Analytical table of contents

The book is divided into four main sections.

- **Section One** is introductory: it covers the scope and special features of psychiatric ethics (Chapter 1) and some of the main ways of reasoning about ethical problems (Chapter 2).
- **Section Two** is the longest section: it includes case histories taken from each of the main stages of the clinical encounter — basic concepts (Chapter 3), diagnosis (Chapter 4), aetiology (Chapter 5), treatment (Chapter 6), prognosis (Chapter 7), and teamwork and the organization of services (Chapter 8).
- **Section Three** looks at the practical applications of the case materials of Section II, in teaching (Chapter 9) and in writing/reviewing research ethics applications (Chapter 10).
- **Section Four** offers two overviews — of psychiatry in an international context (Chapter 11) and of the importance of psychiatric ethics for our understanding of good practice in medicine generally (Chapter 12).
- **Appendix** gives a glossary and guide to the legal cases referred to in the text.

SECTION ONE Introduction: the tools of the trade

This section outlines the scope of psychiatric ethics as both a practical and a theoretical discipline (Chapter 1). It then introduces the main ideas from ethical theory that will be used in the rest of the book (Chapter 2).

Chapter 1 **Theory and practice: the special features of psychiatric ethics**

The special features of psychiatric ethics are introduced. Psychiatric ethics is shown to be wider in scope than traditional bioethics, issues of value (as well as fact) arising in psychopathology and diagnosis as well as in treatment choice. It is also deeper philosophically in that it includes general philosophical problems such as personal identity, rationality, and determinism. Psychiatry is thereby no less scientific than other areas of medicine. Indeed, the proper role of ethics in psychiatry is to facilitate rather than frustrate good science. But what all this amounts to is that clinical problem solving in psychiatric ethics requires even sharper thinking skills than in other areas of bioethics.

Reading Guide — General introductions to philosophy; the philosophy of mind; the philosophy of science; the philosophy of psychiatry.

Chapter 2 **Thinking skills: ethical reasoning and problem solving in psychiatric ethics**

The thinking skills required for clinical problem solving in psychiatric ethics are introduced through an extended analysis of the case history of Mr Able, a man with depression who is treated on an involuntary basis under the Mental Health Act. The relevant skills are both generic and specific. Generic skills include good communication and an understanding of medical law; specific skills include the varieties of ethical reasoning — bioethical (for example, principles, casuistry, and perspectives), general ethical (deontological and utilitarian), and analytic (concerned with underlying conceptual issues). Ethical reasoning is not an algorithm for solving problems. It deepens understanding, improves communication, and helps us to act decisively in conditions of clinical uncertainty.

Reading Guide — General ethical theory; medical ethics and bioethics; psychiatric ethics; involuntary psychiatric treatment.

SECTION TWO Case studies in the clinical encounter

Traditional bioethics has concentrated on problems arising in treatment (consent, resource allocation, and so on). In psychiatry, as shown in Chapter 1, ethical problems (that is, problems involving judgements of value as well as of fact) arise at all stages of the clinical encounter. Hence, the case histories described and analysed in this section cover each stage of the clinical encounter, from basic concepts of mental disorder (Chapter 3) and diagnosis (Chapter 4), through aetiology (Chapter 5), to treatment (Chapter 6), prognosis (Chapter 7), and the organization of services (Chapter 8).

Chapter 3 **Basic concepts: your myth or mine?**

The debate in the 1960s and 1970s about the validity of mental illness was polarized between psychiatrists arguing that mental illness is *no* different from physical illness and antipsychiatrists holding that mental illness is *so* different from physical illness that it is really a moral rather than medical concept. The two cases described in this chapter show that the tension between these two models of mental disorder, although nowadays less overt, remains important in practice. A narrowly medical model of mental disorder is vulnerable to both overuse (Case 3.1, Elizabeth Orton) and underuse (Case 3.2, Tom Benbow). Some of the considerations that can help us to avoid either extreme are reviewed.

Reading Guide — Models of disorder; abusive uses of psychiatry; models of disorder and current practice.

Chapter 4 **Diagnosis: rationality, responsibility, and values in psychiatric classification**

Three of the many ways in which diagnosis may be ethically problematic in psychiatry are illustrated in this chapter, in relation to the rationality or otherwise of suicidal wishes (Case 4.1, Martin McKendrick), in the context of seriously irresponsible behaviour (Case 4.2, Delia Jarrett), and in distinguishing between psychosis and religious experience (Case 4.3, Simon Greer). Case 4.3 illustrates directly the central place of value judgements in the diagnosis of mental disorders.

