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PSYCHIATRIC ETHICS : ROLE OF PHILOSOPHICAL ENQUIRY

Introduction

Philosophy as such is an obscure topic for most. And philosophers help no less in making it more obscure by their approach. This is probably one of the reasons philosophical enquiry is avoided by most professionals as well as professional journals, not only in India[1] but also on the European continent.[2] This is also the reason why it is promptly given up after a brief honey-moon by others who may otherwise profess such a bent of mind. We shall not here try to increase the confussion of either. The pluralistic thrust of the American set-up has of course encouraged discussion of ethical issues (Chavez 1964; West 1968; Braceland 1969; Halleck 1974b; Michels 1976; Redlich & Mollica 1976; Chodoff 1976; Monahan 1977; Somers 1977; Spiegel 1978; Bazelon 19978; Towery and Sharfstein 1978; Moore 1978; Karasu 1980)[3] but that has not necessarily included resolute enquiries into its philosophical fundamentals. Traditionally the philosopher has been used to a form of language so abstruse as to intimidate even the most eager psychiatrist (Bloch and Chodoff 1984a). Of course some philosophers have made efforts to overcome this by offering practical and concrete solutions, of which Hare (1952, 1981, 1984), Warnock (1978) and Singer (1978) are notable examples. In an effort to further this, let us temper the philosopher's absolutism with the psychiatrist's utilitarianism[4]. We believe such a synthesis can be of benefit. especially in a branch like psychiatric ethics, where

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absolute concepts taken originally from philosophy have to be made applicable to the exigencies of professional practice. Moreever, scientific knowledge by itself does not confer ethical sensitivity and 'generalization of expertise' (Veatch 1973) from scientific to moral, when exposed, is an important source of anti-professionalism (Michels 1981). At the same time when moral conflicts arise, no one-level account can solve the problem; if conflicts arise at one level, they cannot be resolved without ascending to a higher level (Hare 1984). At the intuitive level of thinking, the absolutist stance is appropriate but it no longer remains sufficient when conflicts arise between them and/or with other circumstances. Then the critical level of thinking of the utilitarians alone can suffice. We select thereby the principles to be used at the intuitive level and adjudicate between them in cases where they conflict (Hare 1984; also Hare 1981). However, both intuition and critical thinking cannot be allowed to negatively influence each other and part of our energies have to be legitimately utilized in such prevention. A true utilitarian, therefore, is not one who simply maximises utility. He is one who acts for the greatest good of those whose welfare he is charged with; and 'when faced with a moral decision he continues to act in whichever way is best for the interests of those affected' (Hare 1984).

Philosophical exploration is necessary also because in the field of ethical canduct, psychiatrists must be able to do more than convey injunctions against fraudulent or exploitative actions or merely supply a code of professional etiquette (Murry 1979). A grounding in a theory of values is also required (Chodoff 1984), for which tracing of philosophical credentials becomes obligatory.

Code, Regulation

We shall start by asking and trying to answer certain basic questions. In this manner, we may be able to scrutinize some of

our presuppositions, evaluate them, sift the proper from the improper, and lay down certain criteria for sound reasoning.

What is ethics, after all ? It is the science of conduct, whether good or bad, of morals, whether moral or immoral, of propriety, whether proper or improper. If there is to be a code of ethics, it presupposes both the need and the ability to regulate condct according to morality principles irrefutable as to their propriety. A code of psychiatric ethics means there is both the need to regulate such conduct of the psychiatric establishment[5], and an acknowledgement that the bodies entrusted therewith have the ability to do so. When there is a question of ability, both competance and volition come into play. The regulating body, therefore, must be competent to do what it professes to and should have the will to carry it out. Here, conduct, which involves volition and action, comes into the picture. A code of ethical conduct must therefore regulate the *will*[6] to action and guide the *purposiveness* of that action. It must, morever, be intimately related to action itself, to the *activity* of the establishment which is supposed to profess it.

Is there a need to regulate the establishment's activity ? To this the consensus answer would be yes, although some die–hards may disapprove because they intrinsically fear outside interference in their affairs as they fear any accountability; accountability and scrutiny become synonymous with prosecution in their minds which arouses guilt and anxiety and a consequent avoidance behaviour that can be aggressively propelled. Is there a will to bring about such a regulation ? The answer to this again is atleast a partial yes. Most psychiatrists in their individual capacity do so, or atleast expect themselves to do so, and errors of omission, not necessarily born of deceit, are more common here than those of commission. Others who do not have such a will are the black–sheep whose presence is inevitable in any set up;

the most that can be done is minimize their importance and expose their nefarious influence. For both these, a watch-dog type of set–up is needed, comprising of members of the establishment all–right, but also those of other social welfare bodies, whether the establishment wills it or not. The latter's presence is rendered invitable precisely because the establishment's objectivity is likely to be jeopardized when it has to pass judgements over faults of its own members. Whilst some errors can be almost unconsciously condoned, others may be highlighted just to side–track from certain issues or, worse, malign certain sections. Patient rights' advocates in social welfare organisations cannot be kept at bay for long in such a set up. This of course is in spite of howsoever much the establishment wishes to shoo them away. Growing scepticism about the sanctity of science, medicine and psychiatry means that these fields are no longer above rebuke or exempt from active moral review by their recipients, professional peers and others outside of their practice (Karasu 1980). Professional organizations and societies, psychiatry included, must invite this participation in professional decisions (Michels 1981). Appropriate role for non–professionals in professional decision making has already begun in ethics review boards, licensure groups and selection committee, and will probably extend further.

