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Psychiatry

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FROM THE EDITOR

Jumping Brain

Audiey Kao, MD, PhD

One of the most unforgettable experiences of my medical school career occurred during a psychiatry clerkship. I had been on the wards for only 3 months, when I was assigned to the inpatient psychiatric unit at the university teaching hospital. On my service was a patient who had been hospitalized for severe depression. Unfortunately, the patient's depression was resistant to pharmacological therapy, prompting the attending psychiatrist to treat the patient with electroconvulsive therapy.

Electroconvulsive therapy or ECT is a medical treatment that has been around for centuries and has recently gained in popularity, but not without some controversy. Put simply, ECT involves delivering a brief electric current to the brain, which induces seizure activity and, through it, its therapeutic benefit. While the procedure may sound simple enough, witnessing it being performed on a patient was anything but simple and routine. I can still remember the patient on the gurney as he was wheeled into the ECT suite. He was in"soft" restraint. A tourniquet was applied to his left leg below the knee to prevent the skeletal muscle paralytic agent from reaching that portion of his body. As a result, only the left lower leg would be "jumping" around after seizure activity was induced. This was done so as to reduce the risk of physical harm to the patient from generalized seizure activity, while still allowing the physician to observe the desired seizure response.

For the lay person, ECT would seem downright barbaric and a throw back to a time when bleeding the sick was considered standard treatment for febrile illness. For a medical student in his fourth month on the wards, the therapeutic rationale behind ECT struck me as somewhat dubious. However, the attending psychiatrist informed me that, for a select group of severely depressed patients, ECT was the best chance they had to return to any sense of mental normalcy. While my patient was not cured of his depression, he did begin to improve slowly after the ECT treatments. Finally, the practice of "tying off" one of the legs is no longer necessary, because audible EEG tracings are used to determine the extent of seizure activity.

In this issue of Virtual Mentor, we explore the ethical and professional issues that are unique or relevant to the practice of psychiatry. The learning objectives are:

1. Understand the ethical challenges to the patient-physician relationship that are unique to psychiatry, eg, patient's competency to consent to treatment.

2. Understand the tension between psychiatrists' duty to patients and their relationship to the justice system, eg, patient confidentiality versus request to testify or inform.

3. Learn the value of psychiatry in ethics consults.

4. Understand the disparities between medical care coverage and mental health coverage, especially for the indigent.

5. Understand the principal ethical arguments concerning prescription of psychoactive drugs and use of other controversial therapies, eg, ECT.

Audiey Kao, MD, PhD is the editor in chief of *Virtual Mentor*.

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CASE AND COMMENTARY

Drugs for the Shy?

Commentary by Jeremy A. Lazarus, MD

Case

Jonathan Parker was brought to Dr. Reiser, a psychiatrist, by his mother. Mrs. Parker said that Jonathan, aged 22, lived at home with her and his father and seldom left the house alone. He would socialize with his siblings and cousins, occasionally go to the movies with one of them or with his mother, and went to family gatherings and church. But, as Mrs. Parker told it, Jonathan never brought a friend to the house and, since completing his BS in computer science, had not been going out daily for school or work or anything else. He was pretty unhappy and had agreed to his mother's plea that he "get some help."

Jonathan had done well in school, had applied for a dozen or so jobs, and had been called in for several interviews. But he always returned home dejected, saying, "They're not going to call back." So far, he had been right.

Dr. Reiser accepted Jonathan as a patient and began seeing him once weekly. After 3 visits, he asked Jonathan whether he would agree to try one of a class of drugs known as SSRIs. Dr. Reiser wasn't certain it would help, but it had produced some good results in certain sociophobic patients. Jonathan agreed. Jonathan was bright, and, as he became more comfortable with Dr. Reiser, the psychiatrist could see Jonathan's mind at work, trying to understand the responses and feelings he had when he was alone with a stranger or in a social situation without his family members beside him.

After 3 months, Jonathan told Dr. Reiser that he felt ready to leave therapy. He had had a callback following an interview, and a job offer seemed likely. The drug was really working, Jonathan said. He and his family had talked about it and everyone was pleased. Jonathan said he wanted to continue on the prescription and stop therapy. Dr. Reiser opposed the idea, explaining that Jonathan's shyness had causes that would go undiscovered and unmanaged if he masked the symptoms with drugs. The psychiatrist preferred to continue the drug and "talk" therapies in tandem, so that they could get to the bottom of the shyness problem and eventually wean Jonathan from the drug. Jonathan said all he cared about was getting rid of the symptoms. Why did it matter what had caused the shyness if it had disappeared? Jonathan began to get angry. Once he had a job, he said, he wouldn't be able to take time off for the appointments. If Dr. Reiser wouldn't agree to prescribe the drug, Jonathan said, he'd find another doctor who would.

Commentary

This case raises several ethical questions, notably that of appropriate informed consent for treatment. Other questions to be considered are the conflicts between physician beneficence and patient autonomy and conflicts about the patient-physician treatment contract and alliance.

On initial evaluation, it appears that Jonathan had symptoms consistent with social anxiety, but without additional information we would wonder whether he also had some underlying depressive disorder. We hope Dr. Reiser ruled out other more serious mental illness such as early schizophrenia or other psychotic disorders. Dr. Reiser would have wanted to be alert to the fact that the mother of a 22-year-old was making the initial contact and what that might mean for Jonathan's possible illness and symptoms (as well as its psychological meanings). For example, this could be related to Jonathan's "shyness" or could be symptomatic of more serious psychopathology.

In Dr. Reiser's assessment, he would need to determine whether Jonathan had some minimal symptoms of "shyness" or whether it caused him serious problems socially because of extensive inhibition of his activities with others. This might also help him to determine the timing of a therapeutic trial with medications versus an extended trial of more supportive or other psychotherapy. Jonathan's preferences in treatment would also be very important because many patients might be concerned about the meaning of taking medications of any sort. It would be important for Dr. Reiser and Jonathan to discuss those issues early on in the evaluation.

With the probable diagnosis of social anxiety or depression, a trial of antidepressants would be warranted. In addition, Dr. Reiser may have felt that, on the basis of his evaluation, exploration of underlying psychological issues, such as those arising from Jonathan's development or family dynamics, was appropriate. For informed consent, if Dr. Reiser considered the primary diagnosis social anxiety, then he would need to inform Jonathan of the research and benefits of using SSRIs to treat that condition, as well as the potential side effects. He should also explain the type of psychotherapy that he is also recommending and its utility in Jonathan's situation. If Dr. Reiser believed that both treatments were necessary and he had reasonable scientific or clinical experience to warrant that recommendation, he should inform Jonathan about that early in treatment. Of course, he should also inform Jonathan of the potential length of treatment for both the medication and psychotherapy.

This would all be tempered by Dr. Reiser's assessment of the patient-physician alliance and the degree to which he should explain in greater or lesser detail any of these informed consent necessities.

Jonathan's dependency on his family and his mother's role in bringing him to Dr. Reiser might raise issues about confidentiality, although there is no mention that his mother wanted information or intruded in any way. If she did, Dr. Reiser would need to be cautious about sharing any information with her without a full release from Jonathan.

In this case, it is unclear whether it was the medication alone, the psychotherapy alone, the patient-physician relationship, or the combination that led to the clinical improvement. A reasonable ethical and parallel therapeutic course would be for Dr. Reiser to sensitively explain his best psychiatric advice to Jonathan and find a way to leave the door open for further psychotherapeutic treatment if Jonathan chose the medication-only course.

Dr. Reiser's emphasis on stronger advocacy for continuing with therapy to "get to the bottom of the shyness problem" should be reserved for a time when there is a reasonably clear justification for that advice. If Dr. Reiser continued as Jonathan wished, he would still be in a position to monitor Jonathan's response to medication, assure that there were no worsening symptoms and retain a good patient-physician relationship.

Any patient-physician relationship is a combination of science and art—establishing and maintaining the relationship—and balancing physician beneficence with patient autonomy. This is often a challenge. Being able to adjust within this conflict and to choose continuity of patient care would seem the best course. That is, of course, unless there is grave danger in the patient's not taking medical advice for ongoing psychotherapy. Dr. Reiser should draw a line on appropriate duration and frequency of follow-up, even if it is for the prescribing function alone. This would be important for ethical purposes in terms of reasonable observation of the patient's condition and for medico-legal reasons as well. If Dr. Reiser and Jonathan could agree on openness for continued treatment, should that be necessary, the best outcome would be achievable in this case.

Dr. Reiser could feel professionally that he had done a good job with Jonathan, offered to continue with the prescribing of medication and left the door open for further therapy. He would then be respecting the patient's autonomy while not relinquishing his obligation to provide his best medical advice.

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CASE AND COMMENTARY

Psychiatrist's Role in Involuntary Hospitalization, Commentary 1

Commentary by Jennifer Bremer, MD

Case

Psychiatrist Lisa Feinberg had been working with Suzanne Martin for 2 years. Miss Martin was referred to Dr. Feinberg by her primary care physician who suspected that Suzanne's extreme low weight was indicative of anorexia nervosa (AN). Dr. Feinberg agreed with the diagnosis of AN and began meeting with Suzanne weekly. Suzanne Martin, a 19-year-old sophomore at the state university, was an excellent student and fine musician. She managed course work, a 3-hour per day practice schedule, and a regular exercise routine with little sleep and little food. Suzanne Martin made light of what others called her "illness." She met with Dr. Feinberg mostly to keep her parents "off her back." She chatted easily with Dr. Feinberg, but the psychiatrist found it difficult to get Suzanne beyond superficial chatter, on the one hand, and deep theoretical discussions of her studies and her music, on the other hand. Suzanne avoided talking about her illness and the behaviors that must be necessary to maintain her dangerously low weight. She managed to remain just above a level of physical exhaustion and weakness that would have necessitated hospitalization.

One night Suzanne collapsed and was brought to the ER by friends over her protestations. She had received glucose and was gaining enough strength to demand to go home when her parents arrived. Her physician had been called, and he was present also. Suzanne's parents appealed to the physician to say that Suzanne was endangering her life—for all practical purposes, she was suicidal, they said—and hence should be declared incompetent to make medical decisions. Suzanne's physician had been reluctant make the declaration and had summoned to the hospital to confer about involuntary admission and artificial nutrition.

By the normally applied standards, Suzanne Martin was not incompetent to make medical decisions. She could understand the information she was given; she could analyze and measure the consequences of her refusal of treatment against an internal set of values and goals; and she could give back her decision in a coherent and consistent way. Dr. Feinberg figured that Suzanne's finely calibrated system had slipped out of control that day—a bit too much exercise or too little food. She was like a diabetic who takes too much sugar or too little insulin on a given day. One wouldn't hospitalize the diabetic against her will once physiologic balance had been restored. Dr. Feinberg feared that if Suzanne were hospitalized against her wishes and refused to eat all the food that was given her, she would be fed through

a nasogastric tube. Lisa Feinberg knew Suzanne well enough to know that Suzanne would consider this a grave and obscene violation. She thought that hospitalization and the treatment Suzanne would receive if declared incompetent would set her work with Suzanne back seriously. Suzanne might even consider Dr. Feinberg's role in the commitment so serious a betrayal of trust that she would discontinue coming for therapy.

Commentary 1

From the information provided, this patient should go to an inpatient specialty eating disorders unit. Outpatient treatment has failed her; she is approaching an age where no treatment is especially effective for anorexia. Suzanne's recent medical events point towards acute danger. This patient will likely gain weight and benefit immensely from a stay on a specialty eating disorders unit.

More specifics about her medical condition would help elucidate the status of her medical condition. The more unstable the patient's medical condition is, the more justification there is for hospitalization—even if a patient refuses and must be hospitalized against her will.[1] Her response to glucose makes it appear that the cause was hypoglycemia which can be deadly.[2-3] Indicators of medical instability may include: syncope, rapid weight loss, seizures, organic brain syndrome, bradycardia, exercise-induced chest pain, arrhythmias, renal dysfunction, dehydration, tetany, and decreasing exercise tolerance.[4] Abnormal electrolyte levels can also be of acute concern. The assessment of medical urgency in Suzanne's case remains a clinical judgment though, and detailed medical information is lacking here, making this case somewhat difficult to assess.

Fortunately, involuntary hospitalization probably can be avoided with this patient. The parents' request for their daughter's hospitalization suggests that they may be willing to use their influence to effect her hospitalization. Such vigorous persuasion is sometimes viewed as controversial. Using parental influence to help a child's nourishment and survival is reasonable and effective and can be effectual in cases of anorexia nervosa. Data supports the efficacy of the Maudsley family therapy approach.[5] The first phase of such therapy guides parents to use whatever measures they must—within reason—to mandate regular meals large enough to cause weight gain.

It is effective for parents to declare to their child that they will not allow her to starve to death, no matter what steps they must take to make this happen. It is vital for parents to tolerate their daughter's inevitable fury over this mandate and yet insist on hospitalization. In this case, it appears the daughter will comply since she has a history of complying with their treatment wishes. According to the case history, she attended therapy to keep her parents "off her back."

Parents can use different types of leverage successfully but often a firm mandate for hospitalization is enough and is preferred. When further influence is needed, parents can refuse the child privileges, eg, refusing to pay college tuition or car payments until their child is no longer on death's doorstep.

