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Part II: Psychiatrists and Social Justice – When the Social Contract Fails

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ABSTRACT

This second paper explores psychiatrists' ethical obligations in the face of the failure of the social contract – inherent failures in distributive justice, the failure of the sovereign and the reconstitution of the social contract in post-conflict societies. Such situations present many sources of ethical tension between the professional ethical obligations of psychiatrists to their individual patients and to their society.

Distributive Justice and the Failure of the Social Contract

In the previous paper, I outlined the system of distributive justice outlined by Rawls (Rawls, 2001) and subsequent writers. I also noted that issues of justice play out on both global and national canvases. In this contractarian arrangement, 'rational choosers' partake in a process of negotiating the allocation of social goods in order to have equal opportunity of access to either a fulfilled life or a life with dignity. The dilemma posed by the needs of 'non-rational choosers', incapcitated by virtue of the natural lottery, represents a source of failure of this system of distributive justice. I also emphasised that Rawls' emphasis upon the protections of the least privileged in a society made such an approach a worthwhile basis of psychiatric ethics. This approach will form the 'ethical lens' through which this paper views the particular issues of justice.

It would seem intuitive that part of psychiatry's obligations to those who suffer mental illness is to provide a rational voice on their behalf in the ongoing negotiations of the allocation of resources within the social contract. This is enshrined in various codes of ethics of professional organisations representing the interests of psychiatrists. The goal of this advocacy is to ensure the mentally ill have access to healthcare resources to compensate for the vicissitudes of the 'natural lottery'. Whilst mental health differs from physical health, the experience of the Oregon Health Plan indicates that there appears to be public sympathy with the position that mental illness has parity with physical illness as a cause of disability (Sabin & Daniels, 1997).

On the 'flip side' of this argument are the ethical responsibilities faced by psychiatrists in resource allocation. Whilst the procurement and protection of access to limited healthcare resources is one issue, the alternative is the need for some form of financial responsibility. Much of the cost of healthcare is decided at the individual clinical level and whilst exercising fiscal responsibility should not be with the goal of aiding the obscenity of Health Maintenance Organisations diverting health dollars from the clinical setting to corporate profits, the psychiatrist does arguably have ethical obligations to spend mental health dollars wisely (Singh, Hawthorne & Vos, 2001). One of the problems associated with this obligation is that of quantification. The international standard measures of utility in regard to healthcare is the Disability Adjusted Life Year (DALY) (Murray & Lopez, 1996) and the Quality Adjusted Life Year (QALY) (Williams, 1988), despite the fact that these are insensitive measures when applied to psychiatric disorders (Chisholm, Healy & Knapp, 1997).

The social contract routinely fails in considering the needs of non-rational choosers who, by virtue of the 'natural lottery' are incapable of fulfilling its requirements, yet are in need of the benefits of the social contract. This presents an ethical obligation to psychiatrists manifests in both advocacy on behalf of psychiatric paitents and restraint on behalf of society's limited resources. The ethical dilemma remains in balancing the tension within these roles.

Psychiatrists' Role When the Sovereign Fails

The social contract may fail and lead to social injustice when there is a failure of the sovereign to maintain law and order. This breakdown of law and order may occur as a consequence of some calamity occurring in the state, such as natural disaster or foreign invasion, or when the sovereign perpetrates oppressive violence against its citizens. These circumstances have been seen in totalitarian regimes, where widespread persecution by the state occurs. A vivid example of this was the human rights violations seen in Argentina during the period of the military dictatorship which ended in 1982, documented in the CONADEP report (1984). In other circumstances, the

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sovereign may fail to provide the benefits of the social contract to members of a society who may be part of a persecuted or neglected minority. These groups may be denied the benefits of the social contract as a result of institutionalised racism or on political grounds. Many 'decent' members of the international community, themselves signatories to international covenants of human rights, are capable of such social injustice.

In these circumstances, the ethical remit of psychiatrists in regards to social justice may extend beyond advocacy for those with established mental illness, to all those who are disadvantaged and at risk of developing mental illness. The mental health consequences of politicised violence or denial of the benefits of the social contract arguably represent an area of ethical responsibility for psychiatrists. Moreover, psychiatrists may have ethical responsibilities in the process of restorative justice, in which communities rebuild after such failures of the social contract.

Psychiatrists who live in totalitarian regimes have often been persecuted as a group, or for individual actions or beliefs. Individual psychiatrists were 'disappeared' in Argentina under the dictatorship simply for treating survivors of the regime's torture and imprisonment practices (Knudson, 1997). In other circumstances, such as in the former USSR, psychiatrists have been complicit in persecution of citizens of a totalitarian regime, often confecting politically based diagnoses as justifications for imprisonment (Bloch & Reddaway, 1983).

