Moving Forward on New Themes

In this issue of the Journal of Ethics in Mental Health (JEMH) you will witness a continuing commitment to a diversity of articles that brings new ethical mental health issues to the forefront and that adds important international perspectives. Throughout, the voices of those who have experienced mental health challenges, and the voices of those who work on the frontlines as service providers or in supportive roles to those receiving treatment, are a key feature. Balanced with peer-reviewed academic and research oriented articles, this reinforces the values that are fundamental to the Journal of Ethics in Mental Health, now and in the future. We encourage prospective authors to submit their experiences in the form of an article, case report or analysis. Whether a letter to the editor or a comment on an article or case, we welcome debate and dialogue on issues published in the Journal. In our view, this promotes and fosters a healthy presentation of critical ethical issues in mental health in an international context.

Although JEMH is a relatively young journal, we are confident that we have introduced a new and innovative forum to the mental health field, a forum that will impact practice and education and bring ethical issues into clear focus. In this the fourth issue of JEMH, it is my pleasure to report on other developments related to the Journal of Ethics in Mental Health.

First, on behalf of the Editorial Committee of the Journal of Ethics in Mental Health I am very pleased to announce the "Bernard Dickens Student Award for Writing in Mental Health Ethics" to be awarded each year to a deserving student whose article demonstrates qualities of writing exemplifying the focus of the Journal. The recipient of this first award is Lindsay Webb who has written "Above These Badlands: Delusions, Autonomy and Individual Beliefs in Right to Refuse Psychotropic Medication Cases", published in this issue.

Second, I am also pleased to announce that an upcoming theme for the April 2009 issue of the Journal will be ethical issues and the pharmaceutical industry. Dr. Richard Warner, Professor of Psychiatry and Adjunct Professor of Anthropology at the University of Colorado will be the guest editor. The special issue will examine key ethical issues that are raised by the role, structure and business practices of the pharmaceutical industry and will identify strategies that speak to the challenges facing mental health practitioners, policy makers, consumers and families. Expect further details in our next issue in November.

Third, we believe it is important to bring individuals and groups interested in mental health ethical issues together to discuss experiences and focus on education and training pertaining mental health ethics. In this regard, JEMH has sponsored two conferences and is planning another. Details of the conference, to be held this year, will be announced in the near future. As well, JEMH actively promotes the dissemination of articles published in JEMH. At the present time, JEMH is indexed in: Philosophers' Index; CINAHL; and Sociological Abstracts. We anticipate that this list will expand in the near future with the addition of MedLine and others.

Ron Ballantyne MSW MBA
Editor-in-Chief
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LETTERS

Dear Prof. Glannon,

I just discovered with gratitude your newly inaugurated -- and amazing -- Journal of Ethics in Mental Health (JEMH), as some of its articles (including yours on neurodiversity, and Fenton and Krahn's relating to autism, both in Vol. 2, No. 2) seem to provide hope for the beginnings of a rigorous academic basis for the ideas that a mentally disabled scientist, technologist, engineer, or mathematician is innately as cognitively functional (and thus, for example, ideationally creative and productive) as a 'non disabled' or so-called normal one, and that a change in societal, medical, and other (even maladaptive!) attitudes towards the mentally disabled in the STEM professions and in related careers such as architecture and economics that are also quantitative-model based, could lead to greater acceptance of them as neuro-equal representatives of a heretofore unwarrantably pathologized part of the spectrum of what it means to be truly human, and thus, through greater neurodiversity and accordingly greater cognitive diversity, to greater productivity of a country's or nation's socio-economy.

The idea of acceptance of mentally disabled persons as needed representatives of cognitive diversity in the STEM workforce, however, seems from my U.S. perspective to be way ahead of the curve for the latest thinking on how to solve the important problem of achieving better representation of disabled scientists, etc., in science and education, whether that disability is commonly recognized as mental or physical in character -- a distinction which, in my view, is an artificial one as generally a disability is actually a composite of both.

So, then, back to your journal, JEMH: Are any forthcoming issues programmed to deal with the combined theme of "neurodiversity and cognitive disability in science and education," or with a theme like it?

Thank you for helping.

Sincerely,

Harold "Hal" Frost, Ph.D.

Visiting Scholar (unpaid), Department of Chemistry, Dartmouth College, Hanover, N.H., USA

Response

Dear Dr. Frost,

At the moment there are no planned theme issues on the topic you suggest, but we would certainly welcome articles related to these topics.

Ron Ballantyne
Editor-in-Chief

ARTICLE

Synopsis of Psychiatric Ethics: Based on Six Papers Published in Australasian Psychiatry

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ABSTRACT

This invited synopsis summarises a series of six papers recently published in Australasian Psychiatry, in which the authors critiqued various normative ethical theories as they might be applied to the field of psychiatric ethics. Professional contractarian ethics, virtue ethics, the ethics of care, principles based ethics, deontic ethics, utilitarianism and more recent approaches, such as postmodern ethics and discourse ethics, were evaluated on theoretical and clinical grounds. The overall conclusion of the series was that, whilst all the normative approaches to ethical quandaries in psychiatric ethics have merit, the particular issues which differentiate psychiatry from other medical fields suggest that all also have significant limitations.

Utilitarianism and Psychiatry

The subject of psychiatric ethics has been traditionally taught by giving lectures and workshops, recommending seminal texts (e.g. Bloch, Chodoff, & Green, 1999) and classic articles (e.g. Appelbaum, 1990; Gabbard, 1994), supervising and teaching at the 'bedside', and, regrettably rarely, via courses on bioethics. In this invited paper, we summarize a 6-part series on psychiatric ethics, recently published in Australasian Psychiatry, in which the authors set out to provide a critical overview of themes and normative theories of ethics relevant to psychiatry and psychiatric practice, and to "road test" them against a problem that might be encountered in clinical practice. The authors were hopeful that, as a teaching resource, the series would not only complement, but also build on information on psychiatric ethics available elsewhere.

Paper 1: Professional Ethics and Psychiatry

This paper argued that, as a professional enterprise, psychiatry comprised a set of specific skills and knowledge that are applied beneficently, or specifically for the 'common good' of society. The issue of what constitutes the 'common good' represents a problem in that expectations such as public safety place the psychiatrist in a position of tension between professional ethics and the Hippocratic ideals of ethical conduct. This tension is based upon the problematic assumption of moral equivalence between the law and ethics. This issue was explored in a subsequent paper (Robertson & Walter, 2008), in which many of the quandaries unique to psychiatric ethics could be considered manifestations of the so-called "dual role dilemma", in which the psychiatrist is placed in a position of tension between their responsibility to their (Robertson & Walter, 2007c) patient, and their responsibility to third parties, such as the community, the legal system or third-party payers.

Paper 2: Virtue Ethics and the Ethics of Care

The second paper of the series considered the ethics of virtue and the ethics of care in the light of psychiatric practice. The two were considered together, given that they both identified desirable qualities in the ethical agent, as well as presenting similar problems in their adaptation to quandaries in psychiatric practice. The ethics of care (Baier, 1985; Gilligan, 1982; Noddings, 1984) provide a compelling critique of the rational theories of Kant or utility in that these theories fail to acknowledge the particularity of a situation, especially in regards to relationships, and are based on abstract, decontextualised notions of justice. They also neglect the

fundamental human impulse to provide care in relationships – personal or professional. Care ethics have been argued to provide a "different voice" in psychiatric ethics (Adshead, 2002; Bloch, 2007). Applied to clinical settings, care ethics calls for a more pluralistic view of ethical quandaries in psychiatric practice, prompting a more holistic approach to ethical dilemmas than abstract, rational ethical theories.

The consideration of the ethics of virtue in relation to psychiatric ethics emphasized a desirable set of qualities, akin to the 'trained habits' identified in the *Nichomacean Ethics* (Aristotle, 1998). Amongst these cardinal virtues, *phronesis* or practical wisdom was the most apt for approaching the ethics of psychiatric practice. Applied to psychiatric (or any clinical) practice, *phronesis* encourages the consideration of multiple perspectives and issues in evaluating a dilemma and its course of action, as well as a mode of reflection upon choices made in resolving ethical quandaries (Tallmon, 2001). This mode of moral reflection is most starkly identified by Arendt's observations of the trial of Adolf Eichmann in Jerusalem (Arendt, 1963). The other perspective of virtue ethics in relation to psychiatry is MacIntyre's notion of virtue as equating with discharging the duties of citizenship – "*agathos*" (MacIntyre, 1984). This alludes to the issue of the beneficent application of wisdom and skill identified in the earlier paper on professional ethics.

Although both care ethics and the ethics of virtue reflect fundamentally desirable human qualities, neither provides a comprehensive account of psychiatric ethics or a helpful means of resolving ethical quandaries in psychiatry. The paper finds some middle ground in the work of RM Hare (Hare, 1993). In a process similar to Rawls' "reflective equilibrium" (Rawls, 2001), Hare argues for "levels of moral thinking" in psychiatry. The 'intuitive level' is more akin to virtue ethics, or we would argue the ethics of care. The critical level is at the level of practical decision making and has no appeal to moral intuitions. To Hare, it is more akin to the utilitarian position. In this scheme, practical decisions, usually based on the grounds of utility, are reflected upon with the tenets of virtue and care in mind. Such an approach is discussed in a more practical light by Bloch and Green (Bloch & Green, 2006).

Paper 3: Principles-Based Ethics

The third paper in the series evaluated the utility of principles-based medical ethics (Beauchamp & Childress, 2001) as a tool for resolving ethical dilemmas in psychiatry (Robertson, Ryan, & Walter, 2007a). Apart from the critiques of the 'four principles' approach (Clouser & Gert, 1990; Engelhardt, 1996; Harris, 2003), the main limitation in their application to psychiatric ethics is the apparent diminution of autonomy in the patient (Radden, 2002), thus affecting the evaluation of the prima facie dilemma. Given the notion that autonomy is "first among equals" of the four principles in Western settings (Veatch, Gaylin, & Steinbock, 1996), this is particularly problematic. The paper concludes that the four principles offers a form of procedural morality which can be utilised in conjunction with the form of ethical reflection highlighted in the second paper of the series.

Paper 4: The Method of Casuistry

The fourth paper examined the potential applications of the method of casuistry to psychiatric ethics (Robertson, Ryan, & Walter, 2007b). The revival of casuistry (Arras, 1991; Jonsen & Toulmin, 1988; Miller, 1996) provides an approach to reasoning in psychiatric ethics which directly attempts to resolve quandaries by providing a workable and practical methodology. The method of casuistry approximates the legal arguments of common law by adopting a taxonomic approach to 'paradigm' cases, using a technique akin to that of normative analogical reasoning. Casuistic reasoning involves the parsing of a particular ethical quandary or dilemma, considering maxims such as clinical need, the context of the decision, quality of life and the patient's perspective. Once this is done, a particular standard or "paradigm" case (akin to a case-law precedent in a legal setting) is established a series of similar cases is assembled, creating a taxonomy of cases. The case under consideration is placed within the sequence depending upon the similarities and negatively relevant differences to the paradigm case. As such, if the case under consideration and the paradigm case are very similar, there is a stronger argument that the conclusion to the case under question should be similar to the paradigm case.

As a method of ethical reasoning in psychiatry, casuistry suffers from a paucity of paradigm cases and its failure to fully contextualize ethical dilemmas by relying on common morality theory as its basis. There are few paradigm cases in psychiatry, although the Tarasoff case (relating to duty to inform of imminent risk to others) (1976) and the case of Daniel M'Naghten (1843) (relating to diminished responsibility due to psychosis in the case of homicide or attempted homicide) are well recognised in the literature. Moreover, the establishment of paradigm cases would require broad consideration of many views within both the community and mental health profession, highlighting a potential for discourse ethics (see below) to be a methodology relevant to casuistry.

Paper 5: Utilitarianism and the Ethics of Duty

The fifth paper in the series (Robertson, Morris, & Walter, 2007) considers two of he most well known normative ethical theories, utilitarianism and Kantian ethics of duty. Utilitarianism as a basis of psychiatric ethics was considered in detail in a previous issue of this journal (Robertson & Walter, 2007a, 2007b). Utilitarianism is a well-established moral philosophy and has significant instrumental value in dealing with common ethical problems faced by psychiatrists. The two main criticisms of utilitarianism, specifically the 'quantification problem' and the responsibility for consequences which are potentially repugnant are very relevant for psychiatry. Utilitarianism has significant output value and approximates decisions of public policy. Despite this, utilitarianism's fundamental limitation in psychiatric ethics is the fact that decisions based upon the grounds of utility frequently place the psychiatrist at odds with the Hippocratic injunction 'primum non nocere'. This underscores the need for the kind of higher level of reflection, as discussed earlier in this paper.

In highlighting the notion of obligation to 'perfect' and 'imperfect' duties, Kantian ethics provides the pretext for the current codes of ethics for various professional groups of psychiatrists. The criticisms of Kantian ethics are a relevant critique to their providing a foundational construct for psychiatric ethics. Kant's valorization of reason, in particular moral reasoning, as the core of human autonomy has served liberal moral philosophy well. The notion of autonomy as the capacity for self-regulation is at the core of much deliberation in bioethics, yet in psychiatric ethics the disturbance of autonomy brought about by psychiatric disorder is at the core of many ethical quandaries faced by psychiatrists. Hegel's criticism of the 'empty formalism' of Kant (Hegel, 1952), O'Neil's concerns about conflicting duties, the abstraction and neglect of emotions (O'Neil, 1991) are all limitations in their application to psychiatric ethics. The decontextualised nature of the Kantian categorical imperative is particularly troubling, as corrupted and misguided forms of obligation to duty have been associated with the excesses of Nazism (Arendt, 1963) – as MacIntyre notes, "Anyone educated into the Kantian notion of duty will, so far, have been educated into easy conformism with authority" (MacIntyre, 1998) p. 191.

Paper 6: Newer Approaches to the Field

The final paper in the series considers approaches to ethics, which have emerged in response to the perceived failures of Western moral philosophy. The spectre of the Holocaust provoked a crisis in Western moral philosophy, prompting the advent of post-modernism (Lyotard, 1984). Post-modern professional ethics are well articulated by Hugman (Hugman, 2005), who nominates the work of Bauman (Bauman, 1993), MacIntyre (MacIntyre, 1984, 1988) and Foucault (Foucault, 1997) as the key ideas of post-modern ethics. Our distillation of this corpus of work is that the post-modern approach to psychiatric ethics seeks to define the perceived obligations and values psychiatrists hold in their dealings with individual patients and how these relate to broader conceptions of the good in professional and social settings. Far from suffering from the traditional criticisms of post-modernism of "anything goes", such approaches to ethics emphasise the need to return to individual considerations in moral reasoning. There is thus a coalescence between these approaches and those of the feminist ethics of care.

Related to this critique of traditional liberal Western philosophy, the articulation of the method of discourse ethics (Benhabib, 1992; Habermas, 1990) also seeks to move beyond grand theories or the "metanarratives" of Enlightenment philosophy. Discourse ethics sees ethical norms generated by a process of a discourse procedure, in which all members of a discourse are able to express their views.

Discourse ethics allows the generation of moral 'norms', which are universal in as far as all those affected by them can accept their consequences. Applied to professional ethics, psychiatrists are members of a large group engaged in a discourse with diverse parts of society, yet exist within small moral communities (Turner, 2002) in which micro-discourses are compatible with different individual ethical positions.

Conclusion

As we have argued in this series of papers, no one normative theory of ethics is perfectly suited to the complexities of psychiatric practice. All of the theories contribute a valuable perspective to the field, but they all fail to fully apprehend the complexities of psychiatric disorder and its treatment. These complexities lie in the unique vulnerability of the psychiatric patient, the uniqueness of many aspects of psychiatric treatment and the intricate and powerful relationship between the psychiatric profession, the law and other social institutions.

More than any other field of medical endeavour, psychiatry is a socially constructed enterprise. Many aspects of the knowledge of psychiatric disorder and treatment are predicated on social norms and expectations. Moreover, the values that psychiatrists hold as a group emerge in specific social and cultural settings and are therefore relative to others. Such apparent axiological relativism calls into question the validity of universal codes of ethics, such as the World Psychiatric Association's Declaration of Madrid (WPA, 1996). In the light of the human rights abuses perpetrated throughout the recent history of psychiatry, the intuitive notion is that there must be some moral universals. It is not reasonable to assume a moral equivalence between coercive psychiatric treatment based on non-therapeutic public safety grounds, and the murders of psychiatric patients by their psychiatrists in the Aktion T4 programme in Nazi Germany. Nor is it reasonable to turn a blind eye to seemingly improper conduct by individual or small groups of psychiatrists based on some form of intellectually lazy moral relativism. In the moral awakening since 1945, notions such as basic human rights have been assumed to be a naturalistic phenomenon. The challenge to the field of psychiatric ethics - a challenge to share with students and fellow teachers - is to achieve a balance between such universal human values and the particularism of different psychiatrists working in different societies at different points in history.

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"Above These Badlands": Delusions, Autonomy, and Individual Beliefs in Right to Refuse Psychotropic Medication Cases

Lindsay J. Webb BA

At the time of writing this paper Lindsay J. Webb was completing her BA in Philosophy at the State University of New York at Oswego (December 2007). She is now a participant in the Online Program in Mental Disability Law at New York Law School. We look forward to seeing her future work in the area of mental health ethics. Congratulations!

As the recipient of this award Lindsay will receive $500 Canadian.

With every good wish for future success…

The Editors

ABSTRACT

This paper reviews the claim that matters of truth can be arbitrated through general consensus or agreement. Philosopher William James proposed two methods for establishing truth: First, we may be able to directly verify the truth of ideas by checking our hypotheses against the world. Second, when verification is not possible, truth can be approached through the utilization of consensus.

There are some contexts in which a general consensus of truth will suffice. However, a mere consensus of truth is inadequate when reliance on such an agreement may result in the preservation or minimization of individual autonomy. Mental disability jurisprudence is often concerned with the preservation of individual autonomy. Yet, often, individual autonomy is cast aside in lieu of professional agreements. This is especially the case in right to refuse psychotropic medication cases.

Introduction

William James asserts that "true ideas are those that we can assimilate, validate, corroborate and verify. False ideas are those which we cannot" (James, 1981, p. 92). James admits, however, that some ideas cannot be directly verified. Sometimes, this lack of verification results in a reliance on agreement and consensus to lead us toward the direction of true ideas (James, 1981, p. 97). It seems that the direct verification of an idea entails outlining the causal relationship between claiming an idea as true, and then checking our claim against the world. When we are unable to directly verify our ideas by citing a casual relationship, we still may be able to correlate our ideas with reality. We can find an agreement between our ideas and the world (Fawcett, 1911, p. 400).

This paper will focus on delusions as a symptom of mental illness. I will argue that there are situations in which it may be difficult to verify that the beliefs of others are unjustified irrational beliefs. I will question the reliability of utilizing general consensus to assign the label of incompetence to an individual who has been adjudicated as suffering from delusions. Labeling beliefs as delusions and then implying incompetence as a result, may have negative effects on the preservation of individual autonomy in right to refuse psychotropic medication cases.

Psychiatrists are often left without a way to directly verify the irrational nature of a belief and in many cases can only surmise the relationship between a belief and the real world. A common approach to the alleviation of delusional thinking is the use of psychotropic medication. Psychotropic medication is sometimes proffered even when the subject of such delusions clearly objects to the proposed course of treatment.

Many times, the right of a psychiatric patient to refuse medication rests on the judgment of a psychiatrist. Yet there seems to be something unjustifiable in overriding individual autonomy based solely on a conjecture of truth. We should be critical in applying such a framework to situations that will likely result in the invasion of mental privacy and individual autonomy.

In New York, an individual who has been civilly committed to a psychiatric hospital has a right to refuse medication in non-emergency situations. However, if the treating psychiatrist believes that medication is warranted, she may seek to obtain a judicial order allowing for the administration of medication regardless of the patient's objection (Rivers v. Katz). Medication hearings occur in front of a judicial body and often include testimony regarding the severity of the symptoms of a patient's mental illness. Judges issue medication orders when they view a patient as being dangerous to self or others, or not competent to make the decision to refuse medication. The decision to medicate over objection occurs

only when the medication is deemed in the patient's best interests (Rivers v. Katz). One can imagine that evidence of delusions is consistently discussed in judicial hearings. The truth or falsity of a patient's beliefs, and the supposed irrational nature of these beliefs, may support the notion that the patient is incompetent to make decisions regarding his or her medical care.

What constitutes the labeling of a belief as a delusion varies. E. E. Southard (1916) notes that James pays little attention to the concept of delusions in his work, citing merely that he believed delusions to be false opinions about matters of fact that may or may not involve perceptions of sensible things (p. 429). There are many beliefs which may be false or unverifiable but they hardly fit into our normative model of delusions. For example, the belief in God is not physically verifiable, yet we do not label religious persons as being delusional. Dreams and night terrors are a type of data that many individuals interpret and rely on for knowledge. However, we do not seek to label these persons as incompetent, nor do we medicate them over their objections because they seek to interpret their dreams.

James (1889) has discussed how dreams relate to justified beliefs. He cites the example of a dream that contains a winged horse. One can dream about a winged horse and find no trouble with doing so, so long as the horse remains in the world of dreams and the dreamer does not find himself believing that the winged horse is in the right hand stall of his barn (p. 11). Perhaps most individuals do not believe that physical objects in dreams transfer to the real world. Yet we often find ourselves applying the conditions of our dreams to reality, i.e. exhibiting fear, anxiety, or apprehension in real world contexts because something bad happened to us in a similar context during a dream we had last week.

James (1889) states that, "conceived objects must show sensible effects or else be disbelieved" (p. 17). This view suggests that a false idea may be justified, but if the outcome of such a belief is not sensible, a rational agent would abandon the belief. So the trouble with delusions is not only that they are false beliefs, but that they have no sensible effects and only become labeled as delusions when the believing agent is unable to abandon them. This view closely resembles Derek Bolton's (2001) assertion that delusions represent some failure of intentionality; that delusions fail to represent themselves as being "about something" (p. 185). Unfortunately, in many contexts it may prove difficult, if not impossible, to verify the beliefs of others as being without sensible effects. True, there may be certain beliefs that we can show to be false, but the mere falsification of a belief does not mean that we can label the belief as a delusion. We first need knowledge that the belief contains no "sensible effects", and secondly, we need to know that the agent is unable to abandon the belief (James, 1889, p. 17). The label of a belief as a delusion then rests on the beliefs of others about the belief in question. This seems to be an odd and intuitively poor approach to our method for determining beliefs as delusions. To illustrate my point, I will discuss the legal case, Charles Sell v. United States.

In Sell v. US, the Supreme Court concluded that it is not permissible for a state to forcibly administer anti-psychotic medication to a defendant solely to render him/her competent to stand trial (Charles Sell v. United States 539 U.S.166, 2003).

Charles Sell was a practicing dentist who was being tried for Medicaid fraud. He was found incompetent to stand trial and was interviewed by more than one mental health expert. There were conflicting expert opinions as to whether or not Sell suffered from a Delusional Disorder or from some type of Schizophrenia.

At first glance it appeared that Sell was quite deluded and in need of medication to decrease his delusional thinking. However, the court noted that an adjudication of incompetence to stand trial, and the presence of delusions alone, does not necessarily determine incompetence to make personal decisions about one's medical care. The court noted,

> "Why is it medically appropriate forcibly to administer antipsychotic drugs to an individual who 1) is not dangerous and 2) is competent to make up his own mind about treatment?" (Charles Sell v. United States).

The matter addressed at civil 'right to refuse treatment' hearings is not solely the presence of delusions, but whether or not these delusions somehow render one incompetent to make decisions regarding treatment (Rivers v. Katz 67 N.Y.2d 485, 504 N.Y.S.2d 74 N.Y.,1986). In this context, the presence of delusions should bare some relation to the refusal of medication. In Sell v. US, the content of the delusions cited in the record had nothing to do with Sell's refusal to take medication so it is not surprising that this evidence had little weight in the court's final assessment of the case. The issue in Sell, once again, was whether or not it is permissible to administer medication, against an individual's will, solely to render that person competent to stand trial. The issue was not whether or not Sell was competent to make decisions regarding his treatment.

However, at some point, there was a consensus reached regarding Sell's behavior and statements, and three examples were noted by the court as being related to delusional thinking.

1) "The gold he used for fillings was contaminated by communists".

2) "God told me for every [Federal Bureau of Investigation] person I kill, a soul will be saved".

3) "Sell could not sleep because he expected the FBI to 'come busting through the door.'"

Assuming, for the purposes of this paper, that the first two statements are in fact, delusions, I will focus on the third statement; that Sell believed the FBI would come 'busting down his door". Sell had in fact been investigated by the FBI, and was arrested by an FBI agent in the past. It seems somewhat logical that he felt the stress of FBI involvement, and that such stress might have contributed to his inability to sleep. Yet, the above statement was utilized by the court as an example of behavior that was related to delusional thinking. The court might have accepted such a statement as delusional in nature, merely because previous statements clearly seemed to be delusions.

Yet, there is little at stake if we err when asserting that Sell's inability to sleep due to his fear that the FBI will come "busting down the door" is related to delusions. After all, the belief is not related to Sell's refusal of treatment and evidence of his delusions

played little role in the court's decision. However, in civil 'right to refuse treatment' hearings, adjudicating the beliefs of another as delusional may result in the loss of liberty to make decisions regarding one's medical care.

Consider some examples of statements relating to the refusal of medication which might appear to be delusional in nature:

1) "They're putting microchips in the medication so that they can find me when I am released."

2) "I'm always trippin' and I can't think straight".

3) "The Devil told me in my dream that I should not take the blue pill".

