comfort or care. There was no information given and we were left to wonder, on our own, what or whom we were waiting for. I, of course, should have asked staff for information. That would have been the normal thing to do. But it is not a normal situation and I was not my normal self.

Staff looked through us, around us, above us and below us but they did not look at us. At a time of crisis and in a place where you go for help and maybe even care this is hard to bear. This behaviour silences you. And I have experienced this behaviour many, many times in many different hospitals in and around Toronto.

My daughter spent the night in this same crisis unit. The next day, a doctor set up his charts on the nursing station door and proceeded to call out patient's name in a loud voice and interviewed them in front of the whole unit. I watched this and did nothing. I failed to act compassionately and speak up about the mistreatment of patients. Feeling sadness and pain was not enough, action needed to be taken.

Finally action was taken. A patient who appeared very ill and suffering terribly approached the nursing station only to be told by the doctor, with a dismissive hand gesture and an angry voice to, "back up, back up". In a very low voice the man told the doctor to "shut up". For this he was instructed by the security guard to apologize to the doctor. A few feet away from where my daughter and I were standing and within hearing distance another doctor interviewed a very disturbed woman and we heard parts of this woman's story of sexual abuse. In this unit, in the absence of compassion, in my opinion, there was abuse.

Ten or more years ago I visited my daughter in a general hospital and I found she was in an isolation room. She was banging on the window of the isolation room, crying and calling out to me for help. What I felt at that time I can only describe as anguish. A nurse on the unit came and spoke to me. She had tears in her eyes and those tears mirrored my pain. She asked if I would like her to accompany me for a coffee and to talk. She shared in my pain and in sharing it she lessened it. This made it bearable for me to leave my daughter that night. The memory of that nurse and her act of compassion will stay with me forever.

So, I would like to offer people my perspective from the ground. It's really a plea for staff to reflect on their practice, to ponder over how

you are relating to people. I know there is caregiver burnout and that workloads are immense and I know there are cutbacks. These are important issues and they do, for sure, affect how you interact with your patients. Nevertheless, it's vital that people think about how they are interacting with people who are extremely vulnerable and fragile and human like themselves.

Please think about this as you communicate your feelings and attitudes to people. If you cannot think about it at the time, then think about it afterwards. Talk about it with your colleagues. Consider ways and means for staff to get support in talking about their true feelings about their clients and families.

Furthermore, I would suggest that we can advance as much as is humanly possible in brain-imaging, psychotropic drugs, models of therapy and so on. But if you cannot smile, give comfort or even acknowledge another persons' presence, then all of this is for nothing, absolutely nothing.

I would like to close with two quotes that I think express beautifully, much, much better than I ever could, what compassion is all about.

> "Everything is held together with stories. This is all that is holding us together, stories and compassion."
>
> Barry Lopez

> "If you want others to be happy practice compassion, if you want to be happy practice compassion."
>
> Dalai Lama

Thank you for reading this.

Maureen Foy

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BENCHMARK

The "Ultimate Issue" Problem in the Canadian Criminal Justice System

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Abstract

Expert testimony in criminal cases remains controversial. Some of this controversy appears legitimately attributable to clinicians who violate professional boundaries by speaking directly to ultimate legal issues. In this paper, the "ultimate issue" problem that is a salient controversy in American forensic psychology is discussed from a Canadian perspective. Relevant legal, ethical and professional considerations for expert testimony in Canada are reviewed. In the end, it is argued that psychologists who offer opinions on matters of law are violating professional boundaries and unwittingly fuelling the controversy that surrounds expert psychological testimony in the Canadian criminal justice system.

