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Part I: Psychiatrists and Social Justice - The Concept of Justice

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ABSTRACT

These two papers consider the concept of social justice and the ethical obligations psychiatrists may have in its regard. In this first paper, the concept of social justice is defined in terms of the successful function of the social contract. Basic conceptions of justice are then considered.

What is Social Justice?

Articulating justice, particularly in relation to psychiatry, is difficult. Attempts to define justice usually refer to principles of equity or moral rectitude. Some conceptualisations refer to the application of a particular law in an impartial manner. Other definitions of justice rely upon the process of receiving what is owed or deserved, either reward for merit or punishment for wrong doing. Conceptions of justice are contextual to a particular place or time – what was just in medieval France may not be just in the contemporary United States. Justice applied to the distribution of resources in a society (distributive justice) and justice in the context of rebuilding communities after politicised violence (a form of restorative justice) are the scope of this paper. In the light of the insoluble problems of language surrounding the notion of justice, this survey of psychiatry and social justice will yoke the definition of justice to that of the notion of the social contract.

In the most simple terms, the social contract tradition of ethics involves rational individuals choosing to abide by consensual agreements about how to behave towards each other. Ethical maxims are, therefore, a form of negotiated agreement between individuals within a society. This self-interested approach works on the basis that the actors within the covenant of the social contract all benefit from the agreement. The conditions of the contract are enforced by a sovereign, or what the English philosopher Hobbes (1651) called a "Leviathan" (Hobbes, 1651/(1985)), so that those who violate the social contract are punished or excluded. Hobbes had argued for the need for a social contract because he believed in the innate violent aggression of humans in a regressed 'state of nature'. Other social contract advocates saw the need for such arrangements as a means of securing rights of private property, in the case of Locke (Locke, 1960) , or Rousseau's (Rousseau, 2005) notion of the need to return to some primitive state of halcyon bliss denied us by modern life. The modern conception of social contract theory is evidenced in the work of Gauthier (Gauthier, 1986), who emphasises the 'self interest' aspect of contractarian arrangements. Gauthier argues that individuals enter into social contract arrangements to safeguard their own interests, rather than the best interests of the community.

The core of social contract theory is, therefore, the rational agreement between participants of the process to not act in a manner which disadvantages others, and the submission of the participants to a sovereign power to enforce the contract. There are, however, circumstances where the social contract process fails:

a. What of the mentally ill who may be incapable of rational agreement to the social contract process, yet need the protection of the sovereign?

b. What of those members of society who are 'second class citizens' and do not benefit from the social contract, yet are expected to abide by it?

c. What if the sovereign fails in its responsibilities?

These three scenarios will be the themes explored in the second paper of this series.

Psychiatry, Society and Justice

The first assumption in this paper is that psychiatrists, as physicians, are professionals, and are therefore beholden to the ethical parameters that all professionals abide by. A profession is, in simple terms, a group who posess specialised skills and knowledge applied for a collective good (ABIM Foundation, ACP-ASIM Foundation & EFIM, 2002; Pellegrino, 1999). The tenets of this beneficent conduct have been specified as patient welfare and autonomy as well as the just allocation of resources (ABIM Foundation, ACP-ASIM Foundation & EFIM, 2002). One of the key elements in this definition of professionalism is the 'contract' between the profession and society, in particular what is defined as a "collective good".

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This collective definition of professionalism is balanced with the Hippocratic tradition of the individual physician as non-maleficent healer. There is potential for significant tension between these two traditions of 'ethics' as it is possible that an expected action in the interests of a collective good may be deleterious to an individual patient. An additional complexity in this equilibrium is the involvement of third parties, a recent phenomena in the history of medicine brought about by market forces. Such a dilemma has been outlined specifically in the case of psychiatry, with a call to reflect upon the inherent tensions within the notion of medicine as the trade of applied technical skills (Dyer, 1988).

In any setting, the psychiatric profession is thoroughly integrated with the norms of the society in which it exists. Such norms influence both diagnostic and treatment approaches, and exert coercive pressure upon psychiatrists through the imposition of laws which govern many aspects of the way they practice their craft. As such there is a particularity to the ethics of psychiatry functioning in different socio-cultural settings. Such a complex network of relationships and obligations implores psychiatrists to consider the integration of their own personal sense of an ethical life and the virtues of a physician, the discourses of professional ethics of the psychiatric profession and the expectations of the social contract, clearly embodied in law.

