8

Ethical issues in psychiatry and mental healthcare

Chapter outline

- **Key ethical frameworks**
- **Autonomy**
- **Ethical issues in psychiatry and mental healthcare**
- **Conflicts and tensions between psychiatry and counselling**

Introduction

Whether we are aware of it or not, everything we do as helpers (whether we are mental health professionals or counsellors) is underpinned by our ethical position: that is, by our sense or belief that what we are doing is the right thing. But how do we know what is the right thing to do? Alternatively, how do we know when a behaviour or activity is not right, or when we might describe it as unethical? Are we consciously applying ethical reasoning or are we simply falling in line with the dominant values of our profession, organisation or wider societal culture? Even the way I have written this chapter reflects my own ethical stance. What is important is how much I am aware of where I stand and why. Am I aware of the ethical principles and values I am drawing on and what is influencing what I choose to write about and how I write?

Note How often do we hear political leaders make pronouncements on the 'right thing to do', without saying why they believe it is right or owning it as their view, among a number of alternative views or positions that could equally be regarded by their political opponents as the right thing?

All professional helpers need, as far as possible, to be aware of their own values and where they stand

Note My previous book (Freeth, 2007) discusses at length some of the tensions that arise between psychiatry, mental healthcare and the person-centred approach.

on approaches to helping people. In mental healthcare, this means thinking about the many approaches to helping people who are mentally disturbed and experiencing any of the forms of mental distress that are covered in this book. It means thinking about the nature of helping relationships and what we bring to each and every clinical encounter and relationship. It also means considering, for example, issues of power, respect for autonomy, paternalism and the use of coercion and control where these feature as part of mental healthcare. In fact, such thinking and awareness could be considered an ethical duty.

The aim of this chapter is first to provide an overview of some key ethical frameworks. I also provide a discussion of the concept of autonomy, as this is a subject that influences much mental health practice and therefore deserves particular focus. From this I will offer a general picture of the ethical frameworks and more prominent values and ethical principles that underpin psychiatry and mental health practice. I will then explore some areas where there may be a mismatch between the values and beliefs influencing the practice of psychiatrists and mental health professionals and those that inform the work of many counsellors and psychotherapists. In so doing I aim to encourage counsellors to reflect on their own values as well as the many areas of potential conflict and tension. Given that I am both a psychiatrist and a humanistically-orientated counsellor, I experience many of these tensions myself in the course of my work.

Activity In this chapter I frequently talk about 'values' and 'principles'. Sometimes these words are used interchangeably. What do you think are values? How would you define principles?

Key ethical frameworks

As well as having a general awareness of where we stand ethically and what we think is right, we need to have strategies for analysing and thinking through our clinical decisions and actions. We need thinking skills. The collection of ethical theories and frameworks described here can help us develop such skills.

Note Ethics is a branch of philosophy known as moral philosophy. It is the discipline that helps us decide the right thing to do and it is fundamentally concerned with values.

I am aware that to attempt to condense the large and complex subject of ethical theory risks superficiality and oversimplification. For brevity's sake, I am going to take this risk, and to outline here some of the main ethical theories that are likely to

Freeth R (2007). *Humanising Psychiatry and Mental Health Care: the challenge of the person-centred approach.* Oxford: Radcliffe Publishing.

be taught to mental health professionals, including doctors, during their training. I will look at duties, consequences, principles and virtues (although I will by no means be able to cover all ethical theories) in order to provide a reference point for subsequent discussion of areas that are of particular ethical concern in mental health settings, such as risk management and the use of coercion in its various forms. Some of these ethical theories will already be familiar to many counsellors.

Note I will not be covering narrative ethics, ethics of care, and those influenced by feminist theory – all important, but not as commonly applied to healthcare practices as the ones I describe.

Note The British Association for Counselling and Psychotherapy (BACP) provides support and guidance to counsellors and psychotherapists to think about the ethical implications of their work through its *Ethical Framework for the Counselling Professions* (2018).