Is there a need to guide the purposiveness of the establishment's action? Most of us would again agree, although how this is to be done would be no small hurdle to cross. Again, when we talk of the need to guide activity so that it becomes purposeful, we must presume that there is the possibility that this activity can be purposeful as also that it can stray from this purpose. Now, again, in keeping an activity purposeful, interested parties must automatically get involved, and where there is also a question of prevention from straying, the role of watch-

dog agencies that profess to prevent such an eventuality cannot but be envisioned. A code is supposed to regulate activity to make it purposeful and as long as this activity does not become censure-free, regulating bodies must define and redefine priorities and principles to make the establishment's activity as less malevolent and as morally sound as possible.

Coming now to the question of activity, it presupposes atleast two agencies : the actor and the one acted upon. The code thus must be a guideline to the activities of the establishment as it comes in contact with the patient population on which it has to act. We know, however, it is not only these two agencies that are involved. Probably in a secondary manner at present, and we may have occasion to dispute this later, the involvement cannot be circumscribed thus. Of course one would be justified in feeling better off if it remained so, but that is another matter– for one thing, it is no longer practical, for another, it itself is fraught with chances of exploitation, by both the agencies involved.

To obviate the emergence of exploitation or improper implementation, certain other agencies must need enter the picture. One of them is the judiciary, with the judges, the lawyers and even the police-force playing a role. The other is legislative bodies who consider it their duty to legislate on matters of law pertaining to professional transactions. (Of course often this duty is only a subterfuge for rights, but that is another matter). Also, socio-humanitarian activists in the community, as well as others with not so honest intentions, consider it their duty to make their presence felt. 'Critics maintain that in the interest of justice to the public it is essential that non-professional representatives also take part in deliberations about the derelictions and misdeeds of psychiatrists' (Chodoff 1984).

A code of ethics must, therefore, attempt to incorporate the diverse opinion of such groups. What we mean thereby is not necessarily accept their views. Rather it means minimize the chances of friction between the establishment's conduct and the over-seeing attitude of these agencies. In other words, to accept their presence, if not all their views. A code should therefore try to incorporate such barriers that safeguard the profession against unnecessary conflicts with such groups. It must also try to prevent transgressions by members likely to create conflict with its clientele and their champions. It attempts to lay down, in the least complicated manner possible, what a reasonably conscientions professional should attempt, and assiduously guard against.

Two Points

Conscientousness in a professional must be considered a virtue. But by itself it leads to difficulties. If coupled with aggressivity, for example, it may lead to heroic measures in treatment which no doubt help many patients but can equally well arouse resentment and animosity in any number of others. It can also lead to disenchantment and guilt feelings because the best of intentions are either not implementable or when implemented arouse a negative response from the client's side; which again brings home the fact that the best of intentions need not necessarily beget the best of results, even if coupled with competence and professional expertise. Who does not know of the honest psychiatrist who makes a proper diagnosis and carries out the best treatment possible only to be hauled before the court of law for negligence or improper treatment ? Or to be involved in a tacit word by mouth campaign about his very capabilities ? Or worse still, arouse doubts in himself about his own capacities, with reduction in his realistic vigour and zest, imperceptably resulting in an passive acquiescance in the client's paranoia. Do we also

not know that in a case where there is no informed consent, the fact that the treatment was technically well performed and effected a complete cure is immaterial (Slovenko 1985, Kaplan and Sadock 1985) ? Again, it is one malpractice claim under which the requirement of expert testimony can be avoided (Slovenko 1985). Who does not know how often the inability to get informed consent is just a means to avoid coming to decisions likely to be painful to implement or sustain later, besides involving legal hassles as an ever–hanging democles' sword ?

