

Virtual Mentor
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Virtual Mentor

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FROM THE EDITOR

Persons, Bodies, Minds, and Disease

I watched my patient's son cut up the bland, over-boiled hospital chicken and feed it to his mother, who was languishing in the neverland of dementia and stroke. I could see him thinking, "This? *This* is my mother?" It did seem hard to believe; the thousand individual, ordinary attributes that made this woman who she was had been wiped away. No more clunky piano playing, carefully applied lipstick, opinions on the economy, or babies dandled on the knee. For physicians and physicians-in-training, such a scene packs a hard punch because we wrestle personally with clinical decision making regarding the determination of capacity and end-of-life care, but we also watch helplessly as our own loved ones struggle with sporks and barely edible meat.

The theme of this month's *Virtual Mentor* issue is medicine and personhood, which at first glance appears a bit abstruse. "Personhood" sounds like the purview of philosophers and theologians, the sort of topic that is more germane to those heady wine-soaked evenings we enjoyed in college than to the white tiled corridors of the modern hospital. And yet the central questions posed by the concept—questions like "Who is a person and who is not?" "When does one begin—and cease—to be a person?" "Is there an enshrined view of personhood espoused by scientific medicine?"—are extremely relevant to clinical practice today.

In fact, questions of personhood are so relevant that they comprise the most hotly debated political and ethical issues of our time. Stem cell research, abortion rights, end-of-life care, competency to stand trial, capacity to make decisions for one's self, the nature of mental illness—all presuppose a view of the human person. The range of this subject is so large, in fact, that it is impossible to explore all areas in sufficient depth in one journal issue. For that reason, I decided to narrow the scope to the *sine qua non* of the personhood debates: the relationship between mind, body, and brain.

The relationship between mind and brain has been a subject of philosophic argument for millennia. There are two generally accepted views. One, monism, states that the mind is a function of the physical brain. The other, dualism, holds that the mind and brain are separate entities, made of different substances. Many adherents to the dualism position invoke ideas of soul or spirit to convey the concept of mind. Obviously questions about the nature of the mind and its connection to the brain are of great significance and contention in medicine. Psychotherapy versus psychotropic medication, neurologically based signposts of consciousness and personhood, the interplay among somatization disorders, conversion disorders, and other psychosomatic effects of disease—medicine is replete with their puzzling residua.

The human person, however conceptualized, is a delicate interplay of mind and body. Consider the case presented to commentator J. Wesley Boyd: the psychogenic physical suffering of a patient with a pathological fear of a heart attack is relieved by a therapeutic chest X-ray and EKG. Should the physician's attention be focused on the root psychiatric cause of illness, or should the patient's physical symptoms be addressed first? How should a clinician approach the interworking of mind and body? Boyd argues that there is an ethical imperative to treat suffering wherever it is found and pleads for physician humility when treading in this land of unknowns.

Another fascinating area where the dilemmas of personhood come bubbling to the surface is that of neuroethics. Kristi Kirschner comments on a patient who underwent a profound personality change after a traumatic brain injury. Is he the same person as he was before the accident? Can he undo decisions he previously made—that is, can this new personality claim to speak for the past and future patient? Kirschner discusses how to determine and assess decision-making capacity within a philosophical framework of identity and self.

And what of the patient who appears to be more than one person—or at least to have more than one distinct personality? We present a case of a patient with dissociative identity disorder who is fractured into various selves, one of which is capable of violent behavior. Can that antisocial self be subject to the *Tarasoff* Rule, which is the ethical and legal duty physicians have to warn and protect intended victims of harm? Can a part of a person be responsible for the whole in the eyes of the law? Michael Norko discusses the forensic and therapeutic consequences of the dis-integrated person.

Lest it be thought that the emphasis on personhood applies solely to the patients, I would respectfully submit that doctors are people, too. A recent journal article in *Academic Medicine* examined whether or not the algorithms and flowcharts of the evidence-based medicine movement reduces physicians to sophisticated computers. Raymond Raad comments on the article and discusses a new epistemology of medicine based on Michael Polyani's work, which states that subjective aspects of medicine, such as clinical experience, should be valued as highly as study data and other objective features.

Are practitioners of Western biomedicine implicitly biased vis-à-vis their conception of personhood? Scientific medicine rarely participates in discussions about such questions as monism and dualism, but the disparity in funding for research into allopathic treatments rather than into holistic approaches suggests a decided dualistic conception of the patient. James Lake argues that biological neuropsychiatry receives more than 500 times the amount of funding per year that holistic or alternative psychiatric research does. At the same time, the very term "neuropsychiatry" implies a promising move in medicine's understanding of a brain/mind connection. And in a fascinating commentary, Daniel Fu-Chang Tsai discusses the Confucian-based viewpoint of personhood, which derives from both community relationships and

individual autonomy. Many Asian cultures subscribe to this relational definition of the self.

We also examine the person in the eyes of the law. Lee Black discusses the ability of Alzheimer's patients to enter into contracts, and, in the clinical setting, Sean Blitzstein teaches us how to recognize and treat conversion disorders. Lastly, we look through the prism of history; Sneha Mantri writes about the rise of pathologic anatomy and scientific medicine, which coincided with a more objective and depersonalized view of the patient.

Most medical students and residents find their years of clinical training to be replete with moments that make them think deeply about themselves, their beliefs, and the nature of their state of knowledge. I've found the question of personhood to be the most crystallizing—whether it's seeing the look on the face of expectant parents first hearing a fetal heartbeat, interviewing the psychiatric patient so disorganized he can hardly speak, or caring for the woman in a persistent vegetative state and wondering, "Is there anyone in there?" Those sorts of raw moments, for me, were the impetus behind the issue. I warmly hope that you, when clicking through these pages, find cause to reflect on your own experiences as well.

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CLINICAL CASE

Decision Making in a Case of Personality Change

Commentary by Kristi L. Kirschner, MD

As a second-year neurology resident, Dr. Johnson has been fascinated by the case of Mr. Thompson, a construction worker who was nailing shingles to a roof when his co-worker's gun slipped, lodging a nail deep into Mr. Thompson's frontal lobe. Although comatose at first, Mr. Thompson regained consciousness and function under Dr. Johnson's care.

Despite his physical improvements after this accident, everyone in Mr. Thompson's life agreed that he was "not himself." Previously a gregarious, sunny man, according to his family and friends, "the kind of guy who always had a good word for everyone," "a joker," he had now become surly, withdrawn, and disinhibited. Before the accident Mr. Thompson loved having his friends and family around; now he threw everyone out of the room at the slightest provocation, all the while cursing and screaming. Happily married to his wife for 27 years, Mr. Thompson had three children and no prior history of medical or psychiatric disorders. After his accident, however, he disparaged and insulted his wife when she visited and refused to see his children. He had a living will in the chart in which his wife was named as his health care proxy. During his recovery from the accident she had made decisions for him.

When Mr. Thompson had made good progress in his physical recovery, the neurosurgery team brought up the topic of removing the nail lodged in his skull, presenting the risks and benefits of the surgery to Mrs. Thompson. Even though the operation would be tricky, the surgeons firmly believed that the benefits outweighed the risks. Mrs. Thompson opposed the surgery, but Mr. Thompson was adamant about going ahead with it.

Dr. Johnson was called to Mr. Thompson's room. The nursing staff reported that he was particularly agitated after a visit from his wife, during which they had discussed the possibility of surgery. "I'm tired of my family telling me what to do, those jerks," Mr. Thompson grouched. "I don't know why I married Laverne in the first place, and I don't even think the kids are mine. I want to change that living will and get her off of there. Nobody makes decisions for me but me."

Dutifully, Dr. Johnson assessed his patient's capacity. Mr. Thompson was alert and oriented to person, place, and time; he passed the cognitive exam with flying colors. He verbalized understanding of his situation, stated clearly his treatment options and the risks and benefits of his surgery. He appeared to meet all the clinical benchmarks

for decision-making capacity, and he was adamant that he no longer wished for his wife to be his health care proxy.

Dr. Johnson asked his team what they thought. The junior resident said, “the guy has a traumatic brain injury. He’s literally not himself—he’s a different person. He’s impaired. That’s the bottom line.”

“I disagree,” the senior resident said. “He’s clearly oriented and capable of abstract reasoning. Personality changes don’t mean you can trample on his autonomy.”

Commentary

Mr. Thompson reminds me of a famous patient, Phineas Gage. Mr. Gage was a railroad foreman who suffered a devastating injury in 1848 when a tamping iron shot through his left cheek, traversed the frontal lobes of his brain and exited through the top of his skull [1]. His notoriety stemmed not only from his survival in the pre-antibiotic era, but from observations of the dramatic sequelae of the injury. Though initially perceived to be remarkably intact neurologically, this previously respected and successful man experienced a sad denouement in the years that followed. In short, Mr. Gage became a living laboratory for the study of the brain (specifically the frontal lobes) and behavior.

Like Mr. Thompson, Mr. Gage retained the ability to walk, talk, see, hear, remember, and express wishes and preferences. What he lost, though, were the very qualities of behavior, e.g., many of his personality “traits”—his comportment, his judgment—by which people had identified him as Mr. Gage. Prior to the accident he was described by others as having a “well-balanced mind;” he was “shrewd,” a “smart business man,” and “persistent in executing all his plans of action” [2]. After the injury, Mr. Gage was unable to maintain steady employment, his language became profane and his behavior erratic, with one observer writing that he was “at times capricious and vacillating, devising many plans of future operation, which are no sooner arranged than they are abandoned” [2].

Frontal lobe injuries such as the kind sustained by Mr. Thompson and Phineas Gage both frustrate and fascinate not only physicians but also the individual’s intimates and acquaintances. Despite great strides in understanding the neurobiology of the brain and how it affects behavior through the pioneering work of behavioral neurologists such as Norman Geschwind, Antonio Damasio, and Marsel Mesulam [3], the diagnosis and appreciation of the full consequence of frontal lobe injuries often remains elusive, particularly in the immediate aftermath of injury. Bedside neurological examinations and even routine neuropsychological tests such as intellectual quotients and memory tests, can appear surprisingly normal, yet patients like Mr. Thompson and Mr. Gage often experience devastating downturns in their social functioning and personal fortunes.

Friends and families describe such persons as “not themselves” (as happened in both our examples) after such injuries. Research on frontal lobe injuries by Antonio

Damasio and his colleagues has demonstrated that subtle but devastating deficits in social awareness and affective valence can disrupt judgment, reasoning, and ultimately the ability to make wise choices and exercise adaptive judgments [4]. Unfortunately such deficits may only become apparent when the patient's behavior is observed in actual, rather than imagined or laboratory, situations.

Mr. Thompson's Decision-Making Capacity

With this background in mind, how then should the health care team consider Mr. Thompson? Is he now somehow a different "person"? His current conduct reflects impulsivity, thought disorder, and inappropriate social choices, as demonstrated by his wish no longer to see his children whose parentage he now questions, his disparaging comments regarding his wife, and his lack of inhibition. Whether we consider him a "different person" or not depends on the definition we choose when we discuss "person." The definition of personhood as used by the junior resident (and the one often chosen by the lay public) is more akin to the concept of personality—"the unique self; the organized system of attitudes and behavioral predispositions by which one feels, thinks, acts, and impresses and establishes relationships with others" [5]—than to legal, philosophical, or theological definitions of personhood. Indeed, an individual's *social*, or relational, identity arguably hinges more on personality than on physical appearance or even intellectual capacities.

Unfortunately, discussing personhood without establishing and defining the framework—social, legal, philosophical, spiritual, etc.—for the discussion can be frustrating, as demonstrated by the experience of Mr. Thompson's health care team. A vitalist, for example, might argue for a human species definition of personhood (i.e., simply being alive and human means one is a person), whereas others such as John Locke, Immanuel Kant, or Peter Singer might argue that personhood requires self-consciousness, rationality, and a sense of the future [6]. Mr. Thompson is clearly sentient (not comatose or vegetative), a unique human being, with one-of-a-kind DNA and a personal history. He also has some marked emotional, cognitive, and behavioral changes. The question now is how to put all of this information together in understanding Mr. Thompson's capacity to make decisions. To answer this question we need to use information from the above narrative, our tools for assessing decision-making capacity (DMC), and our knowledge of Mr. Thompson's brain injury.

Grisso and Applebaum have written extensively about the criteria for assessing DMC and suggest that a patient must be able to: (1) communicate a choice, (2) understand relevant information, (3) appreciate the situation and its consequences, and (4) rationally manipulate information [7, 8]. When assessing decision-making capacity it is important to remember that it is situation-specific, and the assessment must evaluate the congruence, or the "match or mismatch between the patient's abilities and the decision-making demands of the situation the patient faces" [9]. The more significant the consequences of a decision, the greater the evidence of DMC required. It is the process of evaluating DMC that is critical [10].