The "Ultimate Issue" Problem in the Canadian Criminal Justice System

Testimony by mental heath experts in criminal cases has long been the subject of public, legal and academic scrutiny. In 2001, *Canadian Psychology* ran a special section devoted to this topic (Ogloff & Cronshaw, 2001, Saunders, 2001, Peters, 2001, Yarmey, 2001). In this series of articles, the issue of eyewitness testimony was examined (Yarmey, 2001), a "View From the Bench" was offered (Saunders, 2001), a number of relevant legal cases were reviewed (Peters, 2001), and guidelines for expert testimony were proposed (Ogloff & Cronshaw, 2001). Although differing in their specific focus, these articles shared the common goal of providing information that would assist expert witnesses in structuring their testimony so as to maximize its value to the Courts and overall acceptance in the broader legal community.

In spite of the valuable contributions made by these papers, this series of articles is noteworthy for its failure to directly address longstanding concerns about expert testimony that either intentionally or unwittingly violates professional boundaries by directly speaking to matters that are properly viewed as the exclusive domain of legal fact finders and decision makers. In more succinct terms, I am referring to the "Ultimate Issue" problem that has been a salient and longstanding concern among American forensic clinicians and scholars (e.g., Heilbrun, 2001; Hess, 1999; Melton et al., 1997; Morse, 1978; Rogers & Ewing, 1989; Rogers & Shuman, 2000; Schopp, 2001; Slobogin, 1989. Briefly, the specific concern is that by addressing ultimate legal issues (e.g., whether an individual is criminally responsible), clinicians are violating professional boundaries by: a) offering opinions on matters that lie outside their ken of professional expertise; and b) usurping the role of judge or jury. Ultimate issue testimony is particularly misleading in that it is offered within the context of a legal designation of "expert" that may falsely endow essentially lay opinions with an aura of scientific objectivity. To be sure, Saunders (2001) mentions "the Ultimate Issue" problem (p. 111). However, the issue is given only passing mention en route to discussion of cases concerned more specifically with the general admissibility of expert testimony. Unfortunately, both the first Canadian text book on Law and Psychology (Schuller & Ogloff, 2001) and a recent introductory text on forensic psychology (Pozzulo, Bennell, & Forth, 2006) are similarly silent on this important issue.

The goal of this paper is to review the ultimate issue problem within the context of the Canadian criminal justice system. To this end, legal parameters for expert testimony in Canadian criminal cases will be reviewed, along with professional and ethical issues of relevance. In the end, it will be argued that the ultimate issue concerns that permeate American forensic psychology are also relevant to the work of Canadian forensic psychologists and that increased sensitivity to the underlying professional boundary issues would reduce the controversy that continues to swirl around mental health testimony in criminal cases. Parenthetically, though the arguments in this paper are relevant to other common law jurisdictions, I will intentionally restrict my focus to the Canadian criminal justice system for two reasons: 1) though relevant Canadian case law exists, this problem has thus far been ignored by Canadian scholars and forensic clinicians, and 2) to adequately examine this issue on an international level is simply beyond the scope of a journal article.

Legal Parameters

In 1993, in the matter of R. v. *Marquard* the Supreme Court of Canada ordered a new trial on the basis that expert testimony that spoke directly to the credibility of another witness was inappropriately admitted at the original trial (Peters, 2001). The principle underlying this opinion was that the proper role of an expert is that of providing assistance to the trier of fact without encroaching on areas that are the exclusive purview of legal decision-makers.

Later, in a landmark decision (R. v. *Mohan*, 1994), Mr. Justice Sopinka, writing for the Supreme Court of Canada, set forth clearly articulated admissibility rules for expert testimony in Canada. This so called "Mohan Test" requires that expert testimony be a) relevant, b) necessary to assist the trier of fact, c) not violate any exclusionary evidentiary rule, and d) provided by an appropriately qualified expert. Mention of the need to carefully scrutinize novel theories was also included in this document.