Duties

The first theory to be considered here originated in the thinking of the philosopher Immanuel Kant (1724-1804) and is referred to within philosophical circles as *deontology,* or sometimes *Kantianism*. This approach to ethics is one that proposes that we have duties to behave in certain ways towards other people. An example would be the duty not to tell lies. Another duty may be that of respecting another's autonomy, or treating others with respect. This is an ethical approach in which the action itself has an intrinsic value. In other words, it is the nature of the act rather than its consequences that counts.

However, it is also an absolutist approach in that there can be no watering down or nuanced application of duties according to the particular features of a situation. Duties are not qualified or adapted according to context. Problems can therefore arise when duties conflict. For example, if we have a duty always to tell the truth, as well as a duty not to cause someone harm, how do we manage a situation where telling the truth is likely to harm someone? Respect for patient autonomy may involve letting a patient continue to act in a self-destructive manner, or even take their own life. Clearly, to resolve this conflict, some duties have to take precedence (in the case of suicidal acts, the duty to preserve life may take precedence over the duty to respect autonomy), but how is this decided?

Note Kant (1785/1994: 36) famously wrote: 'Act in such a way that you treat humanity, whether in your own person or in the person of another, always at the same time as an end and never simply as a means.'

Note The medical profession's regulatory body, the General Medical Council, has set out the 'Duties of a Doctor' as a mixture of rules and virtues that require doctors to, for example, keep their professional knowledge and skills up to date, be honest, open and act with integrity, and treat patients politely and considerately (see https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice)

British Association for Counselling and Psychotherapy (2018). *Ethical Framework for the Counselling Professions.* Lutterworth: British Association for Counselling and Psychotherapy.

Kant I (1785/1994). *Ethical Philosophy: grounding for the metaphysics of morals and metaphysical principles of virtue. Book 1* (JW Ellington, trans). Indianapolis, IN: Hackett.

An emphasis on duties also has the potential to create a rule-bound culture that tightly regulates behaviours, and the danger that we just follow rules without questioning why they have been made or what purpose they serve.

Consequences

In contrast to a duty-based ethical approach, *consequentialism* is a collection of moral theories, the central tenet of which is that the right action is the one that leads to the best foreseeable consequences. It therefore necessarily involves being able to predict outcomes and judge which are the best. The most well-known version of this theory is *utilitarianism*, which is associated with the philosophers Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873). Here, the moral goal is to promote human welfare by maximising benefit and minimising harm. This is also known by the maxim: 'Promoting the greatest happiness of the greatest number'. In healthcare contexts, maximising benefit to the patient is known as the principle of *beneficence*, and minimising harm is known as *non-maleficence*.

Activity Consider the following questions:

- What do you think of the notion of maximising human happiness (or pleasure)?
- Do you think happiness or pleasure is a worthy goal?
- How much do you value this?
- How do you evaluate happiness and pleasure, and do you think these are key to our wellbeing?

A number of criticisms can be made of consequentialism, particularly in healthcare contexts. When using this approach to decide on treatments, it may be difficult or impossible to predict the outcome of treatment. This is particularly the case in psychiatry, given that it is frequently not possible to predict the outcome for any individual of taking a particular psychiatric drug. Indeed, it is not possible to predict the outcome of counselling. Added to this is the complexity of deciding what outcome actually is going to be beneficial. Is a good outcome necessarily reducing or eradicating certain mental phenomena (or symptoms) such as hearing voices or worrying thoughts? What if opinions about consequences differ (for example, when a doctor's view differs from the patient's)? This then requires deciding whose opinion should carry the most weight.

Another criticism of consequentialism is that placing the emphasis on consequences, rather than the action itself, may shift attention away from the processes involved in achieving the outcome: that is, it shifts the focus to the ends rather than the means. This is particularly relevant in healthcare settings where there is frequently

a preoccupation with outcomes, especially when driven by economic agendas and the pursuit of cost-effective treatments.

Activity

- Can you think of situations in a healthcare context where the end result of treatment outweighs the process (the means) of achieving it?
- Conversely can you think of examples where you think the end does not justify the means?