So what do we know about the assessment of Mr. Thompson's DMC? We are told he is alert and oriented to person, place, and time and easily passes the cognitive exam. Though this is helpful information, it provides only limited support for criterion 3—i.e., that he has some appreciation of his situation and knows that he is in the hospital [9]. Further, we are told that he can verbalize his situation and the options presented to him including the risks and benefits of the various choices—very important information for assessing criteria 2 and 3. Mr. Thompson is also expressing a preference to go ahead with surgery and to “fire” his wife as his proxy—demonstrating his ability to communicate choices (criterion 1). But is this enough to say he has met all the clinical benchmarks for DMC? I think not. We have at best a superficial, and *verbally mediated*, understanding of his decision-making capacity with strong evidence that his abilities to manipulate information rationally and anticipate consequences are impaired—skills that are critical components of DMC.

Assuming that the information we have about his prior relationships is accurate (and I would look for independent confirmation of this information), his paranoia and beliefs concerning his wife and children are grossly irrational (apropos criterion 4) and incongruent with his history and relationships prior to the brain injury. I also question how much insight he has into his condition. Does he have awareness of the dramatic changes in his personality and behavior, and does he seem to feel appropriately distressed by them? His sexual disinhibition also argues against self-awareness.

Based upon the above analysis, I conclude that Mr. Thompson currently does not have the capacity to make a decision regarding surgery. I believe the critical skills required to weigh decisions of such consequence, to manipulate information rationally, and to choose wisely are the skills most impaired by Mr. Thompson's frontal lobe injury. Efforts should therefore be directed to mitigate the permanency of his brain injury and to maximize his recovery. If there is a chance that removing the nail could help Mr. Thompson recover his decisional abilities and prevent further deterioration (from a complication such as an abscess), then this decision has great future consequence. Indeed, his long term well-being and future autonomy are at stake. At least for the time being, Mr. Thompson needs the protection of a surrogate to help make decisions of major importance. We also must recognize the limitations of this evaluation. This is neither a global nor definitive determination, and frequent reassessments will be needed as Mr. Thompson's condition changes and evolves. Rather, this is only a recommendation for the specific question at hand.

Whether his wife should continue in the role as his proxy, though, is a separate question. For this particular decision an argument could be made to partially honor Mr. Thompson's wishes. Given the conflict that now exists between Mr. Thompson and his wife, a guardian ad litem would be a reasonable alternate decision maker and could serve as a neutral third party to weigh information (from Mr. Thompson, the health care team, and family) and facilitate a decision about surgery. In general, although one must be competent to execute an advance directive, there is a bias in

favor of allowing a person to negate such a document in the future—whether or not he or she is fully competent [11].

The interesting twist here, and one we don't have adequate time or space to address, is Mr. Thompson's preference for surgery (the decision recommended by the neurosurgeons) and his wife's refusal. Though it's tempting to say that Mr. Thompson has DMC because he is making the decision recommended by his health care team (i.e., if he agrees with us we are less likely to question his capacity), it is the soundness of his process of deciding that is important. I believe, as described earlier, that Mr. Thompson's process is flawed and that he does not have DMC.

The wife's decision to refuse surgery because she believes it is "too risky" also raises questions. Surrogates are instructed to make decisions either by using substituted judgment (in which they make the decision they believe the patient would make for him- or herself based upon the patient's prior statements or expressed wishes), or, in the absence of such information, by basing the decision upon the subject's best interests, weighing the expected benefits and burdens of the treatment. Recognizing that we have limited information to understand Mrs. Thompson's rationale, I am hard pressed to understand how her decision meets either criterion. At a minimum, further discussion with Mrs. Thompson is warranted.

In summary, I believe Mr. Thompson has had a brain injury which affects not only his personality but also his insight and reasoning abilities. I do not think he has adequate DMC to make a decision regarding surgery, and the protection of a surrogate is required. I would also emphasize that this determination is for this point in time only, and for this particular decision. His DMC will need to be reevaluated as his condition changes and as new treatment questions arise. Given the current conflict with his wife and the complexities of the situation, I would consider bringing in a guardian ad litem to assist with the decision-making process.

References

1. Damasio AR. *Descartes' Error: Emotion, Reason, and the Human Brain*. New York, NY: G.P. Putnam's Sons; 1994:4.
2. Damasio, 8.
3. Mesulam M-M. *Principles of Behavioral and Cognitive Neurology*. 2nd ed. New York, NY: Oxford University Press; 2000.
4. Damasio, 34-79.
5. Spraycar M, ed. *PDR Medical Dictionary*. Baltimore, MD: Williams and Wilkins; 1995:1335.
6. Walters JW. *What is a Person: An Ethical Exploration*. Urbana, IL: University of Illinois Press; 1997.
7. Grisso T, Appelbaum PS. *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. New York, NY: Oxford University Press; 1998.
8. Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med*. 2007;357(18):1834-1840.

9. Grisso, Applebaum, 23.
10. Kothari S, Kirschner KL. Decision-making capacity after brain injury: clinical assessment and ethical implications. In: Zasler N, Zafonte R, Katz D, eds. *Neurorehabilitation of Traumatic Brain Injury*. 2nd ed. New York, NY: Demos Publishing; 2007:1205-1222.
11. Kirschner KL. When written advance directives are not enough. *Clin Geriatr Med*. 2005;21(1):193-209.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental.

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CLINICAL CASE

Duty to Warn and Dissociative Identity Disorder

Commentary by Michael A. Norko, MD

As a fourth-year student doing a psychiatry rotation, Alana had been researching dissociative identity disorder. She'd worked with a couple of patients with that diagnosis over the month, and one patient had given her permission to sit in on the therapy sessions with the psychiatrist, Dr. Carpenter.

The patient was a woman who appeared to have five distinct personalities. Of average height and build, this patient, whose name was Mary, alternately appeared to be a frightened child, a sexually provocative adult, a male writer, an accountant, and a violent, unrestrained person called "Sam." "Sam" routinely threatened to assault physicians and staff, threw chairs and other objects with great force, and often cursed at anyone who came near him. Dr. Carpenter made certain that restraints were available when "Sam" appeared. He believed that this personality was an unconscious identification with the men who had abused Mary viciously when she was a child and that it would disappear when Mary was successfully treated.

During the last week of Alana's rotation, "Sam" was the primary mode in which Mary presented. He repeatedly made threats about a specific person—the owner of a grocery store near where the patient lived. Midway through one session, "Sam" stated, "I'll kill that guy. You know I will. I've already made a plan and bought a gun. I'm going to shoot him tonight when he gets off work."

Dr. Carpenter tried to calm "Sam," and, after a few minutes, Mary the accountant resurfaced. After about 10 minutes of conversation, Mary left, acting calm and relaxed, with no recollection of "Sam" and his threats.

Remembering the famous *Tarasoff* case, after which the courts decided that psychologists and psychiatrists had legal and ethical duties to inform the police of a threatening patient's plan, Alana asked Dr. Carpenter whether the *Tarasoff* ruling applied to Mary and whether they should inform the police.

Dr. Carpenter seemed hesitant. "I've been working with this patient for 18 months. If I were to turn her over to the police, it would undo all our work, and quite possibly she would not return to therapy."

Commentary

There are many fascinating aspects of this case worthy of discussion, but the place to start is with the ethical dilemma between, as Dr. Carpenter characterizes it, doing

good therapy and “turning the patient over to the police.” I will discuss the issues of police notification and *Tarasoff* duties further, but my first observation is that solving difficult problems is often a matter of finding alternatives early and intervening before a dilemma arises. In this case, Dr. Carpenter not only had earlier opportunities to avoid the decision Alana’s question poses, but probably the responsibility to do so.

Dr. Carpenter has a worthy goal in mind for long-term therapy with Mary—the re-integration of her ego and resolution of negative effects of past traumatic experiences. He is probably right that “Sam” will “disappear” with a successful treatment. The problem is that “Sam” is very real behaviorally, and the presence of this violent tendency within Mary should not be ignored, though it seems that Dr. Carpenter may be doing so.

When Dr. Carpenter attempts to calm the patient and Mary responds to him, it’s not the psychological equivalent of a successful tumor resection. Mary is not “cured” of her “Sam” personality. Just because it was the Mary personality who left Dr. Carpenter’s office and was no risk to others does not mean that Mary—the person—is not a danger. Dr. Carpenter is well aware of the risk that “Sam” poses; he has taken the extraordinary measure to have restraints available when he conducts therapy with Mary.

Unless Dr. Carpenter can somehow feel certain that “Sam” has never appeared outside of a therapy session and never will, he has knowingly allowed a person capable of violence to leave his office after making a specific threat to an identified third party. Were the grocer to be injured or killed by Mary, Dr. Carpenter would have a hard time explaining his rationale for taking precautions to protect his own safety but not considering the safety of an identified potential victim in the community or the risk to his own patient’s well-being should violence or attempted violence occur. This is not to say that Dr. Carpenter’s primary duty is to public safety, but he has done no service to Mary by allowing her to leave without further exploration of the risk and appropriate precautions.

So let’s re-examine the session and its antecedents to see what else Dr. Carpenter might have done when “Sam” appeared in the session and made what seemed to be a credible threat. “Sam” spoke of a particular victim who works in a location near Mary’s home, whom Mary knows and to whom she has access. “Sam” also provided a specific time frame (tonight) and method of killing (gun). In an attempt to calm the patient down, Dr. Carpenter seemed most interested in making “Sam” go away, and, in doing so, he missed an opportunity to probe further the extent and seriousness of the situation so that he might form an appropriate treatment plan with his patient.

Had this been an oral board examination in psychiatry, Dr. Carpenter might well have failed for not assessing homicidality. Why does “Sam” want to kill the grocer? Is this desire based on a paranoid, delusional belief? Is “Sam” angered over some recent offense or slight, or is the grocer a random or symbolic target? Does “Sam” actually have a gun? Can he obtain one? Has “Sam” used a gun in the past? Is there

some meaning to the timing of the threat? Is tonight important for some reason? Because these questions were not asked, we know very little about how serious a threat Mary (the one person) poses to the grocer—even outside of her own awareness.

The American Psychiatric Association, for example, in its *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* recommends asking the question, “Do you have guns or other weapons available to you?” [1] The situation in this case scenario would seem to call for the same inquiry.

Perhaps these questions seemed irrelevant to Dr. Carpenter because, after all, “Sam” is only a portion of a fractured ego, and not a separate, physical person. But Dr. Carpenter knows how real the phenomenology of “Sam” is. He has already engaged in 18 months of hard work to help Mary re-integrate these components of her personality.

The fact that Mary does not recall what takes place when “Sam” is present will not prevent her from being arrested when witnesses report her shooting the grocer, nor is it likely to relieve her of all the criminal consequences of her act. The criminal justice system will not get caught up in thinking of “Sam” as the perpetrator and thus be stymied in efforts to prosecute Mary. Mary’s mental state at the time of the crime will be relevant and may permit her to offer an insanity or diminished capacity defense in many jurisdictions, and her amnesia about the events may well complicate determination of Mary’s competency to stand trial and her criminal responsibility [2]. But even a successful insanity defense or a mitigated sentence is not a desirable outcome for Mary. Juries are suspicious of both amnesia claims and the insanity defense, and an outcome less serious than a murder conviction would not be certain.

Dr. Carpenter is right not to have had a knee-jerk response to call the police when hearing a threat during a therapy session. In fact, there are known negative consequences to mandated warnings, including harm to the therapy [3] and criminal prosecution of the patient [4]. Nevertheless Dr. Carpenter needed to gain more information from “Sam” after the threat was made in order to determine an appropriate course of action. He needed to have further discussion with Mary after she responded to him. Mary should have been made aware of the threat that “Sam” made, so that she and Dr. Carpenter could formulate a plan together for keeping her and the grocer safe from harm. If Mary has a gun or access to one, what steps can she take to protect herself since she does not recall what “Sam” does? Mary may also be unaware of a gun obtained or hidden by “Sam,” and Dr. Carpenter and Mary should have also made plans for this possibility.

If there is any substantial risk of “Sam” making an appearance outside of therapy—especially that very night—it might be necessary to hospitalize Mary. Or perhaps she merely needs to be with people she can trust to monitor her behavior on a constant basis. Is it possible to make such arrangements? If it is possible for Mary’s friends and family to assist her, is it safe for them? Would it be an effective plan? What we

don't know from this narrative is whether Mary (in any mental state) has elsewhere engaged in the kind of violent behavior that Dr. Carpenter has observed. If there are no reliable clinical interventions to prevent this possible homicide, then notifying the grocer and the police must at least be considered.

But all of this should have been talked about before Mary left the session. In fact, it should have been discussed after "Sam's" first display of chair-throwing and violent threats. To some extent it was considered, because Dr. Carpenter has arranged to restrain his psychotherapy outpatient if necessary. Again, the inconsistency of Dr. Carpenter's behavior will bedevil him if the grocer is attacked.

It seems likely that Dr. Carpenter was not prepared to respond to this sudden turn of events because he had not contemplated the range of possible adverse consequences of Mary's violent behavior. Dr. Carpenter was doing precisely what the California Supreme Court was critical of in the *Tarasoff v. The Regents of the University of California* case; he was considering his clinical activity during therapy sessions in isolation from the rest of his patient's experience and interactions in the world.