The psychiatrist also can use her alliance with Suzanne to help her understand what must and will happen. In 2 years, the outpatient treatment appears not to have moved the patient in the right direction. It is a good use of the therapeutic alliance to help hospitalize the patient. The psychiatrist and medical team should discuss at length with Suzanne their treatment recommendations and reasons for the hospitalization. Ideally, the treatment team helps the patient to understand the necessity of inpatient care so that she willingly agrees to follow their recommendations.

Usually, though, the cognitive distortions around body weight and shape which are diagnostic criteria for anorexia nervosa impede a measured reasoning process.[6] In addition, starvation clouds thinking. Data shows processing and attention deficits in patients with anorexia nervosa.[7, 8] In fact, there is anatomical change in these patients' brains such as increased ventricular size.[9] Since the parents' role in treating their daughter's illness is critical, it may be helpful to describe these cognitive changes to Suzanne's parents so they can be firm in their pleas with their daughter.

Under circumstances similar to this case, we rarely hospitalize a patient involuntarily. We avoid involuntary hospitalization because we would always prefer voluntary treatment. We often send patients to inpatient eating disorder units such as the ones at University of Iowa and Columbia University. By law we cannot send patients across state lines involuntarily. I must emphasize the importance of specialty eating disorder programs over general medical or general psychiatric units.

While it will be hard for the patient to go through this, refeeding must be the first priority. The patient's emotional upset is far less damaging than starvation. The psychiatrist's fear about the need for nasogastric feedings is unfounded; most patients do not require such measures on a specialty unit and such measures are usually avoided. While insight and understanding are important for someone with anorexia to move towards greater richness and meaning as she leaves starvation behind, refeeding must come first.

If Suzanne *still* declines a voluntary hospitalization and the patient's medical status is ominous, involuntary hospitalization is appropriate. This is especially true with a relatively young patient who will likely do well with inpatient treatment. While laws vary from state to state and over time, they tend to support paternalism in such circumstances. Consultation with a legal expert or ethicist may help the physician determine the correct path in a specific instance.[4] The subject of competency in anorexia is complicated and controversial, again underlining the importance of achieving voluntary hospitalization.

Amidst such controversy, it helps to recall the Hippocratic Oath's instruction to "first do no harm." Sending this girl home inevitably to starve is doing harm. Hospitalizing her will not be pleasant for anyone but will "do no harm" and may well do much good.

The principle of beneficence requires physicians to care for those who are unable to take care of themselves, as uncomfortable as it may be in our society where liberty and autonomy are treasured values. Hospitalization aims to help the patient regain her autonomy—an autonomy that the anorexia nervosa, not the physician, has taken away.

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CASE AND COMMENTARY

Psychiatrist's Role in Involuntary Hospitalization, Commentary 2

Commentary by Roy Lubit, MD

Case

Psychiatrist Lisa Feinberg had been working with Suzanne Martin for 2 years. Miss Martin was referred to Dr. Feinberg by her primary care physician who suspected that Suzanne's extreme low weight was indicative of anorexia nervosa (AN). Dr. Feinberg agreed with the diagnosis of AN and began meeting with Suzanne weekly. Suzanne Martin, a 19-year-old sophomore at the state university, was an excellent student and fine musician. She managed course work, a 3-hour per day practice schedule, and a regular exercise routine with little sleep and little food. Suzanne Martin made light of what others called her "illness." She met with Dr. Feinberg mostly to keep her parents "off her back." She chatted easily with Dr. Feinberg, but the psychiatrist found it difficult to get Suzanne beyond superficial chatter, on the one hand, and deep theoretical discussions of her studies and her music, on the other hand. Suzanne avoided talking about her illness and the behaviors that must be necessary to maintain her dangerously low weight. She managed to remain just above a level of physical exhaustion and weakness that would have necessitated hospitalization.

One night Suzanne collapsed and was brought to the ER by friends over her protestations. She had received glucose and was gaining enough strength to demand to go home when her parents arrived. Her physician had been called, and he was present also. Suzanne's parents appealed to the physician to say that Suzanne was endangering her life—for all practical purposes, she was suicidal, they said—and hence should be declared incompetent to make medical decisions. Suzanne's physician had been reluctant make the declaration and had summoned to the hospital to confer about involuntary admission and artificial nutrition.

By the normally applied standards, Suzanne Martin was not incompetent to make medical decisions. She could understand the information she was given; she could analyze and measure the consequences of her refusal of treatment against an internal set of values and goals; and she could give back her decision in a coherent and consistent way. Dr. Feinberg figured that Suzanne's finely calibrated system had slipped out of control that day—a bit too much exercise or too little food. She was like a diabetic who takes too much sugar or too little insulin on a given day. One wouldn't hospitalize the diabetic against her will once physiologic balance had been restored. Dr. Feinberg feared that if Suzanne were hospitalized against her wishes and refused to eat all the food that was given her, she would be fed through

a nasogastric tube. Lisa Feinberg knew Suzanne well enough to know that Suzanne would consider this a grave and obscene violation. She thought that hospitalization and the treatment Suzanne would receive if declared incompetent would set her work with Suzanne back seriously. Suzanne might even consider Dr. Feinberg's role in the commitment so serious a betrayal of trust that she would discontinue coming for therapy.

Commentary 2

Dr. Feinberg was not taking a sufficiently active and assertive role in the treatment of Suzanne. Suzanne should be hospitalized. Suzanne is not at all like a diabetic who slips out of control 1 day. Suzanne is more like a diabetic who denies having diabetes than like a typical diabetic who gets a bit sloppy. Suzanne was not really analyzing and measuring the consequences of her refusal of treatment against an internal set of values and goals. There is no indication that she understood the precarious medical situation she was in, that she could have died, that she was undoubtedly doing severe harm to her body and brain, or even that she had an illness. She may well be delusional about her weight and believe that her weight is in the normal range.

Dr. Feinberg was reportedly concerned that hospitalizing her would lead to nasogastric feedings and damage to the therapeutic work. There are problems with this assessment. First, hospitalization would not necessarily lead to nasogastric feeding. Nasogastric feeding against Suzanne's will would require an evaluation of her competence to refuse. Similarly, patients who are admitted to the hospital for medical or psychiatric problems have the right to refuse treatment. To override their refusal a forensic evaluation is needed.

In addition, Suzanne was not making progress in therapy. Suzanne did not appreciate the nature of her illness despite 2 years of therapy. She went to therapy but had not really engaged and does not appear to be on a path in which she would be able to really appreciate and work on her illness. There was not much work to be set back. Moreover, patients with anorexia nervosa often do not make progress in therapy until refeeding has begun and the clouding of their thinking from malnutrition subsides.

Even though Suzanne is no longer a minor, given her precarious condition and the reasonableness of hospitalizing her, the wish of her closest relatives (her parents) that she be hospitalized is material.

As a side issue, there is no indication that Dr. Feinberg obtained a consultation to help with this case. She needs assistance since it is going poorly. There is also no indication that she has experience and training in this area. If she is not highly trained in this area her need for consultation is that much greater.

Roy Lubit, MD is an assistant professor in the Department of Psychiatry at Mount Sinai School of Medicine. He is board-certified in child, adult and forensic psychiatry. He is coauthor of the chapter on Ethics in Psychiatry in the upcoming edition of the *Comprehensive Textbook of Psychiatry*.

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CASE AND COMMENTARY

Psychiatrist's Role in Involuntary Hospitalization, Commentary 3

Commentary by Robert Orr, MD

Case

Psychiatrist Lisa Feinberg had been working with Suzanne Martin for 2 years. Miss Martin was referred to Dr. Feinberg by her primary care physician who suspected that Suzanne's extreme low weight was indicative of anorexia nervosa (AN). Dr. Feinberg agreed with the diagnosis of AN and began meeting with Suzanne weekly. Suzanne Martin, a 19-year-old sophomore at the state university, was an excellent student and fine musician. She managed course work, a 3-hour per day practice schedule, and a regular exercise routine with little sleep and little food. Suzanne Martin made light of what others called her "illness." She met with Dr. Feinberg mostly to keep her parents "off her back." She chatted easily with Dr. Feinberg, but the psychiatrist found it difficult to get Suzanne beyond superficial chatter, on the one hand, and deep theoretical discussions of her studies and her music, on the other hand. Suzanne avoided talking about her illness and the behaviors that must be necessary to maintain her dangerously low weight. She managed to remain just above a level of physical exhaustion and weakness that would have necessitated hospitalization.

One night Suzanne collapsed and was brought to the ER by friends over her protestations. She had received glucose and was gaining enough strength to demand to go home when her parents arrived. Her physician had been called, and he was present also. Suzanne's parents appealed to the physician to say that Suzanne was endangering her life—for all practical purposes, she was suicidal, they said—and hence should be declared incompetent to make medical decisions. Suzanne's physician had been reluctant make the declaration and had summoned to the hospital to confer about involuntary admission and artificial nutrition.

By the normally applied standards, Suzanne Martin was not incompetent to make medical decisions. She could understand the information she was given; she could analyze and measure the consequences of her refusal of treatment against an internal set of values and goals; and she could give back her decision in a coherent and consistent way. Dr. Feinberg figured that Suzanne's finely calibrated system had slipped out of control that day—a bit too much exercise or too little food. She was like a diabetic who takes too much sugar or too little insulin on a given day. One wouldn't hospitalize the diabetic against her will once physiologic balance had been restored. Dr. Feinberg feared that if Suzanne were hospitalized against her wishes and refused to eat all the food that was given her, she would be fed through

a nasogastric tube. Lisa Feinberg knew Suzanne well enough to know that Suzanne would consider this a grave and obscene violation. She thought that hospitalization and the treatment Suzanne would receive if declared incompetent would set her work with Suzanne back seriously. Suzanne might even consider Dr. Feinberg's role in the commitment so serious a betrayal of trust that she would discontinue coming for therapy.

Commentary 3

Suzanne suffers from anorexia nervosa, a chronic condition which carries some risk of life-threatening complications. However she has little insight into the condition or the dangers. An acute complication has now arisen, and her parents want her primary physician or her psychiatrist to declare her incompetent so that she may be involuntarily hospitalized and treated. Her primary physician is uncertain and requests a consultation from her psychiatrist. Dr. Feinberg, her long-standing psychiatrist, is concerned about Suzanne's safety, but she is reluctant to honor her parents' request, fearing that her participation in involuntary hospitalization might threaten her 2-year relationship with Suzanne.

Question: Is it ethically permissible, or even obligatory, to involuntarily hospitalize this patient to protect her from a potentially life-threatening condition?

Patient autonomy has gained prominence, even predominance, in contemporary medical ethics. This focus on the patient's right to self-determination has led to a consensus that it is rarely justified to impose treatment on an unwilling patient if certain conditions are met. It is almost always ethically required to allow a patient to make her own decisions if (a) she has been given adequate information to make an informed decision, and (b) professional recommendations have been made, as long as (c) she has decision-making capacity, and (d) she is not being coerced by others. It is permissible for professionals or family to try to persuade the patient, but it is not permissible to manipulate (eg, by overstating the benefits or understating the risks) or to coerce (ie, to threaten).

Are there exceptions to these criteria? It is generally accepted that a patient may sometimes be treated involuntarily if she presents a danger to herself. It is not uncommon to admit an elderly patient to a long-term care facility over her objection if it is determined that she can no longer safely care for herself. It is, however, often a difficult matter of clinical judgment to predict when a patient's current or future decisions present sufficient danger that the benefit of involuntary treatment outweighs the harm of abridged freedom. In addition, we often allow a patient to make a poor choice which presents some risk, as long as the patient understands and accepts that risk.

Primary physicians and psychiatrists not infrequently have to decide if a patient has sufficient decision-making capacity to allow autonomous decisions that carry some risk. This case narrative says "Suzanne Martin was not incompetent to make medical decisions. She could understand the information she was given; she could analyze and measure the consequences of her refusal of treatment against an internal set of values and goals; and she could give back her decision in a coherent and consistent way." Using these criteria, some might believe that Suzanne has the capacity to refuse treatment. However, it is not entirely clear that she can "analyze and measure the consequences" because of her ongoing denial (see below). It is important to note that "capacity" is a characteristic of the patient.

It might be argued that this patient's denial has led her to make an irrational decision. Rationality (or irrationality) is not a characteristic of a person, but of a decision. An irrational decision is one that is not consistent with the patient's own goals and values. Thus a frail patient who chooses to decline nursing home admission and stay at home, placing herself at risk of a fall and fracture, is making a rational decision if she acknowledges and accepts the risk. A person of the Jehovah's Witness faith is making a rational decision if he decides to forego potentially life-saving blood transfusion based on his eternal values. However, a young man in the ED with meningitis who refuses antibiotics but says he doesn't want to die is making an irrational decision, because the choice he is making is not consistent with his goals and values. When an irrational decision has dire consequences, it is ethically justified to override that decision and treat the patient involuntarily.

Suzanne's refusal of admission cannot be considered a suicidal decision, at least not in the classical sense, since the suicidal patient wants to die. Suzanne does not want to die. She is refusing hospitalization because she believes she is not at risk. This could be interpreted as an irrational decision if her goal is to live, but her choice presents danger of death. Whether it is justified to override her autonomy and treat her involuntarily is a judgment call revolving primarily around the seriousness of the risk.

Dr. Feinberg must make a difficult decision. She must balance the physiologic benefits of involuntary admission with the harms such an action might bring to the therapeutic relationship. There comes a time when the balance tips toward the obligation to protect the patient from her own irrational decisions, but it is often difficult to determine when that time has been reached.

