Ethics in Psychiatry Training

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Contents

Introduction to Clinical Ethics ................................................................. 312
  Fundamental Definitions ................................................................. 312
  Ethical Concepts and Their Application in Clinical Practice ................. 313
General Ethically Relevant Aspects of Psychiatry ................................. 318
  Patient Self-Determination and Psychiatry ....................................... 318
  Coercive Measures in Psychiatry .................................................... 320
Particular Aspects of Clinical Psychiatry ............................................. 322
  Ethics and Psychiatric Research ....................................................... 324
  Ethical Aspects of Psychiatric Genetics and Population Genetics ............ 326
  Patient-Relevant Tools to Support Decision Making in the Field of Clinical Ethics ................................................................. 327
  Neuroenhancement and Wish-Fulfilling Psychiatry .............................. 330
Psychiatry and Society: Ethical Aspects of an Interdependent Relationship .. 332
  Foundations and Historical Aspects ................................................. 332
  Forensic Psychiatry ........................................................................... 336
  Stigmatization and Destigmatization ............................................... 337
  Resource Allocation and Equality of Access in a Global Perspective ....... 338
Conclusion ............................................................................................ 338
References ............................................................................................. 340

Abstract

This chapter begins with a section “Introduction to Clinical Ethics” that defines key terms from the field of clinical ethics and goes on to present and explain the most important ethical concepts.

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The main part of this chapter consists of two sections (“General Ethically Relevant Aspects of Psychiatry” and “Psychiatry and Society: Ethical Aspects of an Interdependent Relationship”). Section “General Ethically Relevant Aspects of Psychiatry” discusses ethically relevant aspects of the relationship between psychiatrists and patients. It starts with a critical normative analysis of patient autonomy in the psychiatric context. This is followed by a discussion of coercive measures in psychiatry and on suicidal ideation, geriatric psychiatry, and addiction medicine. The chapter then focuses on the topic of research ethics. It discusses the opportunities and risks of clinical psychiatric studies that must serve the interests of both medical progress and individual patient safety, before going on to explore ethical aspects of psychiatric genetics and population genetics. This is followed by consideration of patient-relevant tools to support decision making in the field of clinical ethics – namely clinical ethics counseling and advance healthcare directives. The final part of section “General Ethically Relevant Aspects of Psychiatry” offers a critical normative analysis of the recent developments neuroenhancement and wish-fulfilling psychiatry.

The second main section, “Psychiatry and Society: Ethical Aspects of An Interdependent Relationship,” is dedicated to the social and regulatory functions of psychiatrists and thus to the relationship between psychiatry and society. It starts with some basic remarks on the role of psychiatrists in society and on ethical misconduct in the history of psychiatry. Using the example of what happened during the Third Reich, it offers a critical discussion on the reappraisal of historical accountabilities. The chapter then goes on to look at the present and future of psychiatry, demonstrating the potential for conflict between psychiatrists’ clinical role of working for the good of individual patients and their public role of ensuring the good of society on the basis of three examples of ethical relevance: forensic psychiatry, stigmatization, and equality of access.

**Keywords**

Medical ethics · Role conflict · Coercive measures · Autonomy · Decision-making capacity · Historical reappraisal

### Introduction to Clinical Ethics

#### Fundamental Definitions

Before the principles, perspectives, and approaches of clinical ethics can be addressed, it makes sense to define the key terms and what they refer to (Gross 2012).

It is useful to start with the difference between the terms “morality” and “ethics,” as these are often mistaken for synonyms. The term “morality” (Latin *mos*) refers to the lived standards and beliefs of an individual, community, or society. Morality therefore includes the obligations and values that determine the life of a person or a community, and their reciprocal behavior. Morality evolves with the evolution of
society, being also dependent on culture, political system, and religious belief. In contrast, ethics (Greek ethikos) is a scientific reflection on morality. If morality is the sum of the normative beliefs that regulate human cohabitation within a society, ethics is the critical examination of what morality requires or prohibits. Ultimately, therefore, ethics is the science of morality.

Other central terms are “ethos” and “etiquette.” Ethos (Greek ethos) denominates the guiding beliefs of a group, a profession, or an organization. It is often used to denote professional ethics, e.g., the specific ethics of the medical or dental profession. It is originally linked to the Hippocratic Oath. Therefore, the latter can be looked upon as an early example of the ethos of the medical profession, preserving key aspects such as medical confidentiality, doing no harm, rejecting euthanasia, etc.

In contrast, “(professional) etiquette” (French étiquette) denominates a code of conduct. It has a strong focus on the interactions among the members of a profession or a medical professional group. Essentially, the term refers to a code of conduct that is based on professional traditions and describes expectations of social behavior within a group. Codes of conduct do not necessarily have an ethical dimension, but are there, above all, to protect the public image of a profession or occupational group. These include, for example, traditional regulations on how to mutually represent a practice or hand a practice on to a successor, or rules on advertising to ensure adherence to professional standards. Professional etiquette is important for smooth cooperation with colleagues (e.g., not enticing patients away from colleagues, not denigrating colleagues), and for the public image of a profession or specialist group. Many medical declarations contain examples of both professional ethos and professional etiquette, for instance, the Madrid Declaration on Ethical Standards for Psychiatric Practice (WPA 2011).

Many ethical guidelines in medicine and psychiatry are already protected by general legal principles (e.g., medical confidentiality, rejecting euthanasia, etc.) that are enshrined in the constitution or laws of individual states. Others are at least laid down in the declarations and other statements of international medical organizations, such as the World Medical Association (WMA) or the World Psychiatric Association (WPA). Especially, prominent examples include the WMA Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects in the current version of October 2013 (WMA 2013) and the aforementioned Madrid Declaration, as amended in September 2011 (WPA 2011).

Welcome as such regulations are, it is equally important to recognize that moral attitudes and behavior can neither be enforced nor replaced by laws and declarations. Also, medical progress consistently entails the need for new ethical clarifications, so regulations of this type will always necessarily lag behind the latest developments.

**Ethical Concepts and Their Application in Clinical Practice**

Besides the correct use of terms, ethical practice in the clinical context requires the application of suitable ethical theories. These should help achieve acceptable outcomes in cases of clinical dilemmas or ethically relevant issues.
There is a variety of different ethical concepts. The main way to distinguish between ethical theories is the criteria they use to determine what is morally good. Some of these concepts are based on the actor’s characteristics (virtue ethics), while others focus on the action itself (deontological ethics), the consequences of the action (teleological ethics), or on principles derived from common morality (principlism). These ethical concepts are described below with a main focus on principlism.

**Virtue Ethics**

Virtue ethics does not focus on assessing the individual actions of a person, but rather on assessing the person him or herself— in particular his/her character traits and virtues (Gross 2012; Hansen 2015; Radden 2015). Virtue (Latin *virtus*) refers to an inner attitude that causes a person to “naturally tend” to do good actions. Accordingly, good actions are to be expected from virtuous people. The ideal of a virtuous person, that is, a person with the right attitudes and character traits, thus becomes a benchmark for right (virtuous) action. In other words, for virtue ethicists, the proper course of action is not (primarily) deduced from general rules. It rather arises from the virtuousness of the person making the decision. Thus, a person with the right attitudes and character traits is able to make the right decision in a particular situation.

**Deontological Ethics**

By contrast, the terms “deontological ethics” and “duty ethics” (Greek *deon* = obligation, duty) refer to an ethical concept that measures human action by the fulfilment of basic obligations (Gross 2012): I do what I know to be my duty, so the action is good for me and for others. In deontological ethics, therefore, commands or permissions and prohibitions are the cornerstones of actions. The person carrying out the actions is concerned with “moral laws” or with guidelines and existing responsibilities.

Duty ethics assumes that actions, regardless of their consequences, are good or bad in and of themselves. This approach is frequently associated with German philosopher Immanuel Kant (1724–1804, Kantian deontology) and often illustrated with a formulation of “the end in itself,” the categorical imperative. This means the imperative to perform actions in which people are treated as an end and never simply as a means.