Briefly, under the *Mohan* test, relevancy is primarily defined as legal relevancy. Logically relevant evidence may be excluded if it carries a potential prejudicial effect. Necessity, in this context, is defined narrowly so that only information that lies outside the usual range of expertise and knowledge of the trier of fact is deemed necessary and therefore appropriate content for expert testimony. Thus, expert testimony on matters for which a judge or jury can form its own opinion should not be allowed under Mohan. The need to comply with existing rules of evidence that exclude specific types of testimony is obvious, as is the need to for experts to be properly qualified. Cautions regarding the need to guard against the potentially prejudicial effects of testimony offered under the "mystique of science" and experts either willingly or unwillingly inclined to assume legal decision-making duties are also scattered throughout this judgment. Parenthetically, although obvious in the usual sense of having achieved appropriate educational and licensing requirements, the need for appropriate qualifications is also important in that it logically limits expert testimony by any particular individual to matters that legitimately fall within his or her expertise. Thus, for example, a brilliant psychologist should not offer opinions on matters of structural engineering – irrespective of her personal interest in the area or awe inspiring professional standing in psychology. Testimony that falls outside of one's professional knowledge base is, by definition, no longer "expert" testimony. In this sense, the Ogloff and Cronshaw (2001) recommendation that psychologists carefully work within the legitimate boundaries of their knowledge is consistent with *Mohan* and indirectly supports proscriptions against ultimate issue testimony.

Concerns regarding experts who cross professional boundaries and directly testify on ultimate legal issues are subsumed under the necessity and relevance requirements of the *Mohan* test. Recall that these criteria require that expert testimony be legally relevant and concern itself only with matters that lie outside the expertise of judge or jury. Under these criteria, experts are not allowed to offer opinions regarding the credibility of witnesses or, presumably, other exclusively legal issues such as fitness for trial, criminal responsibility, intent, or dangerousness. In the *Mohan* matter, the Court explained the application of these criteria in the following manner:

> There is also concern inherent in the application of this criterion that experts not be permitted to usurp the functions of the trier of fact. Too liberal an approach could result in a trial becoming nothing more than a contest of experts with the trier of fact acting as referee in deciding in which expert to accept.
>
> These concerns were the basis of the rule which excluded expert evidence in respect of the ultimate issue. Although the rule is no longer of general application, the concerns underlying it remain. In light of these concerns, the criteria of relevance and necessity are applied strictly, on occasion, to exclude expert evidence as to an ultimate issue. (pp. 24-25).

More recently, these concerns were reaffirmed in R. v. *Reid* (2003) and R. v. *Rogers* (2005). A broader and more detailed review of legal cases that speak directly to the matter of expert testimony is provided by Peters (2001). Following a review of then available legal cases, Peters (2001) concludes that "Judges fear that the trial process is susceptible to high jacking by psychologists – and other experts – …" (p. 107).

Ethical Considerations

In addition to legal criteria intended to corral expert testimony, specific ethical considerations also argue against ultimate issue testimony by mental health experts. In the third edition of Canadian Psychological Association (CPA) Code of Ethics (2000), these considerations are primarily linked to Principle III. Briefly, Principle III of the CPA Code of Ethics deals directly with the discipline's fiduciary responsibility for integrity in relationships and specifically requires that psychologists avoid misrepresentation and openly acknowledge the limits of their expertise. In a court room setting the social contract that exists between the relatively autonomous discipline of psychology and society is reinforced when a judge, after careful review of a practitioner's credentials, formally endows him or her with the status of "expert". From that point on, the "expert" is expected to provide only professional opinions derived from his or her professional knowledge base. More bluntly, an expert witness is expected to provide professional not personal opinions. Insofar as personal opinions per force reflect personal biases, this legal expectation is mirrored in professional practice guidelines that urge forensic psychologists to guard against the influence of personal biases on their work (*Specialty Guidelines for Forensic Psychologists*, 1991). The Guidelines for forensic psychologists also include an explicit reminder that the appropriate role of a forensic psychologist is one of providing assistance to the trier of fact and Principle III, B. urges forensic psychologists to make clear the boundaries of their professional expertise. Thus, both legally (i.e., *Mohan*) and ethically, expert witnesses are expected to restrict their testimony to "expert" opinions on matters that legitimately lie within their ken of knowledge. Opinions that stray beyond the boundaries of professional knowledge are, by definition, lay opinions.