As the California Supreme Court famously noted, "[t]he protective privilege ends where the public peril begins" [5]. The solution raised by that first *Tarasoff* court was that the therapist had a duty to *warn* the likely victim of a patient's threat. When the case was re-heard, the same court—known as the second *Tarasoff* court [6]—restated that the duty was to *protect* the likely victim. Many mental health professionals were more distressed by the second decision than by the first. After reflection, however, the field came to understand that it was possible to protect the victim (e.g., by hospitalizing the patient and treating the etiology of the potential violence) without violating the confidentiality of therapy.

The state of California ultimately modified the legal requirements by statute in 1985 so that the duty to a third party could be fulfilled by "reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency" [7]. California continued to struggle with the precise nature of the requirements in case law, and the legislature modified the statute again in 2006 to attempt to clarify that there was a duty to warn and to protect that could be fully satisfied by a warning to the victim and police [8]. Many other states have adopted legislative mandates about *Tarasoff* duties; most impose a duty to breach confidentiality, some merely permit it, and others are silent on the issue [7]. Because of the state-to-state variation, mental health professionals must be well-informed of the duty in their own states, which can be simultaneously complicated, vague, and difficult to assess.

Dr. Carpenter should have sought consultation with a colleague familiar with forensic psychiatry earlier in the course of Mary's therapy, certainly upon entertaining the idea of physically restraining an outpatient. That would have allowed him to have the benefit of probing questions and a viewpoint outside of the limited focus of his clinical goals for his long-term therapy patient. Because of Alana's observations, the right question is being asked, but too late to allow the most

reasonable interventions. Dr. Carpenter will either have to call Mary back in, if possible, to engage in the appropriate immediate care plan, or call the police and hope they can be helpful without hurting Mary or the therapy, or do nothing and hope that serious violence will not erupt that evening.

Professionalism does not permit inaction in the face of such adverse potential consequences. Dr. Carpenter may only choose to do nothing (i.e., call neither Mary nor the police) if he is satisfied through his clinical assessment that Mary and the grocer will be safe without such interventions. Given the potential outcomes, Dr. Carpenter should also seek consultation in making this risk assessment. And, as in all clinical and risk assessments, he should be careful to document his decision making and his consideration of alternatives.

References

1. American Psychiatric Association. *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors*. Washington, DC: American Psychiatric Association; 2003:10.
http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx. Accessed February 12, 2008.
2. Bourget D, Whitehurst L. Amnesia and crime. *J Am Acad Psychiatry Law*. 2007;35(4):469-480.
3. Herbert PB. The duty to warn: a reconsideration and critique. *J Am Acad Psychiatry Law*. 2002;30(3):417-424.
4. Weiner JR. *Tarasoff* warnings resulting in criminal charges: two case reports. *J Am Acad Psychiatry Law*. 2003;31(2):239-241.
5. *Tarasoff v The Regents of the University of California*, 529 P2d 553 118, Cal Rptr 129 (Cal 1974), at 561.
6. *Tarasoff v The Regents of the University of California*, 551 P2d 334 (Cal 1976).
7. Herbert PB, Young KA. *Tarasoff* at twenty-five. *J Am Acad Psychiatry Law*. 2002;30(2):275-281.
8. Weinstock R, Vari G, Leong GB, Silva JA. Back to the past in California: a temporary retreat to a *Tarasoff* duty to warn. *J Am Acad Psychiatry Law*. 2006;34(4):523-528.

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CLINICAL CASE

Psychosomatic Elaboration of Distress

Commentary by J. Wesley Boyd, MD, PhD

It was a typical night at St. Matthew's, a large community hospital with a busy emergency department (ED), and Dr. Allison was the intern on duty. The past couple of weeks had been interesting, though tough, for Dr. Allison—making clinical decisions without a lot of time to consult with others.

About half-way through Dr. Allison's shift, a young man, trim and healthy-appearing, lurched in through the ED doors clutching his chest. "I can't breathe!" he rasped. "I'm having a heart attack!" Dr. Allison ran over to help this desperate man. He described crushing substernal chest pain and appeared to be in respiratory distress, based on his rapid shallow breathing and wheezing. The man said that it had started suddenly, a couple of hours earlier; nothing like this had ever happened to him before. He was drenched with sweat. Quickly, Dr. Allison ordered an EKG and a chest radiograph (CXR), and called for a crash cart in case he needed to intubate the young man. Dr. Allison informed the chief resident and the attending physician of the situation and they approved of the plan.

The EKG came back completely normal—a healthy 25-year-old heart. Neither the cardiac enzymes nor chest radiograph showed any abnormalities. Puzzled, Dr. Allison informed the patient of the findings and noted that he already seemed much calmer as he sat hooked up to the telemetry monitoring. Upon hearing that everything was normal, the patient smiled, his breathing normalized, his sweating ceased, and he reported that the squeezing sensation in his chest had passed.

Intrigued, Dr. Allison researched the patient, Mr. Wagner. His name appeared in recent hospital medical records. Dr. Allison learned that a month prior, Mr. Wagner's parents had been brought to St. Matthew's after a fatal motor vehicle accident. Middle-aged and healthy, both had died in the emergency department from their severe injuries.

A week later Dr. Allison was again on call when Mr. Wagner stumbled into the ED late at night, again in obvious distress. He was sweating, clutching his chest, and grossly tachypneic. Barely able to speak, he described tight squeezing around his chest and appeared to be in great pain. Dr. Allison reported the case to the attending physician and mentioned that, on the previous occasion, Mr. Wagner's very real distress was alleviated by the CXR and EKG reports.

Dr. Allison's chief resident said, "The guy needs a shrink, that's all. Put him back on the street. No need to waste money on imaging when we know there's nothing organically wrong."

Commentary

It is never ethically acceptable for people perceived to be neurotic or experiencing psychosomatic elaboration of distress to receive less than the standard of care. Providing anything less would be, in essence, gambling with the patient's health without his or her consent. After all, even though there was no physical basis for Mr. Wagner's complaints the last time he was in the ED, there is no guarantee that he is not having a heart attack this time. Furthermore, irrespective of whether or not he is actually having a heart attack, Mr. Wagner is obviously suffering a great deal, and for this reason he deserves compassion and humane treatment.

This case prompts me to offer a couple of clinical vignettes (with certain identifying features changed) from my own practice. The first centers on a young woman I saw when I was a resident in the psychiatric emergency department after the medical ED had dismissed her complaints of left-sided weakness as "somatic" and "hysterical." She had her share of reasons to be hysterical: she was pregnant, newly divorced, and had just been fired from her job. During the course of my interview, I twice called the medical ED and asked if they were absolutely certain that she hadn't had a stroke, given that they hadn't obtained a CT scan. The ED medical staff assured me that her symptoms were psychiatric and that they would not reconsider their clinical decision.

While I was on the phone the second time, through the exam room window I saw her lift her left arm—the same one she couldn't lift when I'd asked her to do so earlier—push her hair out of her eyes, and then drop her arm again. That arm motion convinced me that the medical ED was right. (I've since educated myself about those brain lesions that don't affect reflexive, unthinking movements like pushing hair out of one's eyes even though they obliterate voluntary muscle movements.) I ultimately discharged her that night from the psychiatric ED, but, given her level of impairment, I asked her to return 12 hours later for a check-in. When she returned she was still very impaired, so I admitted her to the inpatient psychiatry unit. A nurse immediately suspected a stroke, easily convinced the psychiatrist on the unit to order a CT, and the diagnosis was confirmed.

Fortunately, the delay in diagnosing her stroke did not cause the patient any permanent harm. More recently, though, I have been all too close to a case in which mislabeling based on assumptions about the patient turned out to be deadly. The 30-year-old husband of one of my patients was found by EMTs slumped over the steering wheel in his truck. As they were frantically trying to revive him, one of them picked up his cell phone, redialed the last number called, and reached his wife—my patient. They asked her about his medical history. When she told them, among other things, that he was a recovering heroin addict who'd been clean for several years, she heard their urgency to help him all but evaporate.

The EMTs told her where they were taking her husband, and when she arrived at the hospital half an hour later he was still unconscious. She told anyone who'd listen that he hadn't overdosed and that they needed to get a CT scan. She told the attending physician that her husband's father had died from a stroke when he was young. But the ED staff insisted that her husband had overdosed. A nurse even slapped him on the face to "arouse" him. Three hours passed before he finally was scanned—almost as an afterthought—which confirmed that he'd suffered a massive cerebral bleed. He never regained consciousness and died several days later. Had 3 hours been the difference between life and death?

I offer these vignettes as cautionary tales about the dangers of failing to adhere to standard of care, even when there appears to be an obvious explanation that doesn't require a full workup.

In Mr. Wagner's case, even though his symptoms are identical to those he displayed on his previous visit, there's no way to tell *a priori* that he is not actually having a heart attack this time. The only way to confirm the chief resident's impression of what's wrong is to run tests to rule out medical conditions. As an added wrinkle, I'd say that, even if all tests were to come back negative, it is still possible that the problem has a physical basis. Our testing apparatus and medical knowledge are so sophisticated and awesome in their scope and nature that it is easy to believe that, if all tests turn up negative, the suffering at hand cannot be physically based. Although this line of thinking is common, it is also fallacious because there are always limits to our testing methods and to the science underlying their application.

Physicians' Duty to Alleviate Suffering

How can we educate physicians not to be too quick to write off something as "psychiatric," which in medical language often means that it's either not real or unworthy of attention? Teaching humility in the practice of medicine would be a great start. We don't know everything. We're not infallible. Our daily practice of medicine is filled with uncertainty, and the more we take this fact to heart, the less arrogant, cocksure, and potentially demeaning we will be toward our patients. Would the chief resident have been forceful in telling Dr. Allison to get Mr. Wagner out of the ED if the chief understood, in a visceral way, the extent to which uncertainty permeates medicine? I would guess not.

So, even though Mr. Wagner's initial evaluation in the ED did not reveal any cardiac disorder, we cannot assume the same is necessarily true when he returns a week later. What if this time he really is having a heart attack? Should anyone be willing to take that chance and send him away without running a basic set of tests to rule out a myocardial infarction? And even if they were willing, they would be trampling upon Mr. Wagner's rights as a patient.

All of the above notwithstanding, if I had to bet on the outcome, I'd wager that all of Mr. Wagner's current symptoms are in fact psychiatric in nature. But the likelihood

that his suffering is psychiatrically based does not change the fact that Mr. Wagner *is* suffering, and it is a physician's moral duty to attend to suffering in whatever form it takes. Dr. Allison ought to attend to the full scope of his duties as a physician and address Mr. Wagner's suffering, irrespective of its source. For example, after running tests that came back negative, he could sit briefly with Mr. Wagner, talk to him just a bit, and facilitate a referral to a psychiatrist. Doing so will help get him the treatment that he needs and probably also lessen the likelihood that he'll return to the ED in another week with similar symptoms. This would also help prevent further overcrowding in the ED. Until Mr. Wagner's suffering is addressed, he will continue to cast about seeking help, be it in Dr. Allison's ED or some other.

Just as it's true that being paranoid doesn't mean that someone is not in fact out to get you, the hypochondriacal, somatizing patient might just be having a heart attack. Without medical evaluation to know with certainty what the source of the symptoms is, the physician is gambling with the patient's health without the patient's permission, and that is never ethically permissible. Patients deserve to be treated according to the standard of care, and it is the physician's duty to do so. If such treatment does not turn up any cause, the physician should remind himself that his calling is to alleviate suffering and proceed accordingly.

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JOURNAL DISCUSSION

Evaluating Sources of Clinical Knowledge

Raymond Raad

Henry SG, Zaner RM, Dittus RS. Viewpoint: moving beyond evidence-based medicine. *Acad Med.* 2007;82(3):292-297.

It can be difficult to understand how anyone can criticize such an obviously worthwhile idea as evidence-based medicine. After all, who does not believe that medical decisions should be based on evidence? Yet, as Stephen Henry, Richard Zaner, and Robert Dittus explain in their *Academic Medicine* article, evidence-based medicine means something much more specific than the general notion that “medical decisions should be based on the best, most current information available” [1]. Rather, the term refers to the reliance on specific types of epidemiologic studies as the basis for medical decision making. As currently understood in the medical community, evidence-based medicine assumes a hierarchy of evidence, with findings from well-designed, randomized, controlled trials at the top and unsystematic clinical observations at the bottom. In other words, explicit knowledge from population-level data is given precedence over an individual physician’s clinical experience and expertise [2].

Although evidence-based medicine has gained popularity in the last 15 years, it continues to be controversial. Five types of arguments have been made against the movement since its rise in the early 1990s: (1) it lacks a philosophical basis, (2) the definition of evidence is too narrow, (3) the movement itself is not evidence-based, (4) it has limited usefulness in its application to individual patients, and (5) it threatens the autonomy of the patient-physician relationship [3].