This dilemma is not new to moral philosophy, and the ideas of the German philosopher Hegel provide a useful means of conceptualising the 'moral' individual and their relation to the 'moral' society. Hegel distinguished *'Moralität'* - an individual liberal morality and *'Sittlichkeit'* - a community based morality, linking individuals to their community (Hegel, 1952). In considering the *Sittlichkeit*, Hegel saw morality manifest in a community of legal relationships and moral standards, embodied in social institutions and laws. *Sittlichkeit* is thus a socially constructed ethical order. Hegel defined Morality as an internalisation of external, socially constructed aws.

In professional settings, Hegelian *Sittlichkeit* exists as small communities of what the bioethicist Engelhardt called 'moral friends', who shared a meaningful notion of the good (Engelhardt, 1996). Small aggregates of medical practitioners have been described as 'moral worlds' (Turner, 2002), although the influence of such communities is not always for good and this process has been touted as a possible mechanism for the conspicuous moral failures of German psychiatry in the 1930's and 1940's (Dudley & Gale, 2002).

It has been argued, therefore, that psychiatric ethics are a network of interactions between the individual morality of the psychiatrist, the immediate collegiate relationships of the psychiatrist, and the relationship between the psychiatric profession and the broader society (Robertson & Walter, 2007b). The corollary of this is that psychiatry exists within the auspices of a social contract in that, as a profession, it has a tacit contractual obligation to society, and through its dialectic relationship with common morality and the law, has its professional ethics constituted by the society and culture surrounding it. As such, psychiatrists are profoundly impacted by failures of the social contract.

As was described earlier in the paper, one of the particular problems with social contract approaches to social justice is the situation of a member of society who requires the benefits of the social contract, yet may be incapable of a rational choice to abide by it. This is a particular problem with the severely mentally ill, and those who are afflicted with mental retardation or dementia. In contrast to the so-called 'moral free-rider', who seeks to benefit from the social contract without abiding by its requirements, those who cannot necessarily commit to the social contract, by virtue of irrationality or impairment, present an ethical dilemma. Most civilised societies provide some form of decent minimum in terms of basic social goods, such as welfare and some access to health care, however, it is apparent that the mentally ill of most developed societies have failed to benefit from the alleged prosperity of the post-industrial globalised economy. Whether this failure to benefit relates to the incapacity of many mentally ill people, either individually or as a group, to advocate on behalf of themselves or more to the stigma associated with mental illness is unclear.

If the problem relates to stigma, this presents another problem with the social contract tradition, that of the 'second class citizen'. Second class citizens are, in essence, those members of society who are expected to fulfil the expectations of the social contract, without reasonable expectation of the benefits. Second class citizens may become so either through latent predjudices within a society (often on racial or gender grounds) or through government policy. Regardless of the type of failure of the social contract, the clear imperative faced by psychiatrists and their ethical responsibility to their patients, is one of advocacy. The advocacy role presents another ethical tension for the psychiatrists as moral agents – whether their role is as members of a profession, or as a private citizens. Advocating directly to government has been standard practice in most developed societies, particularly in regards to allocation of health care resources. Indeed, such undertakings are listed in many professional codes of conduct for psychiatrists. Advocacy in the public sphere has become more difficult, particularly when psychiatrists risk politicising their advocacy role by speaking out against government policy. Such a dilemma has confronted Australian psychiatrists in recent years, in the face of their Federal Government's policy of mandatory detention of refugee children (Silove, 2002; Steel & Silove, 2004). In the USA, the problem of advocacy has been most acute in the face of the implentation of market forces in healthcare, under the auspices of Managed Care. Managed Care has delivered a number of 'unethical' health systems in the USA, leading to calls for psychiatrists to resist the processes in such systems which disadvantage the mentally ill (Green & Bloch, 2001). There is evidence accumulating that managed mental health care may adversely affect clinical outcomes (Green, 1999) as decisions made on apparent utilitarian grounds of cost containment seem to have the value of reduced access to, rather than improvement of clinical services (Thompson, Burns, Goldman, et al, 1992). The dilemma faced by psychiatrists, and physicians in general, is to reconcile the needs of the patient with that of the society. Such considerations often bring the physician into conflict with the rest of society (Levinsky, 1984). The notion of a tension between psychiatrist's obligations to their patients, and to third parties is protean and has been considered in terms of the so-called 'dual role' dilemma in psychiatric ethics (Robertson & Walter, 2007a).

Distributive Justice

Just allocation of limited mental health care resources is, arguably, a global issue and forms part of the World Psychiatric Association's Declaration of Madrid (1996), which states "psychiatrists should be aware of and concerned with the equitable allocation of health resources" (WPA, 1996). Several recent articles in *The Lancet* have also implored psychiatrists to consider issues of just allocation of resources in a global setting as part of their ethical obligations (Dhanda & Narayah, 2007; Herrman & Swartz, 2007).