Recommendations:

(1) Since this is the first metabolic imbalance of Suzanne's illness and it has now been corrected, it would be acceptable for Dr. Feinberg to honor Suzanne's refusal of admission if (a) she believes continued weekly out-patient counseling will provide sufficient oversight and treatment, or (b) she has an alternative treatment plan that is acceptable to the patient. If however, she deems this collapse to be the first step down a potentially fatal course, it would be justified to involuntarily admit her for treatment.

(2) If Dr. Feinberg wants to try to maintain her relationship with Suzanne, but also feels the danger point has been reached, another option would be for her to request

a second opinion from another psychiatrist, or even to defer entirely to another psychiatrist for this critical decision.

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CASE AND COMMENTARY

Confidentiality of Patient Records Requested by the Court, Commentary 1

Commentary by Howard Zonana, MD

Case

Dr. Santos has been seeing Kyle Green for depression for 8 months. When they began working together, Mr. Green, an accountant, said that his 13-year marriage was falling apart. His work situation was even worse, he said. He worried that his employer, a well-known accounting firm, might be engaging in practices that would considered unethical if scrutinized closely. He was boxed in, he said. He couldn't jeopardize his income and look for another job at this time. Nor could he focus on attempting to fix his marriage due to worry and long hours at the job.

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He wasn't seeing much of his 2 daughters. On weekends, his wife would hustle the girls, aged 8 and 11, out of the house. She said she did not want them exposed to the bickering and hostility between their parents. Besides, she said, Kyle was so preoccupied that he wasn't any company for the girls and couldn't give them the attention they needed. Sometimes the 3 of them wouldn't return until late evening, Kyle said, and his wife would only say they had been at friends. Kyle didn't want to interrogate the girls, but, in answer to his general query about what they had done while out of the house, they usually said that their mother had dropped them off at friends' houses and picked them up later.

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Mrs. Green sued for divorce and custody of the 2 girls. Moreover, she did not want her husband to have visitation rights. She said he had a drinking problem and was suicidal. Her attorney wrote to Dr. Santos subpoenaing Kyle Green's records. When Dr. Santos informed Kyle, he objected to the records being released. He had been more despondent than ever since the divorce proceedings had begun and had spoken candidly with Dr. Santos about suicide.

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Commentary 1
Divorce and custody battles can be extremely bitter and divisive for patients, as well as providing landmines for their treatment providers. This case raises at least 2 major areas for discussion; (1) how to deal with subpoenas and (2) how to think about potential role conflicts in the context of a divorce and custody dispute.

Subpoenas: What to Do
The first principle is that subpoenas should not be ignored. To do so could have negative consequences for both the patient and the psychiatrist. The most prudent course would be to make sure that the patient has legal representation and then have him sign a release that allows you to notify his attorney of the demand for disclosure of treatment records. This gives the attorney the opportunity to raise objections to the court regarding both the need for the records and the extent and timing of any disclosures.

Analyzing psychiatric privilege in custody disputes is complex and varies considerably among states. Privileges may interfere with the goal of obtaining the best evidence by protecting certain pertinent information from the court's consideration. The protection of children has been deemed a compelling state interest that justifies the overriding of the privilege, eg, in situations involving known or suspected child abuse or neglect.

Many state courts will permit some access to psychiatric records if they are considered relevant. The "relevance" analysis may be interpreted broadly, including any factors that appear to be necessary. In theory, this aids the court's fact-finding. In reality, custody disputes in the adversarial system frequently result in each party's making an issue of every aspect of the other's life, hoping to impress the court by showing what a bad parent the other is. Any past history of mental health treatment becomes evidence of the lack of fitness to have custody of the child.

The general rule for waiver of psychiatrist-patient privilege is that the patient must put his or her mental health at issue and the court must find that "it is more important to the interests of justice that communications be disclosed than that the relationship between the person and the psychiatrist be protected." The burden of persuading the court that justice requires the testimony's admission is on the party seeking to admit testimony. These general rules for waiver are difficult to apply in the child custody setting.

First, there is no unanimity regarding the question of whether merely seeking custody puts a parent's mental health at issue and waives the privilege. Second, some courts believe that a balancing of interests is required; privilege is overridden if the evidentiary need for disclosure of the contents of a patient's treatment sessions outweighs the patient's privacy interests. Psychiatrists prefer the view in the US Supreme Court ruling in *Jaffee v Redmond* that created a patient-psychiatrist privilege in federal courts:

"If the purpose of the privilege is to be served, the participants in the confidential conversation [patient and physician] must be able to predict with some degree of certainty whether particular discussions will be protected."[1]

Thus the outcome is not clear in the case of Dr. Santos even though the information may, at first glance, seem relevant. *In re Matthew R.* shows how a Maryland appellate court overruled the trial court's order of disclosure of all records pertaining to the mother's treatment for bipolar disorder, noting that "if one parent in a custody dispute could, by challenging the other parent's mental fitness, get access to the other parent's records by his or her response to the allegations, the privilege would be meaningless."[2] The court reasoned that "the benefits to society of having confidential and privileged treatment available to troubled parents far outweighs the limitations placed upon the court by not having such information revealed."

Roles: Adversaries and Parents

The adversary system can be highly distressing to all participants in custody disputes. Although attempts have been made to create a more humane and child-protective courtroom, engaging in a battle with family members is not a positive experience; certainly it is not for the children who are often placed in the middle of this internecine warfare. Nor is it generally friendly to the parents. The adversary system requires parties to refrain from addressing each other directly; they may communicate only through their attorneys. The adversary system forces parties to present information in a way to help them "win" their case, rather than to examine the facts contextually. For this reason, many states require some efforts at mediation before a full-blown trial.[3]

It is not uncommon in this context for attorneys to request letters from treating psychiatrists attesting to the patient's ability to parent. Such attempts add the role of expert witness to the treatment role. Ethical guidelines developed by the American Academy of Psychiatry and the Law for psychiatrists in this situation recommend that treating psychiatrists should avoid/decline the role of expert. This is recommended for several reasons. First, it may disrupt the treatment relationship, especially if the patient does not succeed in his wishes and blames the psychiatrist-expert for his poor performance. Second, the kind of evaluation required to be an expert witness is very different than an evaluation conducted for therapeutic reasons. The former generally requires interviews with independent sources to confirm information, and a review of all previous records, as well as obtaining psychological testing to bolster clinical impressions. If one is going to offer an opinion that the patient is deserving of custody, an examination of the other spouse would also be required.

If it appears that an expert will be required, it is recommended that a separate expert be hired to evaluate both the children (assessment of special needs) and the parents (capacity to parent and provide for any special needs). In many circumstances the court will appoint an "independent" expert who will report to both sides and the court. This does not preclude the parties from hiring additional experts.

Therefore, in my view, Dr. Santos should first let his patient know that he has received a subpoena. Then he should ask if his patient has obtained an attorney to represent him. If so, he should then have his patient sign a release of information form permitting Dr. Santos to talk with his attorney. Dr. Santos should review with both the patient and his attorney their plans regarding how the subpoena will be handled in court and whether they will try to quash the subpoena. Dr. Santos should also review with the attorney what he is likely to say in response to questions regarding his diagnostic impressions and treatment plan if testimony is required by the court. He should also make clear that if expert conclusory testimony is needed regarding who is best able to provide for the child's needs, a separate evaluation by a non-treating forensic expert should be obtained.

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CASE AND COMMENTARY

Confidentiality of Patient Records Requested by the Court, Commentary 2

Commentary by Jeffrey L. Metzner, MD

Case

Dr. Santos has been seeing Kyle Green for depression for 8 months. When they began working together, Mr. Green, an accountant, said that his 13-year marriage was falling apart. His work situation was even worse, he said. He worried that his employer, a well-known accounting firm, might be engaging in practices that would considered unethical if scrutinized closely. He was boxed in, he said. He couldn't jeopardize his income and look for another job at this time. Nor could he focus on attempting to fix his marriage due to worry and long hours at the job.

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In fact, at first news of the suit, he had stated more emphatically than previously that he had nothing else to lose and didn't see any reason to continue the painful daily routine. In addition to these admissions, Kyle had been discussing his job with Dr. Santos, trying to decide what he should do with that uncomfortable and possibly unethical situation. He certainly did not want this information to get into other hands.

Kyle would not accuse his wife of any unsuitable behavior, so Dr. Santos couldn't get a good idea of why the marriage was failing. Kyle said he didn't know why his wife had stopped loving him and become so nasty to him, but he assumed the responsibility for the failure of the marriage. "Why *should* she love me?" he asked Dr. Santos.

Commentary 2

Judicial authority to compel disclosure of information revealed in psychiatric treatment for use in custody disputes has been frequently litigated. Such records are more likely to be admitted as evidence when the court is using the "best interest of the child" standard in resolving the custody dispute.

The applicable AMA ethical principles relevant to the subpoenaing of Mr. Green's records are as follows:

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

Principle IV: A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.[1]

The compelled release of psychiatric records by the treating psychiatrist is very problematic for reasons that underlie the ethical principle of confidentiality. Mandatory release of records can destroy an existing treatment relationship and may also deter others from seeking needed treatment.

A subpoena does not require Dr. Santos to send the records to Ms. Green's attorney, although it does require Dr. Green to produce them at a specified time at a particular setting (e.g., deposition, divorce hearing, etc.). Dr. Santos should request

Mr. Green to have his attorney file a motion to quash the subpoena, which, if successful, would make Dr. Santos's dilemma moot.

Assuming that the judge does not quash the subpoena, what options are available to Dr. Santos? An American Psychiatric Association task force has thoughtfully considered this issue. This task force recommended that a court deciding custody should permit the disclosure of confidential information revealed in psychiatric treatment only when the information is likely to be of real importance to the custody determination and is not available from other sources. Such breaches of confidentiality should only occur when substantial evidence before the court indicates that the parent whose treatment records are at issue may be psychologically unfit to function as a parent, and that information revealed in psychiatric treatment will be important in resolving this issue.[2]

Mr. Green's attorney could file a motion for an *in camera* review (i.e., a hearing or discussion with the judge in the privacy of his chambers or when spectators and jurors have been excluded from the courtroom) of Mr. Green's psychiatric records to determine which records, if any, are relevant to the custody proceedings. The court may also appoint an independent psychiatrist to review the record, thus assuring that only information pertinent to the patient's parenting capacity is disclosed. Following such an approach, it is very likely that information concerning Mr. Green's employer's questionable business practices would not be disclosed due to lack of relevancy in the custody dispute. Following the American Psychiatric Association (APA) task force's procedural recommendations, disclosure would be permitted in cases in which it was needed to assure the child's well-being, while confidentiality of the therapeutic relationship would be protected to the maximum extent possible.

Compelled disclosures of certain treatment information occur in other circumstances, such as reporting suspected child abuse and taking steps designed to protect a third party from potential harm by a patient in certain specified circumstances (eg, the so-called *Tarasoff* exception). Courts, legislators, and health care professionals have struggled to develop a balance between compelling state interests (such as protecting others) and privacy rights of the patient. It is generally recognized that when a person who needs mental health treatment actually obtains mental health treatment, it often protects other persons too—directly or indirectly. Individuals are often less willing to enter treatment if they know that their disclosures to a psychiatrist might later be used against them in some fashion.

The APA encourages psychiatrists to obtain consent before disclosing medical information, even if not legally mandated to do so either by federal (eg, HIPAA) or state law. Doing so invites patients and their psychiatrists to discuss the nature and limits of the psychiatrist's duty to preserve confidentiality. The APA has held, through its *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, that explicit consent, preferably written, should be obtained from the patient prior to disclosing information to third parties.[3] Thus, Dr. Santos's dilemma could have been significantly lessened had she disclosed to Mr. Green prior to beginning treatment that there were various exceptions to confidentiality, although it would have been unlikely that Dr. Santos could have foreseen (and therefore have informed Mr. Green) the specific exception being put forth.

Assuming Dr. Santos follows these recommendations and the court still orders release of Mr. Green's treatment records, Dr. Santos can ethically release these records.

The dilemma being faced by both Mr. Green and Dr. Santos could be minimized by Dr. Santos's style of record keeping. Specifically, it is often possible to maintain adequate treatment records from both a clinical and legal perspective without including potentially embarrassing information in these records. It is easier for the treating psychiatrist to formulate documentation guidelines if he or she assumes that the treatment records will be made available to either the patient or others.

Experience has also demonstrated that, even in the context of compelled disclosures, it is possible to achieve therapeutic benefit by dealing with the information to be disclosed and the disclosure process. For example, Mr. Green's apparent isolation from his children needs to be addressed in therapy. It is more likely a reflection of his depression and the dynamics within his marriage than a matter of poor parenting. His apparent passive stance in the marriage will also need to be addressed, and may become a more focal issue for him as he discusses the possible compelled disclosures. The detrimental effects of compelled disclosures can be minimized if the psychiatrist effectively involves the patient in the disclosure process from both legal and therapeutic perspectives.

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CASE AND COMMENTARY

Medicine for Malcolm

Commentary by Mary G. Burke, MD

Case

Malcolm Simmons' pediatrician, Dr. Hill, referred him to Dr. DePaul, a psychiatrist, for an evaluation of possible anxiety and depressive illness. Malcolm described himself as worried much of the time, with his specific worries including school performance, getting into college, and dissatisfaction with his friendships. His parents described him as irritable. He complained about going to school, which he said he hated, and wasn't able to talk with his parents or the physician about what was bothering him. The pediatrician's note stated that there was no history or evidence of trauma, psychosis, or substance abuse. Malcolm showed some obsessive behavior, including a preoccupation with cleanliness and germs and indecision that led to procrastination, so that he spent most of the evening in his room, ostensibly doing on his homework. The next morning he would insist that he had some fixing to do on it; he'd check it over and over again. He also became preoccupied with his appearance. Malcolm's parents were frustrated with his behavior, and tended to get angry at him. Malcolm's pediatrician had known the lad from the time he was a small, happy-go-lucky kid, and was contemplating starting Malcolm on an antidepressant. Before doing so, he wanted Dr. DePaul's evaluation.

