Ethical Principles and Skills in the Care of Mental Illness

Laura Weiss Roberts, M.D.

Caring for people living with mental illness is ethically complex, ethically committed work. The ethical complexity derives in part from the ways in which psychiatric disorders affect a person's experiences and sense of self. Mental illness influences beliefs, feelings, perceptions, behaviors, and motivations across time. It may interfere with one's ability to speak, to arrange one's thoughts, to know one's preferences. It may interfere with one's desire to eat, one's ability to find the energy to get up out of bed, one's will to make it through a day. Mental illness ultimately can shape one's development, personality, and capacities for love, self-knowledge, self-reflection, and societal contribution. It is these qualities that define us as human, as individual, and perhaps as moral agents (1, 2).

Because of this special nature of mental disorders, psychiatrists, in their efforts to prevent and alleviate mental suffering, assume a role of unusual significance in their patients' lives and in society. Even more than other physicians, psychiatrists may be called on to use their own values, life experiences, communication abilities, and human relatedness as well as their clinical knowledge and judgment to help their patients. Psychiatrists bring into play their interpersonal skills to transform the feelings, ideas, and relationships of people living with mental illness. They often explore highly sensitive personal information and confront very difficult, disturbing issues of great consequence to their patients. They may be called on to prescribe medicines that change the content and process of an individual's thoughts. Psychiatrists may be required to administer medications against the wishes of an acutely distressed person. While controversial, psychiatrists are called on—and, in many situations, are required by law—to restrict the liberties of a seriously, unstably ill person in order to keep him or her safe or to protect others in the community.

All of these therapeutic activities certainly involve the appropriate use of expertise. More important, from the perspective of ethics, these therapeutic activities entail the disciplined use of interpersonal, institutional, and societal power in an effort to bring about benefit and prevent harm. It is for this reason that caring for persons living with mental illness must also be accompanied by extraordinary ethical commitment.

Bioethics principles

Several philosophical bioethics principles underlie ethical practices in caring for persons with mental illness (Table 1) (1, 3–8). *Altruism* in the context of health care is the commitment of service to benefit others, even at the cost of personal sacri-

From the Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin. Address reprint requests to Laura Roberts, M.D., Professor and Chair, Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, 8701 Watertown Plank RD, Milwaukee, WI 53226.

The author gratefully acknowledges support from the National Institute on Mental Illness, the National Institute on Drug Abuse, and the National Alliance for Research on Schizophrenia and Depression. The author also expresses her appreciation for assistance by Cynthia M. A. Geppert, M.D., Ph.D., in preparing this paper. Dr. Roberts has no financial affiliations with commercial organizations that may have direct or indirect interest in this CME program.

Table 1. Examples of Basic Bioethics Principles

Altruism	Respect for persons	Respect for autonomy
Beneficence	Nonmaleficence	Clinical competence
Fidelity	Integrity	Confidentiality
Veracity	Justice	Respect for the law

fice. *Respect for persons* represents the clinician's ethical obligation to regard the ill individual fully, genuinely, intrinsically. In this sense, the ill individual's life history; personal, cultural, and spiritual values; preferences; and dignity should all be acknowledged for their inherent importance. *Respect for autonomy* is the idea that clinicians have the obligation to honor the ill individual's right to determine what happens to his or her body and mind, that is, the individual's self-governance.

Beneficence is the obligation to seek to help patients by relieving their suffering and by finding ways to enhance their quality of life. *Nonmaleficence* is the ethical duty to avoid harm. *Clinical competence* and scope of practice are closely related to these bioethics principles; they reflect the commitment to apply specialized expertise in the care of the patient, seeking benefit and not stepping outside of one's scope of knowledge and skill so that the potential for harm is minimized. The principle of *fidelity* is the commitment of the clinician to serve the well-being of the patient "faithfully," placing the interests of the patient above personal gain. *Integrity* conveys the sense of consistently honorable conduct and adherence to the values of the profession. *Confidentiality* relates to the duty to protect a patient's information, whether it is learned through disclosure, discovery, or observation in the course of a patient's care. *Veracity* is the duty to be honest—to tell the truth and not mislead through acts of commission or omission. At the societal level, *justice* is the principle of fair and equitable distribution of health care resources and of nondiscrimination. *Respect for the law* is the obligation to abide by laws, state and federal regulations, and other such rules of society.