The points that come across glaringly to even a casual observer are two. Firstly, involvement of other agencies in the profession's code of conduct has come to stay. We cannot wish it away. We cannot also minimize its influence by either hurt resignation or aggressive rebuttal. Refer, for example, to statements like, ' our intentions were and still are, good in this area and that, given the wherewithall, we have a lot to offer. Society's intentions, however, have been proven to be questionable and they have not given us what we need', (Rappeport 1978)[7]. Michels (1981) advocates that the profession's attitude toward this trend itself be professional, an eminently suitable suggestion. If anything this influence is bound to increase, precisely because the psychiatric establishment works less with the body more with the mind. That other medical professionals also face ethical dilemmas is as clear as the the fact that the psychiatrist's difficulties are to an extent unique because of the peculiar nature of the problems he has to come to grips with. The psychiatrist is a rather special variety of physician (Chodoff 1981). It is the mind with which he works, on which he attempts modification, over which the ideals of proper, right and good are super-imposed. He is thus in that very much greater a capacity to both influence the other and to be influenced by him, for good or for evil. There-

fore, we must believe that the code will come under increasing scrutiny of its clients, social activists and the law. Forces within the establishment that seek to question its credentials (Szasz 1963, 1970, 1974) will appear as critical of its capacities as members of the judiciary who pass strictures on the uncertainties of psychiatric diagnoses and therapy, and appear unconvinced even of reality of psychiatric disorders. For example, some Justices in the United States appear firmly convinced that psychiatry is akin to charlantanism and psychiatric diagnoses is no more accurate than palm-reading (Appelbaum 1984). Justice White's majority opinion compared mental hospitals unfavourably with prisons (Vitek v Jones 1980). Justice Stewart considered mileau therapy an euphemism for confinement in the milieu' of a mental hospital (O'Conner v Donaldson 1975). Compare this with Szasz and the other anti-establishment writings that seek to establish mental illness itself as a myth and even identify involuntary hospitalization with slavery (Szasz 1978). This will be more so as long as psychiatrists presume to decide questions for courts by incorporating into their medical judgements factors beyond their medical expertise (Bazelon 1978). They must then face up to the irksome cross-examination of their expertise in courts and elsewhere. They will also have to accept that a court does not feel bound by the opinion of even those psychiatric experts it itself appoints (Rappeport 1978). The trial of John W. Hinckley Jr., the would be assassion of U. S. President Ronald Reagen, by a District of Columbia jury in 1982 also turned out to be a trial of law and psychiatry. The psychiatrists, and the law allowing their testimony, were made culprits for the unpopular verdict of not quilty by reason of insanity : 'The psychiatrists spun sticky webs of pseudo scientific jargon, and in those webs the concept of justice, like a moth, fluttered feebly and was trapped' (opinion quoted by Slovenko 1985).

And yet, somewhere along the line, we must also sound a word of caution. This is the second point. Influence of other agencies, especially law, on the establishment does not amount to transformation of its ethical identity to become one mainly influenced by them. Let us see what we mean thereby. Law, for example, plays an important part in the establishment's code of conduct, especially in its application and in arbitration over disputes. How important this is can be gauged from any worthwhile book on psychiatric ethics for it concentrates mainly on law and legality as applicable to the establishment. This is understandable since the professional has to apply ethical principles in day-to-day practice and must concern himself with practicality more than its conceptual principles; and in an adversarial situation an arbiter cannot but step in, which is what the judicial process essentially is. It is part of professional expertise, then, to be conversant with legal intricacies. And yet we know the impropriety of equating legality with propriety. Ethics is not to be equated with legality, or with legal rights, sanctions and privileges. Or with formulating the means of saving one's skin. It then becomes little more than a trade union, defending the parochial interests of its members against the claims of their employers, in this case the public, while the latter inevitably organize in an adversarial relation to the profession (Michels 1981). Ethics essentially is morality in practice. And anyone who tries to excuse himself, for whatever reasons, pragmatic or for survival, by means of tenuous logic or cover of legality cannot but accuse himself in the bargain. *Qui s'excuse s'accuse*. For example, there can be a tendency, especially amongst the medical profession so mooted in professionalism and worried about indemnity claims, to consider obtaining valied consent in various forms (by valid we do not mean those that are morally proper but those that stand in a court of law – and it is unfortunately necessary to

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make this differentiation) as the major, if not only, concern of ethics in medical research or practice. Legality thus gets confused with proper or improper conduct. Whilst no doubt ethics is concerned with law and legislation (as it is concerned with every issue in which conduct can possibly be involved) it is not to be considered synonymous with the legality of conduct, or be restricted within this sphere. It can of course be so at times because exigencies of practice demand an operational framework; but the conceptual expanse of the establishment's framework itself cannot be limited within it. In fact, it must always keep at the back of its consciousness the belief of that propriety of conduct must transcend legality, that the latter is only an operational framework, a narrow and therefore defective one at that, we acquiesce in for want of another that encompasses all myriads of this subtle mosaic.