Against this backdrop, it seems reasonable to argue that psychologists who express opinions on matters that are appropriately the exclusive domain of legal decision-makers are flirting with unethical practice by engaging in an implicit misrepresentation of professional expertise. This misrepresentation inevitably occurs whenever a mental health practitioner offers a legal conclusion after formally receiving the designation of expert because he or she is expected to offer only professional opinions. By directly testifying that a defendant is or is not fit for trial, or criminally responsible, or a dangerous offender, forensic mental health practitioners are implicitly claiming expertise in the Law. This misrepresentation of expertise and violation of professional boundaries is particularly egregious when it includes appeal to non-existent scientific or clinical criteria such as "medical criteria for fitness to stand trial".

Simply stated, medical or, for that matter, psychological criteria for fitness to stand trial do not exist because fitness for trial is an exclusively legal construct without even remote analogue in medicine or psychology. A similar statement applies to all legal constructs, including dangerousness and insanity.

Along with awareness of relevant ethical issues, sound professional practice in forensic mental health requires some understanding of the legal system and the various roles of its constituents (Heilbrun, 2001). In fact, Principle II. C. of the *Specialty Guidelines for Forensic Psychologists* requires understanding of the legal standards that govern participation in legal proceedings. Ideally, in addition to an appreciation of the Mohan standard, this understanding should include appreciation of the paradigm conflict that is inevitable when scientific/clinical constructs are applied to legal questions. This "imperfect fit" (DSM-IV-TR, 2000; p. xxxiii) between the behavioural sciences and the law is seen to reflect inherently different philosophical underpinnings (Melton, et al., 1997; Schopp, 2001; Slobogin, 1989) that leave the behavioural sciences inclined toward deterministic, nomothetic explanations of human behaviour, while the courts seek answers from the perspective of free will and the individual. Notions of causality also predictably differ between the two disciplines, with science favouring probabilistic conclusions and the courts seeking a 'beyond reasonable doubt' level of certainty that is rarely achieved even in the presence of obvious organic impairment (Melton et al., 1997). It is also widely acknowledged that legal decision-making is heavily influenced by shifting social policies and political agendas that are immune to scientific analysis (Morse, 1978; Melton et al., 1997; Schopp, 2001). Legal decisions also invariably involve consideration of ambiguous concepts such as reasonable doubt, fairness, and justice. Even ostensibly clinical constructs such as "mental disorder" take on purely legal definitions that vary between court rooms and ultimately become the exclusive domain of judge or jury (Schopp, 2001).

The social policies and ambiguous concepts that underpin the practice of criminal law are foreign to the professional work of mental health practitioners and thus cannot reasonably be claimed as legitimate areas of expertise for psychology or psychiatry. Moreover, Canadian society has not entrusted psychologists to formally work with these concepts or to directly engage matters of social policy as they relate to legal notions of culpability and responsibility. In Canada, mental health practitioners are expected to restrict their professional activities to matters of mental health. While these activities may include consultation services to various consumer groups, the definition of mental health services cannot reasonably be expanded to include, for example, adjudication of culpability issues under the *Criminal Code of Canada* anymore than a lawyer or judge can claim diagnostic expertise after perusing the DSM. Genuine appreciation of these interdisciplinary differences is ethically required and should act as an effective barrier that prevents forensic psychologists and psychiatrists from offering opinions on purely legal matters.