First, although it is highly unlikely that medication will contain tracking devices, it is not an idea completely without merit. Parolees are often tracked with bracelets, dogs can be micro-chipped, and sex offenders are registered and closely monitored. Perhaps there is a slight amount of justification for the first belief. However, we can directly verify that the idea is not true by checking the medication. Second, the assertion, "I'm always trippin' and I can't think straight" may be associated with a side-effect of the medication. However, if the subject of a civil 'right to refuse treatment' hearing makes several "outlandish" declarations in court, then the statement, "I'm always trippin' and I can't think straight" might be construed as being related to delusions. Verifying whether or not such a statement is related to delusional thinking might be as simple as asking the subject of the hearing to elaborate. Last, responding to an occurrence in a dream is not all that unusual. As mentioned previously, dreams in themselves seem to fit the definition of delusion, but we do not typically view them this way. When we wake up from having a nightmare we tell ourselves it was just a dream, it was not real. However, often, we remain quite disturbed by what occurred during our dream. In some circumstances, and for several days after a nightmare, we even avoid the people or places that we came into contact with during our dream, even when we know the events were not real. We do not consider ourselves delusional when this occurs, perhaps a bit irrational, but not delusional. The subject of a 'right to refuse treatment' hearing may be in a similar situation with his or her belief. One might impose an idea from a dream onto the real world, but it is not clear that this means the idea is senseless. It seems likely that most of us would be concerned about taking a medication if some figure in a dream warned us against doing so. Faced with a similar situation, many of us may be bothered by the dream, perhaps reluctant to start a new medication, and some of us may decide not to take the medication at all. Most of us would probably not verbalize the reason for our reluctance to our clinician because we know that acting on an idea from a dream seems irrational. However, it is not at all clear that our actions should be determined to be delusions. In fact, if we closely examine the statement, "the Devil told me in my dream that I should not take the blue pill" we see that the content of the dream includes a blue pill. The assertion tells us nothing about whether or not one would be willing to take a green pill. In fact, perhaps the green pill has fewer side effects then the blue pill.

These hearings may indeed be conducted without thorough investigations into the nature of individual beliefs. As a result, judicial

orders of medication may be issued regardless of the individual's desires. If there is a shred of evidence that one's arguments for not wanting to take psychiatric medication is sensible then we may not be able to label that belief as a delusion. If we are unable to label the belief as a delusion, then it does not matter if the belief is false, the belief is still justified. If the belief is justified, we cannot make the claim that the belief somehow renders one incompetent to make personal decisions regarding medical care.

If medication hearings do lack thorough investigation into the nature of beliefs, then such hearings may be invading individual autonomy and one's right to refuse medication, by utilizing mere agreements and heuristic reasoning.

Recall that James is concerned with whether or not ideas are in agreement with the world (Fawcett, 1911, p.300). James (1889) would have also sought to determine not only whether or not one's beliefs have sensible effects, but whether or not one could abandon these beliefs if they did not (p.17). It may not matter whether or not a belief is false, but it matters if an individual still believes absent any justification for doing so.

A history of delusional thinking and outlandish statements to psychiatrists may be presented in a medication hearing thereby impacting how a patient's in-court statements are perceived. Michael Perlin (2005) notes that individuals seek to justify beliefs by relating them to existing stereotypes; this is known as the illusion of validity (p. 17). The judge and psychiatrist may label reasons for refusing medication as being related to delusions since such statements seem to fit the pattern of an existing stereotype, the stereotype of previous delusions. Perlin (2005) also notes that many judges engage in ordinary common sense reasoning. For example, *it is obvious to this psychiatrist that this man is deluded, it is obvious to me just the same, so it therefore must be true* (p. 23).

I am not seeking to claim that the above examples of statements are non-delusional. However, it is important to note that if such declarations are grouped together as delusions, one stands little chance in arguing that s/he is competent to make the decision to refuse psychotropic medication. Recall earlier, I stated that judges issue orders to medicate individuals over their objection when they deem the patient as being a danger to self or others, or not competent to make such treatment decisions (Rivers v. Katz). I argue here that if a court is able to identify one statement as having sensible effects, then that sensible assertion should be evaluated in light of an individual's refusal to take medication. My argument is consistent with how courts have viewed the relationship between mental illness and incompetence in 'right to refuse treatment' cases. For example, the appeals court in Rivers v. Katz rejected the argument that the *"mere presence of a mental illness somehow negates the liberty interests involved in the refusal of antipsychotic medication"*. Since one of the purposes of such a hearing is to determine whether or not an individual is competent to refuse medication, then the above statement would suggest that the Rivers court did not believe that the symptoms of a mental illness necessarily render one incompetent. Although the court in Rivers meant to preserve individual autonomy in 'right to refuse treatment' cases, it attempted to do so while offering us little guidance as to how we should verify the relationship between the symptoms of mental illness and the type of competency in question. The court cited a clinical study concerning the competence

to refuse medication in a footnote. The footnote cautioned that evaluations of competency should investigate whether or not there is an "absence of any interfering pathological perception or belief, such as a delusion concerning the decision [to refuse medication]" (Rivers v. Katz, in Perlin, 2005, 469-470).

So while the Rivers court established the need for a judicial review in right to refuse psychotropic medication cases, the decision did little to explain the judicial methodology needed to evaluate and scrutinize clinical opinions of delusions. It seems though, that the court should have been concerned with such a methodology considering the interest the court had in the preservation of individual autonomy and liberty.

The District court in Lessard v. Schmidt utilized a statement by Philosopher John Stuart Mill in a footnote in the landmark decision that established the minimal requirements of injunctive relief procedures for persons involuntarily and civilly committed to psychiatric hospitals in Wisconsin. The court noted that individuals have a right to manage their own affairs, unless the state can provide a compelling interest to infringe on such autonomy.

> …a statement by John Stuart Mill is worth recalling: "The only freedom which deserves the name, is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental and spiritual. Mankind are greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest". (Lessard v. Schmidt, in Perlin, 2005, p. 76)

Conclusion

A medication hearing is prompted when a treating psychiatrist deems that medication is both necessary and in a patient's best interests, and that the patient is not competent to make the decision to refuse medication (Rivers v. Katz). A general consensus is reached, when a judicial panel reviews the evidence supplied by the hospital's psychiatrist and weighs such evidence in light of individual liberty interests and autonomy. Psychiatric evidence will include documentation of a mental illness and opinions on how the symptoms of the illness correlate with a deficiency in the patient's level of competence. In this paper, I have focused on the symptom of delusions and attempted to show the difficulty we may have in labeling the beliefs of others as delusions. I have further discussed that the verification of beliefs as delusions, and the relation of this verification to incompetence, may be compromised by the presence of ordinary common sense and similar types of heuristic reasoning. Agreements among psychiatrists and judges regarding the nature of another's beliefs may not be leading us closer to the truth of such beliefs. In fact, it may be leading us further astray. We may accept the conclusion that a belief or statement is related to delusional thinking, when in fact, this is not the case. Consensus in these hearings is reached when a patient is adjudicated as being incompetent to make decisions regarding medication due to delusions. Not only is it difficult in some contexts to label a belief as a delusion, it is likely more challenging to verify that these delusions render one incompetent to make treatment decisions

Our efforts to reconcile the direct verification of ideas with how we judge the beliefs of others will be rough terrain to travel. However, I am confident that we can rise above these badlands by strengthening the framework for investigating both the nature of beliefs, and delusions, so that we do not proceed recklessly into situations that pose a threat to mental privacy and individual autonomy. My hope is that mental health and legal professionals, as well as philosophers, will continue to investigate the nature of delusions and offer a thorough account of how delusions are formed and what constitutes a delusion. By critically evaluating the concept of delusions, we may be able to better pinpoint our own assumptions about the beliefs and actions of others.

Note 1: The title of this paper is taken from Bruce Springsteen's tune, "Badlands". This is a joke aimed at Professor Michael Perlin, who insists on using Bob Dylan lyrics for the titles of his publications.

Note 2: I focused on the issue of incompetence as it relates to the refusal of medication and not the concept of danger to self or others, a second criterion for the involuntary administration of medication.

Note 3: This paper does not aim to define or offer an account of delusions. Instead, delusion is plainly referred to as a belief, one that may be unjustified or irrational, that an agent may be unable to abandon.

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The Psyche and the Soul: An "Unholy" or Essential Alliance?

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The title above addresses a most exciting and yet perplexing issue when working with individuals for whom religion and spirituality have major significance. Psychology is often seen as the "demon" influence, designed to take away or subvert the value and meaning of religion and a spiritual viewpoint. On the other hand, clinicians working with clergy and vowed religious have often seen spirituality as an obvious psychological defence against various intrapsychic phenomena that require addressing. How do these benevolent influences co-exist and complement each other? Some people believe they cannot, but I believe they can and, for clergy and religious, they must. The common pathway to understanding is ultimately language and its effective use in clinical formulations and interventions.

The Power of Words

"A picture may be worth a thousand words, but a word conjures up a thousand images". When working with clergy and religious, the power of words and the symbols they represent are all the more important because they have been given a great deal of valence in the training and formation they have received. I have found that certain words and concepts are particularly powerful as therapeutic symbols as well as obstacles to emotional well-being. Let us look at a few words and concepts and see how subtle distinctions can have major treatment implications for those who have committed themselves to ministry.

Inadequacy Words

The first major inadequacy word revolves around the concept of **Sin**. A clinician is sorely tempted to reject out of hand such a notion with regard to mental health issues. I suggest that it is a danger to negate the significance of this concept among clergy and religious. Perhaps a better way for clinicians to deal with this concept is to formulate a secular correlate for it. One such formulation is to think of it as defining a state in which one is less than perfect, struggling against difficulties intrinsic to one's nature when dealing with the ideals of the human condition. This type of formulation can be a good starting point for both lay and religious patients. From there, one is better able to make some important distinctions:

Sin vs. Weakness: If weakness is mentioned in the context of sin, one broaches the portals of theology, and the concept of spiritual weakness is quite different from the idea of psychological weakness. Weakness, in the theological sense, is really not that unhealthy. It acknowledges what clergy and religious like to call their "brokenness." Such a spiritual state can be seen as a precursor to further spiritual growth and, at times, serves as a kind of badge of honour. With this notion of weakness there is little incentive for one to change, and this can pose its own unique psychological obstacles to therapy.

However, if weakness is conceptualized in a more psychological sense, different problems arise. Few relish the notion of being weak. The challenge in therapy is to help redefine the notion of strength. Psychological "strength" is really not the absence of *vulnerability* (often mislabelled as weakness); rather, psychological strength is *resiliency*. If one frames ideas of emotional strength and weakness in this manner, then the therapy focus shifts dramatically away from any implicit notions of weakness. The focus becomes the development of greater psychological resiliency or ego strength. In this light, weakness is not a word that applies accurately to either spiritual or psychological growth.

Sin vs. Flaw: While the notion of sin has a moral underpinning, the concept of "flaw" does not. However, when clergy, religious and other highly spiritual people depict their difficulties in terms of flaws, they unwittingly reveal an underlying perception that provides important therapy material. Persons who view themselves as flawed are essentially depicting their history as a "tabula rasa," a kind of white sheet or chalkboard with a darkened spot or, a slight tear in an unsoiled garment. This self-depiction reflects a fundamental fallacy- a self-image that requires some challenge to its basic assumption about the nature of the human condition. It implies that mental health is a "washing off" or "re-stitching" of an imperfect garment; an erasure of imperfections on the "tabula rasa" of life. The quest for perfectionism is a natural extension of this vision of eliminating flaws, and the mental health difficulties associated with such perfectionism are legion and well known to most clinicians.

Sin vs. Pathology: Among clergy and religious it is relatively easy for the concepts of sin and pathology to be used interchangeably. While in Christian theology, Jesus was free from sin, few would disagree that he was burdened by life stress and emotional turmoil. This theological reality is often forgotten and seems to require revisiting when treating a religious population. Mental health pathology can be best addressed when emotional problems are

defined as concurrent with, rather than causative of, difficulties in the domain of the spiritual. While sinfulness and pathology can clearly co-exist, addressing one is not the same as addressing the other!

Emotional Health Words

Self-Care vs. Selfish: Most clinicians take for granted the notion that therapy is focused on better self-care in both emotional and behavioural ways. Few would argue that better self-care is a positive thing that can and does motivate people to struggle in therapy. However, for some clergy and religious there is a slippery slope between the notion of self-care and the negative trait/behaviour of "selfishness." Among parish priests this is a particularly troublesome issue because often they must choose what is healthy for them at the expense of someone else - a notion that is quite counter to the idealized version of the parish priest as someone whose mission it is to be of service to his people. Feelings of self-care become tinged with self-loathing because there is little distinction made between selfishness and self-care. With clergy and religious in particular, it is helpful to distinguish between an act *against* someone and a reasonable act *for* oneself. It is also useful to stress the need to make a reasoned judgment about the value of self-care *in the service of others*. For example, one needs to point out that a depleted and emotionally empty parish priest has little to give to his parish or his parishioners.

Self Esteem vs. Pride: Fostering positive feelings about oneself is a hallmark of most therapeutic interventions, but all clinicians are well aware of the need to foster a **realistic** sense of self-esteem. An exaggeratedly high level of self-esteem is, itself, a pathology that clinicians tackle when dealing with the narcissistic character disordered and manic individuals, for example. Many clinicians will recognize the curious dilemma of trying to convince a formerly manic individual that **not** feeling as good is actually a sign of health. With religious and as well as with highly spiritual lay people, making the distinction between pride and "hubris" - a more compelling word - is crucial. Few clergy or religious would readily accept the notion that an emphasis on self-esteem is of transcendent value. Some clarification needs to be added. Being happy with one's abilities and successes needs to be couched, at times, in the rubric of "gifts". Natural abilities are often more acceptable when identified as God-given. In this context it is a healthy spiritual act to be happy with one's talents and successes. Another recommendation when dealing with the notion of self-esteem is to focus on the actual abilities and talents evident, rather than the feeling of pleasure itself. With this shift of focus there is less danger for a person to enter the more spiritually dangerous domain of "hubris".

Masochistic vs. Sacrificial: Clergy, religious, and most lay people understand that altruism is an essential part of being a decent human being. However, high levels of self-sacrifice among some clergy and religious can take on a masochistic flavour that is very difficult to address clinically. Anyone who has seen the movie, The DaVinci Code, might recall the perverse satisfaction of self-flagellation, for example. So how does one address this issue with an eye to healthy self-sacrifice? There is no simple answer. One suggestion for lay clinicians is to focus on motives and the degree of choice involved in any exploration of behaviour. Dedicated clergy and religious often develop a habit of self-denial that they stop recognizing. What was initially a conscious act of decency can become an obsessive fixation or a habitual reflex. These folks need to remember the element of choice so that they can master their behaviours better. They can still choose to make sacrifices, but a choice it must be! Some clinicians also need to be reminded that sacrifice can be a valid and healthy choice, at times. There is an implicit danger among clinicians to view all self-sacrifice as pathologically masochistic.

Self-Actualization vs. Hedonism: In therapy there is also a danger of fostering an air of hedonism that does not work well with clergy and religious. One typical misperception is that self-actualization is equivalent to pervasive hedonism. Images of Sodom and Gomorrah, Roman orgies, etc. – surface and disturb! The clinician needs to be sensitive to this possible perception and must be able to accept and, indeed, foster the notion that self-sacrifice can also lead to a greater degree of self-actualization. The really crucial work in therapy is to help the patient understand the importance of choice in behaviour. The choice is not always pleasure-seeking, but it can be. However, one is not a slave to hedonistic impulses, and this is the crucial message to clergy and religious, in particular.

Passion Words

LUST vs. SEXUAL AROUSAL: When it comes to issues seen as sexual, the psyche and the soul are portrayed as far apart. The reality of commitment to chaste celibacy seems to imply that sexual arousal is intrinsically sinful and that 'good' clergy and religious need to eliminate their sexual nature - a kind of psychic surgical removal, as it were - to avoid the dangers of **lust**. This word can readily generate moral indignation; the tone may conjure up thoughts of "fire and brimstone" among many. Yet making a distinction between lust and sexual excitement or arousal is crucial. One needs to stress the inevitable and unpredictable presence of sexual excitement of all forms, and sexual arousal needs to be classified as a normal human response. This form of arousal is not a psychological difficulty. Lust, as a psychological problem, is best explained as a conscious tendency to keep alive, persistently and pervasively, a sensate experience that fosters depersonalization and the mistreatment of people. By analogy, one should not "stoke the coals" too much, lest the fire rage out of control or consume the fireplace itself! This subtle but important differentiation between arousal and "lust" can make a good deal of difference in helping clergy and religious accept their sexual nature.

AGGRESSION vs. ANGER: Clergy and religious often do not differentiate readily between a *feeling* of anger and a *behaviour* of aggression or hostility. The distinction is crucial from a moral/religious point of view since such negative behaviour is not morally justified, while such feelings are not validly subject to the same moral sanctions. There is often the fear among clergy and religious that anger inevitably leads to hostile behaviour. When angry feelings are clearly distinguished from hostile behaviours, the individual becomes free to focus on the management of feelings and the development of more appropriate and morally acceptable behaviours.

CO-DEPENDENCE vs. CLOSENESS: Few would argue that experiencing and giving affection is crucial to healthy human development. However, there is much confusion about the manner

in which this should be done in a healthy way. Clinicians stress the problems of co-dependence, which makes good sense; but it is also important to underscore that the absence of some dependence is, in fact, a "non-relationship". One cannot be independent in a true relationship—as the Latin word *relatio* so clearly implies. The old saying of "no man is an island" [today we might say "no person"…] holds a powerful truth. Closeness for clergy and religious must be clearly differentiated from the notion of *excessive* dependence, i.e. co-dependence. The experience of losing one's identity and sense of self *into* the other needs to be identified as the marker for the pathology of dependence. Being dependent on another's affection, respect, or approval is not a mental health problem in and of itself. The distinction between co-dependence and closeness needs much clarification in the treatment process.

"PFs" vs. INTIMACY: In the training of many clergy and religious the notion of a "PF", or Particular Friendship, is often introduced as a potential problem or pitfall. For clinicians this can seem very strange at first, since a close relationship is almost always somewhat "particular". Indeed, in secular life, a PF is often called a spouse! What exactly is the problem, one might ask? In many organizations of men and women religious there is, indeed, some danger with close friendships. However, the danger is not in attachment between people, but in the potential for exclusion. It is in the *exclusion* of others and the purposeful eliciting of jealousy, that PFs can represent a danger in community life.

Mood Words

DEPRESSION vs. DESOLATION: Among clergy, religious, or highly spiritual individuals in general, the word "depression" tends to take on a special meaning. Within this group depression is evident with the typical vegetative signs and subjective distress, but one additional dimension often needs attention. It is a sense of spiritual emptiness, often defined as "desolation," or "the dark night of the soul." In my experience, *depression* and *desolation* depict similar, but not identical experiences. At times they can be quite distinct. Many can be depressed but find God in their pain; while others can feel happy yet have no sense of oneness with God. It is important to note the difference in these experiential states and give them credence. Often, those who are getting psychologically better through medication or the verbal therapies also begin to develop a more personal sense of God's presence in their lives. What is perhaps more interesting, from a clinical point of view, is that often the growth in spiritual fullness generates a better sense of well-being and a decrease of clinical symptoms of depression. Which is the chicken, and which is the egg? It is hard to tell, but in most cases one experience supports the other, while being distinct.

HAPPINESS vs. TRANSCENDENCE: Happiness seems like a reasonable goal for all people under therapy care, yet happiness among some clergy, religious or spiritual lay people can be a somewhat unique experience. The word that best describes it is "*transcendent*." It has been defined by some as a capacity to stand outside of an immediate sense of time and place and to view life from a larger and more detached perspective - a perspective that sees a fundamental unity that underlies nature. A positive transcendent state is a positive attitude about a universality in the purpose of life; an experience of prayer as providing joy and contentment; a sense of personal responsibility towards others.

Mental health professionals who work with clergy and religious may need to develop a better understanding of this unique type of contentment. In Western culture, happiness is often equated with inner pleasure within the framework of individualism. Certainly, psychotherapy can foster this effectively. However, fostering a sense of positive transcendence among some religious can be another form of psychological health fostered in therapy. This can complement the more traditional notion of a personal psychology of well-being. It stresses the value in the "common good", a notion very important in religious communities. Altruism is not always sacrificial in nature; it can be intrinsically rewarding as well, as many know from experience.

Problem Resolution Words

There are many ways in which people work through difficulties. For clergy and religious certain concepts can pose unique problems. The following ideas, and the words that represent them, seem to be particularly important:

FORGIVENESS: Although very few clergy and vowed religious have actually engaged in morally and legally improper acts such as sexual abuse of minors, for example, when one works with this small subgroup the issue of forgiveness looms large. In some religions there is a naturalistic mechanism for forgiveness that poses unique therapy problems. Certainly within the Catholic Church the notion of sacramental forgiveness, or "Confession" is powerful and provides a psychologically easy way to absolve oneself of behaviours that are unacceptable in society at large. Sexual abuse readily comes to mind, and for some clergy and religious, there is a great potential for having the sacrament of "Confession" be the emotional equivalent of culpability avoidance. With this group, the work of therapy is to hold them responsible. In essence one is saying, "God may forgive you, but you still have issues to address!" They can be oblivious to their culpability, and they need to work on this.

CULPABLE vs. ACCOUNTABLE: The distinction between the words "culpable" and "accountable" often needs to be addressed in treatment, particularly for those clergy and religious who have engaged in immoral and often illegal activity. As noted earlier, for some the clinical focus needs to be on some acceptance of culpability. By this is implied an acknowledgement of wrong-doing; *mea culpa* rings loud to some religious. A sense of guilt is necessary as well, and this is not a clinically problematic issue when appropriately managed. The presence of some guilt for improper behaviour is a clinically healthy sign. However for some - those who violate professional boundaries unwittingly or without conscious awareness of impropriety - one also has to foster a reasonable sense of *accountability*, without extremes of culpability. Some religious who are perpetrators of misconduct do not experience the *culpa* in their conduct, while others are consumed by their sense of guilt and cannot transcend the wickedness of their conduct. The notions of culpability and accountability must be differentially applied in treatment as a function of the nature of the excess present—too much culpability, too little accountability.

RECONCILIATION: Among clergy and religious the term "reconciliation" is a powerful mantra, but often reconciliation is associated with the denial of negative emotions—a "no hard

feelings" notion. Clearly this is a psychological misunderstanding, but it often needs to be explicitly stated. In other words, some need to be informed that, in most cases, true reconciliation and the sense of forgiveness that is the ultimate goal cannot readily occur before outrage, anger, disgust or other types of feelings are fully worked through. This is truly a difficult notion for some clergy and religious to accept. They tend to cling to the concept of peace and positive feelings as the resolution to difficult issues. Conflict is not readily acceptable and negative feelings are often avoided and even considered evil. Another aspect of reconciliation that often needs to be underscored is that it requires an interaction between at least two people. The tendency among some clergy and religious is to focus on the purity or ugliness of **one's own** feelings and behaviour, thus obscuring the crucial point that conflict resolution involves at least a dyadic interaction and dynamic.

In summary, when working with clergy and religious or other highly spiritual individuals, the careful use of words and concepts can be most fruitful. The psyche and the soul are clearly tied by the common rubric of language. Perhaps William James summarized it most compellingly as follows: *"Evidently the science and the religion are both of them genuine keys for unlocking the world's treasure house to him [or her] who can use either of them practically"*.

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Ethical Issues and Tagging in Dementia: a Survey

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Abstract

A good deal of concern is generated when a person with dementia wanders. One putatively easy technological remedy is to consider electronic tagging. This possibility, however, raises a different set of ethical concerns. In this paper we report the results of a survey that was intended to elicit people's views about the ethical issues surrounding the topic of tagging in dementia. There was broad agreement in response to the scenario used in the survey that electronic tagging could be an ethically reasonable way to deal with wandering in people who are confused. It was seen as considerably better than locking doors as a way to maintain a person's safety. There were, however, concerns and uncertainties about principles relating to civil liberties, stigma and dignity. And there appeared to be some weight behind the view that electronic tagging of confused people who wander requires professional involvement, the nature of which would need to be decided. population in general.

Key Words: confusion, dementia, electronic tagging, ethics, wandering

Introduction

Electronic tagging as a means of restricting the liberty of criminals is often in the headlines, but increasingly there are demands for its use in people with dementia, including in the UK by government ministers (BBC, 2007). At the same time, the possibility of using electronic tagging for confused people who "wander" is becoming ever more feasible (Miskelly, 2004). Ethical concerns about the use of tagging and tracking devices in the context of dementia have been discussed for some years (McShane, Hope, & Wilkinson, 1994; Hughes & Louw, 2002; Hughes & Campbell, 2003). The concerns are rising because of the rising numbers of people with dementia as the population ages: the estimates are that 24 million people have dementia in the world and that this will increase to 81 million by 2040 (Ferri et al., 2005). And, since "wandering" is a common enough behaviour in dementia (McShane et al., 1998), many people wish that there might be an easy solution.

The issues are much the same as those that surround other forms of restraint. The conflict is often between, on the one hand, the concern to do good (beneficence) and prevent harm (non-maleficence) and, on the other, the need to allow people freedom to make their own decisions (autonomy). According to the literature (Hughes & Campbell, 2003), there are a number of advantages to electronic devices that tell us when someone has wandered. For instance, patients or residents generally are less restricted since locked doors are not required, the devices are unobtrusive, nurses

and carers do not have to worry so much, and harm might be prevented. There are also disadvantages. For example, tagging is seen as degrading, freedom is still curtailed, and the devices might distract organizations from the need to provide more staff and better training. So, on the good side, not only might electronic tagging allow us to do good and prevent harm, these devices might also extend the person's autonomy, by allowing more choice and by allowing people to take risks. Nevertheless, on the bad side, there is still the concern that tagging will encourage us to think of people as if they are objects, to restrict their liberty and deny them their civil rights. Those who have written about electronic tagging have argued that there is a need for agreed protocols, proper risk assessments, attention to issues of consent and a transparent and just review process (cf. Hughes & Campbell, 2003).