It is hence improper to consider issues that fall within the purview of legal regulations or control as the only legitimate concern of medical, or psychiatric, ethics. Neither need our concepts or activities be guided or motivated solely by considerations that come in contact or conflict with the law. Unfortunately, the history of medical, especially psychiatric, ethics is so influenced to a degree that is not inconsequential. Such an attitude is more an attempt to safeguard one's professional interests. Or, to put it more bluntly, to save one's skin, especially in the face of compensation claims. We kid ourselves into believing it a proper implementation of ethical principles. If ethics is considered synonymous with this attitude, overtly or covertly, it only reflects our lack of understanding of what ethics conceptually involves, and shows how unethical we can be about ethics itself. This becomes more glaring when the need for the psychiatrist to make vital moral decisions is considered pervasive, infiltrating every facet of his work (Bloch and Chodoff, 1984a) : 'And his

task is made more complicated by the fact that most of the ethical problems he faces have not hitherto been dealt with, let alone resolved. Some problems have not even begun to receive systematic study'. There could be an element of denial here, for psychiatric practice itself may be characterised by uncertainties and ambiguities which it constantly struggles to keep within bounds (ibid). It may signify the medical man's search for a system of medicine allegedly free of ethical values (Szasz 1960). Or a belief that his therapeutic activities do not and should not have any political consequences. Halleck (1971) believes that a psychiatrist has a political role to play, whether he is prepared to recognize it or not, and this role has significant social and ethical implications. Bloch and Chodoff (1984a) agree 'thoroughly' with this contention. This, however, is a topic by itself for which much could be said either way.

In all our discussion till now, and further, we will be guided by what Chodoff (1984) has so succinctly put as the dilemma of psychiatry viewing. The psychiatrist has to acknowledge that his dissent, especially if stated very strongly, can harm his profession, and in addition, might confuse the public. But that does not of course mean that the psychiatrist indulge in rationalizations which enable him to ignore his true beliefs.

Involuntary Hospitalization and Informed Consent

There is then the issue of involuntary hospitalization as well as informed consent. In all the meanderings of both these procedures we know the essential core involved. The dilemma is of control and forced conformity by one agency of another. The fears, not altogether unfounded, are of misuse of power when one exercises control over another's mind. Thus involuntary hospitalization raises all the questions about who should decide such a need and under what condition is it invariable. The consensus opinion that emerges is that law enforcing bodies alone

are so empowered, the psychiatrist only acting as an ally who imparts his professional expertise, if asked for. In the case of informed consent, again, the establishment knows how the concept is basically defective, though that need not mean it is not a workable one in the absence of anything better. What are issues like information and consent, after all? They cannot ever be a one-way process. We may impart the best of information but unless grasped by the other side, it cannot be supposed to arouse any reasoned consent. Both information and consent are, in fact, two way processes. Information becomes what it is only when processed by another. Consent again becomes legitimate only if the agency seeking it carries out legitimate activities to obtain it, and the other is in a state of mind to understand what he is consenting for.

We know, however, how both these issues are efficiently sidetracked in most discussions of informed consent. We know also how the very fact that one party may make the most honest attempts to inform – and that may not be altogether without doubt – the basic difficulty is with the person supposed to be informed and in a position to give valid consent. For example, how do you gain a proper informed consent from a paranoid psychotic with most personality functions intact except for his morbid paranoid delusions? He does not believe he is sick. He can convince the Court and the police that he is able to lead a not altogether unreasonable life, albeit with his oddities and eccentricities. And yet the close relatives, the ones with whom he stays and interacts, know the chaos that he causes in their personal relationship, the disruption of intimate bonds that results, and the decline in finer qualities and blunting of appropriate affect. Here we are faced with the difficulty of obtaining any valid consent. Will such a patient be ever certified anywhere unless he lands up markedly psychotic or commits a heinously

barbaric act ? Will such a person ever give a valid informed consent inspite of our best efforts ? This although each psychiartist can vouch for the tremendous amount of social morbidity unleashed by the poison of paranoia let loose on an unsuspecting society thereby. Are we then not essentially only saving our skins by our talk of failure to obtain informed consent ? Are we not shirking our responsibility by letting such individuals loose in society ? This, especially when certain agencies raise the question of individual liberty, of the fundamental right to freedom of expression and movement in this context, – and the establishment responds by sheepishly taking the cover of legal helplessness and hassles. Which is quite unnecessary because every psychiatrist places high on his list the value of individual liberty and right to self-expression or self–decision, and when he suggests the abrogation of these rights, he does so not to force or coerce people into subjugation but to help them regain their earlier levels of judgements and self–expression, if not fully atleast as great a level as is possible; and help temporarily restrain them from harming these rights of others. For any social system to work, both functions are invariable. And the establishment need be defensive only if it is as unsure of its methods as its opponents and detractors make it out to be. Also we know very well that if we continue to value liberty so exclusively we might find ourselves taking an anti–humanistic position Halleck 1974a) and 'the minority who suffer from psychiatric illness .. will suffer if a liberty they cannot enjoy is made superior to a health that must sometimes be forced upon them' (Michels 1973). As Peele and Chodoff et al (1974) state, 'it is a perversion and travesty to deprive these needy and suffering people of treatment in order to preserve a liberty which is in actuality so destructive as to constitute another form of imprisonment'. In other words, the duty of beneficence enjoins us to carry out activities for the benefit of the client and empowers us with the necessary moral

guidelines, whether accepted by law or otherwise. Here a legitimate conflict between the duty of the establishment and the over-seeing authority of the law is inevitable and on moral grounds, both intuitive and critical, the establishment must have the courage to stand by its duty to the client as much as to the social set-up and offer clear explanation and examples of how this should be so. For this of course it needs to be convinced in in its own mind about the moral justification for its activity, and although expediency may indicate discretion, be convinced of no other.