These abstract bioethics principles find expression in everyday clinical practices and safeguards (3–5, 9–11). Informed consent is perhaps the most widely recognized ethical safeguard in clinical care and research (9, 11). Similarly, the ethical and legal safeguards surrounding involuntary treatment are paramount in psychiatric care (4). Another example is the practice of having release-of-information forms signed to document that permission has been obtained when disclosing personal health data to outside entities, such as insurance companies and family members. In psychotherapy, careful adherence to clear, predictable therapeutic boundaries in the therapist-client relationship represents an exceptionally important ethical safeguard (12–14). Documentation of potential conflicts of interest, particularly in research situations, is an additional protection that has grown in importance in recent years. The *Tarasoff* duty-to-warn and duty-to-protect protections represent other concrete practices in which bioethics principles are translated to clinical settings.

CLINICAL ETHICS SKILLS

Skills that may help psychiatrists approach and resolve ethical dilemmas in the care of people living with mental illness are briefly outlined here (Table 2) (1, 5, 10, 15). The first ethical skill is the ability to recognize ethically important aspects of a patient's care. Doing so involves sensitivity to the conflicts and tensions that might exist in the situation, for example, in balancing the patient's preference to live independently when the ability to maintain self-care habits is compromised by illness. The sidebar on the facing page, "Case Illustrations and Relevant Ethical Principles," presents several case examples related to this skill domain. Optimally, mastery of this skill involves ethical awareness and sensitivity as well as a working knowledge of the nomenclature and fundamental concepts of the fields of bioethics, clinical ethics, and, to some extent, forensic psychiatry.

The second skill pertains to the psychiatrist's ability to evaluate his or her involvement, understanding, and potential sources of bias in the patient care situation. This capacity for self-observation and self-critique is a crucial ethical strength that psychiatrists, who are specifically trained in this skill, can bring to ethical patient care practices. It should help minimize the potential for harm to patients, including, for instance, in preventing boundary transgressions in psychotherapy. This second skill is directly linked to the third and fourth skills. The third is the clinician's capacity to recognize his or her psychological discomfort and to see it as an important signal of potential ethical issues or problems in the care of the patient. The fourth is the ability to identify one's areas of clinical expertise and to work within this scope, except under unusual circumstances. The feeling of "being in over one's head" is a vital cue, ethically as well as clinically. A less seasoned or less sophisticated clinician might react to this feeling negatively or defen-

sively rather than seeing it as an invaluable indicator that can help the clinician steer clear of serious ethical binds or poor clinical decisions.

Another critically important clinical ethics skill is to know when external resources are necessary to provide competent, ethical care to a patient. This skill involves the ability to gather additional information or additional expertise, including the appropriate use of supervisors and consultants (e.g., clinical or ethical specialists) to clarify ethical choices. This skill may be especially important in dealing, for instance, with suicidal patients, sexually traumatized persons, people with personality disorders, or persons with extensive addiction issues or a legal history; these patients may have multiple problems, and their psychological and interpersonal patterns may introduce complex ethical tensions in the therapeutic relationship.

The expansion of valuable resources related to ethics and psychiatry in recent years has been impressive. Codes of ethics, policy documents, and other aids have been created, and the central code endorsed by the field of psychiatry is that of the American Medical Association regarding professional physician conduct (Table 3). A large body of empirically derived information has been developed in diverse areas, such as informed consent and decisional capacity in serious mental illness and forensic and clinical issues in end-of-life care (16–20). Excellent policy guidelines, textbooks, and resource documents also have been generated through the diligent efforts of experts and mental health advocates (8, 21–23). Becoming familiar with the resources that can be brought to bear on mental health ethics dilemmas may be extremely helpful to psychiatric practitioners.

PROBLEM SOLVING MODELS

Another key skill is the ability to perform rigorous, defensible ethical problem solving. For some practitioners, this may involve learning how to apply a formal ethical decision-making model to help analyze and choose a sound course of action in ethically complex circumstances (3, 24). The most widely studied bioethics model, developed by Beauchamp and Childress (15), emphasizes the cardinal ethics principles of beneficence, autonomy, nonmaleficence, and justice. In this approach, discerning how these principles relate to and inform a patient's care brings about greater conceptual clarity, which in turn helps in determining an appropriate course of action. Similarly, Hundert (24) has proposed a strategy in which latent conflicting values are identified and are resolved through explicit prioritization and clarification.