There is a need to see the electronic tagging debate in its broader context. For instance, it is important to recognize that the technology that might be used is diverse and developing. An electronic tag might be used in conjunction with a boundary-crossing alarm. So if a confused resident in a home crosses the boundary, for instance to the front door, the alarm would sound. An alternative is that the electronic tag can be used in conjunction with a tracking device, so that – if lost – the person might be found. Increasingly this might be possible using mobile phone systems. The point to note is that different systems would raise different practical and ethical problems. The practical problems would have an effect on the ethical issues. Thus, if the system involved a tracking device that did not work well in built-up areas, its ability to keep the person safe would be compromised and the argument based on the principles of beneficence and non-maleficence would to this extent be nullified. A very basic practical problem is that the electronic tag must be kept on the confused person. This is not always easy (McShane, Hope, & Wilkinson, 1994)!

The broader context also now involves various assistive technologies, including the possibility of 'smart homes' (Cash, 2003). Thus, technology allows most of the movements of a person in their own surroundings to be monitored. Again in the name of beneficence and non-maleficence it can be argued that this sort of monitoring helps to keep the confused person safe and, indeed, in the name of autonomy, might allow the person to maintain his or her independence for longer. The person's use of food, the temperature of the bath water and the person's location can all be monitored. If the person gets up at night, this can be observed and directions given if it looks like he or she might be intending to leave the building. Sudden movements, such as falls, can potentially be detected and help provided.

In many regards this seems like the perfect way to maintain an older confused person independently in the community. However, there is a cost in terms of the person's privacy. And it might be argued that this whole conception of how people might be monitored and managed is dehumanizing. One possible aim is to cut down on the need for personal intervention. Furthermore, it might be feared that, whilst pilot projects would emphasize the need and importance of human contact, once such systems were available on a wide scale, they might simply become another form of institutional care, albeit in the person's own home.

The ethical issues around smart homes are not the concern of this paper. The relevance of them, however, in terms of the broader picture should be obvious. From the ethical perspective, however, it is worth noting that, arguably, we have not reached a consensus on electronic tagging and yet we are now already being encouraged to consider ever more rigorous surveillance (with its concomitant risk of restricted liberty). The movement is not led, seemingly, by any clear ethical consensus or imperative, but by the advent of technological possibilities.[i] All the more reason then to reflect on the basic ethical issues that still surround the use of electronic tagging.

The need for broader public debate on electronic tagging is well recognized (Welsh, Hassiotis, O'Mahoney, & Deahl, 2003), but there has only been one reported survey, which has not appeared in a peer-reviewed journal (Nicole, 1998). We present the results of a survey concerning ethical issues surrounding the use of electronic tagging for confused people who wander.

Participants and Methods

The participants (n = 143) were recruited from convenience samples of main carers of younger people with dementia (n = 6), main carers of older people with dementia (n = 26), people attending a memory remediation group (n = 3), doctors (geriatricians (n = 17), old age psychiatrists (n = 16) and general practitioners (n = 15)), social workers (n = 4), community psychiatric nurses (CPNs) (n = 20), general nurses (n = 31) and occupational therapists (n = 5). The study had ethical approval from the local Research Ethics Committee and informed consent was obtained from participants.

A questionnaire was first piloted with 20 older people on a general medical ward. This was partly for convenience, but also allowed us to test the questionnaire amongst people who were potentially prone to the problems under discussion. The pilot study showed, however, that the patients in this setting found it difficult to engage with the nature of the questionnaire: it seemed difficult for them to contextualize the situation in which the question of tagging might arise. Hence, as well as simplifying some of the questions and reducing their number, an important innovation, in response to the pilot study, was that respondents were forced to choose between three possible strategies. To provide more context we used a case vignette, which described an older person with memory problems who wandered. It is noteworthy, from a methodological point of view, that the use of a vignette has been found to increase decision-making capacity seemingly by making the hypothetical questions more realistic (Vellinga et al., 2005). Following the vignette, the acceptability of electronic tagging was set against locking doors or constantly watching the person.

The questionnaire was distributed to the target groups (described below) in the North East of England and returned anonymously. It sought, first, to obtain respondents' attitudes to electronic tagging using the case vignette. The second part of the questionnaire comprised 10 statements concerning tagging, to which the participants were asked to indicate variable degrees of agreement or disagreement. Finally, there were spaces for further (qualitative) comments.

Terminology

On the grounds that our survey was to involve members of the public, we deliberately left some of the terminology vague in a way that we judged would reflect lay understandings. For example, the questionnaire was headed "Electronic tagging in people with memory problems". Having talked again of people "with memory problems" in the context of a vignette, we then used the term "confused" in our specific questions. We did not try to define the cause of the confusion any more precisely, but our impression was that the lay people had dementia in mind. "Confusion" might also refer to delirium, where the ethical issues might be similar, except that the longer-term nature of dementia raises particular issues that might not be so relevant in the acute situation.

Similarly, although not insensitive to concerns about the breadth of behaviours that might be termed "wandering", we have used the word in keeping with its everyday usage without prejudice to its broader meanings and the possibility that walking by people with dementia might have a variety of purposes (Hope et al., 1994). We have continued to use the term "wandering" in this paper to reflect usage in the survey and to avoid having to specify the types of walking in dementia that might raise the possibility of tagging (McShane et al., 1998). Finally, we are aware that there are various electronic devices, but for the sake of brevity we referred throughout the survey simply to electronic "tagging". The respondents did not seem perturbed by this simplification.

Results

A total of 143 responses were received, a response rate of approximately 67%. Two-thirds of the respondents were aged under 61 years, and 73% were women. Those older than 60 were carers or relatives. Of the 39 men, 72% (28) were doctors; 20 of the 104 women were doctors. Very few respondents (7%) thought that people should be free to wander regardless of risks.

As Table 1 shows, two-thirds of the respondents regarded electronic tagging as the most appropriate and only 8% thought it the least appropriate approach to wandering. Just over a fifth felt that constant watching was the most acceptable strategy. Locked doors were regarded as the least appropriate response by half the respondents. Almost all respondents were willing to be tagged themselves (93%) or to let a relative be tagged (92%). For the people attending the memory remediation group, along with the social workers and the occupational therapists, there was 100% agree-

ment with the idea of being tagged or having a relative tagged, but these were small groups (for all three groups n = 12). Otherwise, age, gender and experience affected the responses. Almost all of those opposed to tagging a relative were female professionals between 41-60 years old. The groups who objected the most to the idea of a relative or themselves being tagged were nurses, with the CPNs showing the biggest reluctance to tagging of a relative. There was a highly significant difference between CPNs and all other groups with respect to being willing to have a relative tagged (χ2 = 11.342, DF = 1, P < 0.001), with the CPNs being unwilling in 25% of cases, whereas for the others the figure was 4%. The one man who objected to a relative being tagged was also a nurse. For self-tagging, 80% of those opposed were women, and 9 were under 61 years. Again, there was a statistically significant difference between CPNs, who were much less inclined to be tagged themselves, and all other groups (χ2 = 4.822, DF = 1, P < 0.02). Those who opposed self-tagging were also those who were less inclined to worry about confused people wandering.

The results in Table 2 can be highlighted in three groups: (a) showing a good deal of agreement, arbitrarily defined as greater than 70%, (arranged as items [i] to [v] in Table 2); (b) showing mixed responses (items [vi] and [vii]); and (c) where the percentage – again arbitrarily determined – neither agreeing nor disagreeing was 20% or over, (items [viii] to [x]).

There was a good deal of agreement with the statements that locking doors was worse than tagging (73%), that tagging would benefit the confused person (80%) and the carer (83%), that it would help people to be looked after in their own homes (71%), but that decisions about tagging should only be made with the involvement of health and social care professionals (82%). Concerning the statement that tagging would be used to benefit carers, there was no strong disagreement (only 6% disagreement). Similarly, there was no strong disagreement with the statement that tagging would help people to remain at home. Although fewer carers (as opposed to professionals) agreed with the idea that professionals should be involved in the decision to tag someone, ignoring those who were undecided, this did not reach statistical significance (χ2 = 1.866, DF = 1, P < 0.10).

In the more mixed reactions, most (64%) were in agreement that tagging would increase the freedom of the person with confusion. Family carers certainly agreed with the idea, whilst most of the disagreement (which amounted to 15%) came from doctors and nurses. There was also ambivalence about whether tagging would mean less worry for carers: 45% agreed or strongly agreed and 41 % disagreed or strongly disagreed. Of those who strongly

TABLE 1: APPROPRIATENESS OF DIFFERENT RESPONSES TO WANDERING		
Response to wandering should be:	**Most appropriate (%)**	**Least appropriate (%)**
Watching the person	29 (21)	57 (40)
Locking doors	19 (14)	75 (52)
Electronic tagging	91 (65)	11 (8)
Totals	**139 (100)**	**143 (100)**

		Agree or strongly agree (%*)	Neither agree nor disagree (%*)	Disagree or strongly disagree (%*)	No response (%*)
TABLE 2: RESPONSES TO STATEMENTS ABOUT ELECTRONIC TAGGING WITH RESPECT TO CONFUSED PEOPLE WHO WANDER (N = 143)					
(i)	It would be used to benefit the carer	119 (83)	12 (8)	9 (6)	3 (2)
(ii)	Decisions regarding tagging should only be made with the involvement of health and social care professionals	117 (82)	8 (6)	17 (12)	1 (1)
(iii)	It would be used to benefit the confused person	114 (80)	14 (10)	12 (8)	3 (2)
(iv)	Locking doors is better	13 (9)	24 (17)	104 (73)	2 (1)
(v)	It would help people to continue to be looked after in their own homes	102 (71)	28 (20)	10 (7)	3 (2)
(vi)	It would increase freedom for the confused person	91 (64)	25 (17)	22 (15)	5 (4)
(vii)	It would mean less worry for carers	64 (45)	17 (12)	59 (41)	3 (2)
(viii)	It would be undignified	26 (18)	33 (23)	82 (57)	2(1)
(ix)	It would result in stigma	26 (18)	32 (22)	32 (22)	3 (2)
(x)	It would improve overall quality of life	73 (51)	55 (38)	14 (10)	1 (1)

* Percentages rounded to whole numbers, so occasionally totals are above or below 100%.

agreed (n = 14), 79% were family carers; of those who disagreed or strongly disagreed (n = 15), 75% were psychiatric nurses. If the respondent was opposed to tagging overall, 63% disagreed that it was a means of decreasing the worry for carers.

There were three statements with which more than 20% of the sample were unable to agree or disagree. Most people (57%) neither agreed that tagging was undignified nor that it would increase stigma. (In fact, no one strongly agreed that it would be undignified.) Of those who were opposed to tagging overall, 82% thought it would be undignified and 58% thought it stigmatizing. But in both cases, over 20% seemed to be neutral or could not make their minds up. Similarly, despite the marked agreement (71%) with the idea that tagging would facilitate independent living, 20% neither agreed nor disagreed. There was a more marked reticence about whether tagging would increase the quality of life for the confused person: 51% agreed or strongly agreed that it would, but 38% neither agreed nor disagreed.

Discussion

In developing the questionnaire we found that asking abstract questions about tagging led to ambiguous responses. The case vignette and the forced choice of management strategies proved helpful in rooting the questions in some sort of reality. At least in the context of a vignette about an older person who wanders, this survey suggests that, amongst professionals and carers, most people are not worried on ethical grounds about the use of electronic tagging as a way of looking after people with memory problems who wander. And yet, there is a strong inclination that such use needs to be monitored and there are obvious ethical concerns being voiced.

In general, as in an earlier survey across several European countries (Nicolle, 1998), people would be accepting of tagging for themselves as well as for others. Our survey demonstrates that carers of people with dementia are particularly in favour of the use of tagging. Concerns persist, however, with some people (about 6%) taking the libertarian view that wandering should not be restricted. There was also a view that tagging would not increase freedom; and it is noteworthy that worries about dignity and social stigma were evident in about 18% of respondents (with another 22-23% being unsure). Again this mirrors the earlier European survey (Nicolle, 1998). This reticence perhaps underlies the feeling (amongst 82% of the respondents) that health and social care workers need to be involved in some unspecified way in the use of electronic tagging, albeit this is not so popular with family carers.

The conclusions of the study are limited by the relatively small number in each of the samples, which precludes more detailed analysis. In particular, despite some effort, it was difficult to recruit many people with even mild memory problems. This deficiency would need to be addressed in any future similar study. Non-professionals are represented by the main (usually family) carers, who appear to focus more on issues of safety and less on the

arguments to do with civil liberties, no doubt reflecting their experiences. It could also be argued that professionals share the same concern with safety, although the tendency for CPNs to veer towards a more libertarian view is noticeable.

We have not explored the nature of this tendency. We could conjecture that it reflects a greater awareness of the requirements for person-centred care in dementia and for attention to be paid to issues of consent and to the needs of vulnerable adults. It may be that professionals are more aware that restrictions of liberty in those who cannot consent (but who might seem passively to assent) need to be justified. But then it is striking that there was a difference between the views of nurses, especially CPNs, compared to other professional groups. It is equally striking that family carers, who have often experienced the reality of the person they care for being lost (at least to them), were seemingly more inclined to favour tagging. The debate comparing issues of safety over against considerations of liberty and autonomy has recently been discussed following a broader literature review (Robinson, et al., 2007a).

That we have not explored the nature of this tendency reflects the nature of our survey. A larger qualitative study would be required to do so. Not only would this allow a greater understanding of the ethical issues, but it might also encourage further probing of the practical issues with their concomitant ethical implications. For instance, if some form of tagging were thought to increase safety (seen as ethically good), but as a result there was less surveillance, so that the confused person was in fact able to wander and be put in harm's way, the practical outcome would argue (at least to this extent), on the grounds of non-malfeasance, against the ethical use of tagging.

Some of the issues in this survey have been touched upon in a systematic review of the literature on wandering in dementia, which considered the ethical implications and acceptability of various non-pharmacological interventions (Robinson, et al., 2006; Robinson, et al., 2007b). It found that there was considerable ethical concern in the literature over the use of electronic tagging and tracking devices. However, the majority of the papers reviewed were discussion papers with little empirical evidence to support the arguments presented.

This survey demonstrates broad agreement that electronic tagging is an ethically reasonable way to deal with wandering in people with memory problems who are confused. However, there is a real sensitivity to wider concerns and principles relating to civil liberties, stigma and dignity. This suggests the use of electronic tagging is something that should be monitored and sanctioned in a formal way. Such formal procedures should, perhaps, be required in the light of legislation to do with consent, capacity, duties of care and rights to liberty. Further research might wish to study the specific circumstances under which electronic surveillance (by whatever means) is considered appropriate. The exact context is likely to determine the extent to which electronic tagging is ethically acceptable for any particular individual (Hughes & Baldwin, 2006).

Endnote

[i] However, it is interesting to note that E M Forster considered relevant ethical and social issues a century ago in "The Machine Stops", long before the advent of recent technological possibilities! See: http://brighton.ncsa.uiuc.edu/prajlich/forster.html

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Part 1: Conceptual Issues and the Case of Argentine Psychiatry

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An Argentine is an Italian who speaks Spanish and thinks he's British - Anon

ABSTRACT

In Part 1, we consider the ethical approach of communitarianism. Such an approach sees values constructed within a community in a certain socio-cultural and historical context. We then provide an account of the main themes in Argentine history and the history of psychiatry in Argentina in order to place in context the consideration of the values constructed by Argentine psychiatrists (These values are then considered in Part 2.)

Introduction

Whilst the shadow of the Holocaust implored us to consider the notion of moral universals, such as the concept of human rights, the idea of liberal autonomy as the unquestionable basis of a global concept of moral philosophy is problematic. The core of the communitarian position in regards to moral philosophy is such a critique of Enlightenment rationality and liberal humanism as the basis of moral philosophy. In the communitarian view of ethics, values are constructed within communities and are contextualised to particular cultural, social and historical settings. Given that psychiatric disorder, and the concept of mental health generally, are socially constructed this perspective is quite compelling in regards to psychiatric ethics.

Core Concepts

Communitarianism

Communitarianism is a secular moral philosophical theory that has both moral and political applications. It is considered a desultory group of theories, which have been divided into 'militant' and 'moderate' forms (Beauchamp & Childress, 2001). The main point of cohesion in this moral philosophy is their criticisms of Rawlsian liberalism (Rawls, 1971; Rawls, 1993), in particular the priority of rights and duties over a conception of the good and the primacy of the individual over the collective. The 'militants' such as Charles Taylor (Taylor, 1985b; Taylor, 1989; Taylor, 1988), Michael Sandel (Sandel, 1981; Sandel, 2006) and Alisdair MacIntyre (MacIntyre, 1984; MacIntyre, 1988; MacIntyre, 1990) saw people as constituted by communal values and as best able to achieve a good life through community life. They argue for an intersubjective understanding of the practices of an individual, not understandable in isolation. Community can be seen as geographical 'communities of place', 'communities of memory' linked by a historical narrative, and 'psychological communities' who share common moral sentiments (Bell, 2004). The latter are perhaps akin to what Engelhardt described as "moral friends" who share a 'contentful' moral philosophy, as against the negotiated norms of "moral strangers" in a pluralistic society (Engelhardt, 1996).

MacIntyre's concept of 'good' relates to individual psychology, rather than a form of social life (MacIntyre, 1984). MacIntyre's alternative view is to argue that ethics reside in group practices occurring within a particular cultural and historical context (MacIntyre, 1998). 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 sees morality not as a subjective process, but one embodied in a community of legal relationships and moral standards and social institutions (Gutman, 1985). We can approach the lives of individuals living within a social life in terms of those customs or conventions. These customs are internalized in the process of socialization or acculturation. Charles Taylor interprets Hegel's project as one of reconciling the ontological tension between rival notions of man either being part of the natural and social world or the Kantian view of humans as autonomous and self determining free individuals (Taylor, 1975). Hegel reconciles the two by constructing both the natural and social worlds as expressions or embodiments of a '*Geist*'. In doing this Hegel argued that any adequate account of the human subject must rely on an understanding of persons existing in interaction, and becoming individuals only through participation in an intersubjective reality. Charles Taylor sees that Hegel was ultimately wrong, taking the view that Hegel's contribution to moral philosophy was to provide a richer perspective on the individual and his or her relation to society. Taylor seeks to locate morality outside of the individual subject (Taylor, 1989). Taylor argues that the Enlightenment doctrine of autonomy and self-sufficiency inflict a process of "atomism" on Western culture (Taylor, 1985a). He rejected this view, arguing that ethical norms make no sense outside of a particular socio-cultural and historical context.

David Bell attempted to lay out a communitarian "ontology" (Bell, 1993) arguing that we unreflectively act on the values of our shared social practices, which constitute the source of our personal identity. Bell distinguishes "universalism" from "particularism" in terms of ethics (Bell, 2004). Bell defines particularism as the claim that there are no defensible moral principles. Despite this, he argues that the communitarian position, at least in a geopolitical sense, is one of cultural particularism (Bell, 1996). Bell argues for particularism along a number of lines. Firstly, cultural factors affect how different societies may prioritize rights. Secondly, cultural factors may affect the justification of rights. Thirdly, cultural factors provide "moral foundations for distinctive political practices and institutions".

Social Constructivism

Social constructivism emphasizes the importance of culture and context in understanding what is happening in society and how knowledge is constructed within that particular setting. Burr (Burr, 1995) stated that the constructivist position had a series of assumptions. Firstly, the world is known through human experience, rather than objective fact, a process largely mediated by language. Secondly, this process is one of social interaction, which is unique to a particular group at a particular point in time. Third, the 'knowledge' derived from the first two factors is sustained by social processes, largely determined by the conventions affecting the way in which information is communicated. The final assumption is that reality is socially constructed by patterns of communication behavior within a social group or culture.

Applied to psychiatry, the social constructionist position looks at how disorders and their treatment are viewed, and how the profession constructs its values in a particular social context. Horwitz defined the constructionist position in regards to psychiatric disorder as being constituted by social systems of meaning,

not naturalistic phenomena (Horwitz, 2002). Psychiatric disorders are defined by cultural rules evident in language such as 'unreasonable', 'dysfunctional'. The limits of the constructionist position of psychiatric disorder are, firstly, that it pays no heed to the observation that many conditions have underlying brain pathology, and therefore cannot provide an account of such extant universals as severe mental illness. Moreover, the constructionist position is undermined by its incapacity to provide an account of comparisons of psychiatric disorders between cultures and therefore it does not provide a coherent system for critiquing mental illnesses. The process of how psychiatrists construct values in a form of social contract has been discussed elsewhere (Robertson & Walter, 2007)

Argentine Psychiatry

Argentina is one of the most enigmatic countries in South America. Argentina is comprised of a highly urbanized population and many originally regarded themselves as a European enclave. Argentine literature displays narratives of disillusionment, isolation and colonization from European cultures. José Hernández's poem *La Vuelta de Martín Fierro* (1879), considered to be somewhat of an Argentine foundation myth, depicts themes of a gaucho's hope for a better life in the face of 'Europeanization' of Argentina, only to be bitterly disappointed. Manuel Puig's novel *Betrayed by Rita Hayworth* (Puig, 1981), tells of the virtual solipsism of Argentines locked into an insular perspective of their lives. One particular feature of the lives of *Los Porteños* (residents of Buenos Aires) is the national preoccupation with psychoanalysis. Argentina has 29 analysts per million people, one of the highest concentrations in the world (Plotkin, 2001). Sandra Baitia described the recent Argentine experience:

> "I live in a country that has faced lots of societal tragedies in the last three decades. We've had military governments that spread terror and literally made thousands of persons disappear. We have had consecutive financial crises that dropped thousands of people into poverty, malnutrition and unemployment…We have lots of people who had to deal with the effects of several kinds of traumas, in which there was always a constant and deep sense of not being important to those who are supposed to care about you." (Baita, 2005b)

Themes in recent Argentine history

1. Peronism

During the late nineteenth and early twentieth centuries, Argentina's economy grew rapidly, supported by a high volume of exports and high levels of foreign investment. Consequently, Argentines identified themselves with Europe and North America rather than with Latin America. Unfortunately, for the remainder of the twentieth century, Argentine history has been characterized by instability, corruption and coercive use of state power. Military coups occurred in 1930, 1943, 1955, 1962 and 1976. The populist leader Juan Perón was elected president of Argentina in 1946 and pursued quasi-national socialist policies of nationalisation of industry and empowerment of the working classes. The political

philosophy of Perón's party, the *Partido Justicialista*, was similar to Fascism or Gaullism. Surprisingly, Perónism developed into a type of anti-establishment view, in particular when Perón was in exile for 20 years from the mid-1950s. Argentina's obsession with Perónism was embodied in the cult of celebrity which surrounded his first wife Eva (or 'Evita'). Perónist national socialist ideals may partly explain why Argentina was a haven for ex-Nazis like Adolf Eichmann, Erik Priebke and Josef Mengele (Goñi, 2002)

After the death of Juan Perón in 1974 a military coup d'état removed his second wife Isabel from office in March 1976. There followed a military junta led consecutively by Generals Videla, Viola, Galtieri and Bignone. Political persecution predated the Dictatorship and it is possible up to 1000 Argentines disappeared under the rule of Isabel Perón, whose complicity with the military prior to the dictatorship led to her being indicted for crimes against humanity in January 2007(2007).

2. Dictatorship

The military dictatorship from 1974-1982 was the bloodiest in South American history. Up to 30,000 Argentines perished in what was described as a "mini holocaust" (Knudson, 1997). The military had seized power on the pretext of instability caused by insurgency within the population. As one author described:

> "In the years that preceded the coup d'etat of 1976, there were acts of terrorism that no civilized community could justify. Citing these deeds, the military dictatorship unleashed a terrorism infinitely worse (p.5)" (Sabato, 1985)

The Argentine military had a tradition of perpetrated pogroms. 'Throat slashing squads' were in operation during the nineteenth century Pampas wars. After the end of the military junta in 1982, many of the perpetrators of human rights abuse outsourced there 'expertise' to other dictatorships in Guatemala and El Salvador (Maechling, 1981-82).

Following the assumption of power, the military embarked on a programme of "National Reorganization Process" (*el Processo*) - pro-market reforms and deregulation to attract foreign investment. As part of this, the military also prosecuted "*La Guerra Sucia*" (The Dirty War") against activist groups such as trade-union members, academics, journalists and students. Argentine citizens who suddenly vanished were dubbed *los desaparecidos* meaning "the missing ones" or "vanishing ones." To be "disappeared" was a new verb in the Argentine lexicon. 'Torture centers' were established, the most notorious being the Escuela de Suboficiales de Mecánica de la Armada (ESMA) or 'Naval School'. Tortured prisoners were either executed and buried in the outskirts of Buenos Aires, or thrown from helicopters into the mouth or the Rio Plata in a process dubbed *vuelos de la muerte* ("death flights"). The Argentine press remained silent out of self interest, although there were elements of fear. Individual journalists and editors collaborated with members of the dictatorship (Knudson, 1997). Some medical practitioners assisted in the torture of prisoners, however, there is no credible evidence of systematic abuses of human rights by the psychiatric profession in the prosecution of *La Guerra Sucia* (Lewis, 2002). The dictatorship ended after Argentina's defeat in the Malvinas (or Falklands) War in 1982.