**Teleological Ethics**

In turn, teleological ethics focus on the purpose or the goal of an action (Greek *telos* = goal, purpose). The best-known teleological approach is consequentialist ethics, or consequentialism (Latin *consequentia* = effect, consequence). Both terms refer to an ethical theory in which actions are assessed on the basis of direct or indirect effects or consequences for the person affected by that action (Gross 2012; Teller 2013). It is therefore relevant whether or not the intended purpose or goal is achieved. Frequently, consequentialism is illustrated by the aphorism “the end justifies the means.” This ethical theory thus differs fundamentally from both
Deontological ethics (which assumes that the action itself is good or bad) and virtue ethics (in which the virtue of the actor is considered decisive). Accordingly, critics accuse advocates of consequentialist ethics of not going far enough because they do not see the “innate” nature of the act itself as morally relevant, but only its consequences.

A more powerful expression of consequentialist ethics is utilitarianism, which assesses actions based on their general utility (Latin uti = benefit). An action is considered to be useful, and therefore good, if – to the extent that this can be predicted – it maximizes the total welfare of those affected. The core of utilitarianism can be summed up by the demand to act in such a way that procures the greatest amount of happiness. Utilitarian ethics is therefore aligned to the issue of which actions provide the maximum benefit for the greatest number of people, i.e., it is based on maximizing of the sum of “interpersonal benefits.” The main argument against utilitarian approaches is that they only consider the sum of the benefit, but not the best possible care of the individual patient, so certain individuals could “fall through the cracks.”

**Principilism**

The ethical theories described above could be seen as fundamentalist, as they declare as authoritative and indispensable a particular area of the moral inventory (virtues, duties, consequences, etc.). A more pragmatic route was taken by American medical ethicists Tom L. Beauchamp and James F. Childress, who advocated principlism (Beauchamp and Childress 2009). The basis of their approach is four relatively simple principles derived from common morality, which given equal priority – and considered together – are supposed to constitute benchmarks for responsible ethical judgment. The four relevant principles are (Allen et al. 2015) respect for a patient’s autonomy, (Arolt et al. 2011) nonmaleficence, (Avasthi et al. 2013) beneficence, and (Beauchamp 2015) justice.

Principles ethics is currently very popular in the assessment of clinical cases, so it is worth presenting this approach in more detail:

1. **Respect for a patient’s autonomy**
   
   This principle means that the physician or psychiatrist recognizes the maturity and self-determination of the patient, and thus the individual’s independence from the medical authorities (DGPPN 2014). This principle ensures the personal decision-making capacity of patients with regard to their own interests. After all, decisions always involve individual values and attitudes relating to how one wishes to lead one’s own life. Respect for patient autonomy is the most historically recent of the four ethical principles. The recognition of this principle brought about a palpable change in the doctor-patient relationship; it meant a significant reduction in traditional medical paternalism (Latin pater = father). However, it should be emphasized that patient self-determination may be limited for a number of mental disorders, in cases where the patient lacks capacity to consent, and for other vulnerable types of patient (e.g., minors). In these cases, this patient right must be exercised by a legal representative (see section...
“Patient Self-Determination and Psychiatry” of this chapter). Besides, respecting patient autonomy does not mean that psychiatrists are ethically bound to do whatever patients request. Especially, when a patient requests an action that would harm him or her, the physician might act morally by denying that request.

(2) Nonmaleficence

The principle of nonmaleficence, on the other hand, can be traced back to the Hippocratic Oath. It is built on the principle of *primum nil nocere* (Latin, “first, do no harm”).

Nonmaleficence is the principle that no physician may inflict unjustified harm on a patient or subject any patient to unnecessary burdens. Even the (careless or intentional) omission of a measure can also be defined as harm, and therefore as a violation of the imperative to do no harm.

In fact, the principle of nonmaleficence is about negligence and about not exposing patients to unpredictable and unreasonable risks. Thus, any form of abuse of power by the treating physician is also prohibited – be it narcissistic, sexual, or economic.

(3) Beneficence

The principle of beneficence (Latin *bonum facere*) describes the medical obligation to promote patients’ welfare. While the principle of doing no harm aims to avoid or omit, the principle of beneficence is about positive actions – concrete assistance such as pain relief or curative and rehabilitative measures. There are also conceivable situations, however, in which a patient’s welfare can only be promoted by, for example, putting them under intravenous sedation if they represent an acute danger to themselves or others.

It is important to note that the principle of beneficence is sometimes used or misused as justification for medical paternalism. This is an attitude in which the physician or psychiatrist takes on the role of a caring father, making decisions in the patient’s (supposed) best interests, and thus disregarding the patient’s autonomy. While strong paternalism is directed against the will of an autonomous person, weak paternalism is manifested in nonautonomous action, that is, it is applied to persons who cannot decide autonomously. In fact, the extent to which the medical duty of care can be used as a justification to override (supposedly irrational) autonomous patient’s decisions is a recurring matter of debate in medical practice. In any case, it should be noted that, properly understood, care must always aim at promoting or restoring the self-determination of the patient.

(4) Justice

The fourth principle of the Beauchamp and Childress approach is justice (Latin *iustitia*). At the heart of this principle is the equitable distribution of available goods, services, and opportunities. This constitutes a special obligation to society to ensure that every citizen has access to medical services. Justice also means that the attention of the psychiatrist to his or her patients is fairly distributed.

In fact, it means that each patient should get an equal amount of time, commitment, and care, that physicians treat everyone as fairly as possible, and that they do not treat persons solely for the sake of increasing their own benefit.
The four principles can be used to solve almost all medical ethical dilemmas. If the individual principles conflict, a balance should be struck between them. Beauchamp and Childress (Beauchamp 2015; Beauchamp and Childress 2009) emphasize that there is no hierarchy between the four principles. Ultimately, it is up to the respective physician or psychiatrist to decide how he or she balances them. The weighting and the subsequent decision can (and may) turn out quite differently for different therapists. What is decisive, however, is that physicians have a plausible ethical basis for their decision, that is, they can cite the leading normative arguments for their decision and do not decide based on “gut feeling” or pure convention (“we’ve always done it this way”) (Table 1).

It has been mentioned that principles ethics is a particularly well-accepted approach to assessing conflictual clinical cases. There are four main reasons for this (Gross 2012):

1. In contrast to the ethical theories discussed above, the four principles require no philosophical knowledge and are also immediately accessible to nonexperts in ethics (the principles are plausible and intuitive).
2. Principlism is not fundamentalist; that is, it does not declare a particular area of the moral inventory to be an inviolable foundation (nondogmatic approach of principles ethics).
3. The four principles enjoy broad acceptance regardless of cultural origin and religious or philosophical convictions (ability to achieve consensus on principles).
4. The principles are well suited to analyzing specific cases; that is, they have clear practical relevance (practicality of the principles).

Beside the aforementioned four principles, a number of other ethically relevant criteria are also essential for a trusting doctor-patient relationship. These are summarized below:

- The honesty of both parties is a prerequisite for building confidence and treatment compliance and thus for a strong therapeutic relationship.
- For the psychiatrist, empathy is equally important. This means the sensitive perception of the needs of the patient. The treating physician not only requires a personal talent for this, but especially professional training and continuing education. Alongside empathy, the therapeutic process requires other characteristics such as a capacity for introspection, correction, and transparency. Empathy should not be equated with a lack of distance. Instead, both principles are

<table>
<thead>
<tr>
<th>Table 1</th>
<th>The four principles according to Beauchamp and Childress (2009)</th>
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<tbody>
<tr>
<td>Principle</td>
<td>Meaning</td>
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<tr>
<td>Respect for patient autonomy</td>
<td>Recognizing patient self-determination</td>
</tr>
<tr>
<td>Nonmaleficence</td>
<td>Principle of doing no harm (to the patient)</td>
</tr>
<tr>
<td>Beneficence</td>
<td>Principle of doing good (to the patient)</td>
</tr>
<tr>
<td>Justice</td>
<td>Fair distribution of goods and opportunities</td>
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required; distance from the patient is part of the practitioner’s professional conduct.

- Finally, the principle of economic neutrality is required. This has already been addressed under the justice principle. Of course, therapeutic intervention may be economically profitable. From an ethical perspective, however, it is important that a therapeutic option is chosen independently of how lucrative it is for the practitioner and is strictly based on the needs and interests of the patient.