The late Harvard philosopher, John Rawls, crafted a conception of distributive justice over his career (Rawls, 1971; Rawls, 1993; Rawls, 2001). The elements of Rawls' contractarian approach to justice related to a hypothetical notion of having moral agents conceptualise an 'original position', which was pre-social and pre-historical. The participant in this social contract would be blinded as to who they were going to be in this future society through a 'veil of ignorance'. Based on these constraints, the moral agents would then define a just distribution of goods in this future 'well-ordered society'. Rawls believed that all would operate on the assumption that they would end up the least advantaged person in the society and through a process of "constrained maximisation" allocate resources accordingly. Such 'resources' were not merely wealth, but also freedom, mobility of labour and equal access to opportunity to achieve fulfillment in life. In stark contrast to Rawls' liberal egalitarianism was the free-market 'libertarian' ideas of Robert Nozick (Nozick, 1974), who averred that the only constraint the state should place on the free exchange of resources within a society should be ensuring of the legitimacy of the acquisition and subsequent exchanges of property. Libertarianism has become the dominant paradigm in post-industrial developed economies and many health systems have evolved based upon the principles of such free exchanges of goods and services between individuals.

Whilst Rawls' contractarian method was ingenious, there are problems with what he defined as 'social goods'. Rawls saw that all members of a 'well ordered society' had equal entitlement to access social goods to have the opportunity to live fulfilling lives. Rawls took the Kantian view that individual fulfilment is a product of autonomy, or rational self-governance. As such, social goods are instrumental in achieving this, and the just distribution of these social goods assists members of society to achieve this autonomous existence. As Nussbaum points out, such an approach falters when we consider the situation of those whose capacity for autonomy is impaired life-long. A person with disabling chronic schizophrenia may never be truly capable of autonomy and so their needs are poorly met in Rawls' philosophy. As such, Nussbaum builds on the so-called 'capabilities approach' to justice (Sen, 1993) to provide a more workable account of the primary social goods at the centre of Rawls' distributive justice (Nussbaum, 1999). Nussbaum's capabilities are necessary for the capacity for the ultimate end of a life with dignity, rather than Kantian autonomy. The capabilities extend from reasonable life expectancy, sensory and bodily integrity, through to capacity for affiliative behaviour, play and some control over one's environment. Nussbaum thus sees that the ends of just public policy with regards to people with psychiatric or intellectual disabilities is the guarantee of their basic dignity (Nussbaum, 2006).

Rawl's theories have been extended to the specific areas of health care by Norman Daniels (Daniels, 1995). Daniels defines 'healthcare' broadly, as varying from individual medical services, preventative interventions, public health initiatives, workplace safety and social resources for chronically ill and disabled. Daniels argues that the 'right' to healthcare carries the implicit assumption that access to healthcare is on a parity with other civil rights, which equates healthcare with other social goods. Daniels provides a closer consideration of what healthcare actually is by citing an "argument from function" defined as "the needs which interest us are necessary to achieve or maintain species-typical normal functioning (my italics)" (p. 26). To Daniels, such functioning refers to the individual's capacity to construct a plan for life or a conception of 'the good'.

The rationale of providing healthcare paid for by third parties, such as government is, therefore, to help restore normal function by decreasing the effect of disease or disability. This compensates for the 'natural lottery' in which liability for disease is considered an accident of birth, rather than the individual failings of the sufferer. A guarantee of access to healthcare does not have the goal to enhance well being or general capability, but merely correcting for the natural lottery.

Sabin and Daniels (1994) have applied these concepts specifically to mental health (Sabin & Daniels, 1994). They advance a 'normal function model' in the light of how mental illness may affect that function. They propose that the goal of mental health care is to obviate the disadvantage arising from mental illness, thus making everyone equal competitors for social resources. Their model of justice, achieved through mental health care, has three dimensions :

a. A "normal function model" of mental health care seeking to create 'normal' competitors for social resources

b. A "capability model" seeking to create equal competitors for resources.

c. A "welfare model" addressing the fact that people suffer because of attitudes or behaviours they did not choose and cannot choose to overcome, which should justify access to mental health care.

The 'normal function' model allows a society to draw a plausible boundary around the scope for insurance coverage. They argue that the capability and the welfare models are the most morally substantive, but are the most problematic in implementation.