Virtues

Virtue theory is concerned with a person's virtues (an old-fashioned term for positive character traits). It places the focus on the agent rather than the action, so the right action is what a virtuous person is motivated to do, but not simply out of duty. According to Aristotle (4th century BC) it is the nature of a person's character traits that determines whether they will live a flourishing or 'good life'. Aristotle, along with other Ancient Greek philosophers, proposed a range of particular virtues, such as wisdom, justice, courage and patience. Other virtues that we might identify as particularly important for helpers are trustworthiness, honesty and integrity.

Activity

- What do you think makes a virtuous doctor or psychiatrist?
- What virtues are needed to be a counsellor or psychotherapist?
- What virtues do you think are needed to work with people who are more severely mentally disturbed (diagnosed with mental disorder)?

One of the problems with virtue theory is a lack of consensus about which are the most essential character traits. A further challenge to virtue theory concerns the question of whether virtues rely on a person's innate disposition or can be taught and cultivated. Bloch and Green (2006) also argue that virtue theory is not adequate to guide clinicians in complex situations that may involve a number of different parties with potentially competing interests. Another challenge is that it demands considerable self-reflection and awareness on the part of the practitioner of their motivations, intentions and desires. Gardiner (2003) notes that virtue ethics makes room for emotional reactions alongside reason, and these will vary in different situations. This means being aware also of how emotions are intertwined with reason, and how this influences assessments and judgements.

Bloch S, Green S (2006). An ethical framework for psychiatry. *British Journal of Psychiatry 188*: 7-12.

Gardiner P (2003). A virtue ethics approach to moral dilemmas in medicine. *Journal of Medical Ethics 29*: 297-302.

Activity Consider your working environment and/or your profession:

- Do you think they facilitate a focus on virtues as a foundation for approaching ethical decision making, or is there more reliance on protocols and rules?
- How much do you think Western healthcare organisations rely on rules and how much on virtues?

Principles

The most influential model in medical ethics, and the basis of ethics teaching for most healthcare professionals, is *principalism*. Proposed by Beauchamp and Childress (2013), it takes account of both consequences and duties by weighing up four main principles:

- beneficence – doing good or acting in a patient's best interests
- non-maleficence – avoiding harm
- respect for patient autonomy – helping patients come to their own decisions and respecting those decisions
- justice – enabling equal and fair access to healthcare, often taking into account limited resources.

This model provides a clear and pragmatic framework for thinking about a range of issues and dimensions to healthcare. One of its limitations, however, is that, while theoretically these four principles carry equal weight, this may not be borne out in practice. The model provides no guidance on how to weigh the principles against each other, or which to prioritise when they are in conflict. In other words, on its own it is an insufficient method for making decisions. Values must come into play in deciding which principles take precedence over (are more valued than) others.

Note BACP's ethical framework (2018) applies a mixture of values (expressed as ethical 'commitments'), principles and virtues (which it describes as the personal moral qualities of the counsellor). The UK Council for Psychotherapy (UKCP, 2019) has its own code of ethics), as does the British Psychological Society (BPS, 2009).

Using ethical frameworks in clinical practice

All ethical theories have strengths and limitations. Therefore, one of the issues faced by helpers is which one to use. Drawing on an established ethical code or overarching framework of ethics will certainly be useful, and adhering to an ethical code or framework is a requirement of membership of, or registration with,

BACP (2018). *Ethical Framework for the Counselling Professions*. Lutterworth: BACP.
Beauchamp TL, Childress JF (2013). *Principles of Biomedical Ethics* (7th ed). Oxford: Oxford University Press.
British Psychological Association (2009). *Code of Ethics and Conduct*. Leicester: BPS.
UKCP (2019). *Code of Ethics and Professional Practice.* London: UKCP.

all professional bodies representing healthcare professionals (such as BACP). While UK doctors are aware of their duty to behave ethically, according to the GMC's 'Duties of a Doctor', this is very general guidance and does not make reference to specific ethical frameworks or suggest how to resolve ethical dilemmas or conflicts.