When Mrs. Simmons and Malcolm came in, Dr. DePaul saw a good-looking teenager who greeted him politely and shook his hand. During the introductory session, after Mrs. Simmons had left, Dr. DePaul asked Malcolm why he had agreed to come. "I guess cause I hate school and Dr. Hill said maybe you could prescribe something that would help me 'cope' with it better." What did he most hate about it? "I don't know," Malcolm said. "Everything." Was the work tough? "Yes, and most of the kids are smarter than me," Malcolm said. Did he worry about grades? "Well," Malcolm said, "I usually get As and Bs, but I spend all night on it. I should be doing homework right now." Did he play on any sports teams? "No. Sports is a really big deal at our school. Only super jocks make the team." Malcolm did not look like a super jock. He was not overweight, but not particularly fit, either. At first, Malcolm spoke about his dislike of school—and life in general—as though he were talking about someone else's problems. After about 20 minutes, he began checking his watch, and his answers got shorter and less informational. He wanted out of there saying, "I thought you were going to give me some Prozac." Dr. DePaul began to observe some of the anxiety Dr. Hill had mentioned, as he thought about the many factors that would influence his prescribing decision.

Commentary

The dilemma in which Dr. DePaul and his pediatric colleague find themselves is common. However, it is not a clinical dilemma. A thorough psychiatric evaluation of Malcolm, a psycho-education about anxiety, depression, and sadness, and a collaborative discussion about the risks and benefits of different treatments with Malcolm and his family will make Dr. DePaul's clinical decision easier and also get Malcolm and his parents more actively involved. There is concern that unhappiness in children has become "medicalized," reflecting larger social trends that devalue children's fundamental needs, especially for relationships and legitimate autonomy. The promotion of SSRIs to treat mild to moderate anxiety in children is partially the product of managed care business practices and clever marketing by the pharmaceutical industry.

Dr. DePaul would be on firm clinical ground if he insisted that Malcolm participate in a complete evaluation that includes at least 1 family session before he wrote Malcolm a prescription. Dr. DePaul's "bio-psycho-social" evaluation should start with an examination of Malcolm's constitutional and biological vulnerabilities including family history, his early and current relationships, his external stressors including trauma and violence, and the larger cultural and economic context that may be affecting him.[1-7] Dr. DePaul would be doing Malcolm a significant disservice if he ignores these "nonbiological factors." Of course, Dr. DePaul also needs to rule out several significant psychiatric illnesses that commonly present with symptoms of anxiety such as psychotic illness, bipolar affective disorder, severe depression, post traumatic stress disorder, incipient personality disorder, and substance abuse. Several medical conditions such as thyroid disease, though less common, can also present with psychiatric symptoms.

After careful evaluation Dr. DePaul should have a more comprehensive understanding of the sources of Malcolm's distress. Let us say, for the purposes of this paper, Malcolm has mild symptoms of obsessive compulsive disorder (OCD), mild-to-moderate pervasive anxiety that is both free-floating and related to performance, and some mild symptoms of depression, which affect his ability to function. He has no history of trauma, but his relationship with both parents is significantly conflicted. At this point Dr. DePaul might take the opportunity to talk to Malcolm and his parents about the biology of the limbic system, explaining that anxiety, per se, is not a disease but a feeling that plays an important biological role in the perception of, and response to, threat.[8, 9] Dr. DePaul can also describe sadness and involution as biological responses to loss and chronic subordination and helplessness. Within this framework, he can acknowledge that certain individuals are biologically more likely to respond to threat, stress, loss, or subordination with excessively anxious or depressed feelings that can evolve into disorders. Dr. DePaul should then ask Malcolm and his parents to think about circumstances that might be contributing to Malcolm's distress.

Dr. DePaul will be able to address Malcolm's search for a "magic pill" by talking with Malcolm and his family about the possibility of other treatment interventions.

The American Academy of Child and Adolescent Psychiatry (AACAP) has stated that "pharmacologic treatment should not be used as the sole intervention" for anxiety disorder in youth.[10] Dr. DePaul can recommend various psychotherapeutic strategies—individual, group, family, or cognitive behavioral—which all have demonstrated efficacy when used appropriately by trained clinicians.[10-13] When compared to pharmacologic therapy, these treatment options have the advantage of being free of side effects. Dr. DePaul must act as Malcolm's advocate in this discussion by helping him and his family reorganize his world to make it less stressful and provide more opportunities for developing relationships that are meaningful to Malcolm.

Dr. DePaul should specifically discuss the risks and benefits of the SSRIs. The SSRIs are "the most rapidly increasing psychotropic to be used to treat children and adolescents in the United States."[14] Although there have been no long-term studies of the safety or efficacy of these agents in children, the use of anti-depressants in pre-schoolers approximately doubled between 1991 and 1995.[14-16] Of the 4 most commonly prescribed SSRIs, only sertraline (Zoloft) has been approved for the treatment of OCD in children. Neither citalopram (Celexa) nor fluoxetine (Prozac) has been approved for use in children. The FDA issued a warning in June of 2003, that the fourth, paroxetine (Paxil) should not be used to treat major depressive disorder (MDD) in children because of the concern that it increases suicidality. With the exception of treatment of OCD, the benefits of SSRIs in children and adolescents are not robust especially when compared to the benefits of various forms of psychotherapy.

Dr. DePaul should also bring up other concerns about pharmacotherapy such as the concern that SSRIs may induce "behavioral activation." There is now significant debate about whether these drugs induce rapid mood cycling even in patients who are not biologically vulnerable to bipolar affective disorder.[17] This potentially serious side effect may outweigh the benefits of the drug therapy for a patient like Malcolm who has mild to moderate symptoms. The SSRIs often cause weight gain, and a recent case series also has shown cessation of growth secondary to abnormal growth hormone, related to SSRI use.[18] Besides the commonly discussed side effects, they can also cause a (reversible) "amotivational (frontal lobe) syndrome," which can be subtle enough to escape early detection. In this condition, the child becomes unmotivated in many areas, which can be particularly damaging in school. The child himself is unaware of the syndrome, due to the brain structures involved.[19] In my own practice I have also seen teens develop anti-social behaviors due to the loss of necessary anxiety (article in progress), without any evidence of either behavioral activation or the "amotivational syndrome."

Let us now explore the implications of using the SSRIs in children. These drugs alter the limbic functioning, changing a child's emotional response to the external world. A large body of research on attachment and affect regulation has documented the vital role that emotion plays in organizing memory, effecting relationships, cognition, and behavior.[9] The physician must carefully weigh the risks to Malcolm of introducing this chemical agent into his system, which may blunt or otherwise alter his innate signaling system. Dr. DePaul must also recognize that the long-term risks of the drugs are poorly understood; the documented benefits are unclear; and Malcolm, as a minor, may not truly be able to give informed consent.

Clearly, there are psychiatric illnesses for which medications play an essential treatment role. In the last 10 years we have seen a sophisticated effort led by the pharmaceutical industry and its marketers to describe mild to moderate dysphoria as a disease entity.[20-24] This has resulted in prescribing more SSRIs to children without clear medical justification[15-16, 25] In this case if Dr. DePaul prematurely writes a prescription, he may not fully address Malcolm's need for healthy relationships and may pass up the opportunity to develop a new relationship that will be potentially therapeutic for Malcolm.

As both the public and psychiatrists pursue pharmaceutical remedies for childhood distress, we neglect the obvious. Common sense and developmental research show that the large majority of children thrive when they are raised in cohesive families and strong communities.[7] These essential factors have rapidly eroded in the last 30 years.[26, 27] Psychiatrists, pediatricians, and parents need to be much stronger advocates for the social institutions that make happy, stable children.

Finally, should Dr. DePaul give Malcolm a medicine? I think he should feel confident recommending a time-limited trial of the nonpharmaceutical interventions listed above. He and Malcolm can agree to reconsider medication after 2 months for Malcolm's symptoms of OCD if Malcolm is still experiencing significant distress or sooner if Malcolm deteriorates.

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MEDICAL EDUCATION

Stigma, Society, and Specialty Choice: What's Going On?

Sam Huber

If psychiatry offers the flexible and reasonable hours, compensation, and autonomy that students cite as important to their lifestyle as a physician, why do applicants to psychiatry residency programs remain steady? If mental health has such an impact on disability adjusted life years (DALY) and lost productivity, why won't health insurers cover proper treatment, and why do we cloak records of mental illness in secrecy?[1] The answer, some say, is the continued social stigmatization of mental illness.[6] Stigma is present among medical students as well as the general public, and a poor opinion of psychiatric patients has spread to include the professionals who care for these patients.[7, 8]

Much has been written about student and general public attitudes about both the mentally ill and psychiatric treatment, but little effort has been made to examine whence these attitudes might come. Attitudes include a public perception of danger from the mentally ill, imprecision in diagnosis and diagnosis by phenomenology, ineffectiveness of treatments, and difficulty with chronic disease in general as well as an opposing general accusation that mental illness does not exist at all except as an instrument of social control.[9-11] In addition, the public's fear of violence is greater now than in past decades despite analysis to the contrary.[1, 11]

Rather than address individual claims about the veracity of mental illness or the efficacy of current diagnosis and treatment, this discussion will address ideas about the sources of stigmatizing attitudes. Beyond historical misunderstandings of psychiatry's checkered past and individual experiences of mental illness, little consideration has been given to why we are thinking this way. With the intention of provoking critical thought and discussion, I propose 3 interrelated constructs that contribute to our popular (mis-) understanding of the mind and mental illness.

Underlying our opinions are Descartes' mind-body dichotomy, popular mistakes about Freud, and trouble with the concept of the nature-nurture relationship inherited from Sir Francis Galton. Together, these 3 features (1) form a popular understanding of the mind that only vaguely resembles what contemporary psychiatry has to offer; (2) create a disjuncture between reality and public opinion; and (3) fuel negative attitudes about contemporary psychiatry. Understanding this model will help in efforts to reduce both the stigma of mental illness and the undesirability of psychiatry.

Generally, when we think about the mind, we comfortably make the distinction between things "out there" and the thoughts we have about them inside our heads. Even when thinking about our own bodies, we can distinguish between ourselves (a thing out there) and the thoughts that play out inside our heads. This idea is derived mainly from a Cartesian conception of the body and the world with input from Kant.[12] Descartes envisioned a mechanistic body with strings and pulleys and a separate soul that pulled the levers.[13] In fact, he worked for some time with William Harvey of blood-circulation fame. The operational dichotomy that develops is called mind-body dualism, a result of intricate church-science social relationships and a mainstay of Cartesian thought.[14]

The Cartesian mind-body paradigm leaves a legacy of reductionism. It neglects psychosocial and multifactorial etiologies of mental illnesses in favor of linear and biologic mechanisms. Furthermore, it makes personal thoughts inaccessible to anyone other than the individual who is having them, thus making it difficult to generalize any insight gained on the "mental" side of the mind-body gap.[15] Most importantly, it separates treatment loci to either physical *or* mental domains. With a Cartesian model, either psychiatry should look a lot like neurology, or it should not resemble "physical" medicine at all. This understanding limits our imagination when it comes to disease states or methods of addressing them.

A second facet of our popular understanding of the mind is evident in the Freudian terms that are littered throughout our vernacular. They are found in mainstays of popular culture from sitcoms to coffeehouses and fashion magazines, though much of their original meaning has been lost. The weaknesses and criticism of Freud's models have been misinterpreted and also become entrenched in contemporary popular thought. We talk about egos, Oedipus complexes, Freudian slips, anal retention, and the subconscious or unconscious without much regard to their source or original definitions. Freud has also been interpreted as being pessimistic about the ability of anyone to be happy or free from mental illness.[16] It doesn't matter in this instance if he is right or wrong, merely that we fail to think clearly about his theories. The result is a caricature: psychiatry is about obsession with sex and childhood, mental disorders are unavoidable since there is unconscious determination of many actions, and the best we can hope to be is only a little neurotic. Popular Freudianism also leads to a skewed view of what treatment in psychiatry looks like, and skepticism about both the diagnosis and treatment of mental disorders.