Conclusion

In this paper, the principles of social contract theory and Rawlsian distributive justice have been outlined. Rawls provides us with a form of social contract theory which ensures the least privileged in society are protected. As such, a Rawlsian based social contract system is a worthwhile approach to psychiatric ethics. Nussbaum's modification of Rawls, in particular her emphasis upon "dignity" as the ultimate good, enhances this approach to psychiatric ethics. It is clear that the individual moral agent cannot be decontextualised

from the socio-cultural environments in which he or she exists. Psychiatry, as a profession, is in a contractarian relationship with the society in which it exists. The mentally ill present a dilemma to social contract views of social justice both in their putative status as second class citizens, and their incapacity to participate as rational choosers in the social contract.

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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.

Daniels, N. (1995) *Just Health Care*. Cambridge: Cambridge University Press.

Dhanda, A. & Narayah, T. (2007) Mental health and human rights *The Lancet*, 370 1197-1198.

Dudley, M. & Gale, F. (2002) Psychiatrists as a moral community? Psychiatry under the Nazis and its contemporary relevance. *Australian and New Zealand Journal of Psychiatry*, 36, 585-594.

Dyer, A. (1988) Ethics and Psychiatry: *Toward a Professional Definition.* New York: American Psychiatric Press.

Engelhardt, H. (1996) *The Foundations of Bioethics 2nd Edition*. New York: Oxford University Press.

Gauthier, D. (1986) *Morals by Agreement.* New York: Oxford University Press.

Green, S. (1999) The ethics of managed mental health care. In Psychiatric Ethics 3rd Ed (eds S. Bloch, P. Chodoff & S. Green), pp. 401-421. New York: Oxford University Press.

Green, S. & Bloch, S. (2001) Working in a flawed mental health care system: an ethical challenge. *Am J Psychiatry*, 158, 1378-1383.

Hegel, G. (1952) *Philosophy of Right.* Oxford: Clarendon Press.

Herrman, H. & Swartz, L. (2007) Promotion of mental health in poorly resourced countries. *The Lancet*, 370, 1195-1197.

Hobbes, T. (ed) (1651/(1985)) *Leviathan.* London: Penguin.

Levinsky, N. (1984) The doctor's master. *New England Journal of Medicine* 314, 1573-1575.

Locke, J. (1960) *Two Treatises of Government* Laslett, P. Ed. Cambridge: Cambridge University Press.

Nozick, R. (1974) *Anarchy, State, Utopia*. New York: Basic Books.

Nussbaum, M. (1999) *Sex and Social Justice.* New York: Oxford University Press.

— (2006) *Frontiers of Justice*. Cambridge MA: Bellknap.

Pellegrino, E. (1999) Professional medical associations: ethical and practical guidelines. *Journal of the American Medical Association.*

Rawls, J. (1971) *A Theory of Justice.* Cambridge MA: The Bellknap Press.

— (1993) *Political Liberalism.* New York: Columbia University Press.

— (2001) *Justice as Fairness: A Restatement.* Cambridge MA: Harvard University Press.

Robertson, M. & Walter, G. (2007a) The many faces of the 'dual role' dilemma in psychiatric ethics. *Australian and New Zealand Journal of Psychiatry* (In Press).

— (2007b) Overview of psychiatric ethics VI: newer approaches to the field. Australasian Psychiatry 15, 411-416.

Rousseau, J. (2005) The Social Contract http://etext.library.adelaide.edu.au/r/rousseau/jean_jacques/r864s/ (accessed April 30 2007).

Sabin, J. & Daniels, N. (1994) Determining 'medical necessity' in mental health practice. *Hastings Center Report,* 24, 5-13.

Sen, A. (1993) Capability and Well-Being. In *The Quality of Life* (eds M. Nussbaum & A. Sen), pp. 30-53. Oxford: The Clarendon Press.

Silove, D. (2002) The asylum debacle in Australia: a challenge for psychiatry. *Australian and New Zealand Journal of Psychiatry,* 36, 290-296.

Steel, Z. & Silove, D. (2004) Science and the common good: indefinite, non-reviewable mandatory detention of asylum seekers and the research imperative. *Monash Bioethics Review,* 23, 93-103.

Thompson, J., Burns, B., Goldman, H., et al (1992) Initial level of care and clinical status in a managed mental health care program. *Hospital and Community Psychiatry*, 43, 599-603.

Turner, L. (2002) Medical facilities as moral worlds *Journal of Medical Ethics: Medical Humanities,* 28, 19-22.

WPA (1996) World Psychiatric Association - Madrid Declaration on Ethical Standards for Psychiatric Practice http://www.wpanet.org/generalinfo/ethic1.html (accessed 23 Nov 2007)

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