

Our curriculum does not claim to be comprehensive, but is rather an introduction to topics in psychiatric ethics. For more information on important topics, including informed consent, confidentiality, capacity, end of life, and gifts by patients, we suggest the following books.

**Dubovsky, S. L., & Dubovsky, A. N. (2007).** *Psychotropic Drug Prescriber's Survival Guide: Ethical Mental Health Treatment in the Age of Big Pharma.* WW Norton & Company.

Below are selected short excerpts from this book addressing topics mentioned above:

- “A core tenet of **informed consent** is that the patient chooses the treatment that seems best after understanding the potential risks and benefits of rational options. Deferring to a patient’s preference for a particular medication is often entirely appropriate. When a demand for a certain treatment, however, has been stimulated by marketing or incomplete information and it does not make sense—for example, when a patient who has had a difficult time responding to antidepressants and has finally found one that works well wants to change treatments after seeing an advertisement for something better—informed consent becomes much more complex.” [135]
- “One potential impact of DTC [direct-to-consumer] marketing is that a 30-second sound bite can present information so definitively that patients end up feeling that the medication is being advertised is the best treatment for their condition. This makes it more difficult for the physician to discuss alternative treatments and obtain **informed consent**. What physician has the credibility of a movie star or a figure on national television? For their part, physicians, who are increasingly pressed for time, when given a choice between helping the patient understand the range of treatment options or spending a minute acceding to the patient’s request and writing a prescription that probably makes sense anyway, will probably write the requested prescription [Karpay 2005].” [39]

**Roberts, L. W. (2016).** *A clinical guide to psychiatric ethics.* American Psychiatric Pub.

Below are selected excerpts from this book addressing topics mentioned above:

- “**Informed consent** is a philosophical and legal doctrine that serves as the cornerstone of ethically sound clinical care. Informed consent requires that a patient truly understand and freely decide to undertake—or not—a proposed treatment approach in light of his or her healthcare goals. Informed consent emphasizes respect for the individual, and it is inherently rational—that is, it occurs in the context of a professional relationship.” [51]
- “Strategies for enhancing the effectiveness of **informed consent** interactions:
  - 1. Information Sharing
    - Pay attention to the patient’s interpersonal cues and communication style.

- Avoid technical jargon and provide information at the right level to foster understanding.
    - Involve translators if necessary.
    - Offer both verbal and written material whenever possible.
    - Be aware of timing and context of information sharing so that patients do not experience an information overload devoid of personal meaning.
    - Encourage the patient to seek advice from loved ones.
    - Create opportunities for questions and dialogue.
  - 2. **Decisional capacity**
    - Assess the patient for deficits in decisional capacity.
    - Provide emotional support and reassurance.
    - For patients with decisional capacity deficits, approach things in a stepwise fashion—seek consent for beginning treatment, and as the patient’s symptoms and functioning improve, approach the patient for the larger decisions.
    - If the patient is not capable of providing consent at all, designate an appropriate family member as an alternative decision maker.
  - 3. Voluntarism
    - Establish a trusting relationship.
    - Seek to understand the values and choices of the patient now and in the past.
    - Address symptoms and illness phenomena (e.g., negative cognitive distortions, compromised insight) to whatever extent possible.
    - Avoid pressuring the patient for a quick decision unless absolutely necessary; reduce pressures in the environment when possible.”
  - (Pages 67-68)
- **“Decisional capacity**, the third element of informed consent, represents a sophisticated clinical assessment of an individual’s global and specific cognitive abilities within a particular context. Such an assessment can be a very subtle and complex exercise. Decisional capacity must be understood according to the type of decision to be made; the enduring, emerging, and fluctuating attributes of the individual; the nature and severity of the person’s symptoms; the precise nature of the patient’s situation; the individual’s prior experiences, personal values, psychological defenses, and coping style; and other factors.” [52]
- **“Confidentiality**, understood as trust, is gradually being eroded in modern health care. Medical information should be shared between practitioners only with the explicit consent of the patient. Insurance companies, however, freely share pooled information about every claim, provider encounter, diagnosis, and treatment, and signing up for electronic medical records is a prerequisite for care. Although consent is tacitly recognized in both cases, the patient has no choice. The patient cannot use insurance without giving consent for review of records and cannot receive care without inclusion in the electronic medical record. Perhaps most disturbing are guidelines that eliminate formal requirements for patients to consent specifically and prospectively to the use of their medical information for many and diverse purposes, far beyond the scope of the patient’s direct care.” [42]