Psychiatrists and psychotherapists are primarily bound by the treatment mandate — that is, to diagnose, maintain, and restore the health of the patient. This task and its potential ethical implications are discussed below in the first main section. Psychiatrists and psychotherapists also have a significant social or regulatory function — for example, in cases when patients’ behavior endangers themselves or others (see section “Coercive Measures in Psychiatry”). These two functions can lead to a role conflict, so it seems necessary from an ethical perspective to discuss the interactions between psychiatry and society. We do this in a further section.

General Ethically Relevant Aspects of Psychiatry

Patient Self-Determination and Psychiatry

As mentioned above, the traditional doctor-patient relationship used to be characterized by medical paternalism. Based on their technical expertise and treatment experience, doctors claimed to know what was best for their patient. This view is seen as outdated nowadays. In today’s society, autonomy and self-determination are fundamental values. This applies to both healthy and ill citizens (Arolt et al. 2011; DGPPN 2014; Hoff and Hinterhuber 2011, Radoilska 2015). Everyone has the fundamental right to make decisions about their own life and therefore on matters that affect their own health. Accordingly, both the informed consent of the patient — that is, consent based on full information — and shared decision making are prerequisites for gaining consent for specific diagnostic or therapeutic measures. Thus, it is the duty of physicians and psychiatrists “to empower the patient to come to a rational decision according to personal values and preferences” (WPA 2011).

However, in certain cases, mental illness can limit a person’s capacity for discernment and self-determination. The mere presence of a mental illness does not mean that a patient is not capable of making decisions (DGPPN 2015). In such cases, expert examination of a patient’s capacity for self-determination is all the more important. Especially in the context of affective disorders, obsessive-compulsive disorders and delusions, a patient with limited capacity to act may lose the freedom to choose between different options. Equally, it cannot always be assumed that the wishes that patients express correspond to what they actually want.

This relates to the ethically relevant question of whether, or in what circumstances, a psychiatrist may admit that a patient is not making decisions for his or her own presumed good. This reflects the particular situation of psychiatry. It is
controversial to what extent the established concepts of self-determination and informed consent, which were mainly developed for physical medicine, can do justice to the requirements and problems in the field of psychiatry and psychotherapy – if at all. Particularly in borderline cases, further ethical orientation is required for good medical conduct. A distinction must be drawn between autonomy as a right and autonomy as a capacity (Birnbacher and Kottje-Birnbacher 1999): the right to autonomous decision making is fundamental in nature and should not be relativized; however, it may only be exercised if the patient is actually capable of making such decisions. As mentioned, in some cases, psychiatric patients are not (entirely) capable of discerning or making judgments. However, seemingly irrational behavior does not always necessarily mean that a psychiatric patient is not capable of making decisions. Rather, it should be emphasized that in principle, of course, the patient has the right to make (supposedly) unreasonable decisions – if he or she can grasp the probable consequences of those decisions.

Capacity for self-determination and the right to want something unreasonable are, therefore, not fundamentally mutually exclusive (Bundesärztekammer 2015). In fact, also in physical medicine, it is often the case that patients exercise self-determination to reject a measure that would actually benefit them. If a patient is capable of self-determination and no significant acute danger exists, such a decision has to be accepted. Everyone also has the “right to illness.” It is equally important at this point to note that patients who are unable to work can be perfectly capable of making self-determined decisions on specific medical measures. Even the existence of legal assistance does not fundamentally exclude the capacity for self-determination (Schneider et al. 2015).

The criteria for self-determination in a specific case are the capacity to understand the information (i.e., when doctors explain the situation, patients must be able to develop an understanding of what needs to be decided), capacity for discernment (i.e., patients must realize that they have an illness or that their own health is limited), capacity for judgment (i.e., they must be able to recognize and comprehend the importance of the decision to be taken), and capacity for expression (i.e., they must be capable of expressing their decision verbally or nonverbally). The above capacities have various gradations in individual cases and therefore, from an ethical perspective, these capacities need to be thoroughly examined for each decision that has to be made. In cases of doubt, the assistance of an independent colleague who is not involved in treating the patient is advisable, both for professional reasons and for quality assurance, documentation, and forensic security purposes in the event of an impending conflict.

If a patient is not capable of self-determination in a specific case, it is necessary to obtain proxy consent – that is, consent by a named or legally appointed representative – or, in cases of acute danger to patients themselves or to others, the practitioner must first take a paternalistic approach. Even then, however, the medical measures taken should aim to restore understanding and discernment and enable patients to exercise their right to self-determination (DGPPN 2015).

A basic principle of the Madrid Declaration applies (WPA 2011): “No treatment should be provided against the patient’s will, unless withholding treatment would
endanger the life of the patient and/or the life of others. Treatment must always be in the best interest of the patient.” Furthermore, each case of limited capacity to discern and give consent should be treated individually and decisions made on a case-by-case basis. Patient-centered ethics in psychiatry should thus constantly seek to balance the traditional paternalistic approach and a radically interpreted patient right to self-determination.

Patient self-determination fundamentally includes being informed of the diagnoses made.

Coercive Measures in Psychiatry

Coercive measures are generally understood as keeping mentally ill persons in a medical institution against their express wishes and other measures (such as isolation or restraint) to confine patients against their will. Medical coercive measures are diagnostic and therapeutic interventions (e.g., drug treatment) against the express will of the patient (Allen et al. 2015; Arolt et al. 2011; Ernst et al. 2012; Hoff and Hinterhuber 2011; Liégeois and Eneman 2008; Vollmann 2010).

Coercive measures on psychiatric patients usually have two components: medical and regulatory. For the psychiatrist, the medical task – ensuring the patient’s welfare – takes priority; however, both these aspects of coercive measures need to be considered.

Unlike most physically ill patients, some psychiatric patients lack the capacity to discern that they are ill and require treatment – a fact that often leads them to refuse treatment classed as medically necessary. In these cases, a balance needs to be struck between a patient’s right to individual freedom and protecting society from the threat of a patient who represents a danger to others or protecting the patient from life-threatening behavior in line with the respective legal requirements.

It is one of the tasks of psychiatry (as well as of the state) to protect any mentally ill persons who present a significant danger to themselves. The actions of the psychiatrist must conform to the legal framework and be implemented in an ethically appropriate way in the individual cases. The principle of proportionality applies here. Accordingly, the Madrid Declaration (WPA 2011) states that no treatment should be carried out against the will of a patient, unless withholding such treatment would endanger the life of the patient or other persons around him or her.

In serious cases, society legitimizes repressive measures to protect the welfare of patients. Confinement, like any restriction of a person’s liberty, is a serious infringement of individual personal rights. Forced treatment is a violation of the fundamental right to physical integrity. Confinement and forced treatment are therefore only ethically defensible when persons who are acutely incapable of self-determination concretely and significantly put their health and life at risk (self-endangering behavior) and when this cannot be avoided by any other means, such as targeted attempts to convince patients of the danger of their behavior and their need for treatment. The moral prerequisite for such coercive measures is that patients’ refusal of treatment is an expression of their mental illness and not of
their autonomous free will. Coercive measures taken by doctors must be reasonable in terms of the expected benefits and burdens, and correspond to the presumed will of the patient. Treatment for the exclusive welfare of third parties or the general public is ruled out, because the welfare of third parties must not take precedence over the welfare of the patient. Thus, confinement can serve to avert danger to others (i.e., a threat to the health and life of other people) as well as danger to the patients themselves, but treatment measures against a person’s will that restrict his or her freedom solely in the interests of third parties or society (e.g., danger to others) is not covered by the medical code of ethics and therefore cannot be arranged or performed by doctors (Bundesärztekammer 2015; Bundesärztekammer 2016).

Let us take as an example a situation in which a patient cannot decide for himself and rejects treatment that is necessary from a medical perspective in order to prevent serious health problems and avert life-threatening conditions (e.g., acute risk of suicide or severe cognitive impairment due to dementia). Treatment against the self-determined will of the patient should, on the one hand, protect against serious damage to his health and, on the other hand, — as long or as soon as possible — restore his capacity for self-determination. This always involves taking into account not only the potential benefits and risks of the procedure itself, but also the subjective experience of the patient, possible effects on the therapeutic relationship between patient and doctor, and finally the possible adverse effect of compulsion on treatment success. The fact also needs to be considered that avoiding coercion may also constitute failure to provide vital assistance.