A third source of a stigma-prone model of the mind is the nature-nurture relationship first characterized by Sir Francis Galton in 1869.[17] The nature-nurture dichotomy asks whether certain traits, diseases, personality, and other factors arise in individuals because "they were born that way," or because of their upbringing and environment. To answer the question requires either a dogmatic choice of nature or nurture or what has been called the "commonsense" answer that both play a role in any situation.[12] Choosing nature, nurture or both tends to be a dynamic decision, with variable answers for different situations. So, the question becomes "what is the source of *this* particular trait?" Applying the nature-nurture paradigm to the mind generates a tension between the contemporary fascination with both genetic determinism (nature) and the primacy of autonomy and free will (nurture). Neither nature- nor nurture-based theories leave the individual mind a sophisticated role, and suggest that psychiatry is unable to make a useful contribution to health. Either the mind is at the mercy of fate and genetics, or it is a *tabula rasa*, continually being written upon and shaped by the environment, without active participation of its "owner" other than conditioned (learned) responses. Regardless of its merits, choosing to think within Galton's structure discourages us from considering other models of the mind and mental illness; models that move beyond or coordinate mechanistic genetic explanations and environmental factors. An example of such innovative thinking is the biopsychosocial model of health and illness first proposed by George Engel, and other articulations of the holistic health movement in contemporary medicine.[18]

From these tacit (even "unconscious") philosophical underpinnings comes an understanding of the mind and psychiatry that is neither flattering nor prima facie true. Using the above constructs, it is easy to think that the mind and body (brain) are completely separate, that parts of the mind control behavior without our knowing it, and that any attempt to explain how the mind works is tangled up in a web of conjuring, projection, and the problem of brain chemistry versus upbringing and free-will behavior.[12, 15] This model leads us to think that mental illness is either ubiquitous (ie, we can't help it) or nonexistent (a lack of self-discipline disguised as illness) and that those with mental illness are fundamentally different from the rest of us. Seeing others as foundationally different rather than just functionally different is a key point in the development of stigma because it allows for a complete separation between the sick and the well.[19] Sociologically speaking, it is easier to stigmatize and denigrate someone who is in a different category than we. Keeping illness and health separate fosters stigma in this way.

Thinking "outside the box" of Cartesian dualism is just the beginning for combating stigma and changing attitudes, but recognizing where some of our current thoughts come from is an important step toward awareness. Our collective attitudes toward patients and the professionals who treat mental illness have an impact on research, reimbursement, and physician supply, not to mention the quality of life for patients and communities.

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IN THE LITERATURE

Pro/Con: Outpatient Commitment for the Severely Mentally Ill

Jacob Kurlander

Many communities struggle with how to care for people with severe mental illness, a population often poorly served by existing mental health services.[1] The problem gained public attention following several high-profile crimes committed by persons with mental disorders, like the case of a schizophrenic man who pushed a woman, Kendra Webdale, to her death before a New York subway train in 1999.[2] New York soon responded with Kendra's Law, which established procedures for outpatient commitment of some mentally ill persons.[3] Legislatures nationwide soon followed suit, and virtually every state now has similar provisions; yet, disagreement continues over the ethics and efficacy of the practice.[1]

Outpatient commitment involves a court order requiring a patient to follow a treatment plan.[4, 5] The treatment plan may include participation in self-help groups, psychotherapy, medication and may require supervised living, and urine or blood tests. Noncompliance may result in inpatient commitment or forced compliance.[4] In March 2001, *Psychiatric Services* devoted a section to the subject of outpatient commitment. Authors E. Fuller Torry and Mary Zdanowicz argue that outpatient commitment has a legitimate role in the treatment of severely mentally ill individuals, who may lack an awareness of their disease. Michael Allen and Vicki Fox Smith raise concerns about outpatient commitment's effectiveness, legality, and long-term effect on the delivery of voluntary health services.

Torrey EF, Zdanowicz M. Outpatient commitment: what, why, and for whom. *Psychiatric Services*. 2001;52:337-341.
Torrey and Zdanowicz argue that the current voluntary mental health system cannot appropriately care for severely mentally ill patients. They assert that many people with schizophrenia and bipolar disorder are cognitively impaired and lack the ability to make decisions about their treatment.[4] Consequently, those patients often fail to comply with physicians' orders, endangering themselves and the public. Numerous studies show that severely mentally ill people who are noncompliant face significantly greater risks of homelessness, suicide, violent behavior, and incarceration.[4] Those risks, the authors argue, justify coerced treatment.

Torrey and Zdanowicz recommend outpatient commitment for anyone with a severe psychiatric disorder "who has impaired awareness of his or her illness and is at risk of becoming homeless, incarcerated, or violent or committing suicide."[6] It would constitute another form of assisted treatment, alongside advance directives and assertive case management, and would not replace inpatient commitment for truly dangerous people. The authors estimate that 100,000 people in the United States might qualify for outpatient commitment[4]

- **Efficacy.** Torrey and Zdanowicz point to evidence that outpatient commitment at least doubles rates of treatment compliance and can reduce the need for hospital admissions by 60-80 percent.[4] One study found that extended outpatient commitment halved the probability of violent behavior.[7] The authors note that in all of these studies outpatient commitment "had to be combined with available and adequate outpatient services."[8]
- **Competence.** Like Alzheimer's disease and cerebrovascular accidents, schizophrenia and bipolar disorder affect the prefrontal cortex, an area essential to insight and understanding.[4] These deficits often cannot be remedied with medication. Torrey and Zdanowicz argue that many people with severe mental illness may lack the self-awareness to understand and follow treatment recommendations. For these individuals outpatient commitment may be the appropriate solution, the authors contend.
- **Patient-Physician Relationship.** Some argue that coerced treatment may damage the patient-physician relationship and make it less likely that the patient will continue to seek treatment. Torrey and Zdanowicz present studies showing that most people with severe mental illness who are coerced into treatment agree with the decision in retrospect.[9, 10] Seventy-one percent of patients in one survey agreed with the statement, "If I become ill again and require medication, I believe it should be given to me even if I don't want it at the time."[11]
- **Civil Liberties.** Perhaps Torrey and Zdanowicz's most contentious claim is that mental illness itself may constitute a biological deprivation of liberty. Rather than restricting a patient's free will, they suggest that outpatient commitment actually enables it. They note that delusions and hallucinations often influence the thoughts and actions of mentally ill people and that outpatient commitment may help these patients think rationally again.[4] The authors further make the case for outpatient commitment as a tool to protect the public by comparing it to the accepted practice of involuntary hospitalization of patients with communicable diseases like tuberculosis.[4]

Allen M, Smith VF. Opening Pandora's box: the practical and legal dangers of involuntary commitment. *Psychiatric Services*. 2001;52:342-346.
Allen and Smith dispute Torrey and Zdanowicz's essential claim that outpatient commitment has benefits over existing mental health services. Furthermore, they argue that it poses significant risks to patient autonomy and individual civil liberties and may erode trust in the patient-physician relationship.

- **Efficacy.** Allen and Smith question the conclusions of the studies cited by Torrey and Zdanowicz since few of them were controlled. They point to a controlled study from New York's Bellevue outpatient center, published in the same issue of *Psychiatric Services*, that showed outpatient commitment was no more beneficial than enhanced voluntary services.[12] Although a few studies show benefits to long-term outpatient commitment when matched with high-intensity community services, the authors suggest caution in the absence of definitive evidence.

- **Competence.** Outpatient commitment "seeks to override the expressed wishes of a legally competent person who is thought to have some potential to become dangerous or gravely disabled in the future," Allen and Smith write[13]. Yet, mental illness does not necessarily preclude the ability to determine one's own treatment, they argue, a right protected by law. The authors point out that by law an adult is presumed to have the capability to make his or her own medical decisions and suggest that this right should not be violated in the absence of a compelling state interest.[5]
- **Patient-Physician Relationship.** Outpatient commitment threatens the provision of voluntary mental health services for the mentally ill by undermining the trust-based "treatment alliance" between patient and professional, the authors write.[5] While patients may be compliant during the course of an outpatient commitment, the right to refuse treatment is essential to a patient's participation in ongoing treatment, the authors assert. When outpatient commitment ends, patients may be wary of future treatment.[5]
- **Civil Liberties.** Although the courts set strict limits on the use of coerced treatment, many states allow for the extension of the treatment for long periods without explicit criteria for stopping the treatment.[5] In nonemergency cases, courts generally require a person to be found both incompetent and a danger to herself or others before imposing mental health treatments.[5] Dangerousness can be especially difficult to prove, the authors argue. Courts have generally found it unacceptable to restrain someone on the possibility that he or she might become dangerous at some future time, and forced medication is generally only permitted in emergencies.[5] The same legal standard would likely extend to outpatient commitment, the authors assert. If a patient is truly dangerous, the person ought to be hospitalized; otherwise, forced treatment infringes on the civil liberties of the patient.

Conclusion

The authors' views on outpatient commitment are illuminated by their responses to the case of Russell Weston, a severely mentally ill man who shot and killed 2 guards at the US Capitol in 1998. Although he had trouble with noncompliance, Weston repeatedly sought treatment but was turned away.

Torrey and Zdanowicz argue that this case demonstrates the dangers of untreated illness and the need for outpatient commitment. They view the primary problem as noncompliance born of clouded thinking, regardless of the availability of voluntary mental health services.[4]

Allen and Smith argue that the Weston case points to the need for improved voluntary mental health services.[5] Had they been available, services such as peer outreach could have addressed Weston's problems. It is likely that Weston would not have been a candidate for outpatient commitment in any case because he sought voluntary treatment, Allen and Smith write.

Among the unanswered questions in this debate is whether the few severely mentally ill people who are both incompetent and dangerous are better served by enhanced voluntary treatment or outpatient commitment. This question will likely be answered against the backdrop of another unsettled debate running through both articles over the relative costs of outpatient commitment and enhanced voluntary treatment.

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HEALTH LAW

In Defense of Exceptions to Confidentiality

Dudley Stewart, MD

Examination of Confidentiality in Psychiatry after *Tarasoff*

In 1968 two students at the University of California at Berkley, Tatiana Tarasoff and Prosenjit Poddar, met and began dating. Poddar believed the relationship to be more serious than Tarasoff did and became preoccupied and withdrawn when she rejected him. In the summer of 1969 Tarasoff left the country to do field work. Poddar went to the university health service for treatment of his depression.

The psychiatrist at the health service prescribed Poddar a mild anti-psychotic and sent him to a psychologist for outpatient therapy. In these therapy sessions Poddar described fantasies of hurting an unnamed girl. The psychologist also found out from a third person that Poddar had been considering buying a gun and became concerned about Poddar's potential for violence. After consulting with his supervising psychiatrist and the psychiatrist who had initially evaluated Poddar, the psychologist called and wrote the campus police asking them to apprehend Poddar. When the campus police went to Poddar's apartment they found him to be, in their judgment, rational. The police warned Poddar to stay away from Tarasoff but did not take him into custody.

Two months later Poddar went to Tatiana Tarasoff's home. Tarasoff's mother told him Tatiana was not home and asked him to leave. Poddar returned later with a pellet gun and a butcher knife, found Tatiana home alone, and killed her.

Tatiana Tarasoff's parents filed a suit against the university campus police and the health services, arguing that Poddar should have been apprehended and their daughter should have been warned about his threats.

In its final ruling on the case in 1976 the California Supreme Court found that therapists have a duty to protect their patients' potential victims. Various state courts have struggled with how to define the duty a physician may owe patients' potential victims. In general the physician's duty to protect has extended to clearly foreseeable victims of clearly foreseeable threats.[1]

Commentary

Confidentiality is the cornerstone and a sine qua-non of the patient-psychiatrist relationship. In the American Medical Association's *Code of Ethics* we reiterate the importance of confidentiality in a manner consistent with our mission "to advocate for our patients, physicians, and the public health."

It is the "public health" concern that has chipped away at the ideal of absolute confidentiality that still exists in priest-penitent interactions. Even attorney-client communications have a "disclosure" element if a crime is about to be committed where injury is likely to occur.

Our AMA's *Code of Ethics* addresses confidentiality in Principle IV: "A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law."[2] In their current opinions, the AMA's Council on Ethical and Judicial Affairs states that "the obligation to safeguard patient confidences is subject to certain exceptions, which are ethically and legally justified because of overriding social considerations. Where a patient threatens to inflict serious bodily harm to another person or to him or herself and there is a reasonable probability that the patient may carry out the threat, the physician should take reasonable precautions for the protection of the intended victim, including notification of law enforcement authorities."[3]

These public health or social concerns of organized medicine have been traditionally linked to communicable diseases but more recently have been expanded upon by various legislative initiatives that either require or permit disclosure. For physicians the "permissive" statutes are epitomized by the "Tarasoff" doctrine (1974-1976), in which confidentiality may be breached to *protect* an identified third party from harm. The doctrine has been extended by the courts to even unidentified individuals.

Currently there are 23 states with Tarasoff-type legislation including the state in which I practice, Louisiana.[4] In 1985 Louisiana did not have this legislation and, until revised, it was problematic, as are laws that suggest the "threat" must be "immediate"[5] or "imminent" as in the old American Psychiatric Association ethical guidelines. The current Louisiana law follows the new APA guidelines by suggesting that confidentiality may be breached in cases where there is "a threat that is deemed significant in the clinical judgment of the treating psychiatrist."[6] These changes in both the Louisiana law and the APA guidelines came about as a result of a lawsuit against a clinical psychologist and myself (*Viviano vs Moan et al*). We were sued for breaching the confidentiality of a patient by notifying a sitting federal judge, Judge Veronica Wicker, that this patient was stalking her and was planning to kill her and others but not until after his retrial took place. He had previously won a verdict in her court for over $1 million. After thanking the jury and dismissing them, Judge Wicker had turned to Mr. Viviano and his lawyers and said, "Though I've never done this before, I'm overturning the verdict—because you sued the wrong defendant."

Mr. Viviano first saw Dr. Moan, the psychologist in the suit, shortly after his first trial and then was referred to me for possible medication. His homicidal intent was present from the first, but it intensified over time, and a confluence of events, drug use and abuse, medication noncompliance, and missed appointments made the probability of his carrying out the threat far greater than the probability that he would not do so. He reported to me that he had watched the judge, could see into her home, and knew where she parked; he chronicled her morning "routine," including her "jog." During this time I consulted with colleagues and an attorney experienced in health care law, and notifying the judge was the unanimous recommendation. Involuntary hospitalization was not an option because his "dangerousness" did not flow from a mental illness but rather from his rage at being deprived of his $1 million, and his plan was to commit these murders after his upcoming trial.