Professional Practice Considerations

Melton et al. (1997) offer a compelling argument that evidentiary rules in the American legal system are intended to limit forensic clinicians to testimony that provides incremental (i.e. assistance to the trier of fact) rather than absolute validity (i.e., assume the role of trier of fact). Review of the *Mohan* criteria indicates that the Canadian criminal justice system has similar expectations. From this perspective then, forensic clinicians are encouraged to limit their analyses and subsequent opinions to matters that are the substance of common clinical discourse. Thus, for example, forensic assessment of a psychotic patient within the context of a fitness for trial hearing would confirm the presence of a psychotic spectrum illness (or conversely, empirically establish the patient is malingering) and describe how the illness impacts the patient's functional abilities (e.g. ability to sustain a coherent conversation). Paranoid delusions, for instance, would be evaluated for the degree that they encompass the legal system in general and, more specifically, the pending trial process and its various participants. Behavioural disorganization would be evaluated with an eye toward the patient's ability to behave appropriately in court and reality contact would be reviewed with specific focus on the individual's appreciation that he or she is the subject of legal proceedings. Assuming this information is well received by the trier of fact, it would then become a component in a larger decision-making process that includes consideration of the various socio-political issues that underpin legal decisions. This process of offering clinical input to legal decision-makers *without* directly addressing legal issues is recommended by the American Bar Association (1989), the American Psychological Association (1980), and the American Psychiatric Association (1982).

In spite of these multidisciplinary recommendations urging forensic mental health experts to avoid speaking directly to the ultimate legal issue, arguments have been offered in support of clinicians who testify directly to legal conclusions (e.g., Hess, 1999; Rogers & Ewing, 1989; Rogers & Shuman, 2000). From this perspective, a forensic clinician can and should make judgments regarding, for example, the need for incarceration or a defendant's criminal responsibility. In fact, it has been argued that failure to directly address the legal issue in question undermines the integrity of a forensic assessment (Rogers & Ewing, 1989). In essence then, from this perspective, a forensic clinician should assume the functions of a trier of legal facts in order to provide coherent and helpful input to the legal system.

In significant measure, arguments in favour of ultimate opinion testimony revolve around the observation that individual judges expect and value opinions that encompass ultimate legal issues. Both personal experience and some data (Borum & Grisso, 1996) support this contention. Nonetheless, to argue that members of a self regulating discipline such as psychology should routinely violate professional boundaries and misrepresent their expertise in response to the desire of a consumer group seems misguided at best. A more ethically sound course of action would involve education of relevant consumer groups regarding the limits of the profession's knowledge base and, more generally, the "imperfect fit" between clinical/scientific knowledge and the law.

In a frequently cited paper that has come to provide the foundation for arguments against ultimate issue proscriptions, Rogers and Ewing (1989) make an argument that directly touches the core of the ultimate issue debate. Specifically, while acknowledging that broad agreement among psychologists and legal scholars exists that legal opinions involve consideration of complex political and moral issues, Rogers and Ewing argue that judgmental and dispositional conclusions in any given case involve simple

"psycholegal" questions that can effectively be divorced from the underlying moral issues and are, therefore, a legitimate area of practice for forensic clinicians. More recently, Rogers and Shuman (2000) have reiterated this position without substantial change: "While the law expresses moral ideas, clinical data related to specific standards does not address the law's morality." (p. 47). To my mind, this statement is categorically correct providing that clinical data remain clinical data. Once the data are translated into legal terms they become infused with sociopolitical ideologies that are inconsistent with the stated goal of scientific objectivity. Consider, for example, that substance induced psychotic disorders are often, at a functional level, clinically indistinguishable from a primary psychotic condition (e.g. cocaine induced psychosis and paranoid schizophrenia). Yet, voluntary intoxication precludes an exculpatory defence under the Canadian Criminal Code while a primary psychotic disorder provides a strong starting point for a criminal responsibility hearing. In this example, two virtually identical clinical databases are assigned different legal status based on a moral decision not to allow an exculpatory defence to an individual who is directly responsible for his or her compromised state of mind. Thus, the ultimate legal decision – i.e., whether to hold an individual responsible for a criminal act – is a number of steps removed from the ostensibly objective clinical data that informs it. Clinical testimony in either case would be virtually identical. The most significant difference would occur when the data are subjected to legal analysis. It is precisely this step of assigning legal significance to clinical data that produces an ultimate legal conclusion, and it is this final step of data interpretation that lies outside the legitimate knowledge base of forensic psychologists and psychiatrists.