Coercive measures in the event of danger to others also raise specific ethical questions. If a patient presents a potential danger to others, he or she is expected to make a particular sacrifice in the interests of the threatened integrity of the community – namely to undergo coercive measures. The criterion of averting danger is closely linked to considerations in forensic psychiatry. Despite everything, medical treatment in the event of a patient presenting a danger to others may not be justified exclusively for the benefit of third parties or the general public; instead, it must protect patients against unwanted and serious (health) damage and restore their capacity for self-determination. Force is also justified through the concept of care (beneficence), which provides for the referral and confinement of the person concerned, especially as an action to help that individual. Quite fundamentally, coercive measures must be preceded by serious efforts to obtain the assent of the patient to cooperate. Here, a distinction must be drawn between an ethical attempt to convince and manipulative persuasion. There is a fine line between these two situations, which is why the use of force on mentally ill people is justified only under strictly defined conditions. This makes regularly continuing professional development for psychiatrists all the more important. This includes participation in quality control circles, best practice case discussions, and/or communication skills training. The fundamental ethical premise is that coercive treatment should be a last resort to avert imminent harm (DGPPN 2015).

If it seems possible that a patient could present a danger to themselves or others, it is advisable to create psychiatric treatment agreements at a stage when the patient is more lucid and thus capable of doing so. These agreements can serve as a guide
when decisions need to be taken, increase the autonomy of people with mental illness, and help reduce instances of forced treatment (see section “Advance Healthcare Directives and Joint Crisis Plans”).

To ensure that the ethical conditions for a coercive measure are met, the decision on forced treatment should be taken by a multidisciplinary team of professionals, in line with the legal requirements.

From an ethical perspective, particular attention should be paid to the setting, aspects of the procedure and quality assurance, and aftercare. Psychiatrists should tend to use those interventions that are least restrictive to the freedom of the patient. Coercive measures should be as gentle as possible. Furthermore, psychiatrists should seek advice in areas “in which they do not have primary expertise.” When psychiatrists have to assess a patient, it is indispensable to first inform and advise the patient “about the purpose of the intervention, the use of the findings, and the possible repercussions of the assessment” (WPA 2011). If a patient’s freedom of movement is restricted by restraint, a caregiver must stay close to them and be available for conversation and assistance. Emergency coercive measures such as restraint, isolation, and restrictions on freedoms of any kind must be precisely justified and documented. The decision to implement a coercive measure must be reviewed at short intervals. When the restriction is lifted or the psychopathological situation improves, the reasons for the measure must be clearly explained to the affected patient in a way that she or he can understand. It is necessary to work toward obtaining subsequent acceptance of these measures. From both a clinical and an ethical point of view, it is imperative that all those working in psychiatric institutions receive regular training to ensure that all patients are treated in a nonviolent manner. Such training includes de-escalation seminars, subject-specific standardized debriefing of the entire team after coercive measures have been applied, and awareness of the correct procedures for coercive measures as a firmly integrated part of continuing professional development programs.

From a clinical ethical perspective, it is also necessary to question the opinion that forced treatment should be avoided whenever possible because it is more invasive than “mere” confinement and thus implies further escalation. This stance is based on the argument that a danger to others can be averted without treatment, through measures that restrict freedom and provide protection (e.g., restraint) alone. This argument does not tell the whole story, however. Restraining highly agitated – e.g., psychotic – patients without providing accompanying therapeutic measures is highly controversial from both a clinical and an ethical perspective. It is associated with increased risk of injury to both patient and treating physician – especially because without accompanying treatment patients often have to be restrained for a longer period – and thus may also increase the risk of psychological sequelae (trauma).

**Particular Aspects of Clinical Psychiatry**

**Suicidal Ideation**

The treatment of suicidal patients raises particular ethical issues (Hoff and Hinterhuber 2011). This topic relates clearly to the question of coercive measures
in cases of self-endangerment (see section “Coercive Measures in Psychiatry”). When there is a risk of suicide, confinement may be necessary, which often has a negative effect on the level of trust between doctor and patient.

From an ethical point of view, the relationship between respect for patient autonomy and medical prevention of suicidal behavior – which corresponds to the ethical principle of nonmaleficence – is a particularly delicate issue. Nearly all suicidal acts can be explained by mental illness (e.g., depressive symptoms, addiction, or a psychotic disorder). That means that the act is not an expression of free will – which is precisely the ethical basis for psychiatric intervention in the event of (threatened) suicidal acts.

As is the case in the period after initial confinement, the patient-psychiatrist relationship is vulnerable when the patient is placed in psychiatric in-patient care after a suicide attempt or is placed under observation for suicide prevention. In all these cases, alongside the appropriate therapeutic care, the focus is on encouraging empathy and creating a situation in which the patient feels safe and cared for. This includes not only providing medical empathy and comfort, but also working to counteract feelings of guilt, bolster self-esteem, and contribute to improving a patient’s living situation as far as is possible.

**Geriatric Psychiatry**

Geriatric psychiatry involves a wide range of ethical issues (Dunn and Misra 2009; Hoff and Hinterhuber 2011; Hughes 2015). These include dementia patients’ ability to give consent, their individual needs and preferences, and issues relating to limitations on psychiatric services provided to elderly patients (resource allocation). Many problems are exacerbated by social conditions. Examples include patients’ lack of mobility and restrictions on autonomy imposed by the social setting (e.g., accommodation in nursing homes or at-home care), problems taking or metabolizing prescription drugs, or even medication against a person’s will. Insofar as far as they can, psychiatrists should try to influence the following social and individual ethically relevant issues (Hoff and Hinterhuber 2011):

- Expanding out-patient and mobile services with the sociopsychiatric goal of allowing people who have become dependent to continue living in familiar surroundings as far as is possible.
- Expanding day care and providing respite care options so that working people can continue to take care of their relatives at home, or relieve them temporarily.
- Empowering nursing-home residents and integrating them in internal decision-making processes.
- Promoting (social) activities among nursing home residents, including promoting the possibility for (community) spiritual or religious activity (if the patient so wishes).
- Enabling equal access to medical and psychiatric treatment and care services.
- Ensuring dignified end-of-life care.

The latter also includes careful definition of the indications for tube feeding. The principles of informed consent or any statements made by persons with power of
attorney or by the patients themselves in written advance directives are to be observed. Nevertheless, the responsible psychiatrist also always has to determine whether refusing food is simply a characteristic of a psychiatric condition.

**Addiction Medicine**

Sooner or later, alcohol dependency, illegal drug use, or addiction to prescription drugs leads to social and physical impairment. In addition, the comorbidity of addictions and mental disorders is considerable. Moreover, many addicts experience social stigma (see section “Stigmatization and Destigmatization”). In this respect, psychiatric treatment of addicts is especially challenging (Hoff and Hinterhuber 2011) from both an ethical and a therapeutic perspective. Addicts often lack the awareness of their condition that is required for a positive therapeutic alliance. They are also often unwilling to submit or adhere to treatment. In addition—as with most other mental disorders—dependency is often affected by the social environment, which can lead to a variety of conflict situations, with third parties often approaching the psychiatrist with their own expectations and demands. This can result in a conflict of loyalties between the interests of the patient and those of the patient’s family and of the social environment. Even when a psychiatrist’s task clearly extends beyond responsibility for the patient, he or she must make decisions based first and foremost on the patient’s welfare. The goals of addiction therapy are: Survival, harm reduction (with, if necessary, adequate substitute treatment), promoting quality of life, and— the long-term and most challenging goal— permanent abstinence.