This is one sphere in which we must avoid taking the cover of legality. Or avoid coming to grips with the problem altogether. Both these are reactions of moral unconviction no doubt born as much out of extraneous influences as self-doubt and an enthusiastic but misdirected self-scrutiny.

Once beaten twice shy can be the response of the pragmatic practising psychiatrist faced with one such patient in his life-time. He then avoids any persuasion. Persuasion becomes for him a form of coercion. The paranoid patient's way of looking at things becomes the professional's cover for his own self-deception. He escapes thus but also lets loose so much morbidity for the society to face. This may be perfectly camouflaged by him in an interpretation of professional rights and privileges by means of which a physician may refuse to take on the treatment of a patient. But here a concentration on rights amounts to selfish evasion of one's duties. Ethics being essentially concerned with duties, must therefore be undermined by such practices. This must becoms one of the problems to tackle.

The second is involuntary hospitalization. The law of course steps in whenever there is the question of control over a citizen' fundamental rights of freedom of speech, expression, movemene

etc. But if this becomes for the establishment a front to avoid taking any decision in the welfare of the sick, having decided that one's role is limited to treatment and diagnosis of willing patients alone, the psychiatrist can be morally accused of underplaying his role. Discretion may dictate circumscription of one's role around these two concepts. But, ethically speaking, his role transcends that. His prime purpose is to bring about reduction in social morbidity. He must moreover also educate, he must as well create awareness, in the society at large and legislators and the judiciary in particular. That they would view his role with concern bordering on suspicion (Appelbaum 1984, Daes 1986) is a natural phase in this relationship which can undergo a complementary status only over a period of time, as both sides work through their interpersonal conflicts – to borrow a concept from psychodynamics – and are able to get rid of insecurities that force them to erect barricades to realisation and healthy interaction. To achieve this the establishment will need to develop a proper sense of accountability in which it acknowledges 'an obligation to present to the public a reasonably coherent picture of the nature, scope, effectiveness and limitations of the profession' (Chodoff 1981). It will, moreover, have to be clear whether its professional expertise can definitely help those whom it seeks to involuntarily hospitalize, or the targets of their hurt. It will have to produce concrete unimpeachable evidence to this effect. It will, further, need to deal thoroughly and decisively with the black-sheep and mischievous amongst its own ranks. Only then can the average psychiatrist stand up and say with moral authority that to confine a suicidal depressive or a homicidal paranoid will help the former get rid of his suicidal, and the latter of his homocidal, ideation. We are sure this happens in most cases where treatment can be delivered without unnecessary constraints and every psychiatrist knows that, but for some treatment failures, the therapeutic procedures at his

disposal can bring about remission to a satisfactory degree in the majority of cases; and in those where remission occurs the relief and gratitude of the patient as well as his relative is the bonus of good-will on which the whole establishment rests. The difficulty is that treatment failures complain and seek redress and there is no corresponding rebuttal from the side of those who have benefitted. This is but natural and is understandable. Also natural and understandable is the establishment's defensive attitude in such circumstances. But what is natural and understandable is not what is necessarily appropriate. Here again we must ascend in our thinking and critically judge for ourselves whether what we are doing is for the general welfare of our patients or not. Have we been consistently successful in some types of psychiatric problems? Have we consistently failed in certain others? And are both these mainly related to our present expertise? In such a case, we should categorically be able to say that in 'X' type of case, involuntary confinement helps, but in 'Y' type, according to our present level of expertise, it does not. And after setting such limits, we must stick to them consistently till we have evidence to refute or modify this line of action. If our activities are directed thus, inflated and unnecessary duelling would stop, while healthy questioning and consequent modification continues.

In all this the psychiatrist may sometimes have to act at personal risk, and that is part of the hazard of being a professional in this unique branch. For psychiatrists need to be alert to the possibility that they are avoiding responsible action because it is difficult and painful (Chodoff 1984). We do not mean to say one invites troubles for oneself by being rash or over-bearing. Far from it. This in fact is what has encouraged the improper control by other agencies of the psychiatrist – patient relationship which has caused estrangement in both. It has even prompted

agencies like a United Nations Committee to find involuntary admission unjustifiable and worthy of abolition since it is 'abused' in several parts of the world 'especially against persons who defend fundamental freedoms or exercise their human rights', (Daes 1986), for psychiatric mistreatment is a sinister abuse of scientific and medical technology and psychiatric drugs are used for torturing persons diagnosed as mentally ill (Daes 1986). What we need is neither an aggressive over-lordship nor a meek acquiescance. We need a firm commitment toward the good of both the client and the social framework in which he exists, irrespective of the constraints and the paranoia that may exist in societal agencies. By irrespective we do not sanction a steam roller aggressivity. What we rather mean is a firm, persistent commitment to certain values of professional conduct and an abiding conviction in the worth of action that follows therefrom. No code of conduct which condones any of these can be said to exist on morally sound principles. No sound philosophical basis, therefore, can be claimed for them, either. As Chodoff (1981, 1984) states, 'It is a hallmark of psychiatry that in a number of areas (e.g. involuntary hospitalization, the insanity defense) the psychiatrist operates as an interface between the rights of the individual and the requirements of society. On such occasions the sometimes difficult issue to be faced is whether true responsibility to society necessitates adherance to professional standards or to societal dictates'. And he states further, ' a psychiatrist may find himself in circumstances when he believes that he can discharge his proper responsibility to society only by resisting its dictates if he believes that these are intolerable because they are in conflict with the ethics and values of his profession'.