Consider another example: In one case, a person with paranoid schizophrenia is not compliant with his medication and decompensates to the point that he assaults a stranger on the street. In a parallel case, a cocaine addict relapses and embarks on a cocaine binge that ultimately produces a psychotic state, during which he assaults a stranger on the street. In both cases, the individual directly contributed to the psychosis by either refusing to take medication or using cocaine and the resulting the mental illness is virtually identical at the functional level (i.e., paranoid psychosis, agitation, aggression). In the case of the schizophrenic person, a criminal responsibility defence is a viable option. In the case of the addict, it is unlikely that such a defence would even be considered. Yet, the clinical datasets are identical and both conditions are formally diagnosable mental illnesses under the DSM. The decision to accept one state of mind as legally compromised but not the other reflects a prevailing zeitgeist which identifies schizophrenia but not a substance abuse disorder as potentially exculpatory. Moral reasoning and prevailing political thought underpin this decision not the objective clinical data as Rogers et al argue. It is conceivable that this legal opinion would change as a function of shifting social policy while the clinical datasets of relevance would remain constant. This disconnect between "the data" and the ultimate legal decision occurs precisely because legal decision-making is a moral rather than clinical or scientific endeavour. More generally, all judicial decision-making involves, to varying degrees, considerations regarding social retribution and punishment that are undeniably moral, vary across time and jurisdictions, and cannot be handled by forensic clinicians without explicitly adopting a social control function.

Conclusion

According to Schopp (2001), mental health law (i.e. legal decisions that involve mental health issues) involve two components: A clinical component and a normative one. The former includes the legitimate subject matter of psychology, psychiatry, and any other mental health discipline with relevant knowledge. The normative component of mental health law is a legal judgment that incorporates the clinical component but primarily reflects prevailing political morality. The clinical component will vary minimally and (ideally) only in response to legitimate clinical and scientific advances. The normative component, on the other hand, will shift in response to shifting social mores and the prevailing political winds. The disconnect between these two components is significant, with similar clinical datasets potentially leading to different legal conclusions.

Legal decision-making, then, is qualitatively distinct from clinical or scientific inquiry at least by virtue of being based heavily on a protean moral landscape. Legal decision-makers also enjoy public endorsement and trust in their roles as agents of social control and visible representatives of the state's police powers. Conversely, clinicians have a much more humble social role: We are simply expected to help alleviate discomfort and, occasionally, answer questions from the perspective of our highly specialized and occult knowledge base. We are not expected to assume the role of legal fact-finder or decision-maker and our contract with society does not include provision for the assumption of a social control function or dispensation of "justice" in a criminal court room.

When a psychologist, or any other clinician, is formally granted the status of "expert" in a criminal court, he or she is expected to provide expert opinions in a manner consistent with the legal parameters that govern expert testimony. In this country, *Mohan* provides the legal template for appropriate expert testimony. Even cursory review of this judgment reveals that concerns regarding inappropriate testimony by "experts" permeate this ruling. Beyond these general concerns, Mohan specifically requires that expert testimony comply with existing rules of evidence, be legally relevant, necessary, and provided by an appropriately qualified expert. Though legal relevance and necessity are matters that are appropriately decided at trial by a judge, the "properly qualified" requirement of Mohan dovetails with the professional responsibility of all psychologists to avoid misrepresentation of their expertise. Thus, the Mohan criteria and the CPA code of Ethics can be seen to converge in a manner intended to prevent excursions by psychologists into areas that lie outside of their legitimate range of expertise. Insofar as psychologists cannot claim expertise in legal decision-making or moral reasoning, they are required by existing legal and ethical considerations to avoid offering ostensibly professional opinions on purely legal matters. Forensic clinicians who ignore this proscription are offering essentially lay opinions in the guise of professional knowledge and, in so doing, are misleading a consumer group who expects exclusively professional opinions. More directly, unless the legal system formally forfeits judicial responsibility to clinicians, ultimate issue opinions remain the exclusive purview of judge or jury. To ignore this simple truth will continue to invite controversy regarding expert mental health testimony in criminal trials.