Sidebar: Case Illustrations and Relevant Ethical Principles[a]

Case 1

The mother of a 44-year-old man with active alcohol dependence and significant depressive symptoms wishes to speak with his treating psychiatrist. The patient has not given permission for the psychiatrist to reveal information to his family, although it is acknowledged that he is receiving mental health treatment. The clinic receptionist relays that the mother is very distraught and claims that it's a "matter of life or death." The psychiatrist calls the patient at home and finds that he is very irritable and dysphoric. He nevertheless agrees to permit the psychiatrist to talk with his mother. "You can listen," the patient says, "but don't say anything to her about me." The patient is asked to come to the clinic, and he does, accompanied by his mother.

Examples of relevant principles: Respect for the patient's confidentiality, nonmaleficence, respect for the law

Case 2

A 34-year-old woman diagnosed with obsessive-compulsive disorder is provided information about different treatment approaches. She prefers not to use any medications. She requests psychotherapy alone rather than medication alone or combination therapy. The psychiatrist and the patient together develop a treatment plan involving an initial 6-month period of psychotherapy, with clear goals and criteria for moving toward the introduction of medications.

Examples of relevant principles: Respect for autonomy, beneficence

Case 3

A 52-year-old man with long-standing bipolar illness has recently been admitted involuntarily after violently threatening his wife and physically damaging his home. He is offered medications that help him sleep, but he declines mood-stabilizing agents.

Examples of relevant principles: Beneficence, nonmaleficence, respect for the law, respect for autonomy

Case 4

An 18-year-old college student with a serious eating disorder is treated successfully with antidepressant medication. She requests that her psychiatrist double her prescribed dose so that she can avoid an additional copayment every other month, making her medications last longer. She requests this because her financial resources are limited.

Examples of relevant principles: Veracity, nonmaleficence, justice, respect for the law

Case 5

An elderly man who has lived in a remote area for his entire life is brought to the mental health clinic by a nephew. The elder has lost more than 20 pounds and does not appear to be taking care of himself well. On evaluation, he is cooperative and is found to be depressed. The psychiatrist believes that the patient needs a thorough physical workup. The elder adamantly refuses admission to the hospital in a nearby city.

a Note that all of these cases present interesting issues with regard to the stringency of standards for informed consent or refusal of treatment.
These cases were prepared by the author with assistance from Cynthia M. A. Geppert, M.D., Ph.D.

Table 2. Clinical Ethics Skills in Psychiatric Practice

The ability to apply a working understanding of the nomenclature and core concepts of bioethics and clinical ethics and the ability to recognize ethical features and values in a patient care situation
The ability to reflect on how one's life experience, attitudes, and knowledge may influence the care of the patient
The ability to recognize one's internal discomfort as a signal of potential ethical conflicts
The ability to seek resources that will help in approaching ethical issues, e.g., finding additional clinical, ethical, legal, or other information, obtaining supervision or consultation
The ability to identify one's areas of clinical expertise and to work within this scope, except under unusual circumstances
The ability to apply a formal ethical decision-making model to an ethically complex patient care situation
The ability to anticipate ethically risky or problematic situations
The ability to mobilize and construct appropriate ethical safeguards in the patient care situation

Source: Adapted from Roberts (1)

Jonsen and colleagues have outlined a clinical ethics decision-making strategy that focuses on the ethical principles of fidelity, beneficence, clinical competence, and nonmaleficence (3). Analyses guided by this model are patient centered as opposed to society centered, and they focus on expertise-driven standards of care and use of best practices. This clinical decision-making model highlights four components; listed in descending order of importance, they are clinical indications, preferences of patients, quality of life, and socioeconomic or external factors.

Consider the example of a severely depressed and suicidal woman who is undergoing a life-threatening asthma attack and is brought by a neighbor to the emergency department. The patient states that she wishes for no intervention and refuses intubation, indicating that she wishes to die and that this is her "right." In this case, there are fundamental tensions between the principles of beneficence (i.e., providing emergency treatment in order to save her life) and autonomy (i.e., the stated preference to die). The clinical ethics model resolves this problem through the following logic. Intervention is clinically indicated and is likely to bring benefit. It is the appropriate standard of care in essentially all emergency contexts in this country, and it is the expectation and duty of a physician to respond in this manner. In addition, there are reasons to believe that the patient has significant mental illness processes—that is, preexisting depression with suicidality and acute distress and discomfort—that may be distorting her ability to formulate or express sustained, authentic wishes. Moreover, the consequences of not intervening are grave, and failure to act will very likely bring about irreversible harm. This approach is not meant to diminish the autonomy of the individual, but rather it acknowledges that forces may be operating that are already interfering with her genuine autonomy. In less acute situations, patient preferences and personal values can more substantively influence the course of care, such as in the case of a patient choosing from among psychotherapy, medication treatment, combination care, or no treatment with close follow-up for an anxiety or mood disorder.