It has been argued that, for psychiatrists, virtue theory might have a particular appeal, given the emphasis on therapeutic relationships within psychiatry, relative to other medical specialisms, and also on how a psychiatrist's emotional responses (for example, compassion) influence decision-making (Bloch & Green, 2006). While there have been proposals for developing a structured ethical framework for psychiatry – one that incorporates rule-based and character-based theories – currently psychiatrists are more likely to rely on a principles-based approach, although the application of principles will be heavily influenced by the individual psychiatrist's values.

However, it is not routinely obvious or made explicit that mental health professionals should undertake an ethical analysis of situations in their day-to-day clinical work. To do so requires time to think and reflect. The pressures of workload and emotional demands on the front-line practitioner can militate against purposeful ethical reasoning and reflection on how values influence decisions. Cultural and emotional factors, particularly anxiety and fear (for example, fear of being blamed if a patient comes to some harm), may play a powerful role in influencing clinical decision-making processes and professional behaviour. It is also one thing to hold an ethical position in theory, but quite another to hold to it in the face of the complex array of influences and pressures faced in day-to-day psychiatric practice, such as organisational expectations, professional obligations and the attitudes and judgements of colleagues. It can also be very difficult to hold onto a minority position and risk professional isolation and alienation.

Autonomy

Activity Consider the following questions:

- What do you understand by the term autonomy?
- Do you think of it as a right, as some form of personal power and authority or as a capacity?
- Is autonomy something we are given by others or do we develop it naturally?
- How does your understanding of autonomy influence your approach to helping?
- Did your appreciation and prizing of autonomy influence the counselling modality you chose to train in?

Bloch S, Green S (2006). An ethical framework for psychiatry. *British Journal of Psychiatry 188*: 7-12.

Note As well as being relevant to the ethics of healthcare, and counselling and psychotherapy, autonomy is of particular interest to moral philosophers and political and feminist theorists, as well as personality theorists and those interested in exploring the meaning of personhood.

The meanings of autonomy

Autonomy is an important moral and political value and highly prized in liberal Western cultures. Respect for autonomy has also become an increasingly important consideration in healthcare over the past 30-40 years, influencing many changes in clinical practice. Before discussing how this key ethical principle influences mental health and counselling practice, I will briefly explore how autonomy may be thought about and understood.

While the meaning of autonomy is often assumed, it is actually a concept with many dimensions and meanings, depending on the context in which it is being considered. This is complex philosophical and ethical territory and its meaning can often seem ambiguous. The many dimensions of autonomy are skilfully captured by Dworkin (1988: 6), as follows:

> It is apparent that… 'autonomy' is used in an exceedingly broad fashion. It is sometimes used as an equivalent of liberty… sometimes as equivalent to self-rule or sovereignty, sometimes as identical with freedom of the will… It is identified with qualities of self-assertion, with critical reflection, with freedom from obligation, with absence of external causation, with knowledge of one's own interests… It is related to actions, to beliefs, to reasons for acting, to rules, to the will of the other person, to thoughts and to principles.

Although autonomy literally means self-rule or self-government (as originally applied to Ancient Greek city states), the concept has been broadened and extended and, as highlighted by Dworkin, is now applied in relation to a number of other important ideas and concepts. Within health and social care contexts, however, autonomy essentially refers to the rights of individuals to make their own decisions, summarised as the principle of *respect for patient autonomy* or *respect for autonomous choices*. It is an aspect of the right to live one's life and act according to one's own values and beliefs, as enshrined in the United Nations Universal Declaration of Human Rights (1948). However, exercising the right to make a decision or choice requires the freedom and ability to do so.

Philosopher Isaiah Berlin (1969) talks about two types of freedom: positive freedom is the freedom to do something (self-mastery); negative freedom is freedom from constraints such as coercion. Thus, freedom of action requires the absence of external constraints (and sometimes also facilitative support from others), and it also requires an

Berlin I (1969). *Four Essays on Liberty.* Oxford: Oxford University Press.