3. After the Dictatorship

The military dictatorship ended after Argentina's defeat in the Malvinas (or Falklands) War in 1982. Subsequent governments faced the difficult task of maintaining social stability, appeasing the military and leading efforts to come to term with the nation's violent recent past. One of the first attempts at the latter was the establishment of a truth commission, the "National Commission on the Disappearance of Persons" (*Comisión Nacional sobre la Desaparición de Personas* or CONADEP), created by President Raúl Alfonsín. The results of its investigations were documented in the *Nunca Más* (Never Again) report, delivered to President Alfonsín on 20 September 1984 (1984). During the activities of CONADEP, psychiatrists provided support to individuals who suffered from the psychological effects of trauma (Gomez-Cordoba, 2001). Many survivors drifted into institutional psychiatric care.

A particular theme in the account of the national narrative over *el processo* was of denial or repression of the event (Baita, 2005a). Repression, dissociation, and denial are as much phenomena of collective social as well as individual consciousness (Herman, 1992). As one writer observed of how Argentines dealt with such events, "the answer, perhaps for the majority of Argentines, was that you got over it by pretending it had never happened (France, 1998) (p.64)" . Baita has argued that this relates to the post- Perón influence of Lacanian thought in the Argentine culture (Baita, 2006).

At a political level, such denial manifests, ultimately, as gross injustice in dealing with the perpetrators of human rights abuses. Following CONADEP nine former junta members were tried for mundane violations of Argentine law, not for "crimes against humanity". Attempted prosecutions of members of the military led to three abortive uprisings against Alfonsín. To safeguard his rule, Alfonsín then passed *Ley de Punto Final* ('full stop law) in December 1986; this decreed that there would be no new prosecutions relating to the dictatorship after 60 days. Alfonsín also passed the Ley de Obediencia Debida (Obedience law), which exempted low ranking officers against prosecution, virtually enshrining in law the 'Nuremburg defense'.

4. Financial Crisis

Carlos Menem was elected President of Argentina in 1989. Nominally a populist Perónist, Menem presided over the dismantling of the Perónist project in Argentina with the closure of nationalized industries, ending government centralism. Such libertarian policies led to rising unemployment, abrupt shifts in wealth and the disruption of traditional social structures. Much of the Argentine population declined into poverty. Political discontent grew through the 1990's. By mid 2002, the Argentine peso, previously pegged to the US Dollar, was worth about $0.25 USD. Riots in mid-December 2001 led to 26 deaths, prompting De la Rúa to declare a 'state of siege' and the imposition of censorship of all news outlets from Buenos Aires. In 2002 Nestor Kirchner became president heralding a retreat from the complete laissez-faire approaches of his immediate predecessors.

Themes in the history of psychiatry in Argentina

Argentina has been characterised as a conglomerate of psycho-analytic culture, a recent history of political violence and an "unrealized project of social modernity" (Lakoff, 2005) (p.44). In Argentina, psychiatry is on the margins of medicine. Contemporary psychiatry in Argentina comprises "a heterogeneous set of practitioners - psychoanalysts, neuroscientific psychiatrists, drug marketers, patient activists and others" who "creatively assimilate multiple techniques into their work of expertise" (Lakoff, 2005) (p. 177).

Psychiatry was not defined as a separate discipline in Argentina until the late 1940s. Early twentieth-century Argentine psychiatry was closely linked to criminology and was strongly influenced by alienism and mental hygiene. The *Liga de Higiene Mental* was founded in 1929. Crime and 'degeneracy' were considered a consequence of immigration and the large wave of migration to Argentina in the early twentieth century were considered responsible for the increase in crime. Psychiatry, predominantly based in large asylums ("*manicomios*") became part of a larger medical apparatus set up by the state to control the new urban masses (Abelard, 2003; Plotkin, 2001). Argentine psychiatrists adopted Kretschmer's constitutional psychiatry. Psychiatric patients, mainly immigrants or residents of poor rural areas, fell victim to psychiatric admissions processes in which civil codes were largely ignored. A number of patients faced involuntary admission on the basis of pecuniary family interests (Abelard, 2003).

Initially, psychoanalysis was considered to be a therapeutic tool to be employed by physicians. In Argentina, it became part of general culture. This is reflected in the articles published in *Psicoterapia*, Argentina's psychoanalytic journal, which conceptualised psychoanalysis as a response to the problems of modernity. It advanced a progressive political agenda which comprised the complete renovation of society through psychoanalysis. In an attempt to integrate the ideas of Freud and Marx, it was argued that the psyche was merely a reflection of the social order. Argentine psychiatry evolved a tradition of social action. The mental health community in Buenos Aires defined itself as "*mundo-psi*". Poverty, social injustice and socio-political tensions were considered in *mundo-psi* as contributory to mental illness and therefore of concern to psychiatry (Guerrino, 1982). Peron barred psychoanalysts from the public health system, which saw psychoanalysts distance themselves from psychiatrists and adopt a more Lacanian view. Psychoanalysis then morphed from a medical intervention into a cultural response to Peronism (Plotkin, 2003). As Plotkin argues "in the 1960's psychoanalysis was simultaneously used as a therapeutic method, a means to channel and legitimize social anxieties, and an item of consumption that provided status to a sector of the population obsessed with "modernity" (Plotkin, 2001) (p 71). Psychiatry was equally politicized in the Perónist era and after the overthrow of Peron 1955, Argentina was effectively 'de-Peronized'. With this came the emergence of the concept of "mental health". The *Instituto Nacional de Salud Mental* (INSM) was formed in 1957. Subsequent repressive regimes in 1966-73 further radicalized psychiatry, with some psychiatrists persecuted for their social activism. To the junta leaders, psychiatry was an instrument of social and political struggle. The *Salud Mentale* movement of the 1960's championed psychoanalysis as a means

of social advancement; the focus of intervention had always been towards "the social" rather than "the medical".

During *El Proceso*, Marx and Freud were denounced as intellectual criminals and *Salud Mentale* as a means of subversive indoctrination. Psychiatrists and psychologists were persecuted. *Salud Mentale* practitioners were targets of kidnapping and torture during the dictatorship. However, some forms of psychoanalysis were encouraged by the dictatorship, insofar as they were viewed as fostering introspection and discouraging attempts to change social and political conditions (Plotkin, 2001). *Salud Mentale* practitioners returned to positions of influence after the dictatorship, but in a diminished capacity. The *Salud Mentale* experience of the dictatorship carried with it a type of "historical consciousness" (Lakoff, 2005). Plotkin argued that the main consequence of *El Processo* was the uncoupling of psychoanalysis and the political left. This depoliticization also provided oxygen for Lacanian thought (Plotkin, 2003).

The economic and social crisis of late 2001 had a significant effect on Argentine psychiatry. Psychiatrists lost income streams – in some circumstances, cheap or free psychotherapy was offered as part of a barter system in so-called *clubs de trueque* (exchange clubs). The widespread economic instability imperiled the bourgeois demand for psychoanalysis. The use of antidepressants and briefer psychotherapies increased significantly. This process had started under Menem, following a World Bank (Worldbank, 1993) recommendation of reallocation of healthcare resources, creation of a competitive market environment and the introduction of auditing techniques – a model akin to US-style managed care. With the modernization of the Argentine health system, commercial pressures began to influence psychiatry in Argentina. The introduction of the DSM system and the influence of pharmaceutical companies influenced younger psychiatrists. The resistance to North American Psychiatry was based upon its association with the unwanted reforms of the 1990's, although it is argued that it may relate to a deeper resistance to Northern Hemisphere intellectual influences based upon a long standing sense of Argentina being a form of "peripheral modernity" (Lakoff, 2005).

Conclusion

The recent history of Argentina has been characterised by great instability and an unusual amount of trauma imposed by military governments in the form or brutal political repression. More recently, economic problems have caused severe hardship for many Argentines. During the military government, psychiatrists were both witness to the suffering inflicted on political dissidents or suffered themselves. The general cultural approach to these traumas, which appears to emphasise forgetting and moving on, provides the cultural framework in which the psychiatric profession has to work. Because of their embrace of psychoanalysis and idealist philosophies, psychiatrists and psychoanalysts embraced broader social and political views in addition to individualised therapeutic ones. This approach has been epitomised in the activities of the *Salud Mentale* movement. The ideas of psychoanalysts resonated with the public, which led to Argentine having one of the highest relative numbers of psychoanalysts.

Recently, psychiatrists are experiencing the influence of North

American approaches in psychiatry, most visibly embodied in the use of DSM and the use of psychopharmacological treatment. Most Argentine psychiatrists feel that North American approaches are not easily combined with their own approaches. However, because of the vulnerable position of Argentine social institutions, they feel that they are unable to counter them.

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Part 2: A Pilot Ethnomethodological Study

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ABSTRACT

This second paper reports on a small ethnographic study of Argentine psychiatrists. A carefully selected group of six psychiatrists currently practicing in Buenos Aires participated in an in-depth semi-structured interview. The transcripts of the interviews were coded and a thematic analysis method was applied to construct a local theory of the professional values constructed by Argentine psychiatrists, and the circumstances in which such values were constructed. Our analysis indicated that Argentine psychiatrists constructed a number of values, frequently perceived as obligations to their professional group and the needs of their patients. The two main strategies employed by Argentine psychiatrists were the diagnostic act and advocacy. We also identify that these values emerge in the context of recent broad historical and cultural influences upon the profession of psychiatry in Argentina, and the Argentine population in general.

Introduction

In our previous paper (Robertson, Pols and Walter, 2008), we argued that the values held by Argentine psychiatrists, like those of any community, are best considered as socially constructed. The values that a group of psychiatrists create, evolve from their experience of the world and their joint construction, and the patterns of communication of this experience (Burr, 1995). As such, these values are highly contextualized to a particular historical and sociocultural setting. Related to the constructionist view of understanding how psychiatrists form their values is the approach

of ethnomethodology (Garfinkel, 1967; Garfinkel, 2002). The background assumption of ethnomethodology is that the social order is fundamentally chaotic. However, its appearance of order and comprehensibility is a process enacted by the social actors. Garfinkel's original work described "the documentary method" of selectively abstracting certain facts from a given social situation, observing a pattern within the assembly of such facts and then comprehending the pattern. The development of this acceptable pattern forms the framework for interpreting new facts, which arise within the situation. This engenders a process of "indexicality" in which social actors comprehend an observed phenomenon by contextualizing or 'indexing' it to particular circumstances.

The unique situation of the profession of psychiatry in Argentina made a suitable subject for a small ethnomethodological study to attempt to better answer the following questions: what values did this group construct and what were the contextual factors that influenced this? It was anticipated that this observation would help mental health professionals better understand the field of psychiatric ethics, by considering how smaller groups construct values in their work.

Methods

Sample and Recruitment

This was a small qualitative study, based upon a series of in-depth, semi-structured interviews of selected subjects. The interviews were conducted in Buenos Aires in July 2006 over a period of 5 days. The sample was recruited through a local contact of the first author in the Argentine Psychiatric Association. The recruitment of subjects was achieved by both convenience sampling and

"snow-balling" (Grbich, 1999; Green, 2004), in that each subject was able to facilitate access to subsequent subjects (by suggestion or introduction), albeit in the same setting. To further improve the representativeness of the relatively small sample, the subjects were stratified by age, gender and field of psychiatric practice. Subjects were offered the choice of an interview conducted in English or in Spanish through an interpreter. The interviews were recorded and transcribed by the first author.

Analysis

Data analysis was based on the method described by Richards (Richards, 2005), using the NVIVO7 software package (2006). In short, the interviews were transcribed and then read closely with a view to identifying various categories of speech acts. These were coded into the "nodes" function on NVIVO7 and memos written. The "journal" function of NVIVO7 provided linkages between the various memos and conceptualizations of the data as they developed through the analysis.

The analysis of the interview data by the first author, a psychiatrist, was considered to have been influenced in a 'top-down' way. The analysis took place in an iterative fashion, including reference to the relevant literature about Argentine psychiatry and comparisons with independent coding of the data by another researcher.

The second phase of analysis involved the re-reading of nodes and memos, and the condensation of nodes into the "tree nodes" function of NVIVO7. This generated the initial thematic map. The coded extracts (and linked memos) were then examined for overlap in the different nodes. Extracts which displayed significant overlap were then reformulated with reference to the various nodes in which they were initially coded. In this way, themes were developed and various 'subthemes' were integrated into the larger themes. The nodes which were, ultimately, little represented in the coded extracts were either subsumed into larger themes, rejected or cited as warranting further enquiry in a later study. The final process involved the generation of a thematic map, articulation of the relationships between various themes and the formulation of a model of ethical obligations. The coding of the data came from two perspectives – the values or obligations perceived by the subjects in relation to the practice of psychiatry, and the contextual factors surrounding this.

The construction of a local theory relating to this group of Argentine psychiatrists was based upon a thematic analysis approach, as described by Braun and Clarke (Braun & Clarke, 2006). While the analysis drew upon the Grounded Theory method developed by Strauss and Corbin (Strauss & Corbin, 1998) and refined by Charmaz (Charmaz, 2006), the 'top-down' influences of the coding of the data implied that the thematic approach was more appropriate to this data set. Such reflexivity is considered essential for methodological rigor in qualitative analysis (Kitto, Chesters & Grbich, 2008).

Results

Characteristics of the sample are summarized in Table 1.

The themes for professional values are found in Table 3

Discussion

The literature and analysis of the data consistently describe a specific set of social, historical and cultural circumstances. Psychiatrists in Argentina think of themselves as isolated, vulnerable to waves of intellectual and cultural colonization, and as being firmly socially embedded. The psychiatric profession in Argentina is, and always has been, quite politicized and there remain latent influences of the Salud Mentale and psychoanalytic movements of the twentieth century. The profession remains balkanized along lines of theoretical orientation and political allegiance. The contemporary dilemma facing Argentine psychiatrists is another wave of intellectual (and economic) colonization from the Northern Hemisphere, occurring in the context of the transfiguration of a society that is still in denial about its recent past. This manifests as a process of attempting to modernize the craft of psychiatry in Argentina, mindful of the real social and economic problems which create the preconditions for the development of mental illness in that society.

As we discussed in Part 1, the collective social narrative of modern Argentina is remarkably consistent with that suggested by Argentine literature of the late nineteenth and early twentieth century. It

Table 1: Characteristics of the sample of ARgentine Psychiatrists			
Subject	**Age Range**	**Gender**	**Field of Practice**
1	30-40 yrs	F	General Adult Psychiatry
2	40-50 yrs	M	Academic Psychiatry
3	40-50 yrs	M	Child Psychiatry
4	50-60 yrs	F	Forensic Psychiatry
5	50-60 yrs	M	Psychoanalysis
6	50-60 yrs	F	General Adult Pschaitry

TABLE 2: INITIAL CODES FOR THE DATA "INFLUENCES ON THE PSYCHIATRIC PROFESSION"

Coding	Examples from Sources
Colonization – the successive influence of different Northern Hemisphere cultures on the practice of Argentine Psychiatry	"There is now a strong American influence from the pharmaceutical industry – they invite us to congresses and they give us scientific papers" "After the war, many European psychoanalysts came here and they had a big influence"
History of trauma affecting the profession	"El Processo was terrible - in my personal life. I was in the middle age of my life and I could see what was happening in the hospital and I witnessed many of the disappeared people who were my friends" "I studied during El Processo in the University of Buenos Aires. For me it wasn't a good experience because a lot of people, students, disappeared"
Professional divisions	"We need to join in order to create better conditions because we have psychiatrists who use medication, and psychological treatment is in another way, divided – 'dissociated'" "There are different groups of psychotherapists in Argentina so you might find that one group was shot, some members of it were killed under the military dictatorship. They made group therapy disappear in the '60s and '70s and after this the Lacanians were predominant so the social axis changed for a lot of years after the 'processo' "
Collective memory	"The people traumatized by the military dictatorship, I don't see many of them, I don't see any issues coming from that period, mainly because it was too far away" "We lived in a dictatorship, and had a war in the Malvinas but more recently we have domestic traumas, assaults and kidnaps. We now see victims of assaults and violence...I see that as time has passed, we recognize the trauma (of El Processo) is not relevant"

TABLE 2: INITIAL CODES FOR PROFESSIONAL VALUES

Coding	Examples from text
Use of the DSM	"We are quite well consolidated with the DSM but we are confused by the categorical system of the DSM and the psychoanalytic orientation"
Use of evidence based medicine	"In the last 10 or 15 years the new therapies are having effect and good progress and today there are a lot of centers and psychiatrists are practicing CBT and EMDR. All the new techniques are being used today"
Professional autonomy	"Psychiatry has another access to public health and they are required to do more – the vision is wise and they are coming into areas where they never were before"
Advocating for the psychiatric profession	"I think the doctors are going to change what the society thinks about psychiatry, because in the past psychiatry was denounced and misused, but now there is a big change and we are all working hard to change that impression"
Use of diagnosis as expedient	"We use (DSM) more in our dealings with the health system, the public health system, to offer some information and they ask us to use these symptoms but most of us didn't agree with DSM"
Managing third party relationships	"We are in the middle between the patient and the insurance company or the government"
Advocacy	"The ethical problem is to defend patient rights, for the patient's needs" "Psychiatry has another access to public health and they are required to do more – the vision is wise"
The 'virtuous physician'	"It is necessary for us to be who we are and to do what we decide about our own desires, don't lie to ourselves and to try day by day to do the best for our clients"
Attending to patient's narrative	"The symptoms, the relationship with the symptoms and the actions in her life, with her husband and others and the relationship between her symptoms and her past with the memories of the events…"

is a story of a disaffected people, who are perpetually disappointed with a national experience characterized by the establishment and perpetuation of a European enclave, somewhat alienated from the vast landscape of the country. The dominant Argentine self concept is of a highly urbanized population, vulnerable to the combined effects of a cycle of failure of the state and break down of law and order, and hegemonic influences from the Northern Hemisphere. A consistent theme in the narratives of the psychiatrists interviewed is a disconnection (or dissociation) between the national psyche and the brutal reality of the Argentine experience. As such, the psychiatric profession has evolved as not possessing the capacity to 'problematise' the concerns of its patients, and formulate plans of action. The traditions of Freudian psychoanalysis and Salud Mentale do little more than contextualize the traumatized patient's problems in terms of profound introspection within a broad socio-political canvas.

In such circumstances, the phenomena of 'ethical obligations', perceived by the socially constituted psychiatrist as 'moral agent', can be placed in context. The refined thematic map of "ethical issues faced by psychiatrists in psychological trauma" is depicted in Figure 1.

Given this model, several ethical obligations emerge within the refined themes. In the first instance, the psychiatrists feel obligations to a notion of "justice" and to attend to the "patient's narrative" of their experience of trauma. 'Justice' has a number of perspectives, including rectifying social inequalities, assisting with legal or economic constraints faced by traumatized patients, and fostering access to necessary treatment services. The absence of any perceived obligations in the realm of restorative or retributive justice was remarkable. The ethical obligations towards the patient's own narrative is a well recognized theme in psychiatric ethics, and here it relates not only to the recognition of the experience of trauma as part of the patient's story, but also the acknowledgment that the psychiatric patient's formulation of their difficulties may simply reflect the mundane realities of social and economic circumstances. This seems to have become more prominent in the years following Menem's modernizing reforms and the financial crisis of late 2001. From this follows an obligation to respond to the patient's perception of their needs by focusing psychiatric interventions on addressing the problems in the patient's life. The other obligation faced by psychiatrists in their work with traumatized patients is the need to overcome the intrinsic problems of psychiatry in Argentina – professional divisions, archaic treatment and diagnostic practices, and political rivalries. The 'modernization' of the profession involves embracing the apparent benefits of Northern Hemisphere scientific progress in psychiatry, whilst retaining some form of professional autonomy. Moreover, the modernization of psychiatry in Argentina requires both the development of specialized fields of expertise (such as child psychiatry, and general hospital psychiatry) and the judicious use of medication and structured psychotherapies, on the basis of effectiveness and appropriateness to patient need rather than economic constraint.

Two strategies for dealing with these obligations consistently emerged from the analysis of the data – the diagnostic act, and advocacy. The diagnostic act in psychiatry is as much a social phenomenon as it is a clinical one (Fulford, 1999). The act of diagnosis gives some sort of meaning to the patient's experience, focuses treatment, facilitates a consensually validated understanding of a person's form of suffering and therefore provides coherence in the approach of others to the individual. Sadler sees that, in addition to affording a rigorous and accountable means of furthering clinical action, the diagnostic act has instrumental value in providing a simpler characterization of a complex phenomenon, which can penetrate beneath surface appearances and is comprehensible in multiple contexts, thereby reducing illness complexity (Sadler, 2004). The background issue in modern Argentine psychiatry is the North American DSM system of classification. The tensions identified by the interviewed subjects related to the perils of submission to the DSM system balanced against the value achieved by doing so in the realm of advocacy and efficacious treatment. Sadler defined this tension, generally, as one between "ethnographic particularism" (p.15) and the generalizations of DSM/ICD (Sadler, 2005).

FIGURE 1: THEMATIC MAP OF PSYCHIATRIST 'ETHICAL' ISSUES IN RELATION TO PSYCHOLOGICAL TRAUMA
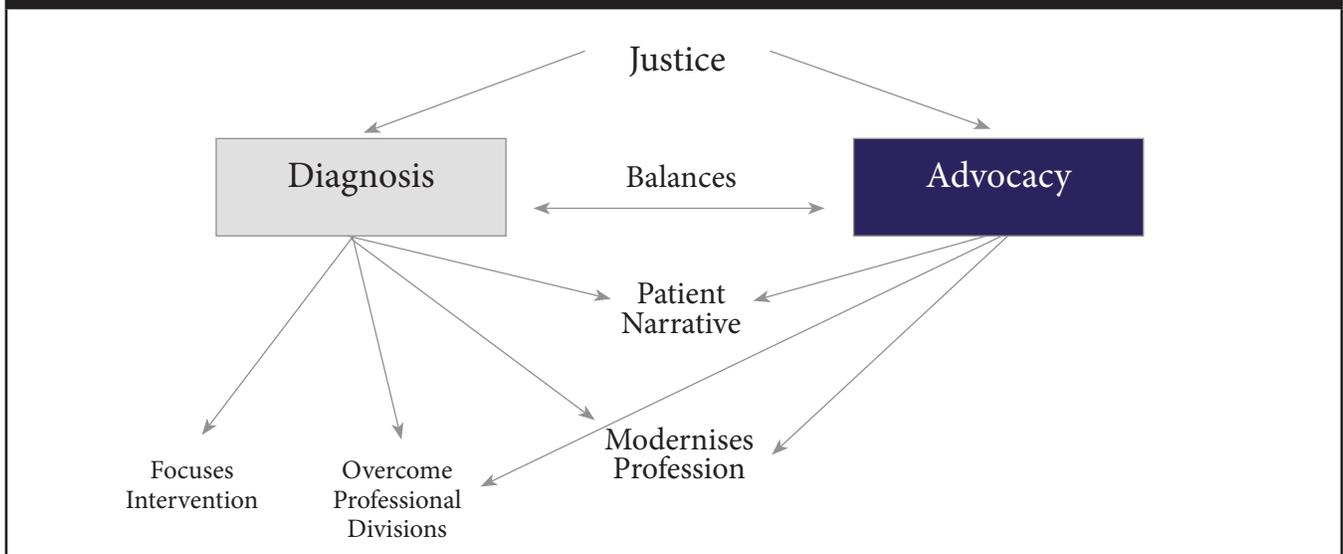
The second strategy of 'advocacy' is one with a variety of contexts. Advocacy for the profession, in terms of its social role and its ongoing development in the light of advances in the profession broadly, was a theme virtually all of the subjects nominated. Advocacy on behalf of the patient in the face of a radically transformed health system was equally prominent in the minds of most of the subjects. Broad social advocacy, particularly in terms of poverty, and access to education and other social goods, was a similarly prominent issue and one that has a strong tradition in Argentine psychiatry. A subtle form of advocacy mentioned by a few of the subjects was the advocacy for recognition of the experience of trauma as a factor in the narratives of their patients, but also in terms of the broad narrative of Argentine society. The latter advocacy is clearly muted by the social processes identified earlier.

Study Limitations

The study is not without limitations. First, despite being quite well stratified, the sample was small. Second, it is not clear whether the data had yet saturated, nor were there any means of diversifying and refining the themes identified through further purposive sampling. Third, the use of interpreters and the setting of the interview likely restricted the spontaneity of the flow of the subjects' narratives and more field work, such as clinic visits, may have yielded more information. In essence, this enquiry is but a starting point for a more comprehensive study. It is anticipated that the refined thematic map derived from analysis will provide points of reference for future work.

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Duty of Care Versus Safety of a Colleague

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The health of my patient will be my first consideration; My colleagues will be my brothers. Declaration of Geneva of the World Medical Association. (adopted 1948, amended 1966 and 1983)

ABSTRACT

This case describes a psychiatric patient who stalked and harassed her former psychiatrist. Balancing the safety risk to her physician against the duty to continue to treat this vulnerable patient, what should the current psychiatrist and the treating institution do?

Key Words: *duty to treat, stalking, safety, continuity of care.*

Arras (1991) has made the case for individual case-based reasoning to address ethical dilemmas. He and others have shown how the circumstances of a case can often clarify the ethical principles behind difficult decisions. The following case illustrates the tension between the duty to treat and continuing treatment that causes distress to a colleague.

Case Report

Patient AC had been an outpatient at a psychiatric hospital since the hospital opened in the late 1960s. She had had several inpatient admissions at that hospital and was being treated there as an outpatient. Despite comprehensive psychosocial treatment and depot medication, she had never been free of auditory, olfactory, and somatic hallucinations, nor of delusional thinking. That being said, she had functioned, on the whole, well. After her parents' death, she successfully lived on her own, maintained a clean and attractive apartment, took care of her own health (she was diabetic), grooming, finances, and sustenance. She also looked after her cat. She went to church, occasionally entertained her one and only friend, and visited with her sister and her nephews.