Henry et al. provide an argument that combines aspects of three of these five criticisms. They do not challenge the value and necessity of evidence-based information in clinical decision making, but they claim it is incomplete as a medical epistemology (the study of *how* we know what we know) because it cannot account for all the factors in a physician’s decision-making process. They recognize a curious fact about evidence-based medicine, namely that, despite the promise of raising objective experimental data above individual experience, its use cannot escape some reliance on such uniquely individual human skills as “clinical judgment and expertise” and “deep understanding” [1]. What is this clinical expertise and how does it develop? How is it used by physicians? Proponents of evidence-based medicine do not answer these questions, even though they recognize the importance of clinical expertise in the application of scientific studies to individual patients [4-6]. Henry et al. submit that these questions *cannot* be answered using evidence-based medicine’s

current tools. They join a number of other physicians and philosophers in calling for a new medical epistemology that incorporates *tacit knowledge*, an element of physician-philosopher Michael Polanyi's theory of personal knowledge [7-10].

Polanyi observed that human knowledge is organized within many categories and that full human understanding requires knowledge from more than one category [7]. For example, in order for a physician to fully understand a patient's story, he must use knowledge from several categories, including information about facial expressions, voice tones, and a few different categories of language information such as letters, words, sentences, and paragraphs. A physician, like all humans, can only focus explicitly on one category at a time, while his information processing in all other categories is implicit, or *tacit* [7-10].

Tact Knowledge

Tacit knowledge, as defined by the authors, is the "taken-for-granted information at the periphery of attention that allows people to understand the world and discern meaning in it" [11]. This concept can be useful in explaining a physician's thought process because it accounts for the wide variety of experience and knowledge that contribute to a single decision. More specifically, Henry and his colleagues claim that it contributes two insights and challenges to current medical epistemology.

First, tacit knowledge explains why a fully explicit medical decision-making process—what evidence-based medicine strives to be—is impossible. In Polanyi's theory, each category of knowledge can be understood explicitly on its own, but the connections between one category and another cannot. Thus a physician can understand the meaning of words and of facial expressions independently, but cannot fully appreciate while listening to a patient's words, the effect that various facial expressions are having on his interpretation of those words. Further, although the connections among the various categories can be explored in observational studies, even then these connections are not open to explicit quantitative analysis. This is due to the fact that observers are by necessity human, and must use tacit knowledge in analyzing their observations. Therefore the full context of a physician's medical decision, which includes explicit and tacit knowledge, cannot be made entirely explicit.

Second, the theory of tacit knowledge explains why experience is essential for learning medicine and why it cannot be replaced by a thorough study of the epidemiological and scientific literature. Since epidemiology and science comprise one category of human knowledge and since humans actually use several categories simultaneously, journal reading cannot be applied to individual patients without the physician's experience mediating his understanding of what is going on. This theory helps differentiate humans from computers, the authors say, since computers do not take tacit information based on experience into account when making decisions. This theory may also help explain why some physicians are more skillful than others—they may be more adept at incorporating tacit knowledge appropriately.

This second insight has applications in the everyday practice of medicine. In the ideal world of evidence-based medicine, physicians would focus on reading and applying the best data for each patient. If, however, tacit knowledge has value as well, then physicians should also pay attention to their own intuition and experiences with patients, especially in complex cases.

In light of these two insights, the authors conclude that the clinical encounter—where the physician uses his tacit knowledge along with explicit “evidence”—must remain at the center of medicine.

Discussion

The concept of tacit knowledge adds to medical epistemology by accounting for the roles that context and experience play in medical knowledge and decision making. It is less certain, I think, that the connection between explicit and tacit knowledge that takes place outside of human awareness explains the difference between a human and a computer. The argument for this conclusion is that some elements of the tacit-explicit relationship are not open to quantitative analysis. Specifically, the authors claim that knowledge in any single category can be made explicit but that the connections between the categories cannot be analyzed explicitly even in observational studies. In the example of the patient’s story discussed above, choice of words and tone of voice can each be analyzed explicitly, but the effect that any one has on the interpretation of another cannot be made entirely explicit and analyzed quantitatively. The authors do not explain why that is the case, and I am not convinced that it is so. After all, even though the connections between tacit and explicit knowledge are subconscious to the physician, they do constitute knowledge and may be encoded in the brain in a manner similar to the way explicit knowledge is encoded.

While physicians cannot be fully aware of the influence of tacit knowledge during a clinical encounter, it is possible—at least in principle—that the relationship between tacit and explicit knowledge can be quantitatively analyzed through observational studies. For example, the effects of patients’ word choices on a physician’s thought process can be examined quantitatively by searching for correlations between word frequencies and final medical decisions. The goal in such an undertaking would not be to eliminate tacit knowledge, since that is impossible, but to educate the physician about his own epistemological habits so that he can improve them.

If the connection between tacit and explicit knowledge is discovered to be open to quantitative analysis, then it might be possible to teach its use to a complex computer. Although a computer cannot use tacit knowledge, it can process two or more categories of knowledge simultaneously, so it can process explicitly what an experienced physician processes implicitly. If the interactions between a physician’s use of tacit and explicit knowledge are analyzed, then the computer can be taught to make the same connections among its various categories of explicit knowledge. Therefore the theory of tacit knowledge may not be sufficient to differentiate humans

from computers. This point, however, disputes neither the existence and usefulness of tacit knowledge nor the belief that man truly is different from a computer.

References

1. Henry SG, Zaner RM, Dittus RS. Viewpoint: moving beyond evidence-based medicine. *Acad Med*. 2007;82(3):293.
2. The Evidence-Based Medicine Working Group. Evidence-based medicine. A new approach to teaching the practice of medicine. *JAMA*. 1992;268(17):2420-2425.
3. Cohen AM, Stavri PZ, Hersh WR. A categorization and analysis of the criticisms of evidence-based medicine. *Int J Med Inform*. 2004;73(1):35-43.
4. Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ*. 1996;312(7023):71-72.
5. Haynes RB, Devereaux PJ, Guyatt GH. Clinical expertise in the era of evidence-based medicine and patient choice. *Vox Sang*. 2002;83(suppl 1):383-386.
6. Haynes RB. What kind of evidence is it that evidence-based medicine advocates want health care providers and consumers to pay attention to? *BMC Health Serv Res*. 2002;2(1):3.
7. Goldman GM. The tacit dimension of clinical judgment. *Yale J Biol Med*. 1990;63(1):47-61.
8. Jha SR. The tacit-explicit connection: Polanyian integrative philosophy and a Neo-Polanyian medical epistemology. *Theor Med Bioeth*. 1998;19(6):547-568.
9. Henry SG. Recognizing tacit knowledge in medical epistemology. *Theor Med Bioeth*. 2006;27(3):187-213.
10. Thornton T. Tacit knowledge as the unifying factor in evidence based medicine and clinical judgment. *Philos Ethics Humanit Med*. 2006;1(1):2.
11. Henry, 294.

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CLINICAL PEARL

Recognizing and Treating Conversion Disorder

Sean M. Blitzstein, MD

Our current understanding of conversion disorder dates back to late 19th-century Paris. At that time, Sigmund Freud was studying neurology with Jean-Martin Charcot and became intrigued with the connection between the mind and body, particularly in women who displayed unusual neurologic symptoms. Many of these women were subsequently diagnosed with hysteria. Freud coined the term “conversion” based on his understanding that these individuals *converted* a psychological conflict or trauma into a physical symptom. Indeed, it was Freud’s study of these patients that led him to develop his initial theories of psychoanalysis.

Conversion disorder remains characterized by neurologic deficits that are not fully explained by a known neurologic or medical pathology. Psychological factors, such as conflicts or stress, are believed to either cause or exacerbate the symptoms. According to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, conversion disorder is classified as a somatoform disorder [1]. Studies have reported that 5-15 percent of psychiatric consultations involve patients with conversion symptoms. The female-to-male ratio of those who suffer from this ailment has ranged from 2-to-1 up to 10-to-1. Although conversion disorder can occur at any age, it is most common in adolescents and young adults, and it is seen more frequently in individuals from rural areas, with less education, with lower IQ, and in military members exposed to combat [2].

The etiology of conversion disorder most likely involves psychological as well as biological and neurological factors. Classically, its symptoms have been explained as a result of unconscious conflict between a forbidden wish of a patient and his or her conscience. The conversion symptom symbolically represents a partial wish fulfillment without the individual’s full awareness of the unacceptable desire. An example of this phenomenon is the person who experiences sudden paralysis of his arm due to an unconscious desire to strike his wife. The resulting condition both prevents him from acting on his wish and, in addition, may express underlying aggression by forcing his wife to compensate for his new disability. Biological factors that may characterize conversion disorder include impaired cerebral hemispheric communication, excessive cortical arousal that inhibits the individual’s awareness of bodily sensations, and possibly subtle impairments on neuropsychological tests.

The *Diagnostic and Statistical Manual of Mental Disorders* diagnostic criteria for conversion disorder require the presence of all of the following [3]:

- A. One or more sensory or motor deficits suggesting a neurological condition;
- B. Psychological factors (stressors or conflicts) associated with the initiation or exacerbation of the symptom;
- C. Symptoms not produced intentionally (as in factitious disorder or malingering);
- D. Symptoms not fully explained by a general medical condition, the effects of a substance (medication or drug/alcohol), or a culturally sanctioned behavior;
- E. Symptoms cause clinically significant distress or impairment of function;
- F. Symptoms not limited to pain, sexual dysfunction, or part of somatization disorder.

The most common deficits of conversion disorder are paralysis, blindness, and mutism. Other common symptoms are anesthetics, paresthesias (particularly of the extremities), deafness, abnormal movements, gait disturbances, weakness, tremors, and seizures (so-called pseudoseizures). In all of the above, the presentation and physical exam are not consistent with a known neurological, anatomical, or physiological pathology. *La belle indifférence* (the patient's lack of concern regarding the apparent magnitude of the deficit), once believed to be a hallmark of conversion disorder, is not consistently present.

The most important and difficult step in treating conversion disorder is making the correct diagnosis. Studies have found that 25-50 percent of patients diagnosed with conversion disorder are eventually discovered to have a medical condition that could have caused the symptoms. A thorough medical and neurologic workup is therefore essential for patients with suspected conversion disorder. Pathologic conditions that can look like conversion include brain tumors, multiple sclerosis, myasthenia gravis, basal ganglia disease, optic neuritis, Guillain-Barre, Creutzfeldt-Jakob, and AIDS. Somatization disorder may manifest with conversion characteristics, but patients with the former have a chronic course with physical symptoms in multiple other organ systems. Conversion disorder is often confused with both factitious disorder and malingering. In factitious disorder, individuals consciously create illness as a means to assume the sick role. Malingerers consciously fake symptoms or illness to achieve secondary gain (e.g., avoidance of work, jail, or military duty or obtaining compensation).

Psychiatric disorders that are often present with conversion disorder include somatization and depressive, anxiety, and personality (particularly histrionic) disorders. It is not uncommon for patients with a conversion disorder to actually have some underlying neurologic pathology (such as a seizure disorder), in which case their conversion symptoms are elaborated.

In most patients, conversion disorder tends to be self-limiting. As high as 90-100 percent of symptoms resolve in several days to a month. While many individuals never experience another episode, up to 25 percent have further episodes during times of stress. A better prognosis is associated with a sudden onset, a definite

stressor, good premorbid functioning, lack of comorbid psychiatric disorders, and absence of litigation proceedings related to the illness. The longer conversion symptoms are present, the worse the prognosis.

Confronting patients about the “psychological nature” of their symptoms can and usually does make them worse. Supportive psychotherapy, focused on coping with the underlying conflicts and stress, can help bring about a resolution to conversion disorder. Hypnosis and relaxation exercises can also be helpful. Administration of amobarbital or a benzodiazepine may help to obtain further history, particularly after an unremembered traumatic event. Other forms of psychotherapy, such as insight-oriented or short-term psychotherapies can also be of benefit.

Notes and References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 1994:445.
2. The description of the general nature, prevalence, and treatment of conversion disorder and the probable prognosis for those with the disorder draws substantially from Sadock BJ, Sadock VA. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences, Clinical Psychiatry*. 9th ed. Baltimore, MD; Williams & Wilkins; 2002.
3. American Psychiatric Association, 457.

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HEALTH LAW

Mental Capacity and Contracts

Lee Black, JD, LLM

An elderly woman with early signs of Alzheimer's disease is widowed. Following her husband's death, the couple's investment account manager offers to administer the estate. Over time, the manager takes a sizeable commission for his work, induces the woman to gift a valuable parcel of land to a company the account manager owns, and assists the woman in planning a new will and power-of-attorney that also benefit him.

This case, *In the Matter of Agnes D. Rick* [1], illustrates the legal and financial dangers faced by those with mental illness or degenerative diseases. Estate planning, investments, property sales, and many other opportunities exist for the unscrupulous to take advantage of the vulnerable. The law, though, provides a way to void some transactions and to protect the rights of the disabled (including those who are mentally incompetent) and their families.

Alzheimer's Disease and Contracts

Alzheimer's is a progressive disease that initially affects the parts of the brain that control thought, memory, and language. The resulting dementia can cause those with the condition to ask the same questions repeatedly, feel lost and unable to follow directions, become disoriented, and neglect personal safety and hygiene [2]. It can be difficult for a person with Alzheimer's to keep track of bills and payments and to know whom to trust.