To the question whether the establishment accord primacy to the dictates of professional conscience or the requirements of social conscience, the answer cannot be simple. Yet some guide-

lines can be definitely offered. At the ideational level, social conscience is of course supreme and all professional considerations have to be made subservient to it. But to say so is not to acknowledge that this social conscience is a concrete unchangeable entity. A major part of all reformist activity must be guided by the knowledge that this social conscience is a concept, and a concept amenable to change and modification. While professional conscience can never tear up or annihilate social conscience, it can, and must, try to educate it, even modify it by legitimate means that the socio-political atmosphere of a region provides. In so doing it will probably realize the true and legitimate political role that some of those we mentioned earlier (Halleck 1971, Bloch and Chodoff 1984a) envisage for the psychiatric establishment. For we do know that a society's concern for unorthodox ideas and behaviour amongst its members appears to be universal (Bloch 1984), whether in closed or open societies although certainly varying in degree. The political dissenters labelled psychiatrically sick is but one manifestation of this phenomenon; it probably occurs in a more ubiquitous manner than the establishment is wont to grant, and not all the popular fiction of psychiatric diagnoses as a tool to ostracize and manipulate can be considered baseless. For "without the stigmatization of some acts and some people as 'abnormal' or 'anti-social', there would be no idea of the normal, no rules to govern social behaviour ... it follows that people whose behaviour is labelled as schizophrenic, criminal, inadequate or otherwise anti-social provide the yardstick by which acceptable conduct is measured. Society is making use of them for its own ends, the orthodox depend on the unorthodox to define their own orthodoxy; but the labels tend to be attached to people haphazardly. Behaviour which is seen as psychiatric disturbance in one society may be regarded as criminal in another, and simply tolerated in a third (1978).

The second question is whether the establishment can ever waive its responsibility towards the community at large. Before we answer this question, let us see what this entails.

Societal Answerability

The ethical thinker, philosophical or otherwise, will have to combine the idealism of the absolutist or deontologist thinker (with his ideals of good and evil, proper and improper) with the utilitarian goals of implementing it for maximising societal mental health while reducing psychological morbidity. While being cognizant of both, he will not be unnecessarily bogged down by their seemingly diverse positions (see Foot, 1967; also Singer 1979, for review). By following the letter, he will of course add to the former. But the ethical code cannot be circumscribed to this alone. In promoting positive mental health, he must interact vigorously with *all* those agencies that have exerted and continue to exert such profound influence on the mental health of the community at large. Its code must therefore envisage a consciousness towards societal good wherein interaction with both local and governmental social welfare bodies, with other professionals, especially of the judiciary, with the fourth estate, the intelligentsia and the media of mass communications play a role. For this the establishment must get over as soon as possible its reluctance to be judged by others. Psychiatry and its practitioners will have to move out of the hallowed precints of their institutions and consulting rooms, and more so, their ivory-towers of encapsulated and isolated world-viewing, and make themselves answerable to the community at large. Psychiatrists exert a significant influence in many areas of public life as well as in the lives of their patients, and they have been insufficiently responsive to the public in accounting this influence (Chodoff 1981). All those who hold power over others have to account for it, politicians, educators, researchers, corporate

officers or others. The psychiatrist can be no exception. They will further have to provide channels of communication and monitoring agencies to assure the public that they are in effective control of their activities and are effectively policing their ranks (Chodoff 1984). And for the goal of maximising mental health, they must be unflinchingly ready to be baptised by the fire of critical, sharp and incisive scrutiny by other social welfare agencies. This appears a tall order with an establishment as wrapped up in self-protective activities as at present. But there is no reason to lament that it will not be able to rise out of this self-inflicted morass over a period of time. This cannot but be so in the case of a branch that has retained its healthy core amidst the most unhealthy draughts, both from without and within. One only wishes the hope inherent in this dialogue matches the conviction of the establishment that must profess it. And a firm philosophical enquiry into its ethical basis should supply it some of the roots to strengthen this commitment and the convictions from which it should spring.