References

American Bar Association (1989). *ABA criminal justice mental health standards.* Washington , DC: American Bar Association.

American Psychiatric Association (1982). *Statement on the insanity defense.* (Released January 1983). Washington, DC: American Psychiatric Association.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th Ed., text revision). Washington, DC

American Psychological Association (1980). *Report on the task force on the role of psychology in the Criminal Justice System.* Washington, DC: American Psychological Association.

Borum, R. & Grisso, T. (1996). Establishing standards for criminal forensic reports: An Empirical analysis. *Bulletin of the American Academy of Psychiatry and the Law,* 24, 297-317.

Canadian Psychological Association (2000) *Canadian Code of Ethics for psychologists.* Ottawa; retrieved from the Web. December, 13, 2005, *http://www.cpa.ca/ethics2000.html*

Committee on Ethical Guidelines for Forensic Psychologists (American Psychology-Law Society) (1991). Speciality guidelines for forensic psychologists. *Law and Human Behavior*, 15, 655-665.

Heilbrun, K. (2001) *Principles of forensic mental health assessment.* New York, NY: Kluwer Academic/Plenum Publishers.

Hess, A.K. (1999). Practicing principled forensic psychology: Legal, ethical, and moral considerations. In B.R. Hess & I.B. Wiener (eds.), *The handbook of forensic psychology* (2nd Ed.; pp.673-699). New York, NY: John Wiley & Sons, Inc.

Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin (1997). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers.* New York, NY: The Guildford Press.

Morse, S. (1978). Law and mental health professionals: The limits of expertise. *Professional Psychology*, 9, 389-399.

Ogloff, J.R & Cronshaw, S.F. (2001). Expert psychological testimony: Assisting or misleading the trier of fact. *Canadian Psychology*, 42 (2), 87-91.

Peters, M. (2001). Forensic psychological testimony: Is the courtroom door now locked and Barred? *Canadian Psychology,* 42 (2), 101 -108. Pozzulo, J., Bennell, C, & Forth, A. (2006). Forensic psychology. Toronto, Ont.:Prentice Hall.

Poythress, N. (1981) *Conflicting postures for mental health expert witnesses: Prevailing Attitudes of trial court judges.* Unpublished data cited in Melton, G.B., Petrila, J., Poythress, N.G., & Slobogin (1997). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers.* New York, NY: The Guildford Press.

R. v. *Marquard* (1993), 85c.c.c. (3d) 193 (s.c.c.)

R. v. *Mohan* (1994), 89 c.c.c. (3d) 402 (s.c.c.)

R. v. *Reid* (2003), 65 O.R. (3d) 723

R. v. *Rogers* (2005). B.C.J. no.1580

Rogers, R. & Ewing, C.P. (1989). Ultimate opinion proscriptions: A cosmetic fix and a plea for empiricism. *Law and Human Behavior*, 13 (4), 357-374.

Rogers, R. & Shuman, D.W. (2000) *Conducting Insanity evaluations* (2nd Ed.). New York, NY: The Guildford Press.

Saunders, J.W.S. (2001) Experts in court: A view from the bench. *Canadian Psychology*, 42 (2), 109- 118.

Schopp, R.F. (2001) *Competence, condemnation, and commitment: An integrated theory of mental health Law.* Washington, DC: American Psychological Association.

Schuller, R.A. & Ogloff, J.R.P. (2001). *Introduction to Psychology and Law.* Toronto, Ont.: University of Toronto Press.

Slobogin, C. (1989) The "ultimate issue" issue. B*ehavioral Sciences and the Law*, 7 (2), 259-266.

Yarmey, A.D. (2001). Expert testimony: Does eyewitness memory research have probative value for the courts? *Canadian Psychology,* 42 (2), 92-100.

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INSIGHT

Olympic Gold – At what price?