AC first became ill at age 16 and had had no opportunity to engage in a social or intimate life. She made up for this with an active imagination and flights of romantic fancy that focused on different men at different times. Whenever her fantasies anchored themselves to a specific male, AC became relatively insistent and importunate in her pursuit. The man at the receiving end of her advances was usually a fellow patient and, much to his embarrassment, she would frequently shout his name down the corridor, proclaiming undying love. AC was not a woman who stirred reciprocating fantasies in the men she so admired. They usually fled when they heard her approaching and some were quite distressed by her pursuit but, over the years, no lasting harm had come from her periodic "crushes."

AC's doctor initially changed every six months, as the psychiatric residents rotated through the service. It was then decided that it would be best for her to have one permanent staff psychiatrist, Dr. J, and that regimen at first worked well, until he became the object of her fantasy. AC became preoccupied with Dr. J and convinced herself that he reciprocated her interest. Various events and conversations on TV confirmed this for her. Whenever a program included a wedding, she deduced that one was in store for her and Dr. J; whenever there was an allusion to babies, she experienced a pseudopregnancy. When pressed as to how she could be pregnant, she explained that the depot injection she received monthly had implanted Dr. J's seed and that she was about to give birth to his child. This delusion brought treatment to an impasse so Dr. J transferred the care of AC to a woman doctor (Dr. M) on his same floor. AC was quite content to be transferred, believing that the doctor-patient relationship had been an obstacle to a more intimate relationship with Dr. J.

AC attended treatment visits with Dr. M but continued her preoccupation with Dr. J. She even bought herself an engagement ring, which she wore and showed to her family. Before or after her appointment with Dr. M, she often knocked on Dr J's door, interrupting his psychotherapy sessions; but most annoying to him were the very frequent phone calls she left on his voice mail system. He was not the only one to receive voice mail from AC. Dr. M received an average of 10 calls per day, which she deleted without listening to them because they tended to be all of a kind – musings about Dr. J. AC's case manager received daily calls, as did the emergency department of the hospital. While most of these calls were greeted with annoyance mixed with fond amusement (because AC was well known to the hospital staff), Dr. J, who was the target, felt harassed and stalked.

He followed the explicit recommendations in the burgeoning stalking literature. He clearly and repeatedly told AC that their relationship had been a strictly professional one in the past and, now that she had another doctor, a relationship no longer existed.

He was firm and unequivocal. He told AC that she was not to call him and she was not to knock on his office door.

The patient's intrusions continued. Months passed, with Dr. J feeling ever more harassed. There was no escalation in AC's behaviour with time but it seemed to fluctuate, depending on what she saw and heard on TV. Well-publicized movie star weddings invariably re-inflamed her fantasies. As per standard advice, Dr. J began to document each incident, noting the time, place, and duration of harassment. He asked Dr. M to stop seeing AC, and to transfer her to another doctor in another hospital.

Dr. M, much as she empathized with Dr. J, felt she could not acquiesce because AC had a right to continuity of care in "her" hospital and she, Dr. M, had a duty to treat. Dr. J asked Dr. M to only see AC on the day that he was out of the office, and this she did, until her schedule changed and the patient again began to attend on days when Dr. J was there. Dr. J had the hospital transcribe AC's phone messages on the grounds that they could contain threats. He contacted the hospital administrator to review the chart, which was done, and it was concluded that the patient's behaviour did not constitute a physical threat to Dr. J, much as it was annoying and distressing. As the behaviour continued, the hospital guards were told to escort AC off the floor whenever she knocked on Dr. J's door. The hospital administration wrote her an official letter emphasizing that she was not to go to Dr. J's side of the floor and, if found there, would be immediately escorted out.

Although she had no history of aggression or violence, and made no physical threats, Dr. J became increasingly uncomfortable with AC's romantic pursuit of him. He was substantially larger and stronger than AC and would have been at an advantage should a struggle have ever broken out. Nevertheless, he was anxious and insisted that pressure be applied to stop AC's harassing behaviour. Verbal pressure in the form of explaining cause and effect produced no appreciable effect on AC; indeed, it reinforced her preoccupation.

Ultimately, the hospital lawyers were called in and, in their view, Dr. J was being victimized by a stalker, with physical threat always implicit in such a situation. "Think," they wrote, "if the doctor were a relatively weak woman and the patient a relatively strong man. We cannot treat this case differently just because the sexes are reversed."

Numerous letters were written to AC telling her to stop and desist, or the hospital would be forced to take legal action. She was told she could only come to the hospital on certain days, could not go to Dr. J's floor (she was to meet with Dr. M on another floor at first; subsequently, since she did not obey the injunction against phone calls, she and Dr. M were told they would have to meet outside hospital grounds). Appeals to the administration and the lawyers (it was winter and meeting outside the hospital was logistically difficult) did not alter this decision. AC's telephone habits did not change. Technical ways of stopping calls from AC's number reaching Dr. J's voice box were judged too expensive to try. Finally, by administrative fiat, AC was transferred to another psychiatrist at another hospital. Dr. M was torn between her loyalty to her patient and her allegiance to her colleague and her hospital. The outcome for the patient was that she died of a cerebrovascular accident one month after transfer, an event probably unrelated

to the move. The outcome for Dr. M was that she was left with an unresolved ethical dilemma.

Ethical Issue

Staying with one's patient through difficult times is a central ethical obligation of physicians (Pellegrino, 1995; Quill & Cassel, 1995), particularly relevant to the care of the chronically mentally ill. The concept is related to the patient's right to continuity of care and to a hospital's mission of client-centered care, meaning that a patient's needs come first, above competing loyalties.

Nonabandonment means fulfilling one's duty to care (Clark, 2005), although a physician, as an autonomous agent, can ultimately decide whom to treat (Clark, 1996). Care is frequently withheld under various circumstances when, for instance, a patient's behaviour becomes intolerable to the physician – erotic transference, missed appointments, nonadherence to the therapeutic regimen, failure to pay fees. It happens when patients do not keep up their end of the patient-physician contract from which, as morally responsible agents, they are not exempt. (Draper & Sorell, 2002; Gauthier, 2005). But the judgment of how responsible patients must be is difficult to make in the case of psychiatric illness where behaviour may not be fully under the patient's control. The tendency would be to tolerate greater infractions of contract from the mentally ill and, therefore, for nonabandonment to be of special import to psychiatrists. (Groves, 1978; Lipsitt, 1997; Sharpe et al., 1994; Strous et al., 2006)

Patients, and not only mentally ill patients, may on occasion pose a direct threat to their care providers. The Canadian Medical Association (CMA), citing virtue ethics, the principle of beneficence, patients' rights, and the fiduciary contract between physicians and patients, is of the opinion that a professional duty to treat continues to exist even at times of substantial risk to the provider (during epidemics or bioterrorist attacks, for instance). (CMA, 2004) This opinion is shared by the American College of Physicians (ACP). (ACP, 2002) Sokol (2004), however, argues that, as human beings assuming a variety of moral obligations, healthcare professionals (and institutions) have responsibility to persons other than their patients. Depending on circumstances, they need to consider the well being of the wider population of the ill and the potentially ill as well as their obligations to their families and to themselves. (Dickens & Cook, 2006) From a utilitarian perspective, a decision would be ethically correct when it does the most good for the most people. (Robertson et al., 2007)

Clinical loyalties do sometimes have to be sacrificed for the greater good (Bloche, 1999; Toulmin, 1986), but being abandoned by one's doctor is not a trivial event for patients (Clarke et al., 2007; Sampson et al., 2004). When it comes to changing hospitals, the issue is even more complicated. Healthcare organizations have fiduciary duties of care to patients. In 1987, a physician discharged a patient from his hospital practice because the patient, who had kidney problems and additional substance abuse problems, verbally threatened the doctor and did not comply with recommended treatment. (Friedman, 2001) The patient sued the doctor for abandonment. Psychiatrists at the hospital were on the patient's side. The Department of Psychiatry filed an amicus curiae on behalf

of the patient. Ethicists and clergymen at the hospital also supported the patient. Their position was that no physician had a right to refuse treatment to a patient who required it. The New Orleans Fifth Circuit of Appeals, however, ruled in favour of the doctor. The judge concluded that requiring a doctor to provide treatment against his will violated his 13th Amendment rights against involuntary servitude. The court also ruled, however, that the medical center where the physician worked had to continue to provide treatment even if the physician did not. The justification for the decision against the medical center was that it was a federally funded institution and, as such, was required by the US Public Health Service Act to provide service to all patients residing in its jurisdiction.

More recently, however, the crime of stalking has emerged as a significant social problem. Restraining orders or protective injunctions are frequently advised because of the potential for violence, although that is more relevant to intimate partner stalking than to morbidly infatuated stalking which tends, on one hand, to be impervious to legal sanctions and, on the other, to be associated with a low incidence of violence. (Gentile et al., 2002; Hoffman & Sheridan, 2005; Kienlen et al., 1997; Mohandie et al., 2006; Mullen et al., 1999)

There is no question, in the case illustrated above, but that the subjective feelings of the physician victim had to be respected. His safety and freedom from harassment needed to be assured by as many means as possible: *arranging escort for the patient, blocking incoming telephones to the victim voice mail from the patient's telephone number, intensifying case management for the patient, and involving family members. Two recent articles (Galeazi et al., McIvor & Petch, 2006) advise healthcare organizations to adopt formal educational programs that help staff recognize stalking behaviour and to develop risk management strategies that consider the personal history of the patient involved in the stalking behaviour, and the best interests of that patient.*

Conclusion

If the safety of the victim can be assured, then it is not consistent with the principle of a physician's duty of care to abandon her patient. If a duty to treat exists in situations such as epidemics and bioterrorist attacks, then it also exists for patients who exhibit harassing behaviours, especially when these patients have little control over such behaviours.

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Ethical and Clinical Deliberations on Protecting Community Mental Health Outreach Workers from Second Hand Smoke

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ABSTRACT

In the Province of Ontario the right to work in a smoke-free work place was granted when the Smoke-Free Ontario Act was enacted May 31st, 2006 (Ontario Ministry of Health Promotion, 2007). Home health care workers have the right to ask a person not to smoke in their presence and can leave without providing further services, unless doing so would present an immediate, serious danger to the health of any person. While the Act may seem clear, employer guidelines informing home health care workers on how to provide a reasonable level of care to vulnerable and at risk clients in this new safety-focused culture are not. This paper analyzes a case study in which client and staff rights and responsibilities within the context of this legislation are reviewed. A real-life organizational solution triggered by the ethical dilemmas in the case scenario is presented.

Key Words: second hand smoke policies, community mental health

Background

If you are a community mental health outreach worker, you most certainly serve clients who smoke and likely encounter second hand smoke on a daily basis. Chronic exposure to second hand smoke may cause you some worry about the long-term effects on your health. However, there are no universal policies or procedures that definitively protect community outreach clinicians from second hand smoke. In the Province of Ontario the right to work in a smoke free work place was granted when the Smoke-Free Ontario Act was enacted May 31st, 2006 (Ontario Ministry of Health Promotion, 2007). In spite of this, mental health outreach workers still accept exposure to second hand smoke as an expected workplace hazard in the community. The Ontario government assumes that there are no safe levels of exposure. We have learned that more than 1,000 non-smokers are expected to die each year in Canada due to second hand smoke. This includes over 300 lung cancer deaths and at least 700 deaths from coronary heart disease (Makomaski-Illing and Kaiserman, 1999; De Groh and Morrison, 2002). As mental health professionals we are excellent at minimizing risk, creating safety plans and advocating for the rights of others. By extension, we also need to address the issue of exposure to second hand smoke in our community work settings and clearly outline the rights and responsibilities of outreach workers and their employers.

The Smoke-Free Ontario Act addresses the right to protection from second hand smoke in community or home settings as follows, "Home health care workers have the right to ask a person not to smoke in their presence while they are providing health care services. If anyone refuses the request, the home health care worker can leave without providing further services-unless doing so would present an immediate, serious danger to the health of any person." The Act also states, "Employers of home health care workers are advised to familiarize themselves with the rights and responsibilities of a worker who chooses to leave a client's home because someone refuses the worker's request to not smoke in their presence." Furthermore, "… the home health care worker must follow any guidelines provided by the employer that are reasonably aimed at ensuring the person to whom the health care services were being provided or were to be provided is kept safe and provided with a reasonable level of care." The responsibility of enforcing the Act is awarded to Local Public Health Units. It is the law that home health care workers must be protected from second hand smoke while at work, and this law is enforceable (Ontario Ministry of Health Promotion, 2006, pp.1-2).

While the Act may seem clear on the surface, employer guidelines informing home health care workers on how to provide a reasonable level of care in this new safety-focused culture are not. Most outreach programs lack policies and procedures to guide decision-making regarding this issue. Clearly this is an ethically charged debate; one that balances the rights of clinicians and the rights of clients to determine what they do in their own homes. Additionally, community mental health practitioners have a special obligation to care for clients who are often particularly vulnerable. Simply ending a visit because of second hand smoke exposure and abandoning a client in crisis, or at risk of harm, is not an option.

Case Study: Ben

Ben (a pseudonym) is a 43-year-old man who lives in a self-contained apartment, subsidized by a supportive housing agency governed by the Ontario Landlord and Tenant Act. He is served by an Assertive Community Treatment (ACT) Team, a homemaker who visits twice per week, housing staff from the supportive housing agency, and family members. Ben has a severe and persistent mental illness, and has very little insight about his illness and the need for treatment. Ben's mother is heavily involved with his care and she serves as the substitute decision maker for treatment decisions. She does not feel that the ACT team is providing sufficient care.

Ben is a very heavy smoker. His brother also smokes and visits Ben regularly while ACT Team members are present. Visiting him in his home has become increasingly difficult due to the high levels of second hand smoke that are a constant presence in his home. All the home health care workers are complaining of not being able to breathe in his apartment, being exposed to harmful toxins, and feeling ill when they visit him. In an effort to reduce the second hand smoke in Ben's apartment, the ACT team purchased an air purifier for his home, with funds provided by Ben's Public Guardian and Trustee. Ben also agreed to open his solitary window and not smoke when workers are present. Regardless of these efforts the team members complain that the apartment remains smoke filled.

Ben requires daily visits from ACT staff due to being on a Community Treatment Order (CTO). These visits ensure that he takes his oral medication. Without such treatment in the past his mental health status deteriorated quickly, resulting in numerous hospitalizations. Ben has voiced many times that he does not like his CTO, nor his daily visits and medications. Ben's workers often have to be quite assertive to gain entry to his home.

Daily entry to Ben's apartment has been very important in order to conduct risk assessments of his home environment. Ben's behaviours continue to pose a fire risk despite ongoing attempts to coach him regarding potential fire hazards. Ben often splices cords and wires with a kitchen knife. Tissues and paper towels cover Ben's countertop, where he smokes and keeps his ashtray. He does not remember to empty his ashtray and has to be prompted to do this daily. Also on the countertop is a hot plate that he frequently forgets to turn off or drapes with cords and plugs. He disassembled his fire alarm to prevent the continual annoyance of its sound.

In addition to these risks, Ben must be assisted in proper food handling procedures. He continually forgets to put food back in the fridge and it spoils. On occasion Ben has eaten the spoiled food and became ill. Food left out also attracts pests into Ben's apartment, and he is at risk of his apartment becoming infested. Ben must be assisted each day to throw out garbage that is scattered across the countertops in his kitchen and on top of his hot plate.

Ben's behaviours have been difficult to change; he is clearly an individual who is at high risk and requires intensive support. However, outreach workers are chronically exposed to high levels of second hand smoke which is at odds with their right not be exposed to second hand smoke in the workplace.

Process for Case Study Analysis

This case study was recently presented for discussion at an Ontario conference for ACT team clinicians. (Ontario ACCT Conference, Niagara Falls, 2008). Approximately 50 mental health clinicians attending the workshop were asked to analyze this case study and make recommendations for new organizational policies and procedures which could guide ACT clinicians on how to protect themselves from second hand smoke while providing a reasonable level of care. Participants were asked to analyze the case scenario using a number of different perspectives. They were also asked to brainstorm regarding ideas for practical program policies and procedures that would integrate the following:

1. Rights and responsibilities afforded to home health care workers within the Smoke-Free Ontario Act legislation.

2. The perspectives of various stakeholders, including the client, the family, the ACT team, and manager ("employer"). Where differences of opinion occurred, alternative dispute resolution or negotiation processes were recommended to attempt to craft outcomes to serve mutual interests.

3. Ethical principles that guide and govern health care provision (Garrett, Baillie and Garrett, 1993). Principles suggested included:

    a) Autonomy, focusing on the rights of individuals to self determination and rooted in society's respect for individuals' ability to make informed decisions about personal matters,

    b) Beneficence & Non-maleficence, focusing on the concepts 'Do good and Do no harm'. This involves making the best decision for the client from a professional perspective, while not harming him.

    c) Justice. This includes ensuring that policies and procedures are morally and ethically justifiable and conscionable.

    d) Duty to Care, focusing on the ACT team's professional obligation to provide care with watchfulness, attention, caution, and prudence, lest it be considered negligent.

    e) Duty to Protect, that is, protecting the client from the possible precipitation of harm despite the fact this may disrupt therapeutic alliance.

Table 1 Brainstorming Responses Generated at ACT forum

Client's Perspective

Insights Regarding the Dilemmas	Possible Solutions/Ideas for new Procedures
• This is my house, my rules, my autonomy and my right to smoke! • Smoking is my way of dealing with stress • Smoking helps with the symptoms of my illness • You're trying to control me by asking me not to smoke • All of my peers smoke, it's my social outlet • I have smoked a long time! • I've quit drinking. I've quit street drugs. Do I have to give up smoking too? • Smoking is all I have left in the world • Some of my community mental health workers smoke with me; some say they don't mind the second hand smoke • Some of my workers buy the cheap cigarettes for me, because I can't get them • My community mental health workers bring me cigarettes when I'm in hospital	• Wear a mask when you come to see me • We'll go out on the porch • I won't smoke when you are here, or I'll only smoke for five minutes • I'll open up the window/turn on the fan • Only send staff to visit me who don't care if I smoke • Take me out for a coffee if I don't smoke

The Family Perspective

• You're abandoning my son (when advised that team members may leave the apartment if it is too smoke filled) • It's your job/you get paid to go in his apartment • Are you singling my son out? • You must see him because he is on a CTO • I'm his substitute decision maker, he doesn't fully understand that his smoking is putting people at risk	• Meet my son outside of his apartment to get away from the smoke • Only meet my son at the door (although a risk assessment of his home environment can not be conducted using this alternative) • Family members can agree not to smoke during home visits, and encourage Ben not to smoke during visits as well • Put my son in the hospital/long term care-he is in too great a risk at his apartment

The ACT Team Perspective

• Team members have the right not to be exposed to second hand smoke but do have a duty to care • Team members have a responsibility to educate clients about the dangers of second hand smoke • Team members feel the dilemma of wanting to respect the client's choice, while balancing health needs of team members, and protecting health status of clients • Team members may have different views on second hand smoke • Is the client competent to make decisions about healthy life choices? Recognizing that while Ben is incompetent for general treatment decisions, the competence required to know smoking is harmful for self and others is relatively low – are there other angles we should address? • Do we have a duty to protect those who live around Ben in the same apartment complex from second hand smoke as well? • Is this the right kind of housing for the client? • Clients' homes in the community are definitely a work setting, but are they a true "workplace" as outlined in the Smoke-Free Ontario Act? • How much should we favour client-centered autonomy over a health centered-approach (beneficence) in order to preserve the fragile alliance with a low-insight client? • How do we define "risks"? Is second hand smoke generally considered a chronic (non-acute) risk and therefore a weak argument for withdrawing service?	• A team must have a consistent approach with each client, even if particular team members have different views about second hand smoke, the policies and procedures have to apply universally • A flexible case by case plan to reduce exposure to second hand smoke must be created • Fostering strong relationships with clients is key- if there is mutual respect, clients will respect our right to not be exposed to second hand smoke • Services may need to be provided in an alternative way that satisfies, if not completely, all concerned (e.g. take it outside or to other environments, reduce length of visits, etc.) • "Risks" may need to be hierarchically ordered for a more coherent and meaningful discussion and to help staff make judgment calls

The Manager ("Employer") Perspective

• How do I know the employee has followed obligations to provide care before terminating the home visit? • Are employees able to deny service when a client lives is a high risk situation? • Has an alternate plan for service been arranged if a staff member ends a visit early due to second hand smoke exposure? • Can some workers who don't mind smoke do the visits with clients who smoke? • Are workers able to refuse to do visits? • Can we change the hiring process and only hire smokers who don't mind the exposure to second hand smoke?	• Manager should consult legal counsel and seek the advice of an ethicist • Must consider if the individual is living in an environment that provides enough support as this could reduce the need for frequent outreach visits into smoky environments • Can ask Fire Marshall to attend client's home and enforce rules • Must foster sense of responsibility within the client to take ownership over this problem • We need to ensure a fair process where clients who smoke are not unduly punished due to counter-transference from clinicians • Advocacy may need to occur at the housing policy level to ensure safe environments • Is there a protective mask that staff can wear during high risk situations?

Discussion Outcomes

Many responses were generated in the brainstorming session. Participants proposed a range of hypothetical objections, opinions and other comments from each stakeholder perspective. This brainstorming assisted participants in developing new insights into the complexities of the dilemma and stirred creativity in finding solutions to guide policy and procedure development for outreach teams. Overall, empathy was expressed for the client's need for autonomy and control over his life, the need to preserve a positive therapeutic relationship with the client, and the importance of negotiation and "thinking outside the box" to address the safety needs of staff. Responses are listed in Table 1.

A Real-Life Organizational Solution Triggered by the Case Study

The case study of Ben represents a very typical scenario faced regularly by outreach workers in the St. Michael's Hospital Community Mental Health Service in Toronto. The Community Mental Health Service (CMHS) encompasses several outreach programs, including ACT, intensive case management (ICM) and early intervention (EI) for psychosis. The clients served by the CMHS experience serious mental illnesses, concurrent substance use issues, homelessness, complex medical conditions and legal issues. The teams routinely do outreach to shelters, boarding homes, private apartments and homes. Since the enactment of the Smoke-Free Ontario Act the teams have struggled with many issues already outlined in this discussion paper. The majority of their clients smoke, many are difficult to engage in service, and adherence to service plans can be sporadic. Many of the dilemmas and insights revealed at the ACT forum had already been identified and debated in staff meetings, clinical case conferences, etc.

In order to develop better guidelines on how to protect outreach clinicians from second hand smoke while providing a reasonable level of care, it was decided that a task force, with representatives from the different outreach teams, chaired by the Clinical Leader Manager of the service, should be developed to tackle the problem. The task force began its meetings in the fall of 2006.

Task Force Steps

Step One: Completing an Internal Scan

The first step was to identify the extent of the second hand smoke problem across the CMHS outreach programs. Clinicians agreed that unlike the younger, "first episode of psychosis" population, the older, longer term clients were more likely to smoke heavily. They were also more likely to have moved into their own apartments over time, due to receiving housing help from the teams. This resulted in living situations with greater autonomy for the clients, but also meant that these clients needed more daily support regarding routine activities of daily living, were less likely to have smoking rules imposed on them (as is the case in boarding homes or other joint living situations, for example), and there was greater chance for exposure to second hand smoke by staff.

The clinicians also agreed that most clients were agreeable to not smoking in the presence of staff or moving outdoors as necessary, although a small percentage (approximately 5%) of the clients found it very difficult to make changes, resulting in increased risk to staff. The story of Ben was one such example, although the circumstances described have been changed somewhat to protect the identity of the client.

Step Two: Completing an External Scan

During the spring of 2007 task force members called several community mental health and other community-based health services in the Greater Toronto Area to determine if any other agencies had developed practical guidelines regarding the issues being explored. At that time, no such policies or procedures were identified. The Clinical Leader Manager also raised the issue amongst Greater Toronto Area ACT teams and on an e-forum for provincial ACT teams and similarly found no work had been done in this area. Most ACT team leaders had not yet considered the implications of the Smoke-Free Ontario Act on their outreach workers.

A literature search was also completed by the team. Overall, there was very little literature related to protecting community workers from second hand smoke and how to develop guidelines to balance staff and client rights and responsibilities. Useful information was, however, received from British sources where nurses and city councils have begun work to protect community workers from second hand smoke (Royal College of Nursing, 2006; Dundee City Council, 2005; Dimond, 2003). A common theme in these resources was the use of decision trees to provide direction regarding the responsibilities of the staff and employers. The decision trees provided guidance in educating clients, informing clients of new smoke-free policies, assessing risk in community settings, and determining when it is appropriate for a community worker to leave a community setting due to second hand smoke.

Step Three: Consulting an Occupational Hygienist

The possibility of using safety equipment, safety masks in particular, had been raised on several occasions by staff. Some team members were familiar with the use of N95 masks during the SARS crisis in 2003 and were wondering if such masks could be worn when working in smoke-filled environments. A St. Michael's Hospital occupational hygienist was asked to serve as a consultant to the task force. Our occupational hygienist informed us that N95 masks were not sufficient and that large, cumbersome, expensive masks with filters would need to be worn to safely filter out the toxic elements of second hand smoke. Each mask would have to be fit-tested to individual staff members, filters would need to be replaced frequently, and staff would need to be screened for pregnancy, heart disease or claustrophobia before being cleared to wear the masks. Clearly these masks were not without their own risk. Furthermore they were flatly rejected by the task force due to the fact that they would interfere with the therapeutic relationship with clients.