The elderly in general are easier targets for fraud and financial abuse than younger people [3]. Declining hearing and eyesight allow both strangers and family to use the older person's age to their advantage. Add to this the dementia caused by Alzheimer's and you have a nearly irresistible opportunity for the unscrupulous. The abuse or fraud is often difficult to detect because the offender is commonly a family member or someone in a position of authority or trust who has the ability to hide what he or she is doing.

Fraud and financial abuse can take many forms. For example, the individual with Alzheimer's may make multiple payments for the same service, or the people providing the services may write checks to themselves from the patient's checkbook without being detected. Family members—or even attorneys—can convince the patient to make cash transfers, power of attorney designations can be abused, and patients can be misled about the value of property and sell it well below market value. In all of these instances, the law provides a remedy.

Certain requirements must be met before a legal contract—be it for property, goods, or services—is valid and enforceable. There must be at least two parties to the contract, both of which must have the capacity to enter into the agreement; that is, each party must understand what he or she is entering into and the consequences of doing so. If a person who does not have this capacity signs the agreement, it may be voided.

Several conditions circumscribe the capacity to enter into a legal agreement. If one of the parties is a minor, the contract may not be enforceable because minors are legally presumed to lack capacity for contracts, even if the particular minor has understood the terms. Adults are generally presumed to have capacity to enter into a contract [4], but this rule is not absolute.

There are two major exceptions to the presumption of an adult's legal capacity, one of which is being intoxicated when the agreement was made because intoxication can affect judgment. The second exception to legal capacity is mental illness or mental defect [5]. Historically, this exception intended to protect individuals who were developmentally disabled or insane. Today, the category has been expanded to include those suffering from degenerative diseases, like Alzheimer's, that may affect their cognitive abilities.

Establishing Mrs. Rick's Mental Capacity

In this case [1], Mrs. Rick's niece was trying to have guardians appointed for her aunt's person (a public guardian) and property (a bank); Mrs. Rick's investment account manager, Mr. Sailer, and Mrs. Rick's brother-in-law and sister-in-law were trying to have Sailer appointed guardian.

The relationship between Sailer and Mrs. Rick began after the death of her husband when Sailer, who managed a small investment account for the Ricks, offered to be the administrator of the estate. Sailer eventually claimed the maximum commission from the estate, although he never explicitly told Mrs. Rick he was to be paid for his services.

An attorney-in-fact had also been appointed for Mrs. Rick, following her husband's death because her deteriorating mental condition was well known. A neighbor served this appointed office. Less than 2 years later (and apparently without the involvement of the appointed attorney-in-fact), Mrs. Rick deeded a parcel of land, without payment, to a company owned by Sailer and his family.

Shortly after the deed was executed, the neighbor resigned as attorney-in-fact, and Sailer replaced her in that role under a previously executed power of attorney. Sailer also served as the executor of Mrs. Rick's will and the trustee for her trust. Mrs. Rick granted Sailer an option to purchase the Rick's home for significantly less than the probable market value.

Soon after Sailer became attorney-in-fact, Mrs. Rick was admitted to the hospital with various physical problems. Her physicians diagnosed her with dementia and eventually placed her in an extended care center.

This complicated set of facts is important, because it shows what can happen to a person with reduced cognitive abilities who enters into legally binding contracts. The issue for the court to decide was whether Mrs. Rick suffered from Alzheimer's when she entered into the land conveyance, the power-of-attorney, and will agreements, all of which benefited Sailer. The testimony of physicians, friends, and neighbors was crucial to establishing her competency.

Much of the testimony indicated that Mrs. Rick's mental capacity had begun to decline years earlier. Following her husband's death, Mrs. Rick's health continued to deteriorate, and she became unable to manage her own finances—often paying the same bill several times and not realizing that a handyman was forging checks to himself on a regular basis. Mrs. Rick also claimed that Sailer was going to marry her, even though he was much younger and already married. (Sailer apparently did nothing to disabuse her of this notion.)

The physician who served as Sailer's expert witness testified that Mrs. Rick became incompetent around the time she was admitted to the hospital and after all the documents in question had been executed. The doctor's diagnosis, though, was based on the testimony that Sailer expected his opponent's witnesses to give. Sailer's expectation was incorrect.

The court accepted much of the testimony from friends and family of Mrs. Rick, discounted much of the testimony offered by Sailer's witnesses, and found that Mrs. Rick lacked the requisite mental capacity to execute the power of attorney and the land conveyance. The court did not directly address the issue of the will because the niece, who was the petitioner, had not raised it in the filing. The court did recognize that Sailer clearly used his position for his own benefit rather than that of Mrs. Rick's future estate. Sailer was removed as both trustee and attorney-in-fact.

Conclusion

Contracts and other legally binding documents are almost always enforceable, and it takes a very specific set of facts to void them. Although there is an exception to capacity for those who suffer from degenerative mental diseases, it can be difficult to show that the person was suffering debilitating effects when the contract, will, power of attorney, or other agreement was entered into or executed.

To complicate matters even further, a person suffering from Alzheimer's may have moments of clarity when she would be judged capable of entering into a legal contract. In addition, fraud and abuse may go on for a long time without detection—especially if a family member or someone with control over contacts and finances is involved. In the Rick case, it was somewhat lucky that there was ample evidence of

her declining condition even before Sailer initiated his relationship with her and that others noticed a problem after a relatively short period of time.

Physicians, unless close to the patient, may not see signs of financial abuse, and the patient may not talk about it or even recognize that he or she is being deceived. A patient who complains of decreased or no funds or who is accompanied by an overly protective caregiver who refuses to allow the patient to speak for him- or herself may be an indication of a problem [6].

Families and physicians must recognize diminishing capacity and evidence of fraud or financial abuse. The law provides some protection against the unscrupulous, but the best defense against its happening is caregivers' and advisers' awareness of the possibility that it can.

References

1. *In the Matter of Agnes D. Rick* (Del Ch, No 6920, 1994 WL 148268).
2. National Institutes on Aging. General information. <http://www.nia.nih.gov/Alzheimers/AlzheimersInformation/GeneralInfo/>. Accessed January 16, 2008.
3. Reed K. When elders lose their cents: financial abuse of the elderly. *Clin Geriatr Med.* 2005;21(2):365-382.
4. *Buckley v Ritchie Knop, Inc.* 838 NYS 2d 84, 86 (NY App Div 2007).
5. American Law Institute. Formation of contracts—parties and capacity. In: American Law Institute. *Restatement of the Law, Second, Contracts.* Philadelphia, PA: American Law Institute:Section 12.
6. Reed at 371.

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POLICY FORUM

Research Funding Favors Allopathic Medications

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The enormous disparity between research funding for studies on conventional pharmacological therapies and nonconventional modalities reflects entrenched biases that promote Western allopathic medicine at the expense of promising treatments from non-Western systems of medicine. I wish to examine some of the ethical and practical consequences of the funding disparity with emphasis on mental health care. The limitations of conventional psychopharmacologic treatments suggest that an important future goal of mental health research should be the systematic evaluation of promising nonallopathic modalities.

Economic factors that interfere with the capacity of Western medicine to provide adequate health care include restrictions on available treatments under managed care, Medicare, and private insurance contracts; limited reimbursement for newer, more effective drugs; increasing costs of medical care for the average consumer; and absent or minimal coverage for most therapies that are not considered standard of care. At the same time, patient surveys indicate growing dissatisfaction with the quality of Western medical care because, in part, of concerns about efficacy and safety. As a result, increasing numbers of patients are turning to nonconventional therapies to treat medical and psychiatric disorders.

In addition to the economic and patient satisfaction elements, the trend is also fed by shifting values, renewed emphasis on healthy lifestyles, and research findings that support the use of such nonallopathic treatments as botanicals and mind-body practices that are common in many parts of the world [1, 2]. Studies have found that approximately 72 million adults in the U.S. used a nonconventional treatment in 2002, representing about one-third of the adult population [3]. If prayer is included in this analysis, almost two-thirds of adults use alternative therapies [4].

Millions of individuals in developed countries have benefited from advances in the neurosciences and psychopharmacology, which have resulted in novel biological treatments of mental illness. But this rapid growth in the use of pharmaceuticals is taking place at the same time that there is heightened concern about the safety and efficacy of many allopathic drugs. Findings from a systematic review suggest that adverse effects associated with prescription antidepressants exceed their desired therapeutic effects [5] and that worries about efficacy are complicated by the high costs of new drugs that render them unaffordable to many, including the indigent and elderly [6].

Biological psychiatry, positing that mental illness is caused by dysregulations at the level of specific neurotransmitters, is *a priori* biased against treatments used in non-Western systems of medicine that do not accept this explanatory model. In the U.S. and other developed countries, one consequence of this basic conceptual difference has been limited funding for studies on the majority of nonpharmacological modalities. In practical terms, the disparate perspectives of Western biomedicine and non-Western systems of medicine translate into a multibillion dollar pharmaceutical industry that conducts internal studies and funds FDA-sponsored, third-party research.

Unfortunately there is little financial incentive to sponsor studies on natural products—which are not patentable—or on somatic, mind-body, and “energy” modalities that are not viewed as potential sources of significant revenues. The National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health is addressing these circumstances by funding studies on herbal medicines and other natural products, acupuncture, yoga, and energy medicine. NCCAM’s budget increased from \$117 million to \$121.4 million between 2004 and 2006; in contrast, growth in research spending in the pharmaceutical industry rose from \$49 billion to \$55.2 billion during the same time period [7]. Limited NCCAM funding for research on nonpharmacological modalities often results in small studies of short duration that produce findings of marginal statistical significance.

The disparity in research funding also has indirect consequences. Relatively few studies of nonconventional modalities are published in peer-reviewed medical journals, and the majority of those that are published are omitted from systematic reviews because they fail to meet inclusion criteria for size, study design, or statistical significance of outcomes. In short, more systematic reviews of allopathic modalities are published and there are more negative or inconclusive reviews of studies on nonconventional than on mainstream Western medical modalities. Publication bias is closely tied to funding sources for medical research. A study of the impact of funding sources on the validity and reliability of pharmaceutical research was conducted by the American Medical Association Council on Scientific Affairs, who found that over half the research contracts in university-industry-sponsored studies permitted researchers to delay publication, more than one-third of the contracts allowed the drug company sponsor to delete unfavorable data prior to publication, and 30 percent of these contracts allowed both delays in publication and selective deletion of information [8].

Publication bias has other consequences—a limited number of citations for quality studies on alternative treatments in the most widely referenced medical databases, including the largest publicly available medical database, PubMed [9], and the establishment of practice guidelines that typically fail to consider research evidence for alternative modalities. For example, the literature review process on which

American Psychiatric Association guidelines are based largely ignores citations of studies about nonconventional modalities [10].

A Case in Point: Treatment for Depression

In part because of entrenched industry-sponsored research funding practices and the publication biases discussed above, Western medicine has failed to address depression adequately. Due to the high incidence of suicide and comorbid medical and psychiatric illness, depression is regarded as the leading cause of death and disability among those who range in age from adolescence through middle age. The total economic burden of depression in the U.S. in terms of direct costs, mortality costs from depression-related suicides, and lost workplace productivity grew from \$52.9 billion in 1990 to \$83.1 billion in 2000 [11]. Monerief's systematic review of the literature found nonsignificant response differences between antidepressants and placebos and concluded that the risks associated with conventional antidepressant therapy "are less likely to be outweighed by their benefits than is currently believed to be the case" [12]. Independent analyses have concluded that the majority of pharmaceutical industry-sponsored trials of antidepressants fail to show significant response differences between the trial drugs and placebos [13-15]. The FDA has been criticized for its failure to disclose negative findings of industry-sponsored studies in general [16] and, specifically, studies of psychotropic medications [8, 17].

Controversy over the efficacy of antidepressants deepened in 2004 following allegations that efficacy data on antidepressants and other conventional pharmacological treatments used in mental health care were positively biased [17]. When published research data are analyzed together with previously classified findings, the effect that many of the antidepressants have are substantially reduced [17]. It has been determined using the Freedom of Information Act that unpublished industry-sponsored studies of antidepressants are *twice as likely* as published studies to report negative findings [18]. Based on that information, Turner concluded that "by altering the apparent risk-benefit ratio of [antidepressants], selective publication can lead doctors to make inappropriate prescribing decisions that may not be in the best interest of their patients and, thus, the public health" [18].

Over half of all patients who use conventional antidepressants are not treated by psychiatrists and have never been formally diagnosed using the widely accepted *Diagnostic and Statistical Manual of Mental Disorders* [19]. Of those who are formally diagnosed and receive recommended doses of antidepressants, between 40 and 70 percent fail to respond [5]. The problem of nonresponse is compounded by reports of overall worsening of depressed mood when antidepressant drug treatment is long term [20]. The controversy surrounding widely prescribed antidepressants recently escalated following reports that chronic use of antidepressants in children and adolescents may be associated with increased suicide risk [21, 22].