Reading Guide — Responsibility; rationality; values in psychiatric classification and diagnosis.

Chapter 5 **Aetiology: causal and meaningful connections**

The title of this chapter consciously echoes an early paper by one of the founders of modern scientific psychiatry, Karl Jaspers, in which he spelled out the need for understanding meanings as well as attributing causes in psychiatry. We might think that with developments in neuroscience (brain scanning, the 'new' genetics, and so on) this is no longer true. Case 5.1, Jane Gillespie, shows that it is still true at least for depression. Case 5.2, Francesca Gindro, shows that it is still true for the psychotic disorders that Jaspers had in mind.

Reading Guide — Causes and meanings.

Chapter 6 **Treatment: trick or treat?**

As in other areas of medicine, involuntary psychiatric treatment (treatment without the patient's consent) is justified, essentially, on grounds of the patient's 'best interests'. Involuntary psychiatric treatment is covered in detail in Chapter 2. In this chapter we examine two particular kinds of problem which arise with the concept of best interests in psychiatry — problems of dual role (Case 6.1, Captain Ahab) and problems of establishing the patient's true wishes (Case 6.2, Ida Harbottle). Case 6.3 (Robin and Alex) illustrates the importance of these issues in child and adolescent psychiatry.

Reading Guide — Autonomy (recent approaches); capacity; competence and consent; personal identity.

Chapter 7 **Prognosis: luck and judgement**

The ongoing clinical responsibilities of psychiatrists in circumstances in which they have few powers of prediction, let alone control, raise some of the most contentious ethical issues in contemporary psychiatry. This chapter explores

some of these issues. It draws in part on recent work in philosophy on what has become known as the 'paradox of moral luck' — that luck as well as judgement is endemic to responsible action in all areas of human activity.

Reading Guide — Predicting dangerous behaviour (ethical aspects); confidentiality; moral luck.

Chapter 8 **Teamwork and the organization of services**

Teamwork is an essential foundation of community psychiatric care. Besides offering a range of treatment skills, a well-functioning multidisciplinary team provides a range of value perspectives, essential for a balanced view of many of the ethical dilemmas described in earlier chapters. Here we describe two cases — one in which teamwork broke down; one in which it was at least partly successful.

Reading Guide — Professional ethics and the role of codes; resource issues.

SECTION THREE Teaching and research

This section pulls together some of the ideas developed in our case histories in relation to teaching (Chapter 9) and to research ethics (Chapter 10).

Chapter 9 **Putting theory into practice: a sample teaching seminar**

In this chapter we revisit our first case, Elizabeth Orton, in the context of a teaching seminar. This shows how the specifically ethical analysis of the problem given in Chapter 3 can be integrated with the other knowledge and skills required for problem solving at the clinical 'coalface'. Presented in the form of a seminar, the chapter doubles as one model for teaching psychiatric ethics.

Reading Guide — Sources and resources for teaching psychiatric ethics.

Chapter 10 **The three Rs of research ethics**

The 'three Rs' of research ethics, like the 'three Rs' at school, are reading, writing, and arithmetic. Presented in the form of an extended case study, this chapter aims to set out the skills required for reading and/or writing a research ethics application. The third R (arithmetic, or statistics) reminds us that ethical and technical aspects of good research design go hand in hand in psychiatry.

Reading Guide — Research ethics.

SECTION FOUR Wider perspectives

In this final section, the ideas and principles developed in the book are set in wider contexts — international (Chapter 11), and in relation to other areas of science and medicine (Chapter 12).

Chapter 11 **Psychiatric ethics: an international open society (by Jim Birley)**

Jim Birley draws on his wide international experience of clinical and public policy issues in psychiatry to draw out a number of lessons from the cases described in this book. The key theme that emerges is that good practice in psychiatry depends on the balance of different perspectives which is provided through an international 'open society'.

Chapter 12 Conclusions: psychiatry first

Because psychiatric ethics is more difficult than other areas of medical ethics, we have had to go 'beyond bioethics' in this book — in scope, in philosophical depth, in partnership with science, and, importantly, in integrating ethical reasoning with other clinical practice skills. In each of these areas psychiatry offers a 'window' on good practice in medicine as a whole.