No doubt some psychiatrists will play a greater role than others here. But none can escape from this role; their commitment will be adviseable in atleast as great a measure as is in their honest capacity. This is also to obviate the compulsions that would be otherwise entailed, if present trends are any indications of future portents. Even pragmatism hence demands it Moreover, the maturity and comprehensivity with which the psychiatrist tackles his patient and his branch must be transparently clear to the community in which he has the honour to be a professional. In this respect, the responsibility of the establishment and its individual members to promote an equitable distribution of services throughout the society, rich or poor, in private practice or in public or charitable institutions, and to as fair a level as is honestly possible becomes a pressing need

(Chodoff 1984). The failure to achieve this goal is a serious problem for all western countries and the rest may not be lagging far behind. Here we will also have to consider how societal responsibility could be maximized by tackling more that a mere handful of patients that psychiatrists all over are wont to do, in private or even in public institutions. The concept of distributive justice has to prevail and the establishment has a duty to obliterate inequities as manifest 'in the difference in treatment goals for the economically or ethnically disadvantaged and for the better off' (Chodoff 1984). Also closely related is governmental and other resource allocation to maximal population coverage as opposed to concentrated service that benefits a few. Already intensive psychotherapeutic set-ups in Britain are being considered a luxury the nation can ill afford on governmental costs. The establishment will further have to answer whether mental health, like health care in general, is a right of citizens rather than an 'optimal consumer good' (Livine 1979). For this Chodoff (1984) feels it must first define what it means by mental health itself, then state if mental health is freedom from disease or a state of self-actualization, then what role its various treatment modalities have in achieving either, and the support it should receive from public resources. He feels 'psychiatry has not as yet provided a firm answer to this question; it is its ethical duty to do so if possible or to acknowledge that it cannot'. Of course the problem cannot end here, for just because no categorical answer can be given at present does not mean work and search for an answer is not proceeding, or cannot proceed, side by side. A true accountability to society would involve doing away with the establishment's reluctance to be answerable on this account.

The establishment must envisage such an implementation of its code of ethics that encourages, nay obliges, members to carry

this out in some measure. Professionals are expected to exercise their moral authority not only as individuals, but as a group when they promote those values for which society has assigned them responsibility (Michels 1981). Only then can it be said that a sound philosophical base exists for psychiatric ethics. Then the ethics of the profession becomes morality in practice and presents ethics for what it essentially is – an affirmation of duties, of conduct, and only secondarily of rights and privileges. And pious declaration becomes proven acts e.g., 'I pledge myself to consecrate my life to the service of humanity'. (Declaration of Geneva 1948) and 'a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self' (Principles of Medical Ethics of American Medical Association 1980); as also, 'A physician must recognize a responsibility to participate in activities contributing to an improved community' (ibid); In research on man, the interest of science and society should never take precedence over considerations related to the well-being of the subject (The Declaration of Helsinki 1964); 'Is this (experimnetal) procedure one which I would not hesitate to advise, or in which I would readily agree if it were undertaken upon my own wife or children?' (Principles of Experimental Research on Human Being of the British Medical Association, 1963); 'the psychiatrist has to consider the ethical implications specific to psychiatry as well as the ethical demands on all physicians and the societal duties of every man and woman' (The Declaration of Hawai 1977); '(the physician must) work conscientiously wherever the interests of society demand'. (The physician's Oath of the Soviet Union 1971); The honoured ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well being of the individual and the

community' (Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry of the American Medical Association)[8].

Concluding Remarks

Of course it is in the nature of an ethical enquiry to raise more questions than it can answer. For, raising of questions means we are alive to the environment and actively interacting with it. But often ethical enquiry gets circumscribed thus. Moreover, it is at present, or rather always was, more fashionable to ask difficult questions that stump our audiences and leave them groping for an answer. Such manoeuvres only camouflage our lack of truly informed concern not only from others, but also from ourselves; for misinformed concern can be no less difficult to manage than unconcern. Henceforth, however, we should avoid all but the most necessary of such games-playing. If every ethical thinker has the right to raise questions, it is also his duty to try and answer some of them. Or suggest suitable pointers. Though we do accept that their expertise may not really lie here, atleast of some of them, and all they may be able to offer as answers are nothing more than worn-out cliches and pious declarations, that in itself will help them, and others, realise where each stands. For the glib questioner will be properly chastised, and the arrogant professional primed to sit up and think for himself. A concrete goal-oriented search for answers to some of our nagging enquiries in the ethical field must now begin to engage our active consideration. Here the philosophical attitude, rather than being a hindrance, can serve both as a catalyst and a governor : for if certain answer-seeking may need to be encouraged, certain others will need to be tempered. The minimum that need happen before anything worthwhile can result is that the average vigilant psychiatrist becomes aware of certain basic concepts of philosophical enquiry as they interact with, or are

useful to, his own understanding of his ethical code (as well as his branch itself), sift the proper from the improper in the light of this, and hold on to the proper while getting rid of the improper. The average vigilant philosopher similarly has a role to play in that although he cannot avoid offering abstract generalisations he need also offer concrete working concepts in his ethical enquiries, since the exigencies of this situation demand it.