**Ethics and Psychiatric Research**

The need for basic scientific research and clinical trials is undisputed, but the fundamental danger of abuse of patients and of corrupt behavior by drug trial investigators who accept personal financial contributions (Arolt et al. 2011; Avasthi et al. 2013; Bracken-Roche et al. 2016; Gross 2011a; Helmchen 2005; Helmchen 2014; Hoff and Hinterhuber 2011) is equally indisputable. Thus, the potential role conflict between the physician as therapist and the physician as researcher can give rise to research ethics issues. Many declarations in the field of medical research are the result of precisely this role conflict and are based on historical experiences. The Nuremberg Code (1947) is a set of research ethics principles for human experimentation. The code was drawn up in response to crimes committed in the name of medical research, particularly the human experiments conducted in Nazi concentration camps (Gross 2014 and section “Foundations and Historical Aspects” of this chapter). The same is true of the Declaration of Geneva. It was adopted by the WMA in September 1948 and most recently revised in May 2006 (WMA 2006). The Declaration of Helsinki, adopted by the WMA in 1964, has particular significance for the field of human medical research. Since its adoption, it has been revised many times, most recently in 2013. It states that economically disadvantaged people or those with health issues are particularly vulnerable and must be protected from harm. The Madrid Declaration has a similar emphasis for psychiatric patients (WPA 2011):
“Because psychiatric patients constitute a particularly vulnerable research population, extra caution should be taken to assess their competence to participate as research subjects and to safeguard their autonomy and their mental and physical integrity.” The Madrid Declaration also requires adherence to further framework conditions: “Research activities should be approved by an appropriately constituted ethics committee. Psychiatrists should follow national and international rules for the conduct of research. Only individuals properly trained for research should undertake or direct it. Ethical standards should also be applied in the selection of population groups, in all types of research including epidemiological and sociological studies and in collaborative research involving other disciplines or several investigating centres.”

One central ethical issue is possible conflict of interest. A conflict of interest exists when a psychiatrist is influenced in his or her professional activity by secondary interests. Collaboration with the pharmaceutical industry in implementing new research projects not only compromises the independent decision-making capacity of the physicians conducting the research but may also influence their judgment. Nonfinancial conflicts of interest (allegiance effect) may arise if certain patients are deprived of the chance of recovery. A concrete example would be the rejection of more effective therapeutic measures for ideological reasons. Although, in certain clinical situations, electroconvulsive therapy represents an effective and safe treatment; it is not used in many hospitals or states or included in studies, which violates the fundamental ethical principle of equality of access and distributive justice.

Placebo-controlled research also deserves special attention from an ethical perspective. Regarding the use of placebos, the Declaration of Helsinki states that: “The benefits, risks, burdens and effectiveness of a new intervention must be tested against those of the best proven intervention(s).” Double-blind, placebo-controlled studies should be viewed critically if patients in the placebo arm are deprived of an established effective therapy. The use of placebos seems appropriate where there is no proven method. Helmchen (Helmchen 2005) believes that placebo-controlled testing of antidepressants is only ethically justifiable for milder depression, and not for more severe depression, because effective antidepressants are available for this. Placebo-controlled studies are not acceptable for schizophrenic patients. There is clear evidence of the efficacy of commercially available antipsychotics, which are eligible for the control arm. A placebo-controlled study should ultimately be considered only if the objective can be reached without controversial practices and only by means of a purely placebo-controlled study (e.g., to demonstrate the efficacy of a new therapeutic principle), and if the burdens and risks for the patient are reasonable.

Basically, as far as is possible, research approaches that benefit individuals should take priority over those that benefit groups or third parties. Also, the integration of subjects capable of consent is obviously less ethically problematic than the inclusion of patients with diminished or nullified capacity for consent (Helmchen 2005; Helmchen 2014). Examples of the latter include treatment trials on patients with acute psychosis or dementia, or on minors. Ethical decision making is a particular dilemma in clinical trials of medicinal products aimed at counteracting cognitive
decline in patients who are no longer capable of making decisions, meaning that the research approach may be of individual benefit or at least group benefit. A categorical ban on such studies would be ethically questionable, although the inclusion of such patients also raises ethical issues (ethical aporia).

Treatment trials are a special case. If certain conditions are met, in most countries these may also be performed on patients who are unable to consent because there is hope of a concrete medical benefit to the health of the patients concerned. In the aforementioned cases, consent must be given by a legal advocate, who decides, to the best of his or her knowledge, in the best interests of the person incapable of consent.

The greatest potential for ethical conflict arises in third-party research on persons incapable of consent. Some ethicists believe that decisions on research that benefits external parties cannot be delegated to third parties, which effectively means a ban on such research. While such studies are generally prohibited from the perspective of deontological ethics, the consequentialist position would allow research on patients incapable of consent where there is an expected benefit to patients with the same symptoms (group benefit research) and the risk to the individual patient is limited.

The Biomedicine Convention of the Council of Europe (Council of Europe 1997) also applies strict conditions to external research on persons incapable of consent. There may be no research of comparable efficacy on persons incapable of consent. In addition, the potential risks to such persons should not be disproportional to the potential benefits of the research. Moreover, the competent authority must have approved the research project according to specific criteria. The persons concerned and, if applicable, their legally appointed guardian must be informed about their rights and the proposed safety measures. Besides, the affected persons should not show any signs of opposition to the planned research. Consent must be granted in writing for each specific instance by the legal representative and a designated authority, and the research must aim to significantly broaden scientific understanding of the condition, disease or disorder of the patient him/herself or other affected persons. In many states, people who have been hospitalized by judicial or administrative order are excluded from participating in such research.

Ethical Aspects of Psychiatric Genetics and Population Genetics

It is foreseeable that rapidly advancing genome research will create a paradigm shift in medicine, leading to personalized interventions that make it possible to identify and prevent diseases in the preclinical stage. However, knowledge about the molecular basis of mental illness is still limited. Accordingly, it is difficult to estimate the future ethical implications (Ryan et al. 2015). For example, the commercial availability of genetic tests for various forms of dementia and other diseases should be viewed in a critical light. The Madrid Declaration (WPA 2011) pays particular attention to the field of genetic research and counseling. The following statement is key: “Psychiatrists involved in genetic research or counseling shall be mindful of the fact that the implications of genetic information are not limited to the individual.
from whom it was obtained and that its disclosure can have negative and disruptive effects on the families and communities of the individuals concerned.” For this very reason, psychiatrists should ensure that both patients and families participating in genetic testing “do so with fully informed consent,” that “any genetic information in their possession is adequately protected against unauthorized access, misinterpretation or misuse,” and that “care is taken in communication with patients and families to make it clear that current genetic knowledge is incomplete and may be altered by future findings.” Further, the Madrid Declaration emphasizes that psychiatrists should only refer patients to facilities that can guarantee “satisfactory quality assurance procedures for such testing” and “adequate and easily accessible resources for genetic counseling.” With regard to family planning, genetic counseling should “be respectful of the patients’ value system, while providing sufficient medical and psychiatric information to help patients make decisions they consider best for them.”

Population genetic surveys connected to psychiatry deserve special attention. These are health initiatives targeted at entire population groups. Such measures aimed at the common good will inevitably give rise to conflicts with the principle of respect for individual autonomy. From an ethical perspective, participation in such mass screening programs must not be declared as an individual obligation, but at the most as a moral imperative. In other words, all potential subjects for such studies must have given their informed consent. Furthermore, the subjects must have the possibility to withdraw from the study without giving reasons.

**Patient-Relevant Tools to Support Decision Making in the Field of Clinical Ethics**

**Clinical Ethics Consultation**

The relatively new clinical tools for supporting decision making in cases of ethical conflict or dilemma include clinical ethics consultation, which is now usually institutionalized in the form of a Clinical Ethics Committee (CEC) (Vollmann 2010).

There are fundamental similarities between clinical psychiatry and clinical ethics. “What the two disciplines have in common is that psychiatric consultation services and clinical ethics consultation have developed in response to medicine as a field that is becoming increasingly technical and more specialized. Both complement the modern, primarily science and technology-oriented approach to medicine with psychosocial and ethical dimensions. Interdisciplinarity requires competence in communication and mediation from both clinical ethicists and psychiatrists” (Vollmann 2010).