Step Four: Consulting the Hospital Bioethicist

Most helpful in the task force process was the consultation provided by the hospital's bioethicist. After carefully reviewing the list of dilemmas faced by the outreach teams, the advice to the
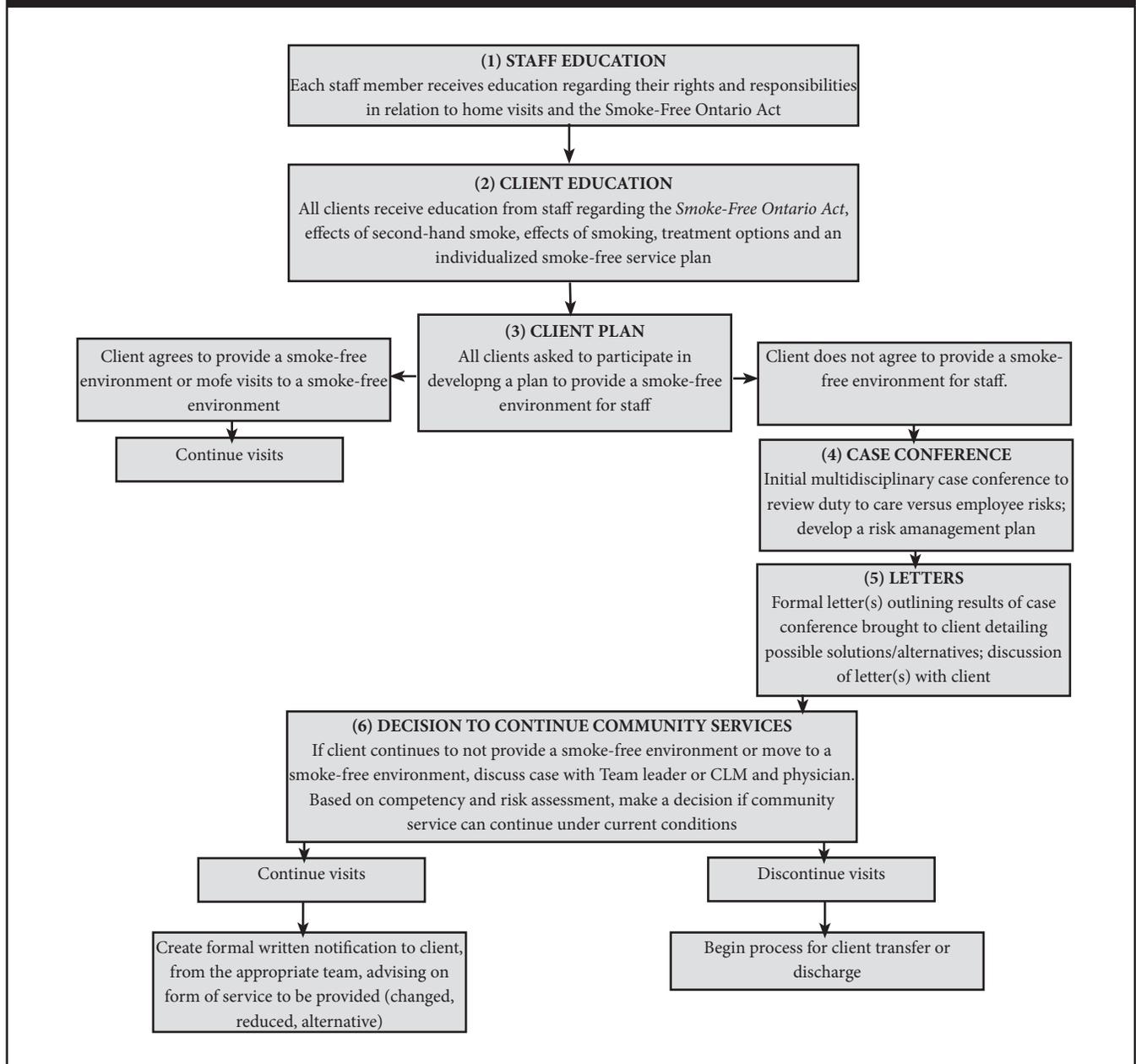
task force was:

1. To use a fair, open, inclusive and transparent process when establishing guidelines for the teams. This should include reviewing all the stakeholder perspectives.

2. To establish guidelines, which are practical, clear, fair and rationally justifiable. The guidelines should consider all the stakeholders' rights and responsibilities, the legislative requirements, human rights, professional standards of practice, duty to care, and duty to protect.

3. To ensure that our most vulnerable clients are not simply abandoned because we now have the right to refuse to be in a dwelling when clients continue to smoke, especially when we know or ought to have known, that a risk of serious harms might befall them in the absence of our interventions.

4. To first exhaust all lesser intrusive/invasive means of managing the situation and reconciling what might appear to be competing rights and interests. This includes an emphasis on negotiation, especially when one has a reasonable therapeutic alliance with the client.

5. To use creative and innovative techniques in navigating "risky" situations with discretion and good judgment.

6. To use team-driven versus individually-driven processes to assist with decisions and judgment calls. These processes should be clear and coherent.

FIGURE 1: SECOND HAND SMOKE EXPOSURE: DECISION TREE FOR HOME VISIT SERVICE PROVISION PLANS

(1) STAFF EDUCATION
Each staff member receives education regarding their rights and responsibilities in relation to home visits and the Smoke-Free Ontario Act

(2) CLIENT EDUCATION
All clients receive education from staff regarding the *Smoke-Free Ontario Act*, effects of second-hand smoke, effects of smoking, treatment options and an individualized smoke-free service plan

(3) CLIENT PLAN
All clients asked to participate in developng a plan to provide a smoke-free environment for staff

Client agrees to provide a smoke-free environment or mofe visits to a smoke-free environment

Continue visits

Client does not agree to provide a smoke-free environment for staff.

(4) CASE CONFERENCE
Initial multidisciplinary case conference to review duty to care versus employee risks; develop a risk amanagement plan

(5) LETTERS
Formal letter(s) outlining results of case conference brought to client detailing possible solutions/alternatives; discussion of letter(s) with client

(6) DECISION TO CONTINUE COMMUNITY SERVICES
If client continues to not provide a smoke-free environment or move to a smoke-free environment, discuss case with Team leader or CLM and physician. Based on competency and risk assessment, make a decision if community service can continue under current conditions

Continue visits

Discontinue visits

Create formal written notification to client, from the appropriate team, advising on form of service to be provided (changed, reduced, alternative)

Begin process for client transfer or discharge

Step Five: Developing New Guidelines for Staff

Using the aforementioned suggestions, the task force then took on the job of developing a policy and procedure document to offer clear guidelines for staff.   Procedures identified by the task force focused mainly on:

1. An education campaign to ensure that all outreach workers are clear about their rights and responsibilities in relation to the Smoke-Free Ontario Act.

2. An education campaign for clients receiving CMHS services. This involved developing an information package to be reviewed with each client.

3. Developing individualized client plans to facilitate a smoke free environment for visiting staff. Client engagement and creativity were encouraged to negotiate strategies, such as use of alternative visit sites, asking family members not to smoke, ventilating the apartment prior to a visit, use of nicotine replacement therapies, etc.

4. Initiating case conferences to develop plans for clients who do not provide a smoke-free environment for staff. This includes a multidisciplinary team discussion to ensure that all factors, including general competence, level of risk, client concerns, etc. are considered in the plan. All attempts should be made to individualize the plan and brainstorm regarding creative solutions. The policy advises that only after several attempts have been made to negotiate with a non-adherent client, and only if he is low risk and competent, could a team decision be made to withdraw service due to the risks of second hand smoke. In such a scenario, alternative services may need to be arranged for the client (e.g. clinic visits where staff members do not enter the private home).
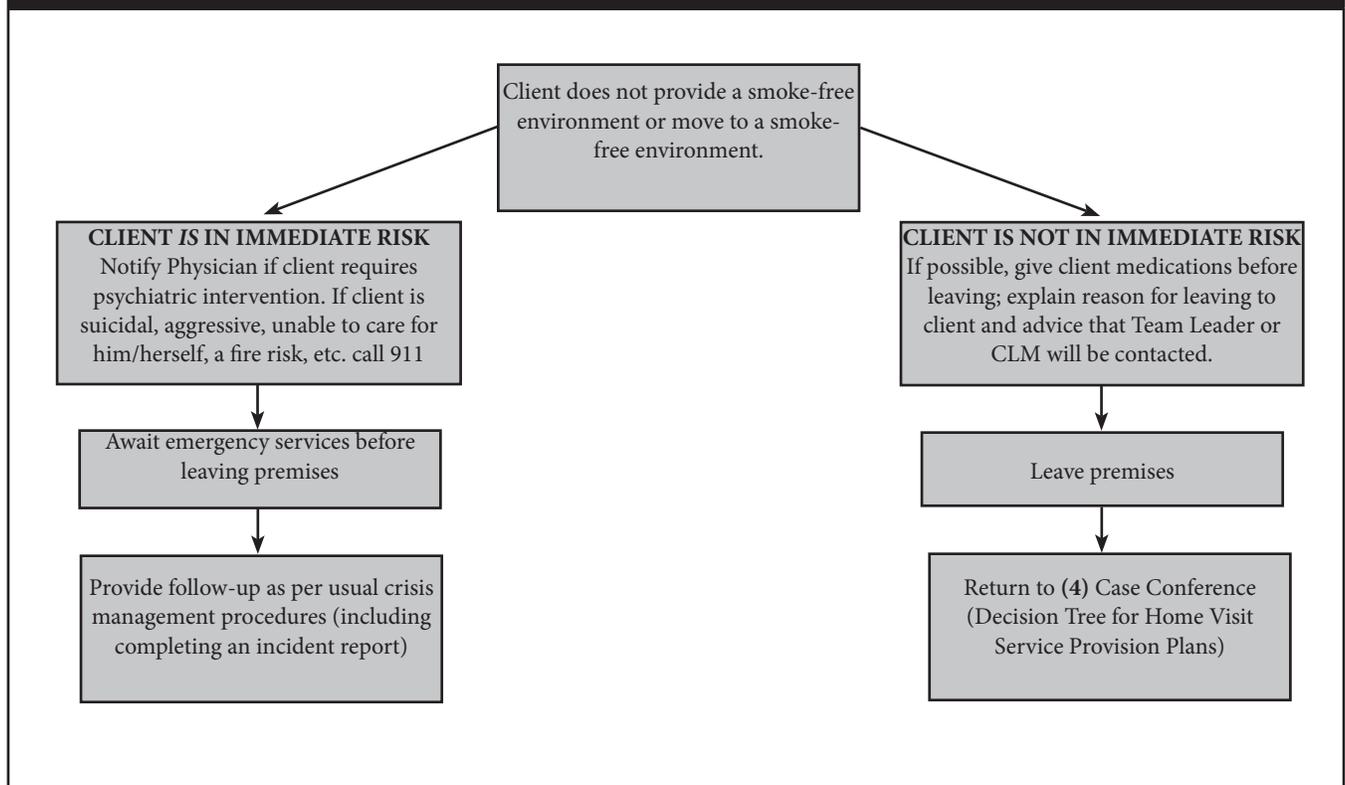
5. Developing decision trees to clearly guide decisions in managing home visits for clients who do not provide a smoke-free environment. These decision trees were designed to help navigate situations in which clients are not in immediate risk and in immediate risk. Samples of the decision trees are provided in Figures 1 and 2.

Step Six: Developing a Smoking Cessation Program for Clients

Lastly, the task force believed it was the responsibility of the CMHS to provide support and treatment options to clients who want help with reducing or quitting their smoking. Clients were provided with information on the effects of smoking and second hand smoke. People were offered information and free access to nicotine replacement therapy, and other smoking cessation aids.

Individuals were given information on how to contact the Smoker's Helpline, the Nicotine Dependence Clinic at the Centre for Addiction and Mental Health in Toronto, and other local community smoking cessation groups. A smoking cessation group was also created and facilitated by CMHS staff. This group provides counseling, assistance, education and support for clients who wish to reduce or quit smoking.

FIGURE 2 SECOND HAND SMOKE EXPOSURE: DECISION TREE FOR TERMINATING HOME VISITS

Client does not provide a smoke-free environment or move to a smoke-free environment.

CLIENT IS IN IMMEDIATE RISK
Notify Physician if client requires psychiatric intervention. If client is suicidal, aggressive, unable to care for him/herself, a fire risk, etc. call 911

Await emergency services before leaving premises

Provide follow-up as per usual crisis management procedures (including completing an incident report)

CLIENT IS NOT IN IMMEDIATE RISK
If possible, give client medications before leaving; explain reason for leaving to client and advice that Team Leader or CLM will be contacted.

Leave premises

Return to **(4)** Case Conference (Decision Tree for Home Visit Service Provision Plans)

The Real-Life Case Outcome

As per the policy of Ben's supportive housing agency, his apartment was inspected bi-annually by the Fire Marshall. Upon the Fire Marshall's last visit Ben was issued a warning to keep his fire alarm connected, or he could face eviction. Six months later when the Fire Marshall visited again he found that Ben had in fact disabled his fire alarm. Ben was issued an eviction notice from the Fire Marshall, and the ACT team moved him into a boarding home. Ben has been successful in adapting his smoking behavior so that he now smokes outside, as is the policy at his new residence.

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EDITOR'S NOTE:

Smoking clearly is an important issue for consumers of mental health services as well as mental health practitioners and service providers. There are significant social, political, cultural and health effects associated with smoking and, most critically, ethical considerations. JEMH invites readers from around the world to comment or submit their views, experiences and perspectives on these important tobacco issues.

Pharmacists Prescribing Psychotropic Medications:

Is This Really a Good Idea?

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Abstract

Legislation enabling pharmacists to prescribe is being drafted and passed in Canada and internationally. But is it a good idea for pharmacists to be prescribing psychotropic medications? In this discussion, the term "pharmacist prescribing" is defined, the issues of the potential conflict of interest of pharmacists discussed, and the education and training of pharmacists reviewed. Finally, an experienced psychiatrist weighs in on the discussion with a personal reflection on this important discussion, concluding that "we should move forward cautiously but in a spirit of collaboration, mutual respect and above all in the best interests of the patient."

Key words: prescribing, pharmacist, conflict of interest, psychiatrist

While Canada's provinces are at slightly different stages in the evolution of the pharmacy profession, there is one consistent trend – pharmacists' important contribution to the health care system is being recognized. In an environment where all health human resources are needed to practice to the full extent of their training, pharmacists are being asked, and are asking for the legislative changes to prescribe medication. Some groups have voiced their concerns over pharmacists having the right to prescribe.(Kondro, 2007) Here four authors, a policy and research director, two pharmacists with advanced clinical training, and a senior psychiatrist, contribute to this honest discussion regarding pharmacists prescribing.

If we assume for one moment that the concerns regarding pharmacists prescribing are not based on so called "turf-wars" between professional groups, then what arguments remain? Some point to the 'inherent' conflict of interest between pharmacists prescribing and their dispensing duties. What are the safeguards against conflict of interest for pharmacists and the other health care professions? Others question whether pharmacists have the necessary education and skills to prescribe medications. What training do pharmacists receive and what do they need for the role as prescriber? These questions are answered in this discussion. Finally an experienced and respected psychiatrist weighs in on this discussion and provides a different perspective.

Most important to any discussion is defining the topic at hand; what are the activities and responsibilities of prescribing pharmacists in Canada?

Pharmacists have been prescribing in Canada for decades. Every time a patient approaches a pharmacist for a recommendation for a medicine for a minor ailment, whether a cold, minor pain, or heartburn, the pharmacist is engaged in prescribing. In these cases, the pharmacist will discuss the symptoms with the patient and make a recommendation either to seek medical advice or to use a medicine that can be accessed without a prescription. This recommendation, in essence, is a prescription.

Every day across Canada, patients with chronic or recurrent conditions, such as hypertension, depression, and dyslipidemia are in a position where the refill authorizations for their medications have run out. For many reasons, some patient-related and some physician-related, a patient may face a delay before they can "legally" refill their prescription. Pharmacists will often provide a temporary supply to these patients rather than letting the patient go without his medication temporarily. Many pharmacists have been doing this for years, though contrary to provincial and federal health

regulations, in an effort to ensure good pharmaceutical care and to avoid unnecessary use of walk-in clinics and emergency/urgent care services. A number of provinces have taken the steps of making this type of stop gap measure legal by granting the pharmacist the authority to provide a "continued care prescription."

Going one step further, the province of Alberta has granted pharmacists the right to prescribe "independently" provided they meet certain defined criteria. It is the first jurisdiction in Canada to take this step. While the act of prescribing would be undertaken independently by pharmacists who have qualified for this level of authority, pharmacists in Alberta do not have the authority to make a diagnosis. The diagnosis must come from another health-care provider who is authorized to diagnose. In the case of mental health, no pharmacist will be starting or adjusting antidepressants, anxiolytics or antipsychotics without a documented diagnosis from a qualified prescriber. Upon receipt of a diagnosis, however, a pharmacist can make the decision about which medication to use. Ideally, this would occur in close collaboration with the diagnostician and other health care providers. This type of arrangement is often seen currently in hospital and in some clinic practices in which clinical pharmacists are well established members of the patient care team.

In other provinces, such as Quebec, the authority to prescribe is delegated to a pharmacist from a physician through legislation. In Ontario, pharmacists can enter into an agreement known as a medical directive that outlines, in detail, for whom the pharmacist can prescribe, what they can prescribe and under what circumstances. This type of dependent prescriptive authority has existed in institutional settings for some time.

On the international front, pharmacists in the United Kingdom have had supplementary prescriptive authority since 2003 and independent prescriptive authority since 2006. For both supplementary and independent prescriptive authority, pharmacists must qualify following criteria laid out by their regulatory authority (Guillaume et al., 2008). This is similar to the situation in Canada where prescriptive authority is granted only after a pharmacist meets the criteria set out by the provincial regulatory authority.

For pharmacists, the concept of "prescribing" differs from the medical concept of prescribing. It is one part of a continuum of activities involved in providing care to a patient. Prescriptive authority provides the pharmacist with the ability to legally take steps to ensure patients are able to continue their therapy and to work with other providers to address problems with medications. But is there an inherent conflict of interest for pharmacists prescribing?

What are the Safeguards Against Conflict of Interest for Pharmacists and Other Health Care Professionals?

There are a number of self-regulated health professions in Canada. In Ontario there are 23 health professions, and 21 Colleges legislated under the *Regulated Health Professions Act* (October 1999). These colleges, among other responsibilities, are accountable for "developing and maintaining standards of professional practice, knowledge, skill and professional ethics for its members."(OAHAI, 1999) It can easily be argued that the members of most of these self-regulated professions could be in positions of conflict of inter-

est. These health professions are constantly placed in positions of confidence with patients; many will recommend health care services to their patients for which they may be remunerated. Examples of these health professions include: audiologists, chiropodists, chiropractors, dental hygienists, dental surgeons, denturists, dieticians, massage therapists, optometrists, occupational therapists, opticians, physicians and surgeons, physiotherapists, and psychologists.

What prevents these health professionals from abusing their relationship with patients and charging or recommending unnecessary treatment or services? One might argue that the health professions attract noble individuals, but we have seen some unfortunate instances of abuse in all professions. In reality, the large majority of health care professionals are just that; professionals who are concerned with the best interest of their patients. In rare circumstances when health professionals are not acting in the best interest of the patient, regulatory authorities have processes to investigate complaints and suspend licenses.

Each regulatory authority has a code of ethics with principles and standards of practice that prevent their members form abusing their power when they might be placed in a position of conflict of interest. For the purpose of this discussion the codes of ethics and/or professional regulations of four health care professions will be compared – dentists, psychiatrists, physicians and pharmacists.

First, each code of ethics (Table 1) emphasizes the responsibility to uphold the interest of the patient before all else. In the case of psychologists (not included in Table 1), they go beyond and indicate that when principles conflict, that the respect for the dignity of patients should be given the greatest weight. "This principle, with its emphasis on moral rights, generally should be given the highest weight, except in circumstances in which there is a clear and imminent danger to the physical safety of any person."(Canadian Psychological Association, 2000) Pharmacists also hold the interest of patients before all else. "Principle I: A pharmacist holds the health and safety of each client to be the primary consideration."(Alberta College of Pharmacists, undated)

As these professionals may find themselves in positions of conflict of interest, codes of ethics have clauses by which their members must abide (Table 1). These codes call for a full disclosure to patients regarding their conflict, and benefits and risks of treatment; all the while, keeping the interest of patients at the forefront. In the case of pharmacists, they should not place themselves in positions, either through employment or through the acceptance of inducements, where they will not be able to act in the best interest of patients. In addition to these principles and guidelines, in the pharmacy business there are restrictions on who may own and manage pharmacies. In every province, but Manitoba, pharmacies must be managed by a pharmacist. In Ontario and Quebec, pharmacies must also be owned by a pharmacist or pharmacist partnership. These pharmacists are obligated to abide by their College's code of ethics and regulations (Competition Bureau, 2007). In Alberta, the first province to enact legislation permitting pharmacists to prescribe, The Alberta College of Pharmacists has added Standard 15 to the *Health Professions Act, Standards for Pharmacist Practice*. This regulation prevents pharmacy prescribers from dispensing medications, except in rare circumstances when it is in the best interest of the patient.

TABLE 1:			
	Interest of the patient before all else	**Conflict of Interest**	**Exceed their comfort level or skills**
Dentists	The Canadian Dental Association enumerates its responsibilities to patients, in Article1: service_"As a primary health care provider, a dentist's first responsibility is to the patient. As such, the competent and timely of quality care within the bounds of clinical circumstances presented by the patient, shall be the most important aspect of that responsibility."(Canadian Dental Association, 1997)	Dentists have a number of clauses that address the potential conflict of interest, including: "Article 8: "A dentist must discuss with the patient treatment recommendations including benefits, prognosis and risks, reasonable alternatives and associated costs to allow the patient to make an informed choice. A dentist shall inform the patient is the proposed oral health care involves treatment techniques or products which are not in general recognized or accepted by the dental profession."(Canadian Dental Association, 1997)	The Canadian Dental Association guides their members with Article 3: Consultation and Referral "Dentist shall provide treatment only when qualified by training or experience; otherwise a consultation and/or referral to an appropriate practioner is warranted."(Canadian Dental Association, 1997)
Physicians	The Canadian Medical Association's number one fundamental responsibility is "1. Consider first the well-being of the patient."(Canadian Medical Association, 2004)	The Canadian Medical Association include in their codes of ethics: "11. Recognize and disclose conflicts of interest that arise in the course of your professional duties and activities, and resolve them in the best interest of patients."(Canadian Medical Association, 2004) "13. Do not exploit patients for personal advantage."(Canadian Medical Association, 2004)	The Canadian Medical Association include in their codes of ethics: "15. Recognize your limitations and, when indicated, recommend or seek additional opinions and services."(Canadian Medical Association, 2004)
Psychiatrists	Psychiatrists regard their responsibilities to the patient as primordial "1. Consider first the well-being of the patient."(Neilson, 2002)	Psychiatrists have a clause in their code of ethics, "2. Treat all patients with respect; do not exploit them for personal advantage, whether physical, sexual, emotional, religious or financial, or for any other reason."(Neilson, 2002)	Psychiatrists also have a similar clause in their code of ethics: "6. Recognize your limitations and the competence of others, and whose indicated, recommend that additional opinions and services be sought."(Neilson, 2002)
Pharmacists	Pharmacists also hold the interest of patients before all else. "Principle I: A pharmacist holds the health and safety of each client to be the primary consideration."(Alberta College of Pharmacists, undated)	The Alberta pharmacists have two overarching principles with guidelines that address conflict of interest, "Principle VI: A pharmacist acts with honesty and integrity, and Principle VII: A pharmacist preserves high professional standards."(Alberta College of Pharmacists, undated) Guidelines under these principles include: "Pharmacists do not accept inducements from a supplier of drugs, non-prescription medications or health related products that could reasonably be perceived to affect the pharmacists' independent professional judgement in the provision of these items to clients." "Pharmacists must be free to exercise professional judgement when carrying out the duties of the pharmacist and should not accept employment under conditions where this freedom may be compromised." (Alberta College of Pharmacists, undated)	Pharmacists, like other professionals, have a similar principle in their code of ethics. "Principle Two: Each member exercises professional judgment in the best interest of the patient, at a level consistent with his or her scope of practice to ensure that patients needs are met."(Ontario College of Pharmacists, 2006) The Alberta College of Pharmacists offers a comparable guideline for their members: "Pharmacists are aware of the limitations of their knowledge and expertise. When their level of professional ability is not able to meet the level of care expected, they refer clients to appropriate health care professionals."(Alberta College of Pharmacists, undated)

TABLE 2: CORE CURRICULAR COMPONENTS FOR A BACCALAUREATE IN PHARMACY	
Basic health sciences	Anatomy, biochemistry, immunology, microbiology, molecular and cell biology, physiology, and pathophysiology
Pharmaceutical sciences	Medicinal chemistry, pharmacology, toxicology, pharmaceutics, biopharmaceutics, pharmacokinetics and pharmaceutical biotechnology
Behavioural, social, and administrative pharmacy sciences	Biostatistics, epidemiology, health care economics, pharmacoeconomics, the profession of pharmacy, ethical and professional standards of practice, cultural diversity, healthcare systems, business and practice management
Pharmacy practice	Clinical pharmacokinetics, collaborative drug therapy, management, complementary and alternative medicines, compounding, diagnostic and point-of-care testing, disease state management, dispensing and prescription processing, drug abuse and dependency, drug information including drug literature evaluation, drugs in pregnancy, emergency first care, evidence-based decision making, geriatrics, health promotion and disease prevention, immunization, information technology practice support tools, medication administration, nutrition, pediatrics, patient assessment and outcomes monitoring, patient and professional communications, patient records and documentation of care, pharmacy law and regulatory issues, pharmacotherapeutics, physical assessment, prescriptive authority, and self care/non-prescription drug use

"Standard 15 – Separation of prescribing and dispensing"
15. A pharmacist who prescribes a drug or blood product based on the pharmacist's assessment of the patient under section 16.4(a) of the Pharmacists Profession Regulation must have the drug dispensed by another pharmacist unless:
(a) the pharmacist is satisfied that adhering to this standard will compromise the health of the patient, or
(b) the patient chooses to have the pharmacist dispense the drug."(Alberta College of Pharmacists, 2007)

Despite these precautions, some may fear that pharmacists will find themselves in a position to offer services that exceed their training. It is conceivable that any health practitioner may find themselves in a position to offer services that exceed their comfort level or skills. Codes of ethics of each of these professions have planned for this eventuality and developed clauses to protect patients (Table 1). Professionals are called to recognize their limitations and refer their patients to, or consult with, other qualified professionals. But do pharmacists have the training required to prescribe medication?