Limited research funding for studies on alternative modalities translates into continued slow progress in the development of promising biological and mind-body treatments. Barring significant policy changes in federal and private research

funding, emphasis on psychopharmacology in mental health research will relegate investigations of promising nonconventional modalities to a low priority. Subsequently, researchers and clinicians will have limited or no exposure to emerging paradigms that may lead to more adequate explanatory models of mental illness including functional medicine, complexity theory, psychoneuroimmunology, and novel models in mind-body and energy medicine.

Conversely, increasing the use of cost-effective alternative and integrative treatment strategies will translate into reductions in long-term costs associated with expensive prescription pharmacological treatments that frequently yield equivocal outcomes. Among alternative modalities that are cost-effective relative to more widely used conventional therapies are acupuncture for migraine headaches, manual therapy for neck pain, spa therapy for Parkinson's, self-administered stress management for cancer patients undergoing chemotherapy, biofeedback for irritable bowel syndrome and other "functional" disorders, and guided imagery, relaxation therapy, and potassium-rich diets for cardiac patients [23].

The debate over the safety and efficacy of nonconventional modalities is taking place in the context of an ideological divide between orthodox biomedical psychiatry and established non-Western systems of medicine. If reason prevails, this controversy will eventually be resolved by policy changes in the FDA and the pharmaceutical industry that will demand unbiased disclosure and publication of all research findings for both conventional and nonconventional treatments of major depressive disorder and other psychiatric disorders. Increased use of validated alternative and integrative treatment approaches can lead to improved mental health care in all segments of the population and commensurate reductions in the enormous medical, social, and financial burdens of mental illness. Increased use of nonconventional modalities in mental health care can yield such important, though less tangible, benefits as increased patient autonomy and reductions in job productivity losses and other indirect costs associated with the high incidence of serious psychiatric disorders that are currently untreated or undertreated.

References

1. Rees L, Weil A. Integrated medicine. *BMJ*. 2001;322(7279):119-120.
2. Astin J. Why patients use alternative medicine: results of a national study. *JAMA*. 1998;279(19):1548-1553.
3. Tindle HA, Davis RB, Phillips RS, Eisenberg DM. Trends in use of complementary and alternative medicine by US adults: 1997-2002. *Altern Ther Health Med*. 2005;11(1):42-49.
4. Barnes PM, Powell-Griner E, McFann K, Nahin RL. Complementary and alternative medicine use among adults: United States, 2002. *Adv Data*. 2004;27(343):1-19.

5. Keitner GI, Ryan CE, Solomon DA. Realistic expectations and a disease management model for depressed patients with persistent symptoms. *J Clin Psychiatry*. 2006;67(9):1412-1421.
6. Moran M. Drug prices rise twice as fast as rate of inflation. *Psychiatric News*. August 20, 2004:18. <http://pn.psychiatryonline.org/cgi/content/full/39/16/18-a>. Accessed January 31, 2008.
7. R&D spending by US biopharmaceutical companies reaches a record of \$55.2B in 2006 [press release]. Washington, DC: Pharmaceutical Research and Manufacturers Association; Feb 12, 2007.
8. Bender K. Reforms to reveal drug study results. *Psychiatric Times*. December 1, 2004:1. <http://www.psychiatrictimes.com/Suicidal-Behavior/showArticle.jhtml?checkSite=psychiatricTimes&articleID=59100047>. Accessed January 31, 2008.
9. Mancano M, Bullano MF. Meta-analysis: methodology, utility, and limitations. *J Pharm Pract*. 1998;11:239-250.
10. Beckner WM, Berman BM. *Complementary Therapies on the Internet*. St. Louis, MO: Churchill Livingstone; 2003.
11. Greenberg PE, Kessler RC, Birnbaum HG, et al. The economic burden of depression in the United States: how did it change between 1990 and 2000? *J Clin Psychiatry*. 2003;64(12):1465-1475.
12. Moncrieff J, Wessely S, Hardy R. Active placebos versus antidepressants for depression. *Cochrane Database Syst Rev*. 2004;1:CD003012.
13. Hollon SD, DeRubeis RJ, Shelton RC, Weiss B. The emperor's new drugs: effect size and moderation effects. *Prevention and Treatment*. July 15, 2002. <http://journals.apa.org/prevention/volume5/toc-jul15-02.htm>. Accessed February 7, 2008.
14. Kirsch I, Moore TJ, Scoboria A, Nicholls SS. The emperor's new drugs: an analysis of antidepressant medication data submitted to the U.S. Food and Drug Administration. *Prevention and Treatment*. July 15, 2002. <http://journals.apa.org/prevention/volume5/toc-jul15-02.htm>. Accessed February 7, 2008.
15. Thase ME. Antidepressant effects: the suit may be small, but the fabric is real. *Prevention and Treatment*. July 15, 2002. <http://journals.apa.org/prevention/volume5/toc-jul15-02.htm>. Accessed February 7, 2008.
16. Bhandari M, Busse JW, Jackowski D, et al. Association between industry funding and statistically significant pro-industry findings in medical and surgical randomized trials. *CMAJ*. 2004;170(4):481-483.
17. Sussman N. The "file-drawer" effect: assessing efficacy and safety of antidepressants. *Prim Psychiatry*. 2004;11(7):12.

18. Turner EH, Matthews AM, Linardatos E, Tell RA, Rosenthal R. Selective publication of antidepressant trials and its influence on apparent efficacy. *N Engl J Med*. 2008;358(3):252-260.
19. Frei R. Dearth of depression diagnoses seen among antidepressant users. *CNS News*. 2004;6(8):1, 11.
20. Fava G. Can long-term treatment with antidepressant drugs worsen the course of depression? *J Clin Psychiatry*. 2003;64(2):123-133.
21. Hinton M, Melonas J. Limiting your risks when prescribing SSRIs. *Psychiatric News*. October 15, 2004:28.
<http://pn.psychiatryonline.org/cgi/content/full/39/20/28>. Accessed January 31, 2008.
22. Weller EB, Kang J, Weller RA. Clinical perspective on pediatric depression: how the evidence tipped SSRIs' risk-benefit balance. *Current Psychiatry*. 2004;3(10):15-18.
23. Herman PM, Craig BM, Caspi O. Is complementary and alternative medicine (CAM) cost-effective? A systematic review. *BMC Complement Altern Med*. 2005;2(5):11.

Relevant Web Sites

American Psychiatric Association Caucus on Complementary, Alternative, and Integrative Medicine, www.APACAM.org.

Integrative Mental Health: Web site of Dr. James Lake, IntegrativeMentalHealth.net.

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MEDICINE AND SOCIETY

Personhood and Autonomy in Multicultural Health Care Settings

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Modern medical ethics has been tremendously influenced, both in theory and in practice, by the four principles approach to bioethics, which was generally developed from the 1978 “Belmont Report” and the work of Thomas Beauchamp and James Childress. According to these models, a physician’s moral obligation toward his or her patient is defined by four ethical principles—respect for autonomy, nonmaleficence, beneficence, and justice. Respect for autonomy dictates that patients who have decision-making capacity have a right to voice their medical treatment preferences, and physicians have the concomitant duty to respect those preferences. Nonmaleficence directs physicians to maximize the benefit to patients while minimizing the harm. Beneficence promotes the welfare and best interest of patients. Finally, justice demands fair, equitable, and appropriate treatment for all patients [1]. These ethical principles are commonly referred to in professional ethical guidelines and applied in clinical decision making.

Adherents to the four principles approach have described them as equal in importance, that is, without hierarchical ranking, and all *prima facie* binding. Western liberal viewpoints, however, argue for the centrality and priority of respect for autonomy over the others [2-4]. According to Daniel Callahan, for example, autonomy is “given a place of honour because the thrust of individualism, whether from the egalitarian left or the market-oriented right, is to give people maximum liberty in devising their own lives and values” [2]. Respect for autonomy has been widely accepted and applied in clinical and research settings over the last 3 decades, primarily through the practice of informed consent. The requirement for obtaining informed consent both for medical intervention and from human subjects in research, has become the norm—and in most cases the law—and that is a positive development. Failure to secure adequately informed consent can lead to serious ethical and legal consequences. In other words, while the best interest of the patient (i.e., nonmaleficence and beneficence) remain at the core of medicine, it is the values, preferences, wishes, and self-determination (i.e., autonomy) of the patient that distinguishes what is beneficial from what is harmful in the Western approach to bioethics.

Personhood and Autonomy

After examining the moral justification for these ethical principles, one realizes that seeing patients as *persons*, who are rational, self-conscious beings capable of valuing their own lives and, hence, entitled to liberty and the right to make choices for

themselves, constitutes the backbone of Western medical ethics. Yet, how did person come to be defined in this way?

Traditional thinking presupposes that all human beings—*Homo sapiens*—are persons and that this is an indisputable, self-evident truth. The Judeo-Christian traditions hold that human beings, having been created in the image of God, must be accorded the dignity, rights, and personhood that flow from this divine origin. These traditional conceptions of personhood are challenged by modern bioethical dilemmas. For example, how do we assess the personhood of an embryo, fetus, severely handicapped newborn, or seriously demented or permanently vegetative human being? Should humans in all states and stages be regarded as persons, deserving of the same dignity, rights, and health care?

Many philosophers have argued against this conception of personhood and have distinguished ‘persons’ from ‘human beings.’ Engelhardt states bluntly, “Persons, not humans, are special” [3]. John Locke differentiated ‘person’ from ‘human being’ in the 17th century, saying that the latter means a corporeal existence only, whereas, the former is “a thinking intelligent being that has reason and reflection and can consider itself, the same thinking thing, in different times and places” [4]. Most importantly, according to Kant, a person is a rational agent capable of exercising free will.

In modern bioethics, Peter Singer distinguishes between two meanings for the term ‘human being’ (1), a member of the species *Homo Sapiens*, and (2), a being who possesses certain qualities such as self-awareness, self-control, a sense of the future, a sense of the past, the capacity to relate to others, concern for others, communication, and curiosity [5]. Singer believes that only human beings in the second sense are ‘persons’ who deserve rights and respect. He also suggests that ‘rationality’ and ‘self-consciousness’ are the crucial characteristics of persons. Similarly, Warren, Tooley, Harris, and Engelhardt [6-9]—all of whom propose definitions of personhood—emphasize that rationality, self-consciousness, and autonomous moral agency are key features. Such a conception of personhood naturally leads to the centrality of patient self-determination and autonomy.

Personhood in an Eastern Confucian Sense

Not all cultural traditions have the same perspective or conception of personhood, a fact that has implications for the application of the four basic ethical principles. Confucianism, for example, which is one predominant cultural and philosophical tradition in East Asia, views persons and their autonomy differently than do most Western traditions. Confucius’ concept of persons, as interpreted, is two-dimensional [10]—the vertical dimension (the autonomous, self-cultivating one) and the horizontal dimension (the relational, altruistic one). This approach views a person not only as a rational, autonomous agent but also as a relational, altruistic identity whose self-actualisation involves participating in and promoting the welfare of fellow persons. In comparison, both the Western secular conception of personhood that focuses on self-consciousness, rationality, and autonomous moral agency, and

the Judeo-Christian traditions that see persons as creations of God's image that reflect God's glory, refer primarily to the vertical dimension. This constitutes an interesting contrast with Eastern views.

According to Fingarette's explication of the Confucian conception of person,

...man is not an ultimately autonomous being who has an inner and decisive power, intrinsic to him, a power to select among real alternatives and thereby to shape a life for himself. Instead he is born as "raw material" who must be civilized by education and thus become a truly human being [11].

Confucianist Liang indicates, "In the Chinese thinking, individuals are never recognized as separate entities; they are always regarded as part of a network, each with a specific role in relation to others" [12]. Tu argues that 'self' in the classical Confucian sense is both the center of relationships and a dynamic process of spiritual development [13]. "One becomes fully human through continuous interaction with other human beings and... one's dignity as a person depends as much on communal participation as on one's own sense of self-respect" [14].

Self-individuation therefore, is possible only through a process of engagement with others within the context of one's social roles and relationships [15]. Moreover, the boundary between self and others in Confucianism is not always clear. The self, as the center of relations, is not merely the privatized self of a closed system; instead, it can and should be broadened to become a public-spirited self [15]. From the Confucian point of view, family, community, country, and even world are spheres of selfhood where one engages in promoting and transforming oneself.

Relational Personhood and Patient Care

While modern Western medical practice interprets patient autonomy as an expression of a person's moral faculties of rationality and self-consciousness, Confucianism perceives autonomy as contextually and conceptually dependent: the ideal person commits himself to altruism autonomously because his self realization consists in moral self-cultivation through giving peace and security to others. When a doctor approaches his patient from a relational personhood perspective, he sees not only a person whose autonomy and dignity are to be respected, but also a relational being with a family, a community, and a social-historical context—a small self, encompassed by one or many greater selves.

In a traditional Asian Confucian context, the family—more than the individual—is considered the basic unit, and doctors tend to seek the opinions of, and value decisions made by, the family as a whole. There are many reasons for this: the emphasis on family values, the large role family plays in caring for the sick, the weakness and vulnerability of patients in times of illness, and the interconnectedness and interdependence between family members; in short, families are taken seriously. After all, medical decisions by the patient often greatly influence the family

members, among whom the ‘morality of intimacy’ cannot be replaced or overruled by the ethics of impartiality, universality, and individualism of moral strangers.