But although professional communication and mediation are said to be key competences of both clinical psychiatry and clinical ethics, the origin, aims, and responsibilities of both disciplines are different: due to their focus on psychiatric and mental diseases, psychiatrists have special competences in that clinical field. Besides, they are personally accountable for their medical decisions. On the other hand, the responsibilities of clinical ethicists include the identification and analysis
of ethical issues. But they are not responsible for the treatment. Instead, their role is to assist with the decision-making process.

Another difference is that clinical ethics consultations, in contrast to psychiatric counseling services, are carried out by an interdisciplinary consortium. Although proof of ethical expertise is key for being asked to serve on a CEC, a CEC usually brings together members with very different medical expertise and specialities (e.g., surgical and nonsurgical) and usually also includes nonmedical representatives (e.g., from the care sector, social work, and pastoral care). Due to their specific aforementioned expertise, clinical psychiatrists should certainly be among the members of the CEC.

In addition, the tasks and areas of application of clinical ethics consultation are also quite varied. Without a doubt, the focus is often on individual advice on clinical and ethical conflicts, for example the question of forced treatment. Clinical ethics consultation gives practitioners the chance to reflect on their own practice by including a facilitator trained in ethical decision-making processes who is not involved in treating the patient concerned. This contributes to best practice training.

But the responsibilities of a clinical ethics committee also cover the continuing training of staff members in clinical ethics. Through continuing professional development events, clinical ethics committees can positively influence the treatment culture and raise awareness of ethical aspects in everyday clinical practice among therapeutic and nursing staff. The tasks of a CEC also include the development of ethical guidelines. Such guidelines can help to structure clinical decision making and ensure ethical standards. They can also serve as a basis for dealing with stakeholder groups and the public.

In sum, clinical ethics can also be an important part of effective clinical governance. For ethics consultation to work, however, it is crucial that it is regularly requested. This is often the case for clinical ethics consultation, while less attention is sometimes paid to aspects of ethical training and guideline development.

**Advance Healthcare Directives and Joint Crisis Plans**

The increased ethical and legal significance of patient autonomy in modern medicine has led to the development of advance healthcare directives, also known as living wills (DGPPN 2014; Hoff and Hinterhuber 2011; Radenbach and Simon 2016; Sass and May 2010). These are intended to give patients the opportunity to make advance decisions for the event that they lose their capacity for self-determination. An advance healthcare directive is a document in which a person specifies what healthcare actions should be taken or refrained from when she or he is no longer able to make decisions. In more and more countries, the directive has gained legal status; in others, it is legally persuasive without being a legal document. Advance healthcare directives emerged because more and more people were worried about losing their right to self-determination in the event of serious terminal illness, due to loss of consciousness or severe dementia. People therefore sought to influence the circumstances and nature of their end-of-life situation. However, advance directives do not only relate to the end of life, but also to many other situations.
In everyday clinical practice, ethical conflict situations can also arise precisely because of the existence of a living will – for example, if patients who have drawn up such a directive reject a potentially effective therapy (such as an antipsychotic medication), thus hindering or preventing recovery of their capacity for self-determination and the treatment of disease-related risks to themselves or others. The key question is whether the advance directive was composed at a time when the patient or author was capable of making such a decision. Legal obligation protects patients from having their treatment needs ignored, but does imply that patients take a high level of responsibility for their own health and course of treatment.

Even if a patient has composed the advance directive while he or she was capable of making decisions, and it is therefore to be viewed as valid, this does not mean that the doctor has to implement any and every measure requested in the directive. This is particularly true of requests that are not medically indicated. Fundamentally, physicians always have the right of freedom of conscience. The patient must respect that a physician will not carry out requests for which he or she cannot take professional responsibility or which go against his or her moral convictions. Otherwise, patient advance directives are binding if they relate to the specific treatment situation and if no circumstances are identified that might imply the patient has distanced himself or herself from the advance directive. If communication between patient and doctor is possible, an advance directive may never be viewed or treated as a document that might make consultation expendable.

Last but not least, due to the problems described, in addition to the “classic” patient directives, advance directives have been developed that are more procedural and participatory and specifically relate to application in psychiatry contexts. Concrete joint crisis plans and the concept of “advance care planning” are more and more based on a structured discussion process between patient and practitioner. This strengthens both the therapeutic alliance and participatory decision making. In psychiatric crisis situations, such as when coercive measures are required, these provide important information about the interventions the patient has requested or rejected. In ideal cases, they also provide written information about what measures have proved effective in similar situations in the past.

The expectations placed on psychiatric advance directives are high. It has been demonstrated that the quality of advance directives increases if patients are supported (by their doctors) in drawing them up. In psychiatry, concepts for “facilitated psychiatric advance directives” that most closely correspond to the overall concept of advance care planning have been implemented mainly within the framework of research projects (Radenbach and Simon 2016).

Fundamentally, the documentation of an advanced directive can relieve all the people involved in acute psychiatric situations and thus, in the long term, also contribute to an increase in the quality of acute treatment. In this respect, it seems sensible to develop advance care planning programs that draw on existing (international) experience and to more firmly establish such programs in clinical practice. This process should be scientifically accompanied, evaluated, and optimized in an iterative process. Like ethics consultations, in the best cases, advance healthcare directives can help reduce instances of coercive measures in psychiatry and mitigate
the potential for ethical conflicts. It is all the more important that these tools in their various forms become a systematic component of continuing professional development. Psychiatry and advisory medical ethics should work closely together to resolve difficulties in everyday clinical practice and to increase the efficacy and positive potential of these tools.

**Neuroenhancement and Wish-Fulfilling Psychiatry**

All ethical aspects discussed so far in this section are more or less directly related to the relationship between the psychiatrist and the patient. Neuroenhancement, or wish-fulfilling psychiatry, is categorically different from this, because it does not just concern treating *patients* (Brukamp and Gross 2012; Greely et al. 2008; Gross 2011b; Levy and Clarke 2008). Neuroenhancement or neurocognitive enhancement is rather defined as a sum of possibilities that improve individual cognitive performance or mental state *in healthy individuals*. This concerns both – essentially visionary – brain engineering measures (Gross 2011b; Laryionava and Gross 2011; Vuilleumier et al. 2014) and medicinal neuroenhancement (Gründer and Benkert 2012). Due to its greater clinical relevance and direct relevance to psychiatry, the focus here is on the latter.

Since the 1980s we have witnessed an increasing “extratherapeutic” use of drugs. Neuroenhancement sounds more impressive and tends to gloss over the rather negative associations of the term “brain doping.” Both terms denominate the use of drugs (and other brain interventions) for enhancement reasons. Such uses include cognitive enhancement, memory improvement, the heightening of attention, mood enhancers, the “modulation” of personality characteristics, and the reduction of the need for sleep.

Notwithstanding the terms used, it should be noted that enhancement is not a therapeutic measure. The starting point is not a diagnosis, but the desire to enhance something that does not require treatment from a psychiatric perspective. The drugs in question were originally developed for patients with attention disorders (e.g., Methylphenidate), dementia (e.g., Donepezil), depression (e.g., Fluoxetine), or narcolepsy (e.g., Modafinil). They are often used for enhanced competitive performance – whether at school, university, or work.

In a liberal society, voices in favor of allowing self-determined individuals the freedom to “enhance” themselves are increasingly making themselves heard. But are psychiatrists required to support their patients in such enhancement efforts? In this context, from an ethical perspective, respect for patient autonomy conflicts with the principle of doing no avoidable harm (nonmaleficence). However, firstly it should be noted that this does not exactly concern a patient and the need to ensure his or her right to autonomy. The person does not require treatment but is requesting a service. Secondly, generally no medical indication can be given for enhancement measures – which is actually a professional prerequisite for providing treatment.

Neuroenhancement measures thus raise medical and medicoethical issues. With regard to the medical issues, it must be stressed that the mechanism of action of
“brainbusters” in healthy individuals is not yet known. In addition, there are also still no secure data available on the long-term mental, physical, and social consequences. This also raises questions about the potential development of dependency or premature cognitive aging. It is also important to consider that there are also less risky “natural” neuroenhancement forms such as psychotherapy, coaching, biofeedback methods, progressive muscle relaxation (PMR), and autogenic training.

Neurocognitive enhancement raises important ethical issues, both on the individual and the societal level.