What Training Do Pharmacists Receive?

In Canada, the minimum requirement for licensure as a pharmacist is a baccalaureate degree in Pharmacy. A small proportion of graduates go on to complete advanced clinical training such as the 1-year intensive hospital pharmacy residency or the 2-year post-graduate Doctor of Pharmacy degree. An increasing number of practicing pharmacists are completing advanced clinical training through several different non-traditional Doctor of Pharmacy programs.

The primary aim of pharmacist prescribing is to support seamless patient access to necessary medications, prescription or otherwise.

It is not to supplant the physician as the primary diagnostician and prescriber in our health care system. A recent UK analysis of pharmacist prescribing attenuates these concerns. Pharmacists contributed 0.004% of all prescribing in 2006, three years after prescribing privileges were granted.(Guillaume et al., 2008) The credentialing and competencies required by pharmacists for this prescribing role should not aim to mimic the training of physicians. The core curricular components required by all Canadian pharmacy programs, established by the Canadian Council for Accreditation of Pharmacy Programs (CCAPP), are summarized in Table 2 (Canadian Council for Accreditation of Pharmacy Programs, 2006). There is no doubt or debate that upon licensure pharmacists are the most extensively trained health professionals with respect to the safe and effective use of medicines by patients. However, most traditional pharmacy positions (e.g., community retail pharmacy) do not provide the opportunity for pharmacists to apply the broad range of their abilities on a regular basis. Other pharmacists, many who work in clinical positions in hospitals or the few that can be found in family practice clinics, regularly take a lead role in the selection and monitoring of prescription medications. In these environments pharmacists are established collaborating members of the health care team and their complete skill set is applied on a daily basis.

The need to update pharmacists' credentials and competencies before bestowing them with prescribing privileges depends on the type of prescribing activities in which the pharmacist wishes to be involved. In most cases, when basic prescribing privileges are sought, for example the ability to provide continuing care prescriptions, no new training is required. However, for other types of prescribing, for example, dependent and independent prescribing authority, the pharmacist needs to demonstrate competency through a process established by the regulatory body of the respective province. Suggested competency requirements are outlined briefly in Table 3.

Given this background information, defining of the stages of phar-

Table 3: Suggested competency requirements for pharmacist prescribers	
Prescribing level	**Competency requirements**
Basic	Continuing care prescribing: The current level of training and competency are sufficient for supporting continuing care pharmacist prescribing activities.
Advanced	Dependent (collaborative) and independent prescribing: The pharmacist must demonstrate competency in prescribing, pharmacotherapeutic knowledge, and patient monitoring. Abilities and knowledge are to be demonstrated in how to safely and effectively select, initiate, continue, switch, combine, and stop medications. Competency standards and assessments will be established by each province. Whether acting as a dependent or independent prescriber, pharmacist prescribing can only occur when a diagnosis has been made and communicated by an individual with the authority to make diagnoses (e.g., physicians, nurse practitioners, dentists).

macists' prescribing in Canada and abroad, reviewing the codes of ethics of self-regulated health professionals, and outlining the education and training of pharmacists, we ask an experienced and respected psychiatrist to comment on the original question: "Pharmacists prescribing psychotropic medications: is this really a good idea?"

A Psychiatrist's Perspective

Kenneth I. Shulman, MD, SM, FRCPsych, FRCPC

I write from the personal perspective of a geriatric psychiatrist who has worked in an academic health science centre for almost 30 years. Let me declare my bias at the outset. I have worked with an outstanding group of hospital-based pharmacists whose pharmacological knowledge I have come to respect and indeed to rely on. In the course of my practice I have also had interactions with numerous community-based pharmacists.

The issue of pharmacist prescribing is one that has gained traction in many parts of the world including Canada (Alberta and Quebec) and the UK, thus giving pharmacists more 'autonomy'. It is rightly noted above that "pharmacists have been prescribing in Canada for decades". This of course relates to over-the-counter medicines and 'continued care prescriptions' which provide temporary supplies for patients in order to avoid being without their medications. However, the value of this discussion is really to determine whether we can enhance health care, including mental health care, by giving pharmacists more autonomy than they currently enjoy while providing the safeguards described in the sections related to conflict of interest and adequacy of training.

I will not address the issue raised by the Canadian Medical Association related to physicians as clinical leaders of the team but rather focus on the potential added value that a pharmacist can bring to the health care team. The expertise that I have sought from pharmacists has been related to their knowledge of drug interactions, side-effect profiles and dosing. In an older population, the pharmacist generally has better knowledge than psychiatrists

about medical drugs and their potential interactions with psychotropic agents.

There appears to be a misconception that pharmacist prescribing is identical to that of physician prescribing. Based on the discussions in this paper, it is proposed that pharmacists act in a collaborative fashion even with so-called 'autonomy'. It is absolutely clear that a diagnosis must be established before any prescribing is done. Diagnosis is best done by a physician who is responsible for taking a complete history which includes a past history of medication use, psychiatric illness, family history as well as assessment of suicide risk. These are important factors in determining drug choice as well as drug quantities dispensed. Pharmacists are generally not privy to that information unless it is communicated by a psychiatrist. This in turn raises the issue of communication within the health care team. I have much less concern about pharmacists prescribing on a continuum from medical directive to 'independent' prescribing as long as there is excellent communication between the physician, the pharmacist and other members of the health care team. This highlights the importance and urgency of implementing an electronic health record which all members of the health care team can access. This would provide the transparent method of decision-making and communication suggested above.

Another related issue is one of access to general practitioners and psychiatrists which is a problem throughout the country. If pharmacist prescribing gives patients better access to care with appropriate safeguards then this should improve medical and psychiatric care. Physicians with a good communication system can 'oversee' pharmacist prescribing as long as they receive notification of any drug changes, dosage changes or initiation of drugs in conjunction with access to lab results. The patient then has the option of accessing their pharmacist or general practitioner as long as the changes are overseen by the treating psychiatrist or family physician.

The shift towards pharmacist prescribing would best be done cautiously and in a graduated fashion including clear safeguards. This appears to have been the case in the UK and in Alberta where

safeguards have been put in place with respect to pharmacists who are qualified to prescribe in a specified manner. Careful monitoring of this experience is essential to determine whether this development provides an improved quality of care as is hoped or whether significant concerns emerge. My own inclination would be to start with pharmacists working in collaborative health care teams where the roles and responsibilities have been established and communication among team members is ongoing. Once we have some comfort with that level of autonomy, one could then proceed with a graduated extension of those privileges as deemed appropriate. A limiting factor for pharmacists may be the liability associated with more independent prescribing.

Overall, we should welcome this initiative by our pharmacist colleagues. Clearly, we do need to provide safeguards for patients but the pharmacological expertise in the pharmacist profession should be harnessed for the benefit of our patients. Based on the arguments put forward by my colleagues in this opinion piece, I do believe that we should move forward cautiously but in a spirit of collaboration, mutual respect and above all in the best interests of the patient.

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Ethics in Peer Support Work

Kate Story, Tanya Shute, Ann Thompson

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Our society's self congratulatory belief that we are free thinking, compassionate and fair people, who hold all citizens equal and worthy, must be challenged. This is especially so regarding our attitudes toward people who have experienced mental health or substance abuse problems. Our society in general, and our clinical systems in particular, consider people with mental health problems or substance abuse as diseased, disordered and disabled – despite that these labels are social constructions that perpetuate pessimism, segregation and discrimination. Being identified as defective, by one's own self as well as by others, and the inherent discrimination associated with "mental illness" or "addiction" blocks recovery for people and affects engagement with services that could support wellness.

Our social systems, primarily conventional clinical services, are intended to support improvements for people in their care; they are intended to reduce symptoms and change quality of life, yet many people still resist engaging with services and many people also describe dissatisfaction with the level of autonomy and support they experience. Similarly, discrimination, in its many forms, including erosion of identity and extinguished hope, as well as compromised access to housing, employment and education, blocks engagement with services and not only frustrates recovery but blinds people to the possibility of recovery (Sky, 2007).

Advocacy by people dissatisfied with their experience in conventional services (Deegan, 1996; Everett, 2000; Storey, 2007; Tosh, Ralph & Campbell, 2000; Valentine, 1989) and awareness regarding the effects of discrimination experienced by people affected by mental health and substance abuse issues has increased the interest in understanding lived experience more fully, and to advance an agenda of recovery. Transforming a system to a recovery orientation requires willingness to critique and reform the availability, appropriateness and effectiveness of existing services… and this willingness is emerging! However, despite a willingness to explore and propose strategies to re-orient clinical services (Social Care Institute for Excellence, 2007), philosophic tensions remain between people living with mental health and substance abuse problems and researchers, clinicians and policy makers.

People living with mental health and substance abuse problems, and people in recovery[1], want social inclusion. They want environmental necessities and comforts. And they want to transform their own journey to wellness, and to ease the journeys of their peers. Researchers, clinicians and policy makers live a different experience. They require definitive and measurable criteria for recovery outcomes, and they strive to identify and utilize *best* practices to guide their practice. Again, professional, clinical services try to support improvements for people in their care and they hope to reduce symptoms and change quality of life – yet a categorical focus on clinical performance sustains a power base that a recovery philosophy hopes to up-end.

Although mental health services have reformed over time and are more inclusive, the power to restrict liberty and negatively affect identity and esteem remains, and casts a shadow that obscures trust and engagement for people who want to, or who are forced to receive services (Sky, 2007). More recently, peer support services, provided by people with personal experience, are recognized as a critical component for recovery, recognizing the equity and mutuality of partnership relationships, and supporting a recovery agenda; but full commitment to recovery is elusive.

The word *recovery* itself is problematic. It is used in medicine to describe a *cure* or the absence of symptoms related to a diagnosis. A person has recovered when he or she reaches the endpoint along the illness continuum, and they are no longer ill. For instance, when my gall bladder is removed, and my body adapts to the changes in diet, I have recovered from my gall bladder disorder or illness. Recovery, from the medical/clinical perspective is defined as the *progression* from illness to cure or when a person responds to treatment with positive outcomes (Jacobson, 2004). The science of "problem – treatment – effect" underpins the conventional

clinical model of service. In this model, recovery is the outcome of effort invested by clinicians toward their patients, or clients, to advance their progression along the illness or disability continuum. Notwithstanding that this approach is preferred for acute physical distress, such as my defective gall bladder, it pales in the face of the complex issues and conditions that frame a psychiatric diagnosis.

From the conventional clinical perspective, the fundamental assumption for entry into formal mental health services is that the person has a *problem* and the problem requires intervention to effect positive outcome. Problems are classified using a system of diagnoses that emerge through comprehensive psychiatric or psychological assessment that identifies and categorizes symptoms and deficits demonstrated by the person. A problem-orientation is not damning in and of itself; we all have problems we hope to resolve.

The critique of a problem-orientation rests not only in the singular logic of its design, "problem – treatment – effect", but in its intended or unintended personal attribution of responsibility toward the person with the problem – for instance, the experiences of trauma and poverty affect mental health but the diagnostic logic of the problem orientation shifts responsibility (frequently read as blame) to the person affected. When the problem is long-standing, it is enshrined as a disability and optimism that the person will progress to the far end of the continuum is extinguished. With this belief, conventional service providers are haunted by *guarded hope*.

On the other hand, a new understanding of recovery is emerging that appreciates the perspective of people with lived experience, especially the experience of "consuming" services. For people advocating from this perspective, the word recovery explains the longitudinal process of transformation to wellness. Recovery by its nature resists classification as either outcome or evidence based (Deegan, 1996). In this perspective, recovery apprehends the complex and multidimensional realities and violations inherent in the social and personal conditions that lead to the challenges to mental health. People in recovery are re-claiming the word "recovery" to properly articulate how they wish to engage with services and supports – or not.

Perceiving recovery as a process or a journey, rather than an outcome, is a significant deviation in the appreciation of the meanings ascribed by people *in recovery* compared to people providing clinical services. In her book, *In Recovery*, Nora Jacobson chronicles the design and development of a recovery-oriented system of service in that began in Wisconsin about ten years ago. Her narrative profiles the tensions related to disparities in understanding and appreciating the perceptions of recovery between people in recovery and people who had to re-orient their services to be consistent with the values and principles of recovery (Jacobson, 2004).

Without reiterating this excellent review, it is fair to summarize that although recovery as a framework for *respectful care* has positively influenced plans and designs of mental health systems, it was, and remains, a contested field. Mental health and addiction services are social services. As social structures, services reflect or parallel culture (Stark, 1971; Foucault, 1980; Foucault, 1988). So, to change both service perspective and practice requires the introduction and commitment to an alternative discourse regarding cultural

identification, engagement, relationships and outcomes. Changing perspective and practice requires a culture shift: building a *Culture of Recovery*.

The *Building a Culture of Recovery Project (www.cultureofrecovery. org)* is a comprehensive education strategy implemented to advance a transformative recovery agenda for the mental health and addiction system in the main, and to support transformation for people in recovery. It articulates a new set of values and principles consistent with a recovery perspective: autonomy and empowerment; building hope; and learning to live from a perspective of wellness, rather than illness. The attempt to address the tension between the interests of professionals and clinicians, and people in recovery emerged from the impact evaluation of *Like Minds: Peer Support Education*, a recovery education program designed and delivered by people in recovery (Storey, 2007).

Like Minds created a space for learning that promoted curiosity, critique, discussion and debate. Using a framework of critique by Foucault (1980, 1988), peer educators engaged in collaborative questioning and critique where they were not only free of reprisal, but where their observations were welcomed and embraced. Although the primary aim of the program was to prepare people in recovery for the role of peer supporter, the process proved to effectively reduce the risk for people in recovery to be *subordinate*, and it fostered curiosity, questioning, and the assumption of leadership roles that led to recommendations for change in the operation of the service system.

The evaluation also confirmed that participants appreciated the opportunity to discuss, consider and reflect about the philosophy of peer support, as well as their experience of discrimination. Participants identified the need for radical change to the service infrastructure, including a commitment to have peer support and peer leadership valued with fair remuneration. They recommended that peers provide recovery education to clinical and system power-brokers to demonstrate the value, credibility, and legitimacy of peer support as an equal but distinct partner in service. *Like Minds: Peer Support Education* was experienced as an effective educational strategy that raised awareness, and provided a framework to debate and advocate rebalancing of power from those who typically hold it, to those who have typically been perceived as less capable and therefore less engaged.

Armed with the strength of these enlightened recommendations by emerging recovery advocates, further peer support education was supported with funding as a priority for the Central East Mental Health Working Group and unspent Mental Health Implementation Task Force funds from the Whitby and Penetanguishene task forces were re-allocated to this project. An early dilemma was, "Should developing peer support education and employment be a priority in the absence of the capacity within the mental health system to accept and sustain it?" Given this question, the vision for the project expanded beyond developing and implementing a structure of peer support service and training, to the broader goal of transforming the system to embrace a *Culture of Recovery*!

Implementation of the project hinged on a primary commitment to education for people in recovery and service providers to ensure a shared understanding that recovery is not something *done* to or for people, but is rather the creation of an environment of hope, op-

portunity and support. Recovery, by its nature, requires that people be active and engaged; people in recovery are equal partners in service. To support this cornerstone of recovery, it was agreed that two emerging best practices in self-help and peer support group programs [Wellness Recovery Action Planning (Copeland, 1997; Copeland and Mead, 2003) and Pathways to Recovery (Ridgway, 2002)] would be embedded in the project, and delivered by peers using a "train-the-trainer" methodology.

Participants were provided with two opportunities to learn personal recovery support strategies during *Orientation to WRAP* followed by an opportunity for certification as a WRAP facilitator. The evaluation of this educational experience included retrospective self-reflection. Results of the preliminary evaluation of this WRAP education indicates that participants report noticeable transformation toward recovery, especially in terms of understanding "recovery" as a concept and the fostering of hope (www.cultureofrecovery.org). To further support efforts to increase awareness, advance recovery, and decrease discrimination, the project supported the development of a full length documentary produced by Sky Works Charitable Foundation, called "Extra Ordinary People" – a collection of personal portraits that reveal the effects of discrimination and celebrates hope and wellness. This film premiered as the final event at the "Rendezvous with Madness" film festival (November 2007) and is now available with an educational tool kit to support discussion (*www.culture-ofrecovery.org*).

Adopting a *Culture of Recovery* first acknowledges and then transforms the balance of power to establish an interdependent framework for relationships. The transformed relationships must deviate from the accepted concept of *care* or *helping*, which implies an imbalance of power. Recovery rebuilds the knowledge base as a platform of equity, empowerment and interdependence, to realize a commitment to wellness and recovery.

Transformation, particularly the radical shift in knowledge and power required to establish a *Culture of Recovery*, requires safe and participatory engagement. Fulsome debate will reveal and challenge the intersections of power embedded in the language and intention of: illness versus wellness, and helper or "carer" versus partner. This debate must expose and dismantle existing relations of intentional and unintentional domination and resistance. Knowledge is required to develop, support and successfully embed inclusion and voice.

Engaging people in recovery with efforts to shift the matrix of knowledge and power requires substantial sensitivity. Wholesale and honest participation by people in recovery in discussion with people who may be future caregivers, regarding services that may not meet expectations, may be perceived as too dangerous. Not only does skill and comfort restrict the willingness of people in recovery to shake the tree of traditional power, but as Everett (2000) suggests: to challenge both the "rational scientific truth" and "higher authority of doing good" is obviously daunting. The observation by Nabokov from his novel, "Bending Sinister", and resurrected by Nafisi in "Reading Lolita in Tehran" (2004) is particularly apt for people in recovery who challenge authority: "curiosity is insubordination in its simplest form".

Transforming systems of power is not an easy process; it cannot be implemented by simply applying a set of prescribed objectives or activities. Transformation requires critical engagement to assess and challenge accepted and established beliefs, practices and structures. Critical theory challenges the basic structure of society, especially the structures which generate and sustain the factors that marginalize people (Hinchey, 2001; McLaren & Giarelli, 1995) – in this case people who are seeking to transform the matrix of power and knowledge in the mental health service system. The development of critical thinking requires reflection, challenging the status quo, and tolerance for ambiguity and uncertainty of analysis and argument (Brookfield, 1987). The following questions focus a power critique: "Who stands to gain from maintaining the status quo? Who drives the process? Who is included and heard?" Power must be understood in order to propose change. What knowledge and experience do people with mental illness need to infiltrate, influence and transform decision-making?

Re-balancing power from the people who hold professional and positional power to people in recovery is not a simple exercise of correcting the hierarchy. The problematic (Smith, 1984) that underlies this proposal assumes that power is a commodity that can be easily transferred from those *with it* to those *without* it; that the powerful generously *empower* the powerless. The preferred concept, embedded in Recovery philosophy, is that of *empowerment* which transforms and improvises power from within the experience of people in recovery by addressing and acquiring power, through education, as it intersects with knowledge and skill (Foucault, 1980; hooks, 1994; Jacobson, 2004).

Education supports the journey of transition, awareness and empowerment, and, using the matrix of knowledge and power, the traction required to sustain reform is strengthened. Knowledge about alternatives positions people to consider and risk change. Equalized power is a tool that transforms the restrictive element that sustains docility and obedience of *patients* in their traditional role, to autonomous challengers of the structures and relationships that sustain perceptions of authority.

Building a Culture of Recovery is a comprehensive recovery education strategy which operates an engaged pedagogy (Hooks, 1994) and that opens a safe and nurturing space where knowledge exchange and acquisition can expose the seat of power and unbind the matrix that sustains both the structure and relationships of power. The project sparks and supports generative dialogue and alternative discourse to reframe and decentre current and accepted power structures – and re-claim recovery, with all its autonomy, empowerment, hopefulness and wellness! Participants describe their experiences as empowering; they identify increased knowledge, skill, awareness and comfort with respect to their relationship with the mental health system as a distinct agent of recovery. Recovery is about hope; we are hopeful that we can support a culture of recovery – for everyone!

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Footnotes

[1] *Language is an artifact that leverages or sustains power and affects engagement. For instance, the medical model, and especially hospital-based services, refer to the people they "care for" as "patients". Community based services often refer to the same people as "clients". The term "consumer" has been adopted in an effort to shift the label and the term "survivor" has been used to indicate the reality of having literally survived the experience of both the experience of mental health problems or diagnosis, and its treatment. For the purposes of this paper, both as a strategy to further shift the attitude and to promote a hopeful and wellness oriented perspective, the term "person or people in recovery" has been used. This term challenges the existing usage and therefore is consistent with the critical perspective inherent in recovery.*

Ethics in Peer Support Work

Cheryl Yarek

Cheryl Yarek is a Case Manager with a Specialty in Peer Support. She has worked since 1999 with the South Etobicoke Assertive Community Treatment (ACT) Team (Toronto, Canada). Cheryl writes on recovery in order to help, support and encourage others. She also enjoys working out at the gym, oil painting, making "wish" collages and, most recently, studying ballet.

What is peer support work? The role involves an individual with an admitted psychiatric diagnosis who is far enough along the recovery continuum to help others in a significant way. It is understood that all individuals with chronic mental health issues will have "episodes" from time to time. Generally, however, a peer support person has their life and symptoms under pretty good control. In fact, this ability is what enables them to guide, support, and encourage other clients.

Every person involved professionally in peer support work has a story. This is mine. When I was about 25-years old, I found myself completely lost. I had a media job but resigned from it. No matter what effort I put into it, I was not able to find any work to support myself. I hated the situation in which I found myself and I hated my life. Given a preference, I would have chosen not to be here. I used cannibas and other drugs to escape mentally. By the time I was 27-years old I was unemployed and unemployable, broke and living with my parents. I was asking them for money to support my cigarette habit, and I assure you, if I ever needed a cigarette, it was *then*.

I had no friends, no hope and it looked like, no future. Finally, on November 23, 1984, I met the psychiatrist on-call in emergency that night. This woman would be my guide back to reality, and one of the greatest supports I would have in my life for the next 24 years. I was given a diagnosis of psychotic depression and I liked getting it. For me, it meant my condition was not new and I was not simply "crazy." The diagnosis had a history and with it symptoms that were common for a multitude of persons. The diagnosis and corresponding medications came with a plan for recovery. With the lessoning of pain, fear and panic, I found something extremely valuable, an admiration for mental health professionals beginning with Dr. Clarke. I was so impressed, I planned to become one.

The journey was a very long but worthwhile one. I started by volunteering at Queen Street Mental Health Centre, serving tea to geriatric patients. What followed were several other volunteer positions including crisis counseling at a distress centre for two years. I returned to university and completed a second degree, this

one in psychology. In 1990, I began my first paid job in mental health. I was a support worker in housing for five years. When I lost that job, I had my first manic episode and was hospitalized for two months and given a new diagnosis: bipolar disorder.

In November of 1999, I began work at Trillium Health Centre as the peer support worker on the South Etobicoke ACT Team. I was totally in love with my job! In 2001, I won the President's Gold Leaf Award for a journal article I wrote on Recovery. I was promoted twice, first to an intermediate position as peer support/case manager and then to full-time case manager in 2005. I work with some of the most interesting, intelligent and thoughtful people in the world: our clients. Many people readily see the significance of what I do for these individuals; however, most people fail to recognize **the enormity of what these clients do for me**. One client asks me about when I might retire. I say, "I don't know, that depends on if I take early retirement or not." She laughs, shakes her head and, adds with confidence, "You'll never do that." (I am surprised she can be more certain than me!) "Why are you so sure?" I ask her. "You'd miss us all way too much." she explains.

In considering the peer support role, there are at least two areas that present very significant challenges. They are: self-disclosure and boundaries. Let me begin with self-disclosure and the impact of it in terms of employers as well as how it affected my work on the ACT Team in disclosing to management, the team (or colleagues) and the clients. When speaking in public, I am asked one question repeatedly: "Should or should I not tell an employer that I have a mental health issue?" I admit to having done it both ways and invariably the honest way is the best way for obvious reasons. However, there are other reasons that might not occur to all people. For example, when I hid my disability (or perhaps more accurately, did not volunteer the information) and I was still working in the mental health field, I worried all the time that someone might show up knowing me from somewhere else. I wondered too if some of my meds might not seem suspicious if I claimed them through a drug plan. And, what if I needed a PRN?

Hiding my disability did not help to make me feel normal or better. I actually felt like a brand new type of fugitive that had not reached programming on the CTV-Network yet! The ability to be honest about my limitations was a huge part of what made me fall in love with Trillium Health Centre and ACTT. When a former employer told me there was a team of professionals I could work with who would see all the difficult and horrendous things that happened to me as positive and important, I knew I wanted the PSW (Peer Support Worker) job. (Talk about the truth setting you free!) I was also told there would be "accommodations" in place to

ensure my success. As a peer support worker, I was given paid time off to see my psychiatrist. I never imagined such a thing. When I got to her office, I said, "Dr. Clarke, you know how all these years you have been getting paid to see me?" "Yes," she said. "Well, now I get paid to see you too!"