The difficulties in doing so are no doubt many, and will be better appreciated if we understand the basic dichotomy in the training, expertise and value-orientation of the philosophical thinker and the practising professional. While the former prides himself, and cherishes, (quite legitimately perhaps), the ability to ask resolute questions, the professional (equally legitimately) concentrates energies mainly to find answers. Hence there can be a basic, and unavoidable, divergence as much of orientation as of emphasis. When, therefore, we think of making our questions relevant to an answer-seeker, as in the present situation, we must avoid any but the most operational ones, and certainly avoid those that appear arm-chair or ivory-tower pontifications not cognizant of applicability. For nothing puts off professionals more than this; and communication thus severed has hardly a chance to be re-established. Philosophers, therefore, will have to indulge in only such questioning as prompts, guides, even excites professionals to search for answers, even as they make them aware of the multitude of questions that remain to be answered. And it must come in this order; if reversed, communication has every chance of being severed or becoming skewed. While so doing, they must avoid smug generalisations or sticky hair-splitting; they must further forbear the impatience of the professional's obsession with solution seeking. Even as they do so, they must endeavour to lay the broad foundations of a solid theory of values, which is their basic philosophical concern. This

should unfold in its majesticity before the professional only as he graduates in his thinking faculties to match those of the philosopher and develops the ability to make and integrate ostensibly anarchical enquiries as philosophical questioning is often wont to do. Only then the foundation of a solid communication that ensures progress would have been laid.

To put it in a nutshell. The philosopher's abstract generalisations, then, will often need to be at a minimum. Their applicable operable definitions and frameworks will have to be maximised. Of course the abstract cannot but be present, but in a covert form, as an under-lying broad principle alive to the special needs of this situation; and therefore one that does not dominate it, for by so doing it would only undermine its own importance. As philosophical concepts become more understandable to those who have to implement them, they will serve the dual purpose of actualizing themselves and getting rid of needless vacuity. They will, further, become vital, and their energizing influence on professionals cannot but afford health-giving feed-back.

This then is the role to which the philosophically oriented must rise; and in so doing they will only hasten their own fulfilment. For, if Plato dreamt of a 'philosopher-king', we have yet to find that commitment amongst his successors which can convert this dream into reality. The establishment itself also needs to know that a robust grounding in a theory of values and striving to make it workable will gain for it that forward thrust which is within its potential but continuously eludes its grasp. For this, some amongst its own ranks must closely study the philosophical base of establishment itself, as well as its ethics and the stance of the moral philosopher, (as indeed of the Social Sciences and the Humanities at large; and even of its detractors),

and find paradigms useful for its own proper growth. Any dampening of vigour that results therefrom can only be over adventitious elements in the branch that have usurped positions of importance. Here, a meeting ground must be first laid down on the basis of a consensus, particularly on the basis of the lowest common denominator, gradually working upward to encompass wider and subtler entities. For this, open-ness to critical scrutiny is a must for the establishment, as is acknowledgement of errors and activities aimed at their speedy termination. Similarly, a necessary second step is to understand rather than neglect the abstruse and acknowledge its importance wherever due. The establishment can give a lead in this, for often philosophical thinkers, being only human, can be unduly pompous and, for all their declared catholicity, more dogmatic about convictions than is healthy for their own philosophizing.

Gradually, then, as barriers of communication are removed, the result will be a sound-based practicality for the professional and a living-philosophy for the philosopher. This need not only remain a hope and a dream; for ideals that cannot be practised are not worthy of being called ideals. In any case, they are hardly likely to fire the imagination of professionals. This then is the challenge to both sides. This then is also our hope.

13/14, Shiv Kripa
Oppo. St. Mary's Convent
Nahur, Mulund (West)
Bombay – 400 080

AJAI R. SINGH
And
SHAKUNTALA A. SINGH

NOTES

1. In India ethics has been discussed only twice in the *Indian Journal of Psychiatry* (Singh 1965, Dube 1982), both well-intentioned forays which have not spawned the interest they should have.

2. Some notable British comments have been Roth (1976) on involuntary hospitalization, Blumenfeld (1974) and Rosen & Rekers *et al* (1978) on ethical issues and the treatment of children, and Jones (1978) on societal responsibility of psychiatrists.

3. This of course is but a representative sample; many more can be cited.

4. We use the two terms in their widest possible cannotation here, wherein absolutism is also the opposite of relativism and utilitarianism is also utility to self, here, the profession involved; this, of course, is not how Hare, 1984, would understand these terms.

5. Unless otherwise specified, the word 'establishment' later on in the text means 'psychiatric establishment'.

6. Words underlined are to be considered italicized.

7. Although Rappeport talks here to the juvenile justice system, it is a typical example of pique and hurt of well-intentioned exasperation. And the broader generalisation about the honesty of the establishment's intentions is implied. Society's intentions are not proven to be questionable here, as elsewhere, precisely because its standpoint is essentially of the championing watch-dog type, and it must, by the very logic of its existence, come at times in adversarial contact with the establishment

8. Parenthesis added. All the Ethical Codes quoted above are from Bloch and Chodoff (1984b).

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