Concentrating merely on the relational perspectives of persons has its risks. For example, emphasising filial piety (*Shiaw*), family values, and the common good may cause patients to subordinate their right to autonomous decision making to the preferential choice of the families or social values. Always putting public interest before self-interest and individual rights, in addition to highlighting the individual responsibility to the group, may lead to collectivism, which could undermine personal needs, rights, and freedom. The traditional Confucian values produced a paternalistic and patriarchal society, and, conversely, social practice may lead to a doctor-patient-family relationship and medical decision making that resembles paternalism. For these reasons, the autonomous perspective, i.e., the vertical dimension of persons, is likely to be suppressed by the relational, horizontal perspective and result in the sacrificing of patient’s rights and autonomy and the jeopardising of the cultivation of an autonomous person.

To avoid that consequence, a competent patient’s decision making should always be an autonomous choice of his own. At the same time, however, the decision-making process should recognize that the patient—the agent—is always a person-in-relation. A balance can be achieved between the traditional social orientation of a self on the one hand, and respect for individual rights and autonomy on the other, and their values can be held in a productive tension. When such a balance is achieved, the vertical dimension of a person is held in equipoise with the horizontal dimension. Health care practitioners from a family-oriented society should be aware of how to protect their patients from being manipulated or coerced by collectivist pressure (mostly from their families) and promote their autonomy without rejecting their traditional family values.

On the other hand, doctors who stress the autonomous, individualistic perspective should realize that not every individual they meet in a clinical encounter is comfortable with the radically individual concept of personhood that assumes that patients are unconnected, autonomous agents. When one is ill, frail, vulnerable, or dying, the value of one’s relatedness, mutuality, and communion with others is no less and sometimes more important than one’s separateness, individuality, and distinctiveness from others. Doctors who rely on informed consent as a means to respect patients’ autonomy—sometimes without sincere concern for their welfare—may appear to be bleak and detached, endorsing a politically correct proceduralism that can eventually leave patients adrift amid alienating choices fraught with emptiness, loneliness, and helplessness. Principlism that merely affirms the ethos that liberal individualism and autonomy must trump other considerations does not describe the whole picture of morality satisfactorily, nor does it give biomedical ethics a solid foundation. To be a human being is to be a part of a family and community; these are the locus for morality. The sense of human dignity and worth is a moral accomplishment for one to attain, not the natural criteria of rationality and self-consciousness one is born with.

Notes and References

1. Gillon R. Medical ethics: four principles plus attention to scope. *BMJ*. 1994;309(6948):184-188.
2. Callahan D. Principlism and communitarianism. *J Med Ethics*. 2003;29(5):287-291.
3. Engelhardt HT Jr. *The Foundation of Bioethics*. 2nd ed. New York, NY: Oxford University Press; 1986:104.
4. Locke J. *An Essay Concerning Human Understanding*. Book 2, Chapter 27. London, UK: Oxford University Press; 1964.
5. Singer P. *Practical Ethics*. 2nd ed. New York, NY: 1993:83. This description was part of a list proposed by John Fletcher as “indicators of humanhood.” For the complete list see Fletcher J. Indicators of humanhood: a tentative profile of man. *Hastings Cent Rep*. 1972;2(5):1-4.
6. Rudman S. *Concepts of Person and Christian Ethics*. Cambridge, UK: Cambridge University Press; 1997:46-47.
7. Tooley M. The criterion of awareness of self as a continuing entity. In: Brody BA, Engelhardt HT Jr, eds. *Bioethics: Reading and Cases*. Upper Saddle River, NJ: Prentice Hall; 1987:146-152.
8. Harris J. *The Value of Life*. London: Routledge; 1985:18.
9. Engelhardt HT Jr, 136-147.
10. Tsai DF. How should doctors approach patients? A Confucian reflection on personhood. *J Med Ethics*. 2001;27(1):44-50.
11. Fingarette H. *Confucius: The Secular as Sacred*. San Francisco, CA: HarperCollins Publishers; 1972:34.
12. Liang SM. *Chung-kuo wen hua yao-i. (The Essential Features of Chinese Culture*. Hong Kong: Chi-cheng T’u-Shu Kung-Hsu; 1974). Cited in Tao J. The moral foundation of welfare in Chinese society: between virtues and rights. In: Becker GK, ed. *Ethics in Business and Society: Chinese and Western Perspectives*. Hong Kong: Springer; 1997:9-24.
13. Tu WM. *Confucian Thought: Selfhood as Creative Transformation*. Albany, NY: SUNY Press; 1985:113.
14. Tu WM, 55.
15. Tao J. The moral foundation of welfare in Chinese society: between virtues and rights. In: Becker GK, ed. *Ethics in Business and Society: Chinese and Western Perspectives*. Hong Kong: Springer; 1997:16.
16. Tu WM, 58.

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HISTORY OF MEDICINE

Holistic Medicine and the Western Medical Tradition

Sneha Mantri

The Western medical tradition spans millennia, extending from the prehistoric use of plants and herbs to heal wounds through the technological advances of the present day. Over that long history, the practice of medicine shifted from prescientific holistic approaches to modern, scientifically supported explanations of pathology. As the practice of medicine became more thoroughly grounded in science, which seeks unified explanations for diseases, many feared the loss of individuality, both for the patient and the physician [1, 2]. Thus it is relevant for modern practice to examine the social and historical forces behind medicine's paradigm shift and what that shift means for the 21st-century patient-physician encounter.

In the early days of medicine, physical manifestations of illness were almost always explained in spiritual terms. In a world where the deities were believed to affect mortals directly, seizures, for instance, were thought to be the result of having angered the gods [3]. In 400 BCE, Hippocrates, often lauded as the father of Western medicine, proposed a new schema in which natural—not supernatural—explanations of illness were sought. (It should be noted that the Hippocratic writings were probably not the work of a single physician but of a group of like-minded practitioners now referred to as “the Hippocratic physicians.”) The Hippocratic treatise *On the Sacred Disease*, opens with: “[epilepsy] appears to me to be nowise more divine nor more sacred than other diseases, but has a natural cause from which it originates like other affections” [4].

This radical approach to medicine was not immediately accepted by peers of the Hippocratic movement. According to medical historian Lawrence Conrad, the pluralism of ancient Greek medicine meant that “healers, both male and female, competed with root-cutters, exorcists, midwives, bone-setters, lithotomists, gymnasts, and surgeons for patients” [5]. Although Hippocratic medicine began as one of many approaches to human illness, the structure of medical education in medieval and early modern Europe encouraged its dominance.

Hippocratic physicians were unable to study anatomy and physiology directly in the human body because dissection of human cadavers was forbidden on religious grounds. Instead, they relied primarily on logic and philosophy to explain disease. The central tenet of the theory was the belief that illness resulted from imbalances among the humors—blood, black bile, yellow bile, and phlegm. The physician's role was to diagnose the problem and tell patients how to restore their humoral balance and thus heal themselves.

Centuries later, Galen, a Roman anatomist who studied pigs, associated each humor with a personality. Certain temperaments were considered to be predisposed to illnesses of their humoral type, especially if the illness seemed to be triggered by emotional shock. Hippocratic-Galenic medicine was integrative, proposing a synergistic and individual relationship between each patient's body, mind, and personality and the outside world. For hundreds of years, this doctrine stood as the basis of Western medicine.

The seeds of change were planted as early as the 1500s when Andreas Vesalius, a Belgian physician, began teaching his students via direct animal dissection rather than by study of Galen's work. In 1539, an Italian judge gave Vesalius dispensation to dissect executed criminals, which changed the study of anatomy forever. Suddenly, structures that were previously only imagined could be visualized, handled, and sliced open to reveal hints of their living function. With the development of scientific, empirical study of human anatomy, the body-mind-personality connection that was so fundamental to Hippocratic-Galenic medicine was rapidly abandoned. As early as 1628, with the publication of William Harvey's explanation for the circulation of blood through a closed system by the pumping of the heart [6], physicians were beginning to view human physiology as the mechanized interaction of organs.

Simultaneously, growth in medical technology spurred the development of pathologic or morbid anatomy. In 1664, Englishman Robert Hooke published *Micrographia*, which revolutionized biology by using the microscope to view cells, a term coined by Hooke himself. Microscopy spread across Europe as a tool to study not just simple organisms but also the disease process. Together, gross and microscopic anatomy changed the ideology of medical discourse from philosophical to scientific. The definitive transformation of clinical medicine into a science based on pathologic anatomy came with Giovanni Battista Morgagni's 1761 publication of a five-volume tome *De Sedibus et causis morborum* ("On the Seats and Causes of Disease"). This catalog of diseases connected etiology to specific anatomical "seats" or locations.

The impact of technology and pathologic anatomy on medical practice had two major foci. First, its scientifically grounded explanations sparked an era of experiment-based medical progress that continues today. Armed with specialized knowledge about human anatomy and pathophysiology, the physician could at last take an active role in treating disease. Second, and more problematically, the voice of the patient, which had been so central to the Hippocratic doctrine, was silenced by the growing medicoscientific dialogue in which the uninitiated patient was unable to take part. In essence, power over the body had been transferred from the patient to the physician.

French philosopher Michel Foucault argues that the dominance of pathologic anatomy "dates precisely from the moment clinical experience became the anatomo-

clinical gaze” [7]. For Foucault, the objectification of the patient is ethically problematic, a view by no means universal until the mid-20th century, if then. In fact, physicians of the 19th century considered the newly scientific basis of medicine “the ethical high ground” [8] and a moral imperative to their patients. French physician Xavier Bichat, writing in 1812, asked “What is observation, if we are ignorant of the place where the evil is seated?” [9]. Only by understanding the science of medicine, early modern physicians argued, would physicians be of service to their patients.

This view persisted through the 19th century. George Weisz, a historian of Victorian medicine, attributes the rise of specialties to “a new conception of disease; it was precisely the influence of localist pathologist thinking, based on pathological anatomy and subsequently on new technologies...that created ‘foci of interest’ in organ systems around which specialties could develop” [10]. Although it allowed for a deeper exploration of individual pathologies, the resultant division of the human body into disconnected pieces further eroded the integrative fundamental tenet that had sustained Western medicine for more than 2 millennia. The explosion of specialization was by no means unopposed; several 19th-century physicians called for a return to Hippocratic integration, arguing that the new trend would “fragment medical science” [11] and ultimately hinder medical progress. Despite such opposition, specialization became an integral part of the modern, scientific practice of medicine. By 1905, 35 percent of Parisian doctors were specialists [12]. Pathologic anatomy would seem to have won its quest to universalize disease processes and divide the body into separate, barely connected domains.

In recent years Western medicine has consciously tried to integrate its ancient, patient-centered roots with modern scientific validity. In the late 20th century, with the rise of illness narratives by authors such as Susan Sontag, Reynolds Price, and Audre Lorde, patients began to reclaim their voices and therefore power over their bodies. The patient rights movement, borrowing from the concurrent civil rights and feminist movements, argued that the patient should be an equal partner with the physician in medical care. In response to these and other pressures to restore patient-centered medicine, medical schools began to revisit holistic medicine. Although evidence-based medicine remains an important part of medical education—123 of the 125 Association of American Medical Colleges schools required students to take at least one such course in the 2004-2005 academic year [13]—most medical students now also study complementary or alternative medicine (111 schools), medical ethics (124 schools), and population-based medicine (113 schools). Medical students of the 21st century therefore inherit from both the Hippocratic and the pathologic schools of thought.

The history of Western medicine chronicles a struggle between two opposing ideologies of patient care. On one hand, the integrative Hippocratic view; on the other, the specialization view, with an ethically problematic depersonalization of the patient that coincides with the rise of pathologic anatomy and medical technology in the early modern era. Although the modern dominance of pathologic anatomy has

yielded centuries of medical progress, at times it threatens to divide and reduce the patient to a silent sum of mechanistic parts. Recent changes in medical education have begun to address the need for holistic medical care. Only with careful attention to both the individuality of illness and the universality of disease etiology can physicians most effectively care for their patients.

References

1. May C, Rapley T, Moreira T, Finch T, Heaven B. Technogovernance: evidence, subjectivity, and the clinical encounter in primary care medicine. *Soc Sci Med.* 2006;62(4):1022-1030.
2. Tanenbaum S. Getting there from here: evidentiary quandaries of the US outcomes movement. *J Eval Clin Pract.* 1995;1(2):97-103.
3. Loukas M, Tubbs RS, Louis RG Jr, Pinyard J, Vaid S, Curry B. The cardiovascular system in the pre-Hippocratic era. *Int J Cardiol.* 2007;120(2):145-149.
4. Hudson RP. *Disease and Its Control.* Westport, CT: Praeger; 1983:78.
5. Conrad LI, Neve M, Nutton V, Porter R, Wear A. *The Western Medical Tradition: 800 BC to 1800 AD.* Cambridge, UK: Cambridge University Press; 1995:16.
6. Bates D. Machina ex deo: William Harvey and the meaning of instrument. *J Hist Ideas.* 2000;61(4):577-593.
7. Wilson A. Porter versus Foucault on the 'Birth of the Clinic.' In: Bivins R, Pickstone JV, eds. *Medicine, Madness, and Social History.* New York, NY: Palgrave Macmillan; 2007:32.
8. Conrad, 322.
9. Wilson, 29.
10. Weisz G. The emergence of medical specialization in the nineteenth century. *Bull Hist Med.* 2003;77(3):544.
11. Weisz, 557.
12. Weisz, 574.
13. American Association of Medical Colleges. *Hot Topics in Medical Education, 2005.*
http://services.aamc.org/currrdir/section2/04_05hottopics.pdf. Accessed January 9, 2008.