Self-disclosure for me has been necessary to management, the team and the clients. Management, historically, has known the most because I have always felt that they are in the strongest position to help me make my role work. I have worked for Trillium Health Centre for eight years and I have been well most of that time. Last year, I became ill and there was anger and confusion on both sides. I do believe, however, that acceptance became possible because a foundation had already been poured to deal with the difficult times. My parents taught my brother and me that any relationship is great, until there is a crisis. At that juncture, you **really** learn about the other party.

Disclosure to the team also involves increasing the level of awareness with regard to the thoughts and feelings of clients. In one instance, I tried to describe "how it feels" to deal with severe anxiety, especially since I had done so for many, many years. I have also discussed with the team my differences with my psychiatrist in certain situations like one that involved anxiety. Dr. Clarke's solution was that I take an additional PRN and my answer was to write several solid affirmations to deal with key anxiety situations. I have outlined for the team how the matter unfolded between my psychiatrist and myself.

At one point, I was the primary case worker assigned to a client who wanted her meds reviewed but she was intimidated by the process. I spoke to the team psychiatrist about her issue and asked permission from the psychiatrist and the client to sit in on the session to help advocate for the wishes of the client. The psychiatrist was agreeable and gracious and the meeting was a big success for us all.

Some of my most significant work has involved early interventions with clients. Sometimes, the team has already tried other interventions. One of my colleagues named my involvement, "the injection of hope." Joanna would say, "Get over there Cheryl and give the injection!" I am going to talk about three different clients and self-disclosure. These individuals seemed to need three different things: 1) social skills teaching; 2) direction with activities; and 3) crisis counseling.

The first client, I will call Jan, did not speak. She was elderly and had a significant work history, unusual for someone with chronic schizophrenia. Despite numerous visits from ACTT, she would not open up or trust. I figured that if she refused to speak, and there was only her and myself, I was going to have to be the one who talked! I tried to engage her; speaking quite a bit about my own diagnosis and journey. She listened but remained completely silent until one Monday when I mentioned "No Frills Grocery Store" and grocery shopping on the weekend. I asked her where she shopped. This started a dialogue between us and Jan's ability to express herself continued and grew very slowly with one-on-one attention. Six years later she is a different person, truly her own best advocate! It speaks to her willingness to struggle time and time again when faced with her own vulnerability.

Chris was another client I worked with closely. She was young, just out of the hospital, and although she was still dealing with some psychosis, she was interested in reading and education and getting busy. The team asked that I meet with her. I brought some of my writing on meds and volunteer work. Chris was interested in occupying her time and even volunteered in a few of the same places I had. She eventually returned to university and studied business. After meeting for five years, we agreed our work together was done. I feel as though I helped her with a foundation.

Ginny was a client in crisis. She was in hospital when I met her. She kept threatening that when she was released she would suicide. The most striking part of her presentation was that as she continued to say she would take her own life, her eyes never left the piece of carpet on the floor between us for two meetings. The third time I met with her I said, "Ginny, if I were you, I would want to know that I had exhausted every avenue and tried every possible thing. Suicide is permanent. I understand that you have seen a psychiatrist for 15 years. What I am wondering is this: how many sessions did you go to prepared, with some notes about your thoughts and feelings?" Ginny lifted her head and looked me straight in the eye. "Never," she said. "That," I explained, "is where we start." The team made me her primary worker after our third meeting. It's a role I assumed happily for seven years. Testimony to Ginny's strength was her ability to accept a change in primary worker, two years ago. She had blossomed. She was ready.

I would now like to talk about the issue of boundaries from three perspectives; 1) lack of boundaries with a friend; 2) boundaries with a client who becomes a friend; and 3) boundaries with a friend who is actually a client. **When you have a mental health issue and you also work in mental health, there will be many, many boundary issues to face.**

One difficulty can be the lack of boundaries in dealing with a friend. Many years ago, I was registering in my final credit course at York University for my Honours BA in Psychology. There were 67 people in the room and I sat beside Anna who, I imagine, was the only one who was feeling suicidal that evening. Anna and I continued our contact and her feelings of suicide came and went over a period of years but were the most intense the first two years I knew her. I was working at a stressful job in housing that I loved. However, there were many nights that in addition to my job responsibilities, I worried about Anna. She lived in another town and sometimes I was left pondering if I would come home in time to find her alive. She refused, again and again, to see a psychiatrist. Anna did extremely well over a period of years even working full-time and loving her job. My friendship with Anna was severed by the unclear ownership of a cat! Ironically, when I was in crisis years later I asked Anna to care for the cat she had given me because I was not able to. She told me the request so offended her, she was not able to speak to me again.

I met a client once who became a friend after many years. I was asked to meet Dawn because the staff working with her thought they would never convince her to take meds consistently. Dawn was viewed as exceptionally bright in many areas. I met with her one afternoon for one hour. The med topic arose and she expressed her inflexibility. I said to her, "Dawn, I would love to tell you something other than what I am going to say. I would love to have a better scenario to run past you, but I don't." I let her know that the bottom

line was she needed to take her meds. I had tried it three times without meds and I had been in emergency all three times. Some day research may free us from these meds but that day is clearly not here yet. I remarked to Dawn, "If you want to do better, take your meds!" Dawn's face showed I had broken through. Dawn said our meeting changed her life. Her words were, "Nobody else had ever explained it to me like that." Today, she is a close friend (we do breakfast and walking on the weekends), and she operates and manages a very popular mental health venue.

Last summer, I found myself in a very difficult situation. I had joined a walking group and one of the women became a friend very fast. She told me she knew about my work and wanted to learn how to recover, do better and succeed. I was asked to become the group leader and I suppose because I was talkative and always showed up, I landed this promotion for myself. It became clear (not soon enough) that I had taken on way too much. With my job at Trillium, the walking group and counseling some of the group, my life began to feel out of control. One night, while talking to a group member on the phone, I started wondering why this person had my home number. This told me, there was a boundary violation here. That night, I called EAP (Employee Assistance Program) and outlined the situation to a counselor there. Following his advice, I left the group. My life was back on track within a week and my stress levels plummeted.

I have been doing peer support work as a PSW then as a case manager for a total of eight years. I have found the role to be very rewarding and very challenging. The decision to self-disclose works different ways for different people and involves numerous things including your personality style. For me, what has worked best has been to be very open about my history and issues, and, well frankly, my limitations. This is what works for me.

It seems that peer work comes with its own blurring of boundaries and the need to be a very skilled and versatile dancer. Still, I believe that one of the greatest joys is the bond that exists between a client and a peer worker in the arena of possibility. One of my clients said to me when I learned to drive at 43, "You give me such hope because I think, if you can do it, then maybe I can!"

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BOOK REVIEW

Defining Right and Wrong in Brain Science: Essential Readings in Neuroethics

Edited by: Walter Glannon, Dana Press, 2007

Reviewed by: Chris Kaposy, PhD, Postdoctoral Fellow
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Neuroethics is a young but very active sub-field of bioethics. Several new academic journals and special issues devoted to considering the ethical implications of developments in neuroscience have emerged since the landmark 2002 conference in San Francisco that is widely credited with stoking the interest in neuroethics. Walter Glannon's book, *Defining Right and Wrong in Brain Science: Essential Readings in Neuroethics*, captures well the debates that have engaged neuroethics and provides a thorough introduction to the field.

The anthology is comprised of Glannon's general introduction, 30 articles organized into six thematic sections with helpful introductions to the sections, and an epilogue by Steven Rose. All of the articles have previously been published elsewhere, and many have been very influential in neuroethics. Included in this volume are multiple articles authored or co-authored by Martha Farah, Judy Illes, Paul Root Wolpe, Joseph J. Fins, as well as William Safire's address to the 2002 neuroethics conference.

The issues covered by the authors in this anthology are diverse, but most articles deal with ethical concerns related to neuroimaging or psychopharmacology. The articles in Part I dealing with "Foundational Issues" ask a number of questions. Will new imaging technologies threaten the privacy of our thoughts? What adverse effects of intervening in the brain (i.e. through pharmacological or psychosurgical techniques) should we be cautious of? Several authors note that enhancing our capacity for memory might alter our ability to forget, which has a therapeutic function, and which also plays a role in our ability to make conceptual generalizations.

Section II on "Professional Obligation and Public Understanding" contains articles that discuss how to involve the lay public in the use and direction of neuroscientific research. These articles also address the problem of maintaining public trust in neuroscience given that this area of science has the potential to reveal sensitive and unwelcome information about ourselves.

The articles on "Neuroimaging" (Part III) deal with issues in the practice of neuroimaging studies and with the consequences of greater knowledge of the brain arising from powerful imaging techniques. How do we manage incidental findings about brain tumours or anomalies that might arise in non-therapeutic brain imaging research studies? There are also concerns about the way neuroimaging data are interpreted, since such interpretation is inevitably shaped by social and cultural frameworks, and since the brain is the seat of our identity, or the "organ of individuality" as Safire puts it.

The fascinating section on "Free Will, Moral Reasoning, and Responsibility" (Part IV) contains articles that discuss what neuroscience can tell us about moral reasoning. There are also several key essays which consider whether knowledge of the deterministic nature of the brain as revealed by neuroscience will cause us to abandon belief in moral and legal responsibility for our actions. Our capacity for free will seems in doubt if the functioning of our brains is determined by the causal nexus, just like any other physical object. Notable articles by Michael Gazzaniga and Stephen J. Morse are skeptical that neuroscience will cause us to resign our belief in moral or legal responsibility.

Part V on "Psychopharmacology" deals with ethical issues in the treatment and enhancement of our brains through pharmacological means. Is the neuroenhancement of capacities like memory or concentration justifiable? Will the ability to blunt or eliminate unwanted memories threaten our future capacities for such necessary emotions as regret, shame or empathy?

The articles in Part VI investigate ethical issues relating to "Brain Injury and Brain Death". What are the neurological indices of death? Are we dead when the whole brain ceases to function, or is death rather the cessation of integrated brain function? With regard to the issue of brain injury, several articles discuss how we could improve the treatment of people with severe brain injury, such as those who exist in a minimally conscious state.

In general, this is an excellent overview of the state of neuroethics. Though I had read several of the articles in this volume before, Glannon's selections offered several pleasant surprises for me. Among them is a very engaging debate between Arthur L. Caplan and Paul R. McHugh on the ethics of cognitive enhancement,

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entitled "Shall We Enhance?" (Chapter 23). In that debate, Caplan provides a lively rehearsal of the argument that enhancing your child's brain through the off-label use of psychopharmaceuticals is no different, in principle, from enhancing the brain through other means, such as by attending after-school study classes. McHugh argues against neuroenhancement by claiming that the desire to use pharmaceuticals in this way contributes to negative social phenomena that prevent many of us from being happy. The exchange between Caplan and McHugh is an accessible and thought-provoking introduction to the ethics of neuroenhancement, a perennial issue of concern in neuroethics.

The Goals of Neuroethics

The articles in Glannon's anthology aim to do many different things. For example, they:

- Identify current and emerging ethical issues caused by advances in neuroscience;

- Make predictions about the social changes neuroscience might bring;

- Debunk or dissolve frightening predictions about the consequences of greater knowledge of, and control over, the brain;

- Propose policies that deal with ethical problems related to neuroscience;

- Propose procedural or institutional mechanisms for solving ethical problems;

- Advance moral judgments based on rational argumentation;

- Exhort us to pursue a different course in response to a problematic issue raised by new knowledge of the brain (for example, in the medical treatment of those in a minimally conscious state);

- Unmask the real motivations that lie behind an application of brain science (for example, in the promotion of fMRI lie detection by private companies);

- Give an account of what neuroscience tells us about moral reasoning (the neuroscience of ethics);

- Make claims about what we should believe about ourselves on the basis of what neuroscience has discovered;

- Undertake legal analyses of some issues relevant to brain science; and

- Make recommendations about the direction neuroscience or neurotechnology should take.

This is not meant to be an exhaustive list of all the goals taken up by the articles in Glannon's book, and many items in the list overlap in scope. The diversity of these goals notwithstanding, neuroethics is a young field of study, and in this volume there is thus a disproportionate focus on issue-identification – the first item in my list – rather than on offering arguments meant to solve ethical issues in brain science. All of the articles in Part I of the book perform this issue-identification service, and many of the articles in the sections on Neuroimaging and Psychopharmacology have a tentative flavour and an unwillingness to make normative claims. In this way, *Defining Right and Wrong in Brain Science* is fairly representative of the field of neuroethics in general. As the field matures, it is likely that more work will be devoted to tackling the issues that have been identified in this early phase of the discipline as deserving ethical attention.

Although Glannon's volume tackles most of the topics that have occupied students of neuroethics, there is one significant omission. There is an important sub-genre of articles and books in neuroethics that advance an ethical critique of the powerful interests that are behind some of the more disturbing uses of brain science. For example, the American military is highly interested in the development of mind reading and mind control technologies. The ethicist Jonathan D. Moreno presents this issue in his book *Mind Wars: Brain Research and National Defense* (2006). A lot of good work has also been done on the overwhelming and sometimes malign influence of large pharmaceutical companies on the development of psychopharmacology. David Healy's work on this topic comes immediately to mind. Essays critical of these powerful institutions and their uses of neuroscience are absent from Glannon's anthology, and since this is an important area of neuroethics scholarship, the anthology might have benefited from the inclusion of a few representative articles.

Our Brains and Our Social Lives

One issue that *Defining Right and Wrong in Brain Science* covers especially well is the examination of neuroscience's potential impact on our conceptions of human identity. The authors included in this book often remark upon the close connection between the brain and the self. Such claims are made in articles by Adina Roskies, Farah and Wolpe, Illes and Eric Racine, and by Lynette Reid and Françoise Baylis. Intervening in the functioning of the brain has the potential to alter our identities and our sense of what it means to be human.

However, in addition to the relation of the brain to the self, another striking connection brought out by Glannon's anthology is the one between the brain and human society. The discussion of ethics in brain science leads quite often into an analysis of more general social norms and the structure of society. Issues in neuroethics appear especially entrenched in wider social concerns. Our motivation

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to know more about the brain through imaging or manipulation of it, and our concern to pursue these scientific ends in an ethical way, are intimately tied to our hopes, dreams, and fears about the nature of our relationships and our place in society.

In his contribution to the article "Shall We Enhance? A Debate" Paul R. McHugh gives a number of examples of patients who come into his office looking for a pharmaceutical cure for some deficiency they see in their lives, or in the lives of someone they care for. In one example, parents seek drugs that will help their son's school performance. In another, a young woman is looking for a way to alter her personality so that she will be more attractive to the men she dates who never want to commit to a relationship with her. In each case, McHugh (a psychiatrist) claims he would refuse to prescribe medications that would provide the desired enhancement. His strategy in counselling such patients is to shift the person's attention away from their desire for a drug that will take away their problems and to focus on the nature of the situation in which they find themselves. He argues that the desire for neuroenhancement reflects values and relationships which might not be conducive to the happiness that they seek – such as academic competitiveness, or "cooperating with a cultural system that permits males to remain perpetual adolescents" (Caplan and McHugh, 2007: 280). McHugh thinks that such patients need to be re-directed towards more realistic attitudes "about what is to be admired and what is to be scorned, about what advances and what retards our human pursuits" (Caplan and McHugh, 2007: 281). In discussing the question of the justifiability of neuroenhancement, we quickly bump up against the old philosophical question of what constitutes the good life for social animals like us. McHugh's thoughts about these patients also make one wonder about who ought to bear the costs of living in a negative social environment. How do we alleviate the unhappiness of individuals who are the victims of these environments? If neurological enhancement is unjustified, then what measures are justifiable?

The way in which discussions of neuroethics often lead into discussions about the structure of social relationships is also illustrated by a number of the articles on free will.

In their essays, Michael Gazzaniga and Stephen J. Morse each consider whether neuroscientific knowledge will undermine belief in the legal responsibility of criminals. According to neuroscience, the brain is like a machine and we are simply physical objects subject to the deterministic laws of nature, with all human behaviour occurring by virtue of causes outside of our own control. Gazzaniga's essay (which is a chapter from his book *The Ethical Brain*) is entitled "My Brain Made Me Do It", and Morse's is "New Neuroscience, Old Problems: Legal Implications of Brain Science". Each author believes that neuroscience will not undermine legal responsibility, and each characterizes the question as based on a mistaken assumption about what neuroscience can tell us.

According to Gazzaniga, even though neuroscience understands the brain in deterministic terms, he says the concept of responsibility is not denied by neuroscience, because the concept simply is not part of the neuroscientific description of human behaviour. Instead, the attribution of personal responsibility "is a socially constructed rule that exists only in the context of human interaction" (Gazzaniga, 2007: 192). To explain, he gives a helpful analogy: an optometrist can measure a person's vision is (i.e. 20/20 or 20/40 vision). However, an optometrist alone cannot make the value judgment about the level of vision one ought to have in order to drive a school bus. This judgment is a social choice. Similarly,

> psychiatrists and brain scientists might be able to tell us what someone's mental state or brain condition is but cannot tell us (without being arbitrary) when someone has too little control to be held responsible. The issue of responsibility (like the issue of who can drive a school bus) is a social choice (Gazzaniga, 2007: 193).

The mistaken assumption is to treat a concept put to use in social interaction, namely personal responsibility, as part of the intellectual apparatus of neuroscience, where it is in fact absent.

Morse's account is similar. The concept of legal responsibility is a product of social interaction. For instance, courts decide when responsibility is present or absent. According to Morse,

> In various legal contexts, how much and what type of rationality is required for responsibility is a social, moral, and political issue that divides people … Science could not answer this question because it is not a scientific issue; the debate is about human action (Morse, 2007: 197).

Again, the mistaken assumption is to suppose that legal responsibility – a social construct – can be measured by scientific means. These examples elucidate the fact that when we debate ethical issues related to new developments in brain science, we are often forced to think about the nature and provenance of our social norms. Discussing ethical issues in brain research often throws us back into thinking about the nature of our social relationships.

In many cases, the articles in *Defining Right and Wrong in Brain Science* suggest that taking a brain-based neuroscientific view of an issue of ethical concern to us – such as the question whether we have ultimate responsibility for our actions – may not be the best way to approach the issue. In order to answer some of the pressing ethical questions raised in this anthology of essays, we need to look outward at our social lives just as much as we need to look inward at the structure and functioning of the brain. This observation is not to question the quality of Glannon's anthology. The essays show a clear awareness of the socially-situated nature of the ethical implications of our increasingly sophisticated understanding of the brain. It is an excellent overview of the current state of neuroethics.

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BOOK REVIEW

Moral Stealth: How "Correct Behaviour" Insinuates Itself into Psychotherapeutic Practice

By Arnold Goldberg MD, University of Chicago Press, 2007

Reviewed by: Barbara Russell PhD, Bioethicist
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It seems vicarious moral distress prompted Goldberg, a psychiatrist at Chicago's Institute for Psychoanalysis, to write this book. He speaks about two psychiatrists whose actions he believes are wrong, but is unsure what exactly is wrong. To better understand such wrongness, *Moral Stealth* enjoins therapists to make explicit and respond to moral considerations that can be appropriately and inappropriately part of psychotherapeutic practices.

Moral Stealth has three sections, each rich with complex cases. The first section begins by questioning who is the legitimate authority to define what constitutes desirable behaviours, thoughts, motivations, and relationships: the client, community, or therapist? The complexity of being a therapist is further explored with the question, "Must a good therapist be a virtuous person (in terms of behaviour and character) as well as technically knowledgeable and skilled?" Rejecting therapists' appeal to moral absolutes and characterological perfections, Goldberg recommends pragmatism. However his pragmatic approach does not privilege whatever works. Instead it is about "continu[ing] the conversation" (42) given the uncertainty, ambivalence, and ambiguity that exist in both morality and psychotherapy.

The second section discusses how expectations of correct behaviour can confound psychoanalysis and psychotherapy. Three commonly lauded behaviours are scrutinized in detail: for therapists, protecting client confidentiality; for clients, being a thoughtful person; for psychotherapy and psychoanalysis, resolving ambivalence. Goldberg concludes that none is as crucial as typically assumed. The last two chapters explore the client-therapist relationship and transference-countertransference. While he favours conversations and paying attention to the language therapists and clients use, the author worries this will ultimately result in "trafficking in themes of social relationships" (94), something antithetical to Freud's work. Accordingly, Goldberg replaces the traditional metaphor of "inner-outer" to explain human behaviour with the metaphor of ownership to help therapists better understand and deal with transference and countertransference.

The concluding section begins by questioning therapists' efforts to remain impartial, their reliance on moral relativism, and their certainty about the moral defensibility of their own behaviour. Goldberg's focus is on outcomes: which psychotherapeutic techniques are most effective for which clients, which therapists qua persons are most effective for which clients, and which clients or situations are least harmful to therapists. Answers to these critical concerns, the author believes, will remain elusive if moral factors and concerns involved in psychotherapy and psychoanalysis are not made more explicit and are not critically examined.

As a philosophically trained bioethicist, I think Goldberg makes a stronger case for morality-ethics (M-E) than he perhaps expects. The cases effectively demonstrate that M-E can arise because a client wants to be a certain kind of person or act in certain ways. But the cases and ensuring analysis also show that M-E is inherent to psychotherapeutic practices (i.e., they don't just "creep in"). Contrary to Goldberg's claim that ethicists focus on rules and moral truths---and so are not very helpful---my experience has been that many bioethicists/clinical ethicists work with diverse values, "thick descriptions," dialogue, reflection, uncertainty, ambiguity, and ambivalence. In addition to the psychotherapy community, Goldberg should find much support from the ethics community for his probing questions and analysis.

BOOK REVIEW

Ethics in Psychology: Professional Standards and Cases (Third Edition)

By Gerald P. Koocher, Patricia Keith-Spiegel, Oxford University Press, 2008

Reviewed by: Nicola Wright, PhD CPsych
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Given the sacred nature of the professional trust we, as mental health professionals, are accorded by our clients and society, we must endeavour to do our utmost to act with ethical integrity. Our clients' well-being is entrusted to us, and necessitates a sound and sophisticated understanding and awareness of ethical issues and the subtleties associated with ethical dilemmas. Koocher and Keith-Spiegel, in their third edition of Ethics in Psychology and the Mental Health Professions: Standards and Cases provide an exceptional resource to inform mental health care ethical decision-making.

Koocher and Keith-Spiegel, in their 2008 edition, have expanded their book to address not only ethics in psychology, but also ethics in other mental health professions, including counseling, social work, family therapy, and psychiatry. This expansion is particularly useful given the wide range of professionals practicing in the behavioural health and mental health professions, and the core themes that cut across the practice of multiple mental health professions. The ability to cross reference with the codes of ethics of key mental health professions is critical given the heightened focus on interdisciplinary care and interprofessional education.

The third edition has expanded from 17 to 19 chapters, and has six appendices, including the codes of ethics of the American Psychological Association, Canadian Psychological Association, American Counseling Association, National Association of Social Workers, American Association for Marriage and Family Therapy, and the American Psychiatric Association: The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry.

The book provides an excellent educational tool, text, and resource for the challenging clinical, educational, organizational, and research decisions faced by students/supervisees, as well as more seasoned mental health professionals. As the authors indicate, the goal of the book is to sensitize the reader to ethical issues that may be encountered with the intent of providing a comprehensive resource on a myriad of ethical issues that may be addressed in the mental health professions. In addition, the goal of the book is to enhance the ability of the mental health professional to prevent or avoid ethical misconduct. Although the book would appear to be primarily targeted at an American audience, the authors' discussion encompasses the Canadian Code of Ethics for Psychologists, thereby complementing books on Canadian ethics and legislation.

The third edition expands on many of the same topics as the second edition not only by enhancing the content and discussion to address multiple mental health professions, but also, for example, by elaborating on the discussion of multiple-role relationships in three chapters rather than two. The latest edition is a comprehensive exploration of ethical issues in a broad array of areas, including psychotherapy, assessment, challenging work settings, academic and legal settings, scholarly publication and research and mental health business and marketing. The chapters "On Being Ethical", "Making Ethical Decisions and Taking Action", and "Knowing Thyself" are particularly important for highlighting the nuances of self-awareness and self-evaluation required for ethical practice. To enhance comprehensiveness, the authors also provide frequent cross-references to inform readers of where other information may be found in the book that is relevant to a particular issue or dilemma. An index at the beginning of each chapter, the summary boxes contained in many of the chapters, and the summary guidelines at the end of each chapter are extremely useful stylistic tools for structuring the content and reinforcing understanding.

The text is beautifully written in a respectful, sensitive, and engaging manner. The authors delicately balance ethical content with thoughtful discussion and deliberation. The book is an extremely interesting read, and uses witty and amusing case-example pseudonyms to add to its readability.

Koocher and Keith-Spiegel use hundreds of case examples throughout the book to enhance understanding of each of the content areas. These examples are garnered and adapted from ethics committees, licensing board decisions, case law, and publicized cases. The authors assure the reader that case examples are fully disguised, with the exception of public information. The authors demonstrate sensitivity and awareness by describing, in a very transparent manner, the use of pseudonyms and the "highly contrived" nature of the case examples.

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Given the sensitivity and complexity of the issues addressed by mental health professionals and the critical role of ethical awareness, understanding, and application in mental health practice, this book is an essential resource for mental health professionals. As Koocher and Keith-Spiegel state in their dedication, this book will provide mental health professionals with the resource they require "to demonstrate the courage to act with integrity."