After an effort to resolve the issue at a deposition where I refused to spell out what he had said in a particular session, a federal magistrate, Michelle Wynn, was called to "settle the issue," but she never returned the call. Three days later, after no contact from the federal magistrate, I tried to call Judge Wicker herself but was put off by her clerk. I then hand-delivered a letter to Judge Wicker. Within minutes she was on the phone, and she dispatched the FBI and US marshals to my office, since it is a federal crime to threaten or murder a federal judge.

Subsequently, the FBI arrested Mr. Viviano. He was armed at the time. He was evaluated prior to being transferred to Springfield where he stayed until his trial for attempted murder. He had a hung jury and then pled guilty to obstructing justice, was fined and sentenced to a private psychiatric hospital. Upon release from this facility he sued my psychologist colleague and me for $10 million for breaching his confidentially.

Though a number of ploys were used by the plaintiff attorney ("it was a dream, it was because of the medication," "it was a joke"), the issue boiled down to the word "imminent" and its definition. The plaintiff said it meant "in the next 10 minutes." We were unable to ascertain what it really meant since the ethics language allowed this threat to stand alone without being evaluated as to credibility, timeliness, or the unpredictability factor.

We won at trial, which took 3 weeks, and occurred after the American Psychiatric Association (APA) passed a change in the language of their ethical code at the Assembly level. The appellate court affirmed the trial court verdict. After the APA Board of Trustees ratified the change, the Louisiana Supreme Court refused to hear the case. The ordeal spanned 7 years and was the first "reverse Tarasoff" case on record.

Retrospectively, I believe that, in the same situation, the same steps need to be taken. Thankfully, the new Louisiana statutes[5] and the revised APA guidelines obviate that dilemma. I couldn't live with the reality of a dead judge and 9 dead attorneys counter-balanced by silence about my rageful patient's intentions with the mistaken belief that his privacy took precedence over the lives of 10 people.

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HEALTH LAW
In Defense of Absolute Confidentiality

Kenneth Kipnis, PhD

Examination of Confidentiality in Psychiatry after *Tarasoff*

In 1968 two students at the University of California at Berkley, Tatiana Tarasoff and Prosenjit Poddar, met and began dating. Poddar believed the relationship to be more serious than Tarasoff did and became preoccupied and withdrawn when she rejected him. In the summer of 1969 Tarasoff left the country to do field work. Poddar went to the university health service for treatment of his depression.

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In its final ruling on the case in 1976 the California Supreme Court found that therapists have a duty to protect their patients' potential victims. Various state courts have struggled with how to define the duty a physician may owe patients' potential victims. In general the physician's duty to protect has extended to clearly foreseeable victims of clearly foreseeable threats.[1]

Commentary

The conventional wisdom on the ethics of medical confidentiality has been largely shaped by the Tarasoff case.[2, 3] In 1969 Prosenjit Poddar, a student at Berkeley, told a university psychologist he would kill Tatiana Tarasoff who had spurned his affections. Reported to the campus police and held briefly, he was released and then did as he had said. The Tarasoff family sued the University of California for Tatiana's death and finally prevailed in its allegation that the university had failed in its duty to protect. Today it is hard to find discussions of the ethics of confidentiality that do not appeal to this parable and, occasionally, to the California Supreme Court moral: "The protective privilege ends where the public peril begins." Taking its cue from Tarasoff, the prevailing standard in medical ethics now holds that the obligation of confidentiality will give way when a doctor is aware that a patient will seriously injure some identified other person. This note is intended as both a challenge to this conventional wisdom and a preliminary defense of a medical confidentiality that does not contemplate such exceptions.

First one must highlight an error that infects much of the writing on this topic. The mistake is to move from a premise that some action is legally required to a conclusion that it is ethically required. The unhappy truth is that ethical obligations can conflict with legal ones. Journalists, for example, are sometimes ordered by the courts to reveal the identities of confidential sources. Although law demands disclosure, professional ethics requires silence. Reporters go to jail rather than betray sources.

Similarly in pediatrics, statutes may require doctors to report suspicions of abuse. Where there are protective agencies that are inept or overworked and foster care that is dangerous or unavailable, these reports are more likely to result in both the termination of therapy and further injury to the child than in either protection or proper care. To obey the law is most likely to abandon and even harm the child, both of which are ethically prohibited in medicine. To assume that legal obligations always trump or settle ethical ones is to blind oneself to the possibility of conflict. Professions have to face these dilemmas head-on instead of masking them with language that conflates legal standards and ethical ones. They must conceive professional ethics as largely separate from the law's mandate. And when law requires what professional responsibility prohibits (or prohibits what professional responsibility requires), professional organizations must press the public, legislatures, and courts to cease demanding that conscientious practitioners dishonor the duties of their craft.

Although laws cannot create ethical obligations by fiat, professions need to distinguish between the state's reasonable interests in the work of doctors—eg, preventing serious harm to children—and the specific legal mandates a state imposes—eg, requiring doctors to report a suspicion of child abuse to a state agency. Just as patients can make ill-considered demands that should not be satisfied so, too, can the state.

It is assumed in what follows that the state has a legitimate interest in preventing harm to people, and that doctors have an ethical obligation to further that public objective. The focus in this short essay is on the shape of that obligation, as it applies narrowly to adult patients, like Prosenjit Poddar, who present for treatment under their own steam. We set aside cases involving (1) children brought in by parents, (2) patients referred for independent medical evaluation, (3) patients in the custody of health care institutions, (4) health care that is the subject of litigation, (5) gunshot and knife wounds and the like, and (6) workers' compensation cases. A longer discussion could cover these.

Here we consider only the patient who somehow volunteers evidence that is ample to support a professional judgment that he or she is going to inflict death or serious injury on an identified other person. We suppose (1) that the evidence emerges under circumstances where it would ordinarily be covered by a professional obligation of confidentiality and (2) that a report would mobilize social mechanisms that will protect the person at risk. But for confidentiality, so the thinking goes, the injury would be prevented.

The most persuasive argument for breaching confidentiality may be as follows. The state's interest in preventing harm is weighty. Medicine has an obligation to protect the well-being of the community. Because the seriousness of the threatened injury outweighs the damage done to the patient by breaching confidentiality, the obligation of confidentiality must give way to the duty to prevent harm to others. Accordingly reporting is obligatory when it averts bad outcomes in this way. Of course clinicians should try to obtain waivers of confidentiality before reporting so avoiding the need to breach. But failure to obtain a waiver does not, on this argument, affect the overriding obligation to report.

As powerful as this justification is, there are problems with it.

First, if the profession accepts that its broad assurance of confidentiality must sometimes be breached, then any such assurances are fraudulent, and the profession should stop making them. If there are exceptions, clinicians have a duty to be forthcoming about what they are and how they work. Patients should know up front when they can trust doctors and when they can't.

Accordingly, the argument for breaching confidentiality has to be modified to support a qualified confidentiality rule, one that acknowledges a duty to report under defined circumstances. (In contrast, an unqualified rule contemplates no exceptions.) Instead of making promises, and then breaking them, doctors must qualify their promises so they won't have to break them. Commentators who have walked through the issues surrounding confidentiality have long understood the ethical necessity of "Miranda warnings."[4, 5] If doctors are ethically obligated to report, they need to say in advance what will be passed along, to whom, and what could happen then. They should never encourage or accept trust only to betray patients afterwards.

But now a second problem emerges. If prospective patients must know in advance that a doctor will report evidence that they will injure others, they will only be willing to disclose such evidence if they are willing to accept that others will know.

If it is important to them that evidence not be reported, they will have a weighty reason not to disclose it to those who will do so. There are 2 groups of prospective patients: the first is willing to have reports made to others; the second is deterred from disclosure by fear of a report.

Consider the first group. Under a no-exceptions confidentiality rule, if the patient is willing to have reports made to others, a doctor should be able to obtain a waiver of confidentiality. Once that occurs, the ethical dilemma disappears and an unqualified confidentiality rule will work just as well as qualified confidentiality. The at-risk party will be protected just the same but with appropriate permission from the patient. In these cases there is no need to trim back the obligation of confidentiality since patients are willing to waive it.

But now consider the second group: those who do not want credible threats reported. These prospective patients control the evidence doctors need to secure protection for parties at risk. If the patient cannot be drawn into a therapeutic alliance—a relationship of trust and confidence—then doctors (1) will not receive the evidence, and therefore (2) they will not be able to report it, and therefore (3) they will not be able to mobilize protection. Reporting rules do not protect at-risk parties in these cases. In contrast, a no-exceptions confidentiality rule has a better chance of getting the evidence on the table, at least to the extent that honest promises of confidentiality can make it so. To be sure, clinicians would have to set aside the 'Should I report?' conundrum and search for creative solutions instead. Perhaps patients can agree to protective measures that will only be implemented under conditions they accept. Perhaps there are pharmaceutical, counseling, or monitoring interventions that can help manage antisocial intent. Perhaps patients will give up weapons or consent to referral or commitment. Patients may be persuaded to comply in order to protect themselves rather than those at risk. To be sure, these strategies will not always work to prevent harm, but they will sometimes. The nub of the matter is that they can never work if they can't be implemented. And they can't be implemented if the fear of reporting deters patients from disclosure. In these cases there is no justification for trimming back the obligation of confidentiality since that reduces protection to parties at risk, increasing public peril.

The argument here is that, paradoxically, ethical and legal duties to report make it less likely that endangered parties will be protected. Depending on the prospective patient, these duties are either unnecessary (when waivers can be obtained) or counterproductive (when disclosure is deterred and nonreporting interventions are prevented). While doctors should accept an overriding obligation to prevent public peril, they do not honor that obligation by breaching or chipping away at confidentiality. The protective purpose to be furthered by reporting is defeated by the practice of reporting. The best public protection is achieved where doctors do their best work and, there, trust is probably the most important prerequisite. Physicians damage both their professional capabilities and their communities when they compromise their trustworthiness.

What may trouble doctors is a fear that they will learn about an endangered person and be barred by a no-exceptions confidentiality rule from doing anything. (Actually there is only one thing they cannot do: report. All other paths are open.) Even if a reporting rule keeps many prospective patients out of the office, or silences them if they are in the office, it protects doctors from the moral risk of having to allow injury to third parties when a simple report would prevent it. This distress is significant and has to be faced.

Here we must highlight a second error infecting much of the literature on this issue: the conflation of personal morality and professional ethics. Like law, personal morality can also conflict with professional responsibility. A surgeon who is a Jehovah's Witness may be morally prohibited from administering blood transfusions to patients needing them. A Roman Catholic doctor may be unable to suggest medically indicated reproduction-related services. And despite understandable moral misgivings, doctors everywhere must be prepared to administer treatments they know will end the lives of some patients. While personal morality should play a decisive role in career choice—one who is morally opposed to capital punishment should pass up work as an executioner—it shouldn't play a decisive role within medical ethics.

Many enter medicine believing that good citizens prevent serious injury to others, even if that means breaking promises. But the task of professional ethics in medicine is to set out principles that, if broadly followed, will allow the profession to discharge its collective responsibilities to patients and society. Confidentiality, I have argued, gets more patients into treatment, brings about better outcomes for more of them, and best prevents harm to third parties. Ethically, it is praiseworthy for honorable people to belong to a profession that, on balance, reduces the amount of harm done to others, even though those professionals must sometimes knowingly allow harm to occur. Although doctors may then feel guilty for knowingly allowing harm to occur, they are not guilty of anything. They are acting exactly as it is reasonable to want doctors to act.

It is hard enough to create therapeutic alliances that meet patients' needs. But if doctors take on the added duty to mobilize protective responses to their patients without waivers of confidentiality, their work may become impossible in too many important cases. And all of us will be the worse for that. The thinking that places the moral comfort of clinicians above the well-being of antisocial patients and their erstwhile victims is in conflict with the requirements of professional responsibility, properly understood. While it will be a challenge for many doctors to measure up to this standard, no one ever said it would be easy to be a good physician.

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POLICY FORUM

Psychotropic Medications and Criminal Defendants

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The right of individuals with severe mental illness to refuse prescribed psychotropic medication has been one of the major issues in mental health law over the last quarter century in the United States.

Treatment refusal as an issue has arisen in numerous clinical and legal contexts such as patients hospitalized in psychiatric facilities, treated as outpatients in the community, detained in jails prior to trial, incarcerated in prisons after conviction—or prior to execution in the case of prisoners on death row. The issue of treatment refusal has primarily concerned patients who have been civilly committed to a psychiatric hospital. Interested parties in this debate have included not only the individuals themselves, but also the treating psychiatrists, family members, and facility administrators, all of whom have generally advocated for overriding treatment refusals.

In many cases, treatment of individuals with severe mental illness is not strictly voluntary. Family members, probation officers, employers, and professional state boards prescribe or order psychotropic medications to individuals who do, in fact, have a choice whether or not to accept that treatment. The available alternative might be loss of family financial support, incarceration, loss of employment, and sanction on a professional license. In these situations, we often refer to the individual's decision as coerced, which reflects the presence of some retained voluntariness of decision-making. When the individual is unable to refuse that treatment, we refer to the treatment being compelled, not coerced.