**Arguments from an Individual Perspective (Gross 2011b)**

- Autonomy and self-determination: Should the decision to enhance one’s mental capabilities be left to the individual’s desire? Some bioethicists proceed from the dominant enlightened ideals of our society. Given this background, they find it difficult to understand why a possible improvement of physical nature based upon this ideal should be less compatible than the traditional ideal derived from mental and moral improvement. On the other hand, it has to be stressed that individual freedom reaches its limits when the rights of other individuals or society are concerned. Thus, the decisive question is if the enhancement causes any harm to third parties. This question cannot, at least, clearly be answered in the negative (see arguments from a societal perspective).
- Human identity: Personal identity is strongly linked to the brain as the organ of consciousness. Neuroenhancement affects the brain and might thereby also influence one’s identity.
- Informed consent: Special attention has to be given to vulnerable groups that are particularly at risk, such as the elderly, who might feel an increasing social pressure for lasting cognitive abilities, and others such as children and adolescents whose parents might find it necessary to “provide” these kinds of neuroenhancement.

**Arguments from a Societal Perspective (Gross 2011b)**

We have to consider the sociocultural context and the anthropological framework in which the medicoethical discussion is placed.

- Coercive influences from societal developments: Neuroenhancement reinforces social disparities and distorts competition. Against this backdrop, many critics compare neuroenhancement to doping in sport. They argue that it is not clear why doping in sport should be banned while brain doping should be permitted as both can be used to gain a competitive advantage.
- “Hypercompetitiveness”: Widely propagated neuroenhancement might result in individuals experiencing indirect coercion to undergo the procedure in order to participate in the new way of meeting the demands of social competition. Therefore, citizens have to be protected from a climate of “hypercompetitiveness.”
- Socially unacceptable path: A further argument illuminates the assumption that it is not the goal of neuroenhancement but the path to that goal which is socially
contested. Enhancement by “classic” learning, meditation, or autogenic training is socially accepted, whereas enhancement by drugs is dubitable. Some argue that it does make a difference if I can ascribe “improvements” to my own conduct and execution, or whether these changes were just accomplished by drugs.

– Shift of normative standards: Neurocognitive enhancement may also change our concept of normality and our perception of what counts as an “average” performance. Given an increasing number of people with enhanced capabilities, the performance of non-“enhanced” people might be perceived as substandard. Besides, the establishment of neuroenhancement could also lead to a lack of acceptance of “deviant” characters.

– Unequal access: It is assumed that neuroenhancement – not only, but especially on a global scale – is not accessible to everyone, so, regardless of the lack of indication, problems of distributive justice also arise.

Given what we know today, medication for merely enhancement purposes must be seen very critically – from both a medical and a medico-ethical point of view. Moreover, this is beyond the psychiatrist’s actual scope of activity. The task of a psychiatrist is to provide diagnoses and prognoses, to alleviate suffering, and to prevent illness (or the recurrence of illness). Neuroenhancement measures are not part of this treatment mandate, but are pure wish-fulfilling medicine. Besides, they carry the risk of psychiatrists being commercially engaged by involved companies.

For all these reasons, neuroenhancement is to be rejected, not least because of the manifold individual and socioethical implications.

The above discussions show that, to a greater extent than almost any other medical field, psychiatry is characterized by diverse social contexts and interactions. These social functions have many ethical implications. These topics will be dealt with systematically in the following section.

Psychiatry and Society: Ethical Aspects of an Interdependent Relationship

Foundations and Historical Aspects

Psychiatrists play a dual role in their professional lives. On the one hand, they are physicians (and/or clinical researchers), but they also have a public, and sometimes a regulatory, role (Miller 2009). Their public role is particularly evident when they are called upon to give an expert assessment in court, for example, or to state whether or not a patient requires confinement or legal care, or to judge a patient’s decision-making capacity when he or she drew up a healthcare directive or living will.

These kinds of public functions always have a political dimension. This can be seen very clearly by looking at the past: Psychosurgical interventions that we regard as highly ethically questionable today had the sociopolitical purpose of tranquilizing patients or of making them more “docile” (Gross and Schäfer 2011). A particularly heinous example of moral misconduct were the medical judgments made in the

332 D. Groß and F. Schneider
“euthanasia” program of the Third Reich and the active role played by psychiatrists and many other physicians in the systematic murder of patients in psychiatric clinics (von Cranach 2010; von Cranach and Schneider 2011). It is important to stress how psychiatry was politically instrumentalized in the service of the Third Reich, and to remember that many medical professionals were very willing participants.

We must also consider the significance for modern psychiatry of today’s efforts to reappraise historical accountabilities, particularly in light of the fact that for many years the German psychiatric society did not take any steps toward reappraising its National Socialist past – that is, the German Association of Psychiatry, Psychotherapy and Psychosomatics (DGPPN) and its predecessor organizations (Jütte 2011).

It was the “Law for the Prevention of Hereditarily Diseased Offspring,” passed in 1933, that launched one of the darkest chapters in the history of German medicine. The law was intended to ensure “racial hygiene” in the German Reich and called for people whose descendants would probably “suffer from some serious physical or mental hereditary defect” to be sterilized. From 1934 onward, doctors forcibly sterilized up to 400,000 people. As many as 5000 people died as a result (Bock 1986).

Hitler then issued a decree to start a “euthanasia” program (subsequently known as Aktion T4). From October 1939, registration forms were sent out and the main selection criterion was the supposed “value” of people’s lives. Medical staff judged the patients in their care according to “curability,” “ability to learn,” and “ability to work.” The selected patients were collected from their hospital or nursing home in buses and taken to one of six mental institutions equipped with gas chambers, where they met their deaths. Approximately, 50 selected psychiatrists and neurologists, among them renowned representatives of the field such as Prof. Friedrich Mauz (Münster) and Prof. Friedrich Panse (Düsseldorf), were appointed as assessors.

Aktion T4 lasted 2 years, during which time more than 70,000 patients were killed. At the same time, over 30 psychiatric and pediatric hospitals began murdering physically and mentally disabled children as part of the “decentralized euthanasia” phase. And the killing went on: tens of thousands of psychiatric and neurological patients were systematically starved to death or killed by a drug overdose in psychiatric hospitals. What’s more, before being murdered, many patients were subjected to medical experiments intended to further scientific research. A total of more than 300,000 psychologically, mentally, and physically disabled people fell victim to a health and population policy based on the principles of “racial hygiene” (Faulstich 2000). And it is not the case that doctors had no room for maneuver against the prevailing ideology in society and could not have taken any action without suffering immediate negative consequences (Schneider and Roelcke 2013); this is proved by the examples of Walter Creutz (Schmuhl 2013), Hans Roemer (Roelcke 2013), John Rittmeister (Teller 2013), Gottfried Ewald (Beyer 2013), and Werner Leibbrand (Seidel 2013). But overall, far too few people put up any kind of opposition.

It was not until 2009 that the DGPPN began systematically reappraising its historical accountabilities and that of its predecessor organizations during the Nazi era. That year, the society added the following text to the first paragraph of its
Articles of Association: “The DGPPN recognises that it bears a special responsibility to protect the dignity and rights of people suffering from mental illness. This responsibility is the result of its predecessors’ involvement in the crimes of National Socialism, in killing and forcibly sterilising hundreds of thousands of patients” (Schneider and Roelcke 2013).

Also in 2009, the DGPPN’s Executive Committee decided to establish an initial international commission of historians to address the activities of the predecessor associations during the Third Reich. This independent commission was made up of four renowned medical and scientific historians. It provided support on DGPPN-initiated and financed research projects investigating the extent to which the DGPPN’s predecessor organizations and their representatives were involved in the “euthanasia” program, in forced sterilizations of mentally ill patients, and in other crimes during the period between 1933 and 1945. Currently, a second research project is running to investigate how the Nazi era impacted on both West and East German psychiatry during the years after 1945 (Schneider 2012).