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Suggested Readings and Resources

American Association of Medical Colleges. *Hot Topics in Medical Education, 2005*. http://services.aamc.org/currrdir/section2/04_05hottopics.pdf. Accessed January 9, 2008.

American Law Institute. Formation of contracts—parties and capacity. In: American Law Institute. *Restatement of the Law, Second, Contracts*. Philadelphia, PA: American Law Institute:Section 12.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association; 1994:445.

American Psychiatric Association. *Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors*. Washington, DC: American Psychiatric Association; 2003:10.
http://www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx. Accessed February 12, 2008.

Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. *N Engl J Med*. 2007;357(18):1834-1840.

Astin J. Why patients use alternative medicine: results of a national study. *JAMA*. 1998;279(19):1548-1553.

Barnes PM, Powell-Griner E, McFann K, Nahin RL. Complementary and alternative medicine use among adults: United States, 2002. *Adv Data*. 2004;27(343):1-19.

Bates D. Machina ex deo: William Harvey and the meaning of instrument. *J Hist Ideas*. 2000;61(4):577-593.

Beckner WM, Berman BM. *Complementary Therapies on the Internet*. St. Louis, MO: Churchill Livingstone; 2003.

Bender K. Reforms to reveal drug study results. *Psychiatric Times*. December 1, 2004:1. <http://www.psychiatristimes.com/Suicidal-Behavior/showArticle.jhtml?checkSite=psychiatricTimes&articleID=59100047>. Accessed January 31, 2008.

Bhandari M, Busse JW, Jackowski D, et al. Association between industry funding and statistically significant pro-industry findings in medical and surgical randomized trials. *CMAJ*. 2004;170(4):481-483.

Bourget D, Whitehurst L. Amnesia and crime. *J Am Acad Psychiatry Law*. 2007;35(4):469-480.

Buckley v Ritchie Knop, Inc. 838 NYS 2d 84, 86 (NY App Div 2007).

Callahan D. Principlism and communitarianism. *J Med Ethics*. 2003;29(5):287-291.

Cohen AM, Stavri PZ, Hersh WR. A categorization and analysis of the criticisms of evidence-based medicine. *Int J Med Inform*. 2004;73(1):35-43.

Conrad LI, Neve M, Nutton V, Porter R, Wear A. *The Western Medical Tradition: 800 BC to 1800 AD*. Cambridge, UK: Cambridge University Press; 1995:16.

Damasio AR. *Descartes' Error: Emotion, Reason, and the Human Brain*. New York, NY: G.P. Putnam's Sons; 1994:4.

Engelhardt HT Jr. *The Foundation of Bioethics*. 2nd ed. New York, NY: Oxford University Press; 1986:104.

The Evidence-Based Medicine Working Group. Evidence-based medicine. A new approach to teaching the practice of medicine. *JAMA*. 1992;268(17):2420-2425.

Fava G. Can long-term treatment with antidepressant drugs worsen the course of depression? *J Clin Psychiatry*. 2003;64(2):123-133.

Fingarette H. *Confucius: The Secular as Sacred*. San Francisco, CA: HarperCollins Publishers; 1972:34.

Fletcher J. Indicators of humanhood: a tentative profile of man. *Hastings Cent Rep*. 1972;2(5):1-4.

Frei R. Dearth of depression diagnoses seen among antidepressant users. *CNS News*. 2004;6(8):1, 11.

Gillon R. Medical ethics: four principles plus attention to scope. *BMJ*. 1994;309(6948):184-188.

Goldman GM. The tacit dimension of clinical judgment. *Yale J Biol Med*. 1990;63(1):47-61.

Greenberg PE, Kessler RC, Birnbaum HG, et al. The economic burden of depression in the United States: how did it change between 1990 and 2000? *J Clin Psychiatry*. 2003;64(12):1465-1475.

Grisso T, Appelbaum PS. *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. New York, NY: Oxford University Press; 1998.

Harris J. *The Value of Life*. London: Routledge; 1985:18.

Haynes RB. What kind of evidence is it that evidence-based medicine advocates want health care providers and consumers to pay attention to? *BMC Health Serv Res*. 2002;2(1):3.

Haynes RB, Devereaux PJ, Guyatt GH. Clinical expertise in the era of evidence-based medicine and patient choice. *Vox Sang*. 2002;83(suppl 1):383-386.

Henry SG. Recognizing tacit knowledge in medical epistemology. *Theor Med Bioeth*. 2006;27(3):187-213.

Henry SG, Zaner RM, Dittus RS. Viewpoint: moving beyond evidence-based medicine. *Acad Med*. 2007;82(3):293.

Herbert PB. The duty to warn: a reconsideration and critique. *J Am Acad Psychiatry Law*. 2002;30(3):417-424.

Herbert PB, Young KA. Tarasoff at twenty-five. *J Am Acad Psychiatry Law*. 2002;30(2):275-281.

Herman PM, Craig BM, Caspi O. Is complementary and alternative medicine (CAM) cost-effective? A systematic review. *BMC Complement Altern Med*. 2005;2(5):11.

Hinton M, Melonas J. Limiting your risks when prescribing SSRIs. *Psychiatric News*. October 15, 2004:28. <http://pn.psychiatryonline.org/cgi/content/full/39/20/28>. Accessed January 31, 2008.

Hollon SD, DeRubeis RJ, Shelton RC, Weiss B. The emperor's new drugs: effect size and moderation effects. *Prevention and Treatment*. July 15, 2002. <http://journals.apa.org/prevention/volume5/toc-jul15-02.htm>. Accessed February 7, 2008.

Hudson RP. *Disease and Its Control*. Westport, CT: Praeger; 1983:78.

In the Matter of Agnes D. Rick (Del Ch, No 6920, 1994 WL 148268).

Jha SR. The tacit-explicit connection: Polanyian integrative philosophy and a Neo-Polanyian medical epistemology. *Theor Med Bioeth*. 1998;19(6):547-568.

Keitner GI, Ryan CE, Solomon DA. Realistic expectations and a disease management model for depressed patients with persistent symptoms. *J Clin Psychiatry*. 2006;67(9):1412-1421.

Kirsch I, Moore TJ, Scoboria A, Nicholls SS. The emperor's new drugs: an analysis of antidepressant medication data submitted to the U.S. Food and Drug Administration. *Prevention and Treatment*. July 15, 2002. <http://journals.apa.org/prevention/volume5/toc-jul15-02.htm>. Accessed February 7, 2008.

Kirschner KL. When written advance directives are not enough. *Clin Geriatr Med*. 2005;21(1):193-209.

Kothari S, Kirschner KL. Decision-making capacity after brain injury: clinical assessment and ethical implications. In: Zasler N, Zafonte R, Katz D, eds. *Neurorehabilitation of Traumatic Brain Injury*. 2nd ed. New York, NY: Demos Publishing; 2007:1205-1222.

Liang SM. *Chung-kuo wen hua yao-i (The Essential Features of Chinese Culture)*. Hong Kong: Chi-cheng T'u-Shu Kung-Hsu; 1974.

Loukas M, Tubbs RS, Louis RG Jr, Pinyard J, Vaid S, Curry B. The cardiovascular system in the pre-Hippocratic era. *Int J Cardiol*. 2007;120(2):145-149.

Mancano M, Bullano MF. Meta-analysis: methodology, utility, and limitations. *J Pharm Pract*. 1998;11:239-250.

May C, Rapley T, Moreira T, Finch T, Heaven B. Technogovernance: evidence, subjectivity, and the clinical encounter in primary care medicine. *Soc Sci Med*. 2006;62(4):1022-1030.

Mesulam M-M. *Principles of Behavioral and Cognitive Neurology*. 2nd ed. New York, NY: Oxford University Press; 2000.

Moncrieff J, Wessely S, Hardy R. Active placebos versus antidepressants for depression. *Cochrane Database Syst Rev*. 2004;1:CD003012.

Moran M. Drug prices rise twice as fast as rate of inflation. *Psychiatric News*. August 20, 2004:18. <http://pn.psychiatryonline.org/cgi/content/full/39/16/18-a>. Accessed January 31, 2008.

National Institutes on Aging. General information.

<http://www.nia.nih.gov/Alzheimers/AlzheimersInformation/GeneralInfo/>. Accessed January 16, 2008.

R&D spending by US biopharmaceutical companies reaches a record of \$55.2B in 2006 [press release]. Washington, DC: Pharmaceutical Research and Manufacturers Association; Feb 12, 2007.

Reed K. When elders lose their cents: financial abuse of the elderly. *Clin Geriatr Med.* 2005;21(2):365-382.

Rees L, Weil A. Integrated medicine. *BMJ.* 2001;322(7279):119-120.

Rudman S. *Concepts of Person and Christian Ethics.* Cambridge, UK: Cambridge University Press; 1997:46-47.

Sackett DL, Rosenberg WM, Gray JA, Haynes RB, Richardson WS. Evidence based medicine: what it is and what it isn't. *BMJ.* 1996;312(7023):71-72.

Sadock BJ, Sadock VA. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences, Clinical Psychiatry.* 9th ed. Baltimore, MD; Williams & Wilkins; 2002.

Singer P. *Practical Ethics.* 2nd ed. New York, NY: 1993:83.

Spraycar M, ed. *PDR Medical Dictionary.* Baltimore, MD: Williams and Wilkins; 1995:1335.

Sussman N. The "file-drawer" effect: assessing efficacy and safety of antidepressants. *Prim Psychiatry.* 2004;11(7):12.

Tanenbaum S. Getting there from here: evidentiary quandaries of the US outcomes movement. *J Eval Clin Pract.* 1995;1(2):97-103.

Tao J. The moral foundation of welfare in Chinese society: between virtues and rights. In: Becker GK, ed. *Ethics in Business and Society: Chinese and Western Perspectives.* Hong Kong: Springer; 1997:9-24.

Tarasoff v The Regents of the University of California, 551 P2d 334 (Cal 1976).

Tarasoff v The Regents of the University of California, 529 P2d 553 118, Cal Rptr 129 (Cal 1974), at 561.

Thase ME. Antidepressant effects: the suit may be small, but the fabric is real. *Prevention and Treatment.* July 15, 2002.

<http://journals.apa.org/prevention/volume5/toc-jul15-02.htm>. Accessed February 7, 2008.

Thornton T. Tacit knowledge as the unifying factor in evidence based medicine and clinical judgment. *Philos Ethics Humanit Med*. 2006;1(1):2.

Tindle HA, Davis RB, Phillips RS, Eisenberg DM. Trends in use of complementary and alternative medicine by US adults: 1997-2002. *Altern Ther Health Med*. 2005;11(1):42-49.

Tooley M. The criterion of awareness of self as a continuing entity. In: Brody BA, Engelhardt HT Jr, eds. *Bioethics: Reading and Cases*. Upper Saddle River, NJ: Prentice Hall; 1987:146-152.

Tsai DF. How should doctors approach patients? A Confucian reflection on personhood. *J Med Ethics*. 2001;27(1):44-50.

Tu WM. *Confucian Thought: Selfhood as Creative Transformation*. Albany, NY: SUNY Press; 1985:113.

Turner EH, Matthews AM, Linardatos E, Tell RA, Rosenthal R. Selective publication of antidepressant trials and its influence on apparent efficacy. *N Engl J Med*. 2008;358(3):252-260.

Walters JW. *What is a Person: An Ethical Exploration*. Urbana, IL: University of Illinois Press; 1997.

Weiner JR. *Tarasoff* warnings resulting in criminal charges: two case reports. *J Am Acad Psychiatry Law*. 2003;31(2):239-241.

Weller EB, Kang J, Weller RA. Clinical perspective on pediatric depression: how the evidence tipped SSRIs' risk-benefit balance. *Current Psychiatry*. 2004;3(10):15-18.

Weinstock R, Vari G, Leong GB, Silva JA. Back to the past in California: a temporary retreat to a *Tarasoff* duty to warn. *J Am Acad Psychiatry Law*. 2006;34(4):523-528.

Weisz G. The emergence of medical specialization in the nineteenth century. *Bull Hist Med*. 2003;77(3):544.

Wilson A. Porter versus Foucault on the 'Birth of the Clinic.' In: Bivins R, Pickstone JV, eds. *Medicine, Madness, and Social History*. New York, NY: Palgrave Macmillan; 2007:32.

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