- “Psychotherapists, among all clinicians, are the first to sound the alarm, affirming the importance of **confidentiality** protections. True therapy cannot occur without the traditional assurance of privacy. A patient could not feel free to talk to a therapist (and certainly not about personal matters) if he or she knew or suspected that such information might be shared with others. Employers could misuse it, or it might be used at some future time to prevent employment or to discriminate against the patient—for example, in obtaining health insurance...the solely commercial understanding of the patient as a “consumer” undermines the understanding, professional relationship as an ethical commitment to the suffering person.” [42]
- “The certainty of death is a truth that people tend not to keep in consciousness but rather to repress, forget, or even deny. Ensuring that explicit conversations about **end-of-life** care occur is an important task for all clinicians, especially given the impact of modern technologies and health care systems on the occurrence and process of death. From a mental health perspective, psychological suffering before death may be immense, and psychiatric disorders may distort decisions in the dying process. Death may trigger significant psychiatric symptoms among grieving loved ones. Psychiatrists, psychologists, nurses, therapists, counselors, and other mental health clinicians may have particularly important roles in preparing patients for death, safeguarding dying persons, and helping those who grieve.” [170]
- Six domains for consideration by mental health clinicians in **end-of-life** care
  - Diagnosis
    - What is the dying person’s medical condition? What is the anticipated course of the illness? Are there features of the illness that will cause physical pain, psychiatric and/or cognitive disturbances, or specific forms of disability? Does the dying person have evidence of a psychiatric disorder, such as delirium, major depression, or anxiety? Has appropriate treatment been initiated?
  - Comfort
    - Have diligent efforts to assess the physical and psychological pain been undertaken? What comfort measures are in place and are planned? Does the dying person understand what pain control measures are in his or her direct control? Have clear approaches to “stepping up” the pain control been discussed, so that the patient can request this?
  - Capacity
    - What is the decisional capacity of the dying person? What is the voluntarism capacity of the dying person? Has every reasonable effort been made to improve the patient’s capacities when he or she is making key treatment decisions (e.g., through careful efforts to address physical pain, to minimize use of unnecessary psychotropic medications)?
  - Clarity
    - Are the patient’s values and wishes clear regarding end-of-life care? Is there appropriate documentation to assist all clinicians and family members involved in the care of the patient?
  - Controversy

- Have the tough issues been addressed with the patient and his or her loved ones? Are the views of the patient, of key decision makers (e.g., family members), and of other individuals involved (e.g., the clinical care team, community members) known? If there are sources of controversy, have these been addressed carefully, with specific roles, boundaries, and decision-making processes and options clearly laid out?
  - Collaboration
    - For the benefit of the dying person, have all of the people—loved ones, multidisciplinary clinicians, community members—been appropriately included? Do other people or resources need to be invited in to help the patient?”
  - (170)
- “Debates about the rights and wrongs of **end-of-life** issues travel from the courts to the bedside and back to the courts and legislatures. Clearly, death is distinctly personal and profound in a manner that cannot be comprehensively captured by the impersonal proceedings of courts and laws. **End-of-life** conversations touch on the most inner, subjective aspects of the meaning of life and death. Psychiatrists who can help keep this focus will do much to serve their dying patients and help families, caregivers, clinicians, and other care providers.” (178)
- “When it is necessary to take actions that would appear to differ from national ethics standards, it is important to think through the reasons and implications of this choice from an ethical perspective. Furthermore, it is optimal to take several steps to ensure that patients are sufficiently safeguarded. For instance, in an interdependent frontier community, accepting **gifts** or bartering for services may be fundamental to the shared life and practices of the community. Even so, there may be gifts that are too large to accept ethically or individuals from whom services and resources should not be traded because of the specific unequal nature of the professional–patient relationship. In such situations where urban ethics rules and guidelines are not readily applied, the processes by which the rural clinician seeks to act ethically gain immense importance. Important process steps for ethical clinicians include comparing their practices with those of other rural and frontier clinicians, seeking consultation from trusted colleagues, developing written clinic policies, documenting decisions, and accurately disclosing what they have chosen to do.” (128-129)