In addition to these more general ethical frameworks, Drane (25) has presented a compelling "sliding-scale" model for upholding ethical and legal standards for decisional capacity and informed decision making. In this approach, higher-risk decisions made by patients—to either accept or decline recommended treatment—necessitate higher levels of decisional capacity and more rigorous consent processes. Lower-risk decisions, on the other hand, may require more modest capacity and informational and decisional processes. For example, the request for discharge made by a patient in the intensive care unit who is seriously medically ill and showing symptoms and signs of substance withdrawal will, in this model, be held to stringent standards for decisional capacity and informed refusal of treatment. In contrast, the choice to delay a serum cholesterol test in the context of an annual physical examination for a healthy individual will not. The wish to decline a lithium serum level determination and thyroid function testing by an individual who has received lithium treatment for many years would fall somewhere in between. It is an ethics skill to assess what level of stringency is needed, given the circumstances.

The next skill is the ability to anticipate and navigate ethically problematic, or high-risk, situations. Examples include "dual agency" situations (e.g., court evaluations, occupational health care, therapy for both an individual and members of his family, and so on), reporting suspected child abuse, caring for a "difficult" multiple-problem patient, dealing with confidentiality issues related to the care of an adolescent with a sexually transmitted disease, duty-to-warn or duty-to-protect issues, or decisions to commit a seriously ill person against his or her wishes (4–6). These situations represent ethical risk because the clinician is entrusted with using power in a man-

ner that may impinge on traditions, expectations, and the usual rights of individuals (1, 4). The care of mentally ill persons living in underserved regions, such as many frontier and rural regions of the United States and in many countries throughout the world, also may be understood as posing distinct ethical risk. Personnel limitations, insufficient resources, and community features may interfere with the psychiatrist's ability to intervene in the care of a patient in an optimally beneficial, minimally harmful, and least restrictive manner. Consider the example of the alcohol-dependent man with multiple charges of driving while intoxicated who is under a court order to participate in therapy and lives in a sparsely populated area of Alaska where his daughter is the only licensed alcohol counselor—in other words, a dual role conflict (26, 27). The exercise of clinical expertise, professional and societal responsibility, and interpersonal power in such circumstances requires great care and, at times, special protections.

Finally, it is critical to build and employ a rich repertoire of ethics safeguards that may offer additional protection in ethically difficult situations. Development of advance directives for psychiatric care or end-of-life care and the inclusion of alternative decision makers or advocates are a few examples of such safeguards. Others include more complete documentation in the care of multiproblem or "difficult" patients and the strengthening of confidentiality safeguards for "VIP" patients. Finally, seeking ethics committee consultation, obtaining supplemental supervision and consultation, and using formal legal proceedings or designations (e.g., financial guardianship) may be excellent methods of introducing further protections into these situations.

Conclusions

Ideally, integrating these bioethics principles and clinical ethics skills in caring for persons living with mental illness will feel like nothing more than common sense or "usual habits of good clinical practitioners." This is the central tenet of clinical ethics, a field that seeks to apply the insights from the multidisciplinary field of bioethics to address morally important aspects of everyday care for individual patients (3, 5).

This approach presupposes that careful efforts to address ethical considerations are indistinguishable from other aspects of clinical excellence. Clinical skills acquired during psychiatric training such as thinking rigorously, examining one's own biases and impact, making latent issues explicit, seeking necessary expertise, and clarifying conflicts are absolutely fundamental to ethics in the care of persons living with mental illness. It is for this reason that psychiatrists may be especially well prepared for the ethical dimensions of their work. It is also for this reason, however, that psychiatrists are held to the highest standards of professional conduct in this ethically complex, ethically committed endeavor.

Table 3. Principles of Medical Ethics of the American Medical Association

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician will uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements, which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Adopted June 1957, revised June 1980 and June 2001

Disclosure of Unapproved or Investigational Use of a Product

APA policy requires disclosure of unapproved or investigational uses of prod-

ucts discussed in CME programs. Off-label use of medications by individual physicians is permitted and common. Decisions about off-label use can be guided by the scientific literature and clinical experience. Off-label uses of commercial products or services are not discussed in this CME program.