Refusal of psychotropic medication became an important and controversial issue in the 1970s, in part, due to the risks of antipsychotic medication available at the time. These risks included the movement disorders tardive dyskinesia and tardive dystonia, which were thought to be prevalent, irreversible, and untreatable. Additional concerns were the erroneous belief that antipsychotic medication constituted exogenous mind, thought, and behavioral control. More recently developed atypical antipsychotic medications have minimal known risk of movement disorders, so that this adverse drug effect can no longer be a significant basis for treatment refusal.

Legal, constitutional arguments underlying treatment refusal have included the First Amendment's freedom of religious expression and the Fourteenth Amendment's due process protections. Constitutional principles and the common law tort of battery provide individuals with a right to bodily autonomy and integrity and freedom from bodily intrusions. In addition, legal and ethical requirements of informed consent to medical treatment are pertinent here and are predicated upon respect for the patient's autonomy and an expectation that the patient can participate meaningfully in making responsible treatment decisions.

Exceptions to Consent Rules

It is important to note, however, that there are exceptions to the requirements of informed consent. One exception is an emergency situation, usually involving physical harm to the patient or others. Another exception to the informed consent requirements is incapacity or incompetence of the individual to make responsible treatment decisions. Both of these exceptions are used as criteria for deciding whether and when to override treatment refusals by psychiatric patients.

A critical distinction has been made between treatment refusals by patients with medical illnesses and those with psychiatric illnesses. Unlike medical diseases, severe psychiatric disorders are often characterized by impaired awareness of illness. Delusional patients, for example, remain convinced of the reality of their particular delusion regardless of others' attempts to convince them to the contrary. Individuals with schizophrenia, delusional disorder, or mood disorders with psychotic symptoms who are not on appropriate psychotropic medication often have limited or no insight into the presence and extent of their disorder.

States have adopted different legal mechanisms for resolving such disputes on behalf of hospitalized psychiatric patients. These procedures were often adopted as a result of litigation but sometimes by state statute or regulation. Many states require that the patient be adjudicated incompetent to refuse psychotropic medication by a court prior to involuntarily medicating that patient. That procedure typically causes a delay in instituting treatment, which incurs risks to the patient's safety and that of other patients and staff if the patient is untreated for months. Other states have adopted an administrative review proceeding which does not require a court hearing, prior to forcing medication. Criteria for overriding treatment refusals at these administrative or judicial review proceedings include:

- the presence of severe mental illness,
- need for treatment,
- treatability of the individual with medication,
- incapacity or incompetence of the individual to make responsible treatment decisions,
- risk of physical harm to the patient or others absent treatment.

It may be necessary to establish that psychotropic medication is the least intrusive treatment that meets the patient's treatment needs.

Empirical research on treatment refusal has been conducted, usually on treatment-refusing hospitalized patients. That research has shown that, in jurisdictions using a judicial review procedure, courts have adjudicated the patient to be incompetent to refuse medication and ordered involuntary medication in the vast majority of cases.

A basic issue is the clinical outcome of individuals compelled to accept medication while hospitalized. One outcome is that the forcibly medicated patient, once treated, develops insight into the presence and severity of illness, and becomes able to say "thank you" to the treatment team. Another result is that some forcibly medicated patients remain unwilling to take medication, do not develop insight into their illness, and become even more resistant to subsequent treatment.

Trial Competence

Refusals of psychotropic medication by detained criminal defendants raise similar, but additional, issues to those in civil psychiatric hospitals. In most criminal prosecutions, it is necessary for the defendant to be legally competent to stand trial prior to trial. A similar competency finding is needed prior to sentencing. Our respect for human dignity requires that society punish only those who are adequately aware of the criminal process and able to participate in it. The specific criminal competence criteria are defined by case law or statute, whether federal or state, but usually entail the requirements that the defendant understand the nature and object of the criminal proceedings against him and be able to assist counsel in his defense. If the trial court finds that the defendant is not criminally competent to stand trial due to a severe mental disorder, then the court typically orders a course of treatment designed to restore the defendant's competence. The incompetent defendant is usually transferred to a secure or forensic mental health facility that specializes in the care of such defendants. Nonpharmacologic, psychoeducational treatment approaches are often useful in restoring the defendant's trial competence, but these do not directly treat the underlying mental disorder.

Though the law sometimes places time limits on the incompetent defendant's psychiatric treatment, refusal of necessary psychotropic medication by the defendant prolongs or forestalls restoration of competence and return of the defendant to jail for trial. Severely mentally ill defendants, absent treatment, often are isolated from other defendant-patients, and can further deteriorate both mentally and physically. Criminal defendants have refused psychotropic medication for fear that the medication would compromise their cognitive functioning and interfere with their ability to consult with counsel, testify, or understand the trial proceedings. Others have refused treatment based upon a wish to present their true mentally ill state to the jury in pursuit of an insanity defense, with the fear that medication would alter their appearance or demeanor. These arguments relate to the possibility of compromising the defendant's right to a fair trial.

In contrast to the defendant's argument that forcible medication abrogates his right to a fair trial, the prosecution contends that society has a valid interest in convicting, and punishing, individuals who commit crimes. A corollary of the argument is that a defendant should not be permitted to escape prosecution by refusing necessary psychiatric treatment, which could restore his trial capacity. In the ordinary, voluntary clinical setting, treating psychiatrists act on behalf of patients and in their best medical-psychiatric interests. Even in the ordinary, voluntary clinical setting, treating psychiatrists have limited legal and ethical duties to protect third parties from their potentially violent patients. To the extent that the treating psychiatrist in a forensic mental health facility seeks to forcibly medicate the defendant to treat a defendant's mental disorder, the psychiatrist is acting in the best medical-psychiatric interests of the defendant although paternalistically. When issues of risk of violence to other patient-defendants or staff arise due to treatment refusal, the treating psychiatrist who seeks to medicate the defendant forcibly is acting on behalf of third parties, not directly for the patient. In contrast, to the extent that the treating psychiatrist seeks to medicate the nonviolent defendant forcibly to restore the defendant's trial competence, that psychiatrist is acting as an agent of the state at large. Even those treating psychiatrists employed in public, forensic mental health facilities, and state-salaried, likely view themselves as agents of the patient-defendant, rather than agents of the state.

Dual Loyalties?

Dual loyalties for psychiatrists often present role conflicts, some of which may be irreconcilable at times. The duty to treat the patient can readily conflict with the duty to protect society from that patient or to warn society. In such situations, psychiatrists attempt to mitigate the conflict by implementing the third-party duty in as therapeutic a manner as possible. For example, psychiatrists attempt to constructively involve the patient in the effort to protect the third party, thus enhancing the patient's autonomy and self-esteem. Still, the third-party duty typically trumps the duty to serve the patient's interest in matters of life and death or of serious physical harm to the patient. In the context of the pretrial criminal defendant, involuntarily medicating the nonviolent defendant treats the underlying severe mental disorder while also helping to restore trial competence.

Courts, too, attempt to resolve the inherent conflict between permitting the defendant to refuse psychotropic medication and compelling it.[1] Courts can authorize involuntary medication on grounds of danger to the patient or others rather than restoration of trial competence. Otherwise, courts seek to order medication when it is necessary to restore trial competence, when it is medically appropriate, and when alternative, less intrusive intervention is unlikely to obtain the same results, so long as the medication does not cause significant adverse effects to the defendant's health or compromise the defendant's right to a fair trial.[2, 3]

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MEDICINE AND SOCIETY

Access to Mental Health Care: A Civil Rights Issue

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In remarks nearly a year and a half ago, the president of the United States called on the country to "make a commitment" to Americans with mental illnesses. He said, "they deserve a health care system that treats their illness with the same urgency as a physical illness."[1] He noted that new drugs and therapies have vastly improved the outlook for millions of Americans with mental illnesses but acknowledged that a "major obstacle to effective mental health care is the often unfair treatment limitations placed on mental health in insurance coverage."[1] President Bush stated that "insurance plans too often place greater restrictions on the treatment of mental illness than on treatment of other medical illnesses," and called on Congress to pass legislation that would eliminate those restrictions—and provide "parity" between mental health and medical and surgical benefits. Congress has yet to respond, and it is not apparent that the president has renewed his call.

Health insurance plan-limits on access to needed mental health care are pervasive. According to a recently published article on mental health benefits, although most workers with insurance were offered some coverage for mental health services in 2002, 74 percent of covered workers were subject to annual outpatient visit limits and 64 percent were subject to annual inpatient day limits. Forty-eight percent of these workers were enrolled in plans that subjected them to both day and visit limits as well as higher cost-sharing for mental health benefits. Only 8 percent of workers were in plans with none of these restrictions. No comparable restrictions were imposed on medical or surgical coverage.

The health insurance industry's pervasive practice of restricting access to mental health care is profoundly inequitable and fundamentally irrational. Mental illnesses are reliably diagnosed and, for virtually every mental disorder, there is a range of treatments and services that has been shown to be effective. The longstanding call for legislation to end health insurance practices that penalize people for their mental illness stems not only from the fundamental unfairness of these discriminatory practices but the tragic harm they cause. People with mental illnesses too often do not get needed treatment even when they have "good" insurance. Arbitrary, discriminatory insurance barriers to needed mental health treatment stand in the way and wreak havoc with American families. Consider, for example, the impact of insurance plans that impose a *lifetime* cap on the number of outpatient mental health visits, regardless of the individual's need for treatment. Rigid insurance limits on access to needed mental health treatment take a severe toll on families—in unemployment, broken homes, other health problems, poor school performance, custody relinquishment to secure needed mental health care, and even suicide.

More than 30 states have already passed and implemented laws that require insurers to provide parity between mental health and other medical coverage. But state parity laws vary widely in scope. Some cover only state employees, others are limited to specified diagnoses, while a number of states have relatively comprehensive measures. But because of overriding federal legislation that protects employer benefit packages (ERISA), no state parity law can regulate self-insured employer health plans, making it critical that Congress pass a federal law.

In fact, Congress has already passed legislation aimed at ending this discrimination against people with mental illnesses. That measure, the Mental Health Parity Act of 1996, established the principle that mental health coverage and coverage for medical and surgical care should be on par, and it requires that large-employer health plans may not impose stricter annual or lifetime dollar limits on mental health care than on medical or surgical care. While that "parity law" represents an important milestone, it has not produced fundamental change. As the General Accounting Office (GAO) reported in May 2000, people with mental illness still face widespread, arbitrary discrimination in health insurance coverage. In studying the law's implementation, GAO found that 86 percent of employers surveyed reported that they had complied with the 1996 parity law. But the vast majority of those employers substituted *new* restrictions on mental health benefits, thereby evading the spirit of the law. The lack of real protection under current law and the loss of life and health attributable to insurance barriers make it critical that Congress take up and enact a comprehensive mental health parity law soon.

The lead sponsors of the original parity legislation, Senators Pete Domenici (R-NM) and Paul Wellstone (D-MN), set out to close the loopholes in current law. Years have passed, but the bill has not. Many had anticipated that Senator Wellstone's death a year ago would spur Congress to pass this legislation which had already won broad bipartisan support in both the Senate and House. But while the bill was reintroduced and named for the late champion, and has again received the co-sponsorship of a bipartisan majority in the House of Representatives and two-thirds of the members of the Senate, the bills have languished in committees in both chambers.

What are the obstacles to passage of the Domenici-Wellstone bill, or any other parity legislation? Parity legislation has provoked strong opposition in the business community. Opponents have mounted many arguments, but each has a common thread–a studied avoidance of the profound impact of sharply restricted access to needed care on the individual and his or her family. Instead, opponents assert baldly that parity will be "costly," or raise the illusory threat that enactment of parity legislation would lead legions of people to abandon health insurance coverage. Underlying these and other arguments, one suspects, is resistance to *any* legislation. Study after study has documented that the cost of parity would be modest, and, in fact, is likely to be offset by such factors as increased employee productivity and reduced sick leave. But business sees the precedent of parity legislation as potentially damaging, even if the measure itself is relatively benign. And many lawmakers are all too receptive to a "no new mandates" mantra.

One is left to speculate on how legislators would respond to the imposition of similar restrictions on any other chronic illness. How would Congress react if health insurers were to impose strict limits on treatments for chronic pain, for example? Would it accept the argument that such limits are necessary and appropriate because of the subjective nature of pain, an argument employed for stricter limits on mental health care than any other illness? One suspects that such limitations would provoke outrage and that Congress would not wait long before passing remedial legislation.

Ironically, congressional leaders who have elected to deny both House and Senate members a chance to vote on mental health parity legislation already enjoy the protection that legislation would provide their constituents. Their own health plans, under the auspices of the Federal Employee Health Benefits Program, have provided them, their families, and their staffs mental health parity since January 1, 2001. Talk about unfairness.

It's late, but it is not too late to pass this legislation. Let lawmakers know how you want them to vote on mental health parity legislation.[3]

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VIEWPOINT

The Ethics of Electroconvulsive Therapy

Loren Mosher, MD and David Cohen, PhD

"First, do no harm" is the healing profession's best-known ethical precept because in the actual practice of medicine doctors may unwittingly do harm.[1, 2] However, is it ethical for physicians to give harmful treatments knowingly?