**American Psychiatric Association. (2008). *Ethics Primer of the American Psychiatric Association*. American Psychiatric Pub.**

Below are selected excerpts from this book addressing topics mentioned above:

- “Psychiatrists are often asked to make judgments about a cognitively impaired patient’s **capacity** to make decisions about his or her medical care. Again, a dilemma arises from preserving the patient’s autonomy and avoiding harm. Discussions about the patient’s decision-making **capacity** need to focus on the medical issues at hand and not on the patient’s global abilities. This often needs to be carefully explained to the patient’s family

and other treating physicians, since the patient may be capable of making decisions about medical care but not about financial dealings.” [24]

- “Often with the combination of advanced age, medical illnesses, and cognitive impairment, the patient’s family and physicians may see little value in the patient’s **life**, and therefore little value in continuing it. The patient may also voice wishes to **end his or her life**. The ethical difficulty that the psychiatrist faces in this situation is the need to look at the situation from the patient’s perspective, rather than from the desires of the psychiatrist, the family, and other physicians. The psychiatrist should also look at ways of maximizing the patient’s quality of life given the medical, economic, and time constraints. Often, small changes in the patient’s environment, treatment regimen, or caregiver can improve the patient’s quality of life.” [25]
- “Psychiatrists may occasionally be challenged when patients or their families attempt to give them **gifts**. The issue is not as black and white as that of sexual boundary violations, and often the appropriate action in dealing with patients’ gifts must be evaluated on a case-by-case basis. The decision of whether or not accepting a gift from a patient is ethical may be affected by several factors, including the nature and cost of the gift, the therapeutic relationship between doctor and patient, and the transference issues that lead to giving the gift.” [45]
- “**Confidentiality** is an ethical cornerstone of psychiatry...the issue becomes slightly more complex when working with children than in the treatment of adults.” [16]
- “There are several exceptions in many states to a psychiatrist’s protection of patient **confidentiality**. These include the threat of a patient’s harm to self, the threat of a patient’s harm to others, and a suspicion that a patient has been a victim of child abuse.” [17]
- “Ultimately, ‘the best interest of the patient is a fundamental parameter by which to measure whether an action is ethically acceptable’ (Lyckhom 1998, p. 1945)” [47]

**Okasha, A., Arboleda-Florez, J., & Sartorius, N. (Eds.). (2008). *Ethics, culture, and psychiatry: International perspectives*. American Psychiatric Pub.**

Below are selected excerpts from this book addressing topics in ethics worthy of further study:

- “Is there one set of rules that should govern the practice of psychiatry as a discipline, or are there as many sets of rules as there are society? The second question is, If there is such a set of rules, what should we do to ensure that psychiatry as a discipline makes a significant contribution to societal good without helping the evil?” [3]
- “The autonomy of the profession of psychiatry is a conflicting and conflicted area and it must be protected as much as the patient’s well-being. In recent months, increasing protests by the public toward managed care’s selfish practices have even found their way into the courts, strengthening the position of those who say that a degree of regulation in the name of fairness and ethics is mandatory and almost unavoidable. The future of psychiatry—is it a profession or a corporation?—is also at stake, with many if not all practitioners of course sticking to the professional identity based on unmovable, essential ethical principles. A

reformulation of sacred documents about ethical standards of the profession...in more precise and contemporary terms is a critical step.” (99)

- “The dialogue between government and mental health professionals carries the moral burden of redressing the wrongs that have been done to mentally ill persons over centuries. In fact, it will be the measure of our civility that we devote ourselves to finding basic principles for creating legislation that will allow professionals to use their training and best resources to integrate not only mental health services but also persons with mental illness into society.” (206)