In modern Australia, psychiatrists face a particular ethical dilemma, which is an exemplar of the problem of the abuse of human rights in otherwise stable and liberal societies. The policy of recent Australian Federal governments has been to enact a draconian appraoch towards refugees, who arrive 'unlawfully' in Australian territory. Part of this process involves the mandatory detention of all 'unauthorised illegal entrants', including women and children, in privately operated "detention centres". Children detained in these settings have been exposed to suicide attempts and self-injurious behaviour by other refugees, compounding their experience of the trauma of the regimes they fled and the perilous voyages made to escape (Steel & Silove, 2001). Given the deleterious consequences of such treatment (Steel, Silove, Brooks, *et al,* 2006), it is clear that this represents an instance of the sovereign of a nation violating its obligations under the social contract. Whilst such propositions can be obscured by debates over nation-state's rights to sovreignty over territory and the status of unlawful entrants under the social contract, the situation faced by psychiatrists in Australia is, quite simply, the perpetration of the abuse of human rights by the state with whom they exist in a contractual professional relationship. Australian psychiatrists face the ethical dilemma of abiding with the reprehensible policy of their society, manifest in the actions of the popularly elected government, or risk politicising the profession by speaking out against harmful actions by a popularly elected government (Dudley, Jureidini, Mares, *et al,* 2004). Such decisions often invoke the political and moral views of individual psychiatrists, resulting in divisions within the profession.

Ethical Dilemmas Faced by Psychiatrists in the Process of Restorative Justice

When societies reform following politicised violence, there are inevitably processes of retribution, reconciliation and reparation These usually occur within the context of an ongoing narrative within a society, taking the form of myths, stories, art, literature and institutions such as memorials or museums (Edkins, 2003). This is argued to be important in the psychiatric care of the survivors of trauma, whose journey to recovery from traumatic stress requires their experience to be contextualised, or 'historicised'(Lykes & Mersky, 2006). In recent times, post-conflict societies have opted for a process of formal narrative occurring under the auspices of so-called 'truth commissions'.

The paradigm truth and reconciliation commission was that held in South Africa following the end of Apartheid. The South African Truth and Reconciliation Commission ('TRC') was created by the 1995 *Promotion of National Unity and Reconciliation Act* 34 (2003). It has been observed that both the individual and collective experiences of politicised trauma exist in a dialectic relationship, and that there are paralells between the processes of recovery occurring in individual psychotherapy and at a societal level, in the process of restorative justice (Brendal, 2006; Swartz & Drennan, 2000). This was one of the presumptions of the convenors of the TRC (Allan, 2000). This assumption placed the psychiatric profession in a similar dialectic between their obligations to individual patients and to their society amidst such processes of recovery. Like all of the ethical dilemmas discussed, there exists a tension as to how psychiatrists position themselves amidst such a process. In the case of South Africa, the conflicting obligations were to the collective good, served by their patients giving public testimony, and to the protection of the individual patient against the deleterious effects of the process (Allan, 2000).

Apart from this fundamental dilemma, the TRC presented other significant ethical problems for the psychiatrists and other mental health professionals involved. The compulsion for the survivors to forgive the perpetrators in the interest of national unity appeared to compromise their mental health (Swartz & Drennan, 2000). The underlying philosophy of the TRC was heavily influenced by the religious views of its convenors (Allan, 2000). The TRC convenors operated under the assumption that national 'healing' would translate into individual recovery for the survivors. This was proven, ultimately, incorrect (Kaminer, Stein, Mbanga, et al, 2001; Swartz & Drennan, 2000). The TRC convenors appeared to have seriously underestimated the mental health care resources that were required for the process. The political reality a decade after the TRC is that there has been no real improvement in the situation of the survivors of the human rights violations of Apartheid, who continue to struggle to receive adequate health care (Simpson, 1995).

Subsequent truth commissions have shown that such processes are not universally succesful, nor do they translate into improved mental health for the survivors. In recent times, the Commission for Reception, Truth and Reconciliation in East Timor (CAVR) provided a different perspective to the TRC. The shame induced by public testimony among the East Timorese survivors proved deleterious to their mental health, again begging the question of

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whether survivors suffer adversely when expected testify publically about their traumatic experience. Apart from the clinical care and advocacy for adequate resources for survivors, the psychiatric profession has to balance the dilemma of protecting individual patients against harm, with the need to participate as both a profession and as citizens in a process of national healing. In a Lancet editorial, the observation was made tha "perhaps the greatest gain for East Timor is that members of society have been free to engage in a spirited debate about the limitations of the CAVR without threat of political repression or of opposing voices resorting to open conflict" (Silove, Zwi & le Touze, 2006).

Conclusion

These two papers have argued that that "social justice" is best conceptualised as the successful operation of the social contract. When based upon Rawlsian ideas, this represents an approach to social justice in which the least privileged are protected by the contract. As a basis of psychiatric ethics, this approach places psychiatrist's ethical obligations is to safeguarding the interests of the least privileged in a society, either those with established mental illness or those vulnerable to mental illness by virtue of social disadvantage. Psychiatric ethics appear to exist in a tension between the contractarian nature of professional ethics and the ethical stance of individual psychiatrists or small 'ethical communities' of psychiatrists. The social contract is problematic in regards to citizens suffering from mental illness, who do not benefit from the social contract either because of incapacity to be 'rational choosers' or defaulting into the status of second class citizens. The social contract also fails when the sovereign fails to discharge responsibilities, either in stable societies or when the social order collapses. I have argued that the ethical aspects of psychiatrists responsibilities occurring after failure of social contract relate to :

1. Advocacy on behalf of those who cannot be rational choosers;
2. Resisting attempts by the sovereign to disadvantage those with mental illness;
3. Provide care for, and awareness of, the plight of those who are disadvantaged by the failure of the social contract;
4. Balancing the individual and collective mental health needs of post-conflict societies

Within all of these is a tension between the psychiatrist's obligation to their patients, and to the societies they serve. This tension appears to lie at the core of the ethical dilemmas presented to psychiatrists by the concept of social justice.

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