Such a course of action might be considered proper if no alternative treatments are available, if the treatment is not only effective but likely to be life-saving, if no coercion is involved, and if true informed consent is obtained for the procedure. Unfortunately, electroconvulsive therapy (ECT) meets none of these conditions. In fact, to the horror of truly ethical physicians, there are several recent instances in the United States of the involuntary administration of ECT, over the expressed repeated wishes of the patient.[3]

The issue is rather simple. The defining feature of ECT (modified or unmodified, bilateral or unilateral)—that which distinguishes it from any other treatment and is indicated in its name—consists in the electrical induction of a generalized seizure. This frequently leads to an acute organic brain syndrome characterized by amnesia, apathy, and euphoria.[4]

Administering ECT to depressed or severely depressed patients shows an "effectiveness" (evaluated by rating scales including many items that would respond to any nonspecific sedative intervention) lasting no more than 4 to 6 weeks.[5] Within 6 months of receiving ECT, 84 percent of patients relapse.[6] ECT is not life saving: no decrease in suicide results from its use,[7] and some increase in suicide may follow.[8]

ECT is not safe: it produces varying amounts of memory loss and other adverse effects on cognition in nearly everyone who receives it, typically lasting weeks or months after the last treatment (as well as many other adverse consequences, from ocular effects to postictal psychosis).

ECT is not necessary: numerous alternative, less harmful interventions—that work with the patient's consciousness, strengths, and social network—are available.[9] ECT is too often given as the treatment of next resort (not, as some of its supporters would insist, last resort) when drug treatment has seemingly failed, as drug treatment often does,[10] especially for the modal ECT patient today, an elderly woman. Less harmful options are not considered for reasons having very little to do with the patient's "condition" and very much to do with psychiatrists' increasing unfamiliarity with nonbiological interventions, professionals' frustration that patients are not recovering "quickly enough," and some institutions' reliance on the procedure as a revenue source.

Needed: A Study of Consent Forms

Finally, we suggest that true informed consent is almost never obtained, because practically no one would sign a truthful consent form for ECT (if any exists) unless coerced—grossly or subtly—to do so. Defenders of ECT might claim that informed consent is scrupulously obtained, but it is at present impossible to evaluate this claim properly. Indeed, despite the importance of divulging the risks of this most controversial treatment in psychiatry, no study describing actual ECT consent forms used in different institutions (even a small sample of 2 forms) has ever been published.

Unless a harmful treatment is life-saving, unavoidable, uncoerced, and its risks are fully divulged, knowingly administering it is unethical.

Here are the words of 3 individuals who received ECT and described publicly what they view as ethical violations involved in their experience of this procedure. Leonard Roy Frank said, "I have concluded that ECT is a brutal, dehumanizing, memory-destroying, intelligence-lowering, brain-damaging, brainwashing, life-threatening technique. ECT robs people of their memories, their personality, and their lives. It crushes their spirit. Put simply, electroshock is a method for gutting the brain in order to control and punish people who fall or step out of line and intimidate others who are on the verge of doing so."[11]

Thomas Hsu wrote, "My ECT's were in 1998. Overall I feel violated and very emphatically wish I had never consented to the treatments and would caution others. While I was not coerced into receiving the 'treatment,' I do feel I was misled and at the very least not suitably informed about the potential negative effects and lack of efficacy in treating depression. I would never consent to receiving ECT again."[12]

Jackie Mishra said, "One moment that I remember clearly from my hospital stay for ECT in 1996 is the horror I felt when after one of my treatments I couldn't remember how old my children were. Not only did the ECT not work for me, but my suffering was compounded when I realized that approximately 2 years of my life prior to the ECT had been erased. My retention of new information is also severely impaired. If anyone had told me that this could happen, even a remote chance, I never would have consented to ECT. I would much rather have lost a limb or 2 than to have lost my memory—my 'self'."[13]

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VIEWPOINT

Ethical Considerations with Electroconvulsive Therapy

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Electroconvulsive therapy (ECT) is a treatment modality which is primarily provided to individuals with very severe episodes of major depression, usually when multiple attempts to utilize treatment alternatives (psychotropic medications and psychotherapy) are either ineffective or poorly tolerated. In a minority of situations, where there is a high degree of urgency or when ECT has proven necessary in earlier episodes, ECT is administered prior to failure of these treatment alternatives.

It has been clearly established that ECT is the most rapid and effective way to induce a clinical remission in individuals with major depression.[1] It is also the case that severe depressive episodes often include clinical features, such as psychosis, suicidal intent, and medical debilitation, which are accompanied by substantial risk in the short term if not successfully treated. Given this situation, the efficacy and safety of ECT must be considered in a relative, rather than absolute, sense; ie, are risk-benefit considerations at a given time in a specific patient more auspicious with ECT than if ECT is not utilized?

There are no truly "safe" treatments in medicine. As noted, even no treatment at all is associated with the risks inherent with the disease process itself; in this case, the risks are considerable. The risks of ECT are several-fold. First, there are relatively common side effects, including transient headaches, muscle pain, and nausea, which tend to be mild and easily managed. Second, some degree of amnesia often develops over the ECT course. In a majority of individuals receiving ECT, this amnesia is temporary, except for a difficulty in remembering items from the recent past, ie, days, weeks, and months prior to the start of the ECT course.

A smaller fraction of ECT recipients, however, report that their difficulty in recalling information prior to ECT (termed retrograde amnesia) is more pervasive, even though such deficits have not been corroborated by research studies utilizing formal memory testing. Still, amnesia with ECT remains a concern to clinicians and patients alike and has raised the question of possible structural brain damage. Contemporary research, however, has not supported such a possibility.

A third type of risk with ECT involves the occurrence of more serious medical adverse effects, including myocardial infarction, stroke, and death. Except for individuals already predisposed to these risks on the basis of certain preexisting medical illnesses, such serious adverse outcomes are extremely rare.

Ethics of consent

Because of its nature, administration of ECT requires informed consent. The hallmarks of informed consent are the delivery of comprehensive and accurate information to the consenter and the ability of the consenter to understand, process, and act upon this information. In the great majority of situations, the patient him- or herself serves as the consenter. In this regard, the presence of psychosis or other irrational thought patterns does not in itself militate against capacity to consent.

There are, however, situations where capacity to consent is lacking. In these cases, the manner in which consent should be obtained is covered by state law. Depending on the state, the applicable regulations range from surrogate consent by the primary significant other to a judicial determination of a guardian specifically appointed to provide consent for ECT.

The process of informed consent raises several ethical questions. First, when does a recommendation for ECT by a clinician constitute coercion? While it is the physician's duty to make a recommendation as to treatment, this recommendation should be accompanied by a rationale for why it was chosen over alternative treatments. In the process of doing so, the physician should not put pressure on the patient to accede to the treatment, nor should he or she threaten the patient with any form of adverse action if the recommendation is not followed.

The second question pertains to how and by whom capacity for consent is determined. While this determination is sometimes specified under state law, more often, as with all other clinical procedures, it is left to the clinical team. In such situations, the determination of capacity should be based upon the patient's ability: (1) to understand that he or she has an illness for which the treatment is being recommended, (2) to comprehend consent-related material which is provided, and (3) to process this information in a manner by which a reasoned decision can be made. Importantly, this determination should also be independent of the desires of the physician or of significant others.

The third ethical question deals with whether and in what manner the wishes of a patient who lacks capacity should be incorporated into the decision-making process (something which is often not prescribed under state law). It is incumbent upon a surrogate consenter to take such wishes into consideration, while at the same time also acting in the patient's best interest. Such patient wishes encompass not only presently stated views, but include in addition any known views on the matter from the past.

The decision regarding whether to administer ECT reflects, in many ways, a balance between the right to have a treatment and the right not to have a treatment. It is the physician's role to allow the patient the opportunity to have a clinically indicated treatment which is relatively safe and effective. At the same time, this role also subsumes the need to help ensure that the informed consent process is meaningful and there is the opportunity to decline treatment. The American Psychiatric Association has recently published comprehensive practice recommendations which cover these issues and help set a standard for the practice of ECT throughout this country.[2]

Severe clinical depression is a debilitating and deadly illness. ECT represents an effective treatment option, which, with proper ethical safeguards, should remain available for use.

References

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PERSONAL NARRATIVE

Understanding Psychotropic Medications as Literary Symbols

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Fifty years ago, the humanities were considered vital to the profession of psychiatry. Academic journals regularly published articles about literature, art, and cinema. Psychiatrists analyzed works of fiction in presentations at professional meetings as a matter of course. And most important, residents learned about the art of the case study by reading works by Robert Lowell, James Joyce, and other writers.

Psychiatry's focus on the humanities grew out of the assumption that works of art provided entry into the human condition; and that the human condition was psychiatry's province to explore. One avenue of analysis was the (somewhat dubious) practice of diagnosing literary characters, and the authors who created them. For instance, Heinz Kohut described Thomas Mann's *Death In Venice* as an expression of the author's "unconscious guilt" and "early sexual overstimulation," resulting in an "(ironical) artistic personality." Clinicians also explored the humanities' therapeutic qualities. The use of "bibliotherapy" brought literature into psychiatric treatment, while the notion of the "therapeutic value" of literature, based in reader-response criticism, emphasized the curative aspects of reading. Finally, works as diverse as the movie *The Snake Pit* and the poetry of Anne Sexton (*To Bedlam and Part Way Back)* were generally considered to offer important, if not always agreeable, critiques of psychiatry.

In the present day, however, the humanities are often assumed to be less relevant to the treatment of mental illness. To be sure, many individual psychiatrists maintain personal interest in literature and painting. Yet the connection of the literary and visual arts to these practitioners' professional identities is far from apparent. For instance, leading journals rarely mention literary figures; book clubs and fiction reading groups are no longer components of academic psychiatry departments; and literary works are no longer discussed as case studies or examined for the lessons they might impart about interpersonal psychology.

Why are the humanities no longer thought pertinent to psychiatry? Managed care, shorter office visits, and the expanded use of medication are but a few of the changes that rendered close textual analysis, and indeed the case study, obsolete. These factors are also symptomatic of a theoretical shift in psychiatry. Psychoanalysis' historical emphasis on unconscious conflicts and drives found their natural correlate in Hamlet's brooding uncertainty, Anne Sexton's painful reflections, or Van Gogh's manic energy. Such connections between text and context can appear less germane when read through contemporary psychiatry's emphasis on brain biology or genetics.

And yet modern-day novels and short stories provide a plethora of texts in which characters struggle, much like psychiatry itself struggles, to come to terms with life in an era when subjectivity is determined by neuroreceptors and neuropharmaceuticals. Such representations speak to the ongoing relevance of the humanities for understanding mental illness and mental health. Humanities texts and methods can thus help psychiatry understand how its clinical values and assumptions are embedded within larger cultural contexts.

As but one example, selective serotonin reuptake inhibitor (SSRI) antidepressant drugs appeared in nearly 200 works of fiction between 1993 and 2000. Prozac makes a cameo appearance in Meg Wolitzer's romance novel *Friends For Life*, where Meredith, "lonely and wan," requests "a birthday cake with Prozac icing!'" In Thom Jones's short story "Superman My Son," psychotropic drugs enable Walter's descent into "normalcy." And in Fay Weldon's novel *Splitting*, Prozac has the power to transform Edwin's father from aging curmudgeon into a 60-year-old love machine: "he started taking Prozac, and six weeks later married that blonde, leather-booted woman." Over this same period, SSRI antidepressants were spoofed in films ranging from Woody Allen's *Everyone Says I Love You* to Boys in the Hall's *Brain Candy. Tank Girl* wore a necklace of silver dipped Prozac, and Homer Simpson concocted "home-made antidepressants."

These examples suggest many ways in which psychiatric medications can encapsulate the abstract properties that humanities methods are designed to illuminate. The humanities can help students of psychiatry understand how psychopharmacology contains powers of metaphor, gender, simile, icon, and other functions well in excess of known neural effects. Literature can thus facilitate discussions that will allow students of psychiatry to think of medications not only as facts, but as theoretical symbols.

For instance, Prozac's role in *Friends For Life* suggests how psychotropic medications can convey socially determined gender expectations. In the novel, Meredith's request for a "birthday cake with Prozac icing" is closely tied to worries that her age will make it more difficult to marry the man of her dreams, while Prozac carries the promise of a drug that will make her more beautiful. Meanwhile in "Superman My Son," medications function as potent brand-name commodities, able to shape symptoms, actions, and ultimately subjectivities in addition to treating them. Jones's protagonist Walter's appearance is controlled by the mood-stabilizing drug Eskalith , his potency by Prozac, and his behavior by Tegretol and Xanax . Walter eventually credits his behavior to the fiction that "the pills have started to work." Similarly in *Splitting,* medications function as symbols of chemical subjectivity: Edwin's father does not control medication through acts of cognition.

Instead, his newfound potency and agency result directly from the Prozac's effects *on* him.

In these and other cases, training in the humanities can help uncover assumptions represented by psychiatric medications. Such awareness has the potential to deepen doctor-patient communication in an age when, due to shortened office visits and quick medication refills, a formula of "description of symptom leads to writing of prescription" can force psychiatrists to think about pharmaceuticals as the responses to multiple choice tests. So too, humanities approaches can help psychiatrists think about larger implications of pharmaceutical treatments. By focusing on the symbolic value of psych drugs, the humanities can help psychiatrists better understand how medications convey a host of connotative implications in literature and, indeed, in clinical practice . These range from patients' predetermined beliefs about antidepressants to unspoken messages of nurturance at play when doctors prescribe (or chose not to prescribe) medications, to the meanings attached to these treatments by the mass media or advertisements. Ultimately, a psychiatrist's awareness of factual data about psychotropic medications is enhanced by awareness of these complex and often contradictory meanings, and their relation to the larger culture of which doctors and patients both are a part.

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