REFERENCES

1. Roberts LW: Ethics as endeavor in psychiatry: principles, skills, and knowledge. Psychiatric Times 2002; 19(12)
2. Roberts LW: Ethical dimensions of psychiatric research: a constructive, criterion-based approach to protocol preparation: the Research Protocol Ethics Assessment Tool (RePEAT). Biol Psychiatry 1999; 46:1106–1119
3. Jonsen AR, Siegler M, Winslade WJ: Clinical Ethics. New York, McGraw-Hill, 1998
4. Simon RI: Clinical Psychiatry and the Law. Washington, DC, American Psychiatric Press, 1992
5. Roberts LW, Dyer AR: Concise Guide to Ethics in Mental Health Care. Washington, DC, American Psychiatric Press, 2003
6. Council on Ethical and Judicial Affairs: Code of Medical Ethics. Chicago, American Medical Association, 2002
7. American Psychiatric Association: The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Washington, DC, American Psychiatric Press, 2001
8. American Psychological Association: Ethical Principles of Psychologists and Code of Conduct. Washington, DC, American Psychological Association, 2002
9. Roberts LW: Informed consent and the capacity for voluntarism. Am J Psychiatry 2002; 159:705–712
10. Roberts L, McCarty T, Roberts BB, Morrison N, Belitz J, Berenson C, Siegler M: Clinical ethics teaching in psychiatric supervision. Academic Psychiatry 1996; 20:172–184
11. Roberts LW, Geppert C, Bailey R: Ethics in psychiatric practice: informed consent, the therapeutic relationship, and confidentiality. Journal of Psychiatric Practice 2002; 8:290–305
12. Epstein RS, Simon RI, Kay GG: Assessing boundary violations in psychotherapy: survey results with the Exploitation Index. Bull Menninger Clin 1992; 56(2):150–166
13. Lakin M: Coping With Ethical Dilemmas in Psychotherapy. New York, Pergamon Press, 1991
14. Gabbard GO, Lester EP: Boundaries and Boundary Violations in Psychoanalysis. Washington, DC, American Psychiatric Press, 2003
15. Beauchamp TL, Childress JF: Principles of Biomedical Ethics. New York, Oxford University Press, 2001
16. Dunn LB, Lindamer LA, Palmer BW, Golshan S, Schneiderman LJ, Jeste DV: Improving understanding of research consent in middle-aged and elderly patients with psychotic disorders. Am J Geriatr Psychiatry 2002; 10:142–150
17. Carpenter WT Jr, Gold JM, Lahti AC, Queern CA, Conley RR, Bartko JJ, Kovnick J, Appelbaum PS: Decisional capacity for informed consent in schizophrenia research [see comments]. Arch Gen Psychiatry 2000; 57:533–538
18. Grimes AL, McCullough LB, Kunik ME, Molinari V, Workman RH Jr: Informed consent and neuroanatomic correlates of intentionality and voluntariness among psychiatric patients. Psychiatr Serv 2000; 51:1561–1567
19. Elliott C: Caring about risks: are severely depressed patients competent to consent to research? Arch Gen Psychiatry 1997; 54:113–116
20. Wirshing DA, Wirshing WC, Marder SR, Liberman RP, Mintz J: Informed consent: assessment of comprehension. Am J Psychiatry 1998; 155:1508–1511
21. Lidz CW, Meisel A, Zerubavel E, Carter M, Sestak RM, Roth LH: Informed Consent: A Study of Decisionmaking in Psychiatry. New York, Guilford Press, 1984
22. Faden RR, Beauchamp TL: A History and Theory of Informed Consent. New York, Oxford University Press, 1986
23. Backlar P, Cutler DE (eds): Ethics in Community Mental Health Care: Commonplace Concerns. New York, Kluwer Academic/Plenum Publishers, 2002
24. Hundert EM: A model for ethical problem solving in medicine, with practical applications. Am J Psychiatry 1987; 144:839–846
25. Drane JF: Competency to give an informed consent: a model for making clinical assessments. JAMA 1984; 252:925–927
26. Roberts LW, Warner TD, Brody J, Monaghan P, Smrcka J, Nguyen KP, Kaminsky A, Battaglia J, Brems C, Johnson M, Speier T: Stigma, ethics, and the frontier: challenges in caring for people with serious illnesses in Alaska and New Mexico. Arctic Research in the United States 2001; 15:2–13
27. Roberts LW, Battaglia J, Smithpeter M, Epstein RS: An OFFICE on Main Street: health care dilemmas in small communities. Hastings Center Report 1999; 29(4): 28–37

NOTES