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On September 15, 2006 an Associated Press article was circulated, reporting on an article in the Beijing Morning Post which noted that the city was "considering hospitalizing all mentally ill people to avoid creating any harm to the city" (1) during the 2008 Olympics, as well as considering other measures such as expelling many of the city's migrant workers, limiting the use of cars and banning the posting of hand bills, shutting down heavily polluting factories and giving many of their residents an extended holiday during the games. Subsequently, On September 27th, AP reported that Chinese officials had denied the plans to expel migrant workers, but were "considering how to keep the mentally ill from damaging the public interest during the Games." (2). In that article Zhou Jidong, the head of the city government's legal department, was quoted as saying that "the city government plans to ask the municipal (council) to make a law about psychiatric health regulations aimed at providing mental health treatment and preventing mentally ill people from damaging the public interest".

Although it is probably not surprising that people with mental illness are seen as requiring control, and that hospitalizing all such individuals is under consideration in China in preparation for the Olympics (despite statements to the effect that the Olympics would help further human rights in China), it is more disturbing to see the response outside of China. One of Canada's leading newspapers, the Globe and Mail, picked up the original AP story the next day and ran it as a small item in the sports section with the headline noting that China planned to limit the use of cars in Beijing during the Olympics. Only in the body of the story was there a brief note about the plans to hospitalize those with mental illness. It seems, in Canada at least, that the news that car use will be limited is seen as more news worthy than the violation of the human rights of a vast group of people with mental illness.

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References:

1. Associated Press Archive, September 15, 2006.

2.Associated Press Archive, September 27, 2006

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Book Review

An Anthology of Psychiatric Ethics

By Sidney Bloch, Stephen Green, Oxford, Oxford University Press, 2006 (Soft cover)

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This is an excellent book. When I received the book to review, I found myself quickly referring to its content when faced with the increasingly difficult ethical consults in my daily work. This fact in itself led me to compare it to my other mental health ethics reference texts. *An Anthology of Psychiatric Ethics* is now my preferred reference text when providing education on ethics to mental health staff.

The text is divided into nine core sections such as Diagnosis and Confidentiality, etc. Each section is introduced and the reader is provided with the basic premises which generally guide the topic and following essays. A bibliography is included at the end of each introduction which provides the reader, and particularly students, more direction to research the topic in detail. This is a very valuable teaching tool for those of us in busy practice environments.

The text begins with a basic introduction to the standard bioethics theories, i.e. principles, utilitarian, etc. Interestingly and refreshingly, Edward Pellegrino's essay on the "Virtuous Physician, and the Ethics of Medicine" as well as Alisa Carse's essay: "The Voice of Care" are included in the theoretical section. In my view, psychiatric ethics tends to brush aside such notions as virtue and care in favour of law and principles. However, it is virtue and care that our patients frequently find lacking in psychiatric treatment.

I also enjoyed re-reading the more classic and controversial essays that have informed and influenced the direction of mental health ethics and treatment. Such essays as Freud's " The Dynamics of Transference (1912), Rosenhan's "On Being Sane in Unsane Places" (1973) and, of course, the notable Thomas Szaz's "The Myth of Mental Illness" continue to be relevant in today's increasingly complex field of mental health. Including these works in an anthology on psychiatric ethics indicates a broad moral understanding of mental health by the editors.

Unfortunately, the anthology is not without its shortcomings. I would have preferred to see more discussion on a number of current ethical issues which seem to be increasingly important in the field. Firstly, although there are one or two essays on dementia, the text generally lacks a through examination of psychogeriatrics. As this population is greatly increasing, the ethics of issues related to living at risk with mild dementia would have been appreciated. Secondly, the area of children's mental health is only briefly attended to by the editors. Thirdly, the related areas of addiction, harm reduction, homelessness and the complex psychiatric patient are basically ignored. Generally, these are the populations which seem to cause the most intense moral distress among caregivers, family members and professionals.

Lastly, a section on consumer/patient views and opinions could have been included... "Whose life is it anyway?"

Nonetheless, even with these shortcomings, I would recommend the text as an excellent reference and introductory text to the topic of mental health ethics.

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