In the meantime, the DGPPN regards the reappraisal of its history as a topic of central importance. Since 2010, the association’s annual convention has dedicated a large number of events to the victims of psychiatry under National Socialism. One of the highlights of the congress in 2010 was a commemorative event with around 3000 participants that publicly acknowledged German psychiatry’s responsibility for the murder of mentally ill and mentally disabled people, forced sterilizations, unethical research, and the expulsion of colleagues. Personal accounts by victims and their relatives poignantly described the terrible fates and suffering of many individuals. The incumbent president of the DGGPN closed his speech with the following words “In the name of the German Association for Psychiatry, Psychotherapy and Psychosomatics, I ask you, the victims and relatives of the victims, for forgiveness for the pain and injustice you suffered in the name of German psychiatry and at the hands of German psychiatrists under National Socialism, and for the silence, trivialisation and denial that for far too long characterized psychiatry in post-war Germany.”

The DGPPN made another important gesture in 2011 when it revoked the honorary memberships of psychiatrists Friedrich Mauz and Friedrich Panse, two former presidents of the society (Schneider and Roelcke (Editorial) 2013).

In order to permanently overcome the decades of silence and to take responsibility for the past, the DGPPN also created a traveling exhibition in cooperation with the foundations Memorial to the Murdered Jews of Europe and Topography of Terror. The exhibition received extensive support from individual medical professionals and from other professional societies and associations and the German Medical Association. Since its initiation, the traveling exhibition has been very well received. It started with a fundraising campaign launched by the DGPPN in late 2011 to raise awareness of the atrocities and to commemorate the victims. The DGPPN then quadrupled the donated sum. The German Bundestag and the Federal Ministry of Labour and Social Affairs also provided considerable funding for the exhibition. The raised funds made it possible to realize the exhibition and to include comprehensive measures to make the exhibition accessible to people with disabilities. Many doctors and psychiatrists have also got involved by organizing the
presentation of the exhibition in their own city or by participating in the accompa-
nying program (e.g., by giving lectures) (Schneider and Lutz 2014). The question of
the value of life is central to the exhibition, and it also considers the intellectual and
institutional backgrounds to the murders; outlines the crimes of marginalization,
forced sterilization, and mass extermination; and considers case studies of victims,
perpetrators, accomplices, and opponents. It also investigates how the topic was
dealt with in the years after 1945.

The exhibition closes with numerous quotes from doctors, politicians, victims’
relatives, care personnel, and others, reflecting on the events of that time from the
perspective of today. The contributors also consider the question of what signifi-
cance the events have for them personally. Most of the stations of the exhibition
include a supporting program, often directed at specific target groups, in order to
explore the exhibition’s themes more deeply. The programs include academic pre-
sentations, discussions, film screenings, and guided tours for school groups and
people with disabilities. Some venues have used the exhibition as an opportunity to
intensively appraise their own regional history and have designed special panels
presenting local victims, perpetrators, or institutions. To give examples, in Munich
the group “psychiatry and care in national socialism in Munich” created five panels
showing a memorial plaque for victims of forced sterilization at the local university
gynecological hospital as well as four regional destinations of forced sterilization
and forced abortion. In addition, Würzburg elaborated forced labor, forced sterilization,
and murder of patients around Würzburg as well as the history of the perpetrator
Prof. Werner Hyde – director of the university hospital in Würzburg as well as
medical director of the “T4” central office and therefore one of the main people
responsible for the “euthanasia” murders – within their accompanying program. In
Vienna, the exhibition was shown within the Austrian Parliament and supplemented
by excerpts of the exhibition “The War against ‘the Inferior.’ On the history of Nazi
medicine in Vienna.” In this context, the president of the Austrian Association for
Psychiatry and Psychotherapy followed the German model and asked the victims
and relatives of the victims for forgiveness for their suffering under psychiatry in
National Socialism.

The traveling exhibition opened in the Bundestag on 27 January 2014 (Holocaust
Remembrance Day, which in Germany is the date on which all victims of National
Socialism are remembered), under the auspices of Federal President Joachim Gauck.
It was subsequently shown at the Topography of Terror. From early 2015, the
exhibition went on display in several state parliaments in Germany, as well as in
many other clinics, town halls, museums and memorials. So far the exhibition visited
more than 30 venues in Germany.

Alongside the original version of the exhibition, poster and roll-up versions were
designed that allow the exhibition to be presented around the globe and in places
with less available space, meaning that a wider range of buildings can be selected to
host the exhibition. The exhibition has thus already been staged in the UK, Austria,
Italy, Canada, South Africa, Japan and Australia. Further stations are planned for
2018/2019. In total, more than 350,000 visitors have seen the exhibition at 50 venues
in 8 different countries (for further information see www.dgppn.de/exhibition).
Partly in response to the psychiatric atrocities of the Third Reich as outlined above, the Madrid Declaration states: “There are aspects in the history of psychiatry and in present working expectations in some totalitarian political regimes and profit driven economical systems that increase psychiatrists’ vulnerabilities to be abused in the sense of having to acquiesce to inappropriate demands to provide inaccurate psychiatric reports that help the system, but damage the interests of the person being assessed.” It continues: “It is the duty of a psychiatrist confronted with dual obligations and responsibilities at assessment time to disclose to the person being assessed the nature of the triangular relationship and the absence of a therapeutic doctor-patient relationship, besides the obligation to report to a third party even if the findings are negative and potentially damaging to the interests of the person under assessment. Under these circumstances, the person may choose not to proceed with the assessment.”

To this day, the public and/or regulatory functions of psychiatrists represent ethical pitfalls, but at the same time, psychiatrists offer a valuable and in many cases indispensable service to society. This ambivalence will be explained in more detail in the following three sections looking at forensic psychiatry, stigmatization, and equal access.

**Forensic Psychiatry**

In forensic psychiatry, there is obvious potential for conflict between psychiatrists’ genuine responsibility for their patients (obligation to promote patients’ well-being, establishing a therapeutic relationship, duty of medical confidentiality) and society’s need for safety or for the “just punishment” of a criminal (Muysers 2014). Forensic psychiatry is thus the medical field in which there is the greatest risk of the lines between justice and medicine being blurred. This risk is particularly great in Unrechtsstaaten (nonconstitutional states) and in countries where dissidents and/or mentally ill people, whether they are criminally liable or not, are treated as guilty criminals. In Rechtstaaten (constitutional states), on the other hand, mentally ill people with diminished or nullified responsibility have the right to remain free from punishment when they commit an offence that is linked to their condition. The question of legal responsibility is a central advisory task for psychiatrists working in the criminal justice system. At the same time, they have to tell the court whether a mentally ill person represents a danger to society, so that the public are not exposed to potential threats. In such cases, the psychiatrist will not be the patient’s medical practitioner, instead functioning merely as an advisor or assistant to the court.

Forensic experts are thus committed to uphold a different ethical reference system from psychiatrists who treat patients. The duty of the experts is to determine and present the truth, even if this is not in the interests of the person being examined. A psychiatrist who is treating a patient, on the other hand, has to put the patient’s interests first. It is therefore all the more important that the psychiatric examination begins with an announcement of the framework of the appraisal and its goals, with particular reference to the fact that the forensic expert is not obliged to keep confidentiality. Psychiatrists working in the field of forensic psychiatry, particularly
physicians treating patients who are detained in psychiatric institutions or consultants working in prisons must ensure that their patients – just like all inmates of a penal institution – are given the care due to them and that their human rights are protected, regardless of the crime they have committed. The Madrid Declaration also expressly states that “psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts.”

**Stigmatization and Destigmatization**

According to universal human rights, people with mental illnesses are equally entitled to access all normal spheres of life, participate in society, and lead as independent a life as possible. In other words, mentally ill people have the inalienable right to the best-possible medical, social, and professional care. Accordingly, the UN Convention on the Rights of Persons with Disabilities, which came into force in 2008 promises “to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity” (Art. 1). The General Principles (Art. 3) of the Convention include individual autonomy, full and effective participation, respect for human diversity, and equality of opportunity (Division for Social Policy and Development Disability 2008).

However, efforts to ensure equality of opportunity are often hampered by stigmatization and discrimination (Ernst et al. 2012; Gross et al. 2008; Maier et al. 2014). Since people with mental illness are particularly stigmatized, it is important to focus particular attention on this problem. This is reflected by a recent survey done by