Dworkin G (1988). *The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press.

United Nations (1948). *Universal Declaration of Human Rights*. New York, NY: United nations. www.un.org/en/universal-declaration-human-rights/ For a summary see www.amnesty.org.uk/files/udhr_simplified.pdf

ability that can, in general terms, be described as the *capacity for self-determination.* Autonomy is also linked here with ideas about **personal agency** and can be viewed as an expression of personal identity. In health settings, autonomy is often linked with the concept of mental capacity (which is described in Chapter 7) and sometimes conflated with it. It is assumed that making an autonomous decision requires the mental capacity to do so. This is important to understand as a patient's autonomy can only be over-ridden to treat a physical illness against their wishes if they are deemed to lack the mental capacity to make a specific decision about their treatment. However, this is not always the case in mental health settings, where other factors come into play, such as management of risk (which will be discussed later). Chapter 7 noted that, in England and Wales, a patient who is sectioned under the Mental Health Act (1983) cannot refuse treatment deemed necessary for mental disorder, even when they have the mental capacity to make this decision, on the grounds of protection from harm. This has been viewed as discrimination towards people with a diagnosis of mental disorder.

Note **Personal agency** is the capacity to make one's own free choices and to act independently, which involves also taking personal responsibility for those choices and actions.

In my own experience, mental capacity is easier to discuss than autonomy. Autonomy is an abstract philosophical concept, lending itself more to academic discussion. When it is talked about in clinical settings, it may be with reference to one of the four principles of Beauchamp and Childress (2013), alongside beneficence, non-maleficence and justice. It could also be thought of as a duty (the duty of treating people with respect and dignity), according to Kant's duty-based approach to ethics (discussed earlier).

Autonomy as an expression of psychological health

Another perspective on autonomy is the view that it is itself a characteristic of mental and psychological health. In my experience, this is not a routine consideration in mental health settings, but to hold this view will influence approaches to mental healthcare and the value a health professional attaches to respecting autonomy. For example, where a patient finds it difficult to make a decision on aspects of their treatment, a mental health professional should do all they can to help them to make the decision, not just because they have the right to decide but because being able to do so (the ability to exercise choice) is an expression of psychological health and maturity.

Becoming an autonomous individual can therefore be regarded as a developmental process, beginning in childhood. Psychologist Carl Rogers (1902-1987) talks about autonomy in relation to the inherent process of actualisation: '… the inherent tendency of the organism… [is] toward autonomy and away from heteronomy, or control by external forces' (1959: 196). The ability to be self-directed and act autonomously is, for

Beauchamp TL, Childress JF (2013). *Principles of Biomedical Ethics* (7th ed). Oxford: Oxford University Press.

Rogers C (1959). A theory of therapy, personality and interpersonal relationships, as developed in the client-centered framework. In: Koch S (ed). *Psychology: a study of a science. Study 1: Conceptual and systematic. Volume 3: Formulations of the person and the social context.* New York, NY: McGraw-Hill (pp184-256).

Rogers, a component of psychological health, encapsulated in his concept of the 'fully functioning person' (1959). Taking this perspective seriously in mental health settings would also mean having greater sensitivity to the potential emotional and psychological consequences of over-riding a person's autonomy, as this would potentially undermine a person's growth process and therefore could be harmful. (See also the discussion of locus of evaluation and locus of control in Chapter 5.)

What do you think? There are many other aspects of autonomy that we might consider. For example, do you think autonomy should be thought of more as a state or as a process, or both? Do you think of autonomy in an all or nothing way, or do you think there are degrees of autonomy?

Rogers C (1959). A theory of therapy, personality and interpersonal relationships, as developed in the client-centered framework. In: Koch S (ed). *Psychology: a study of a science. Study 1: Conceptual and systematic. Volume 3: Formulations of the person and the social context.* New York, NY: McGraw-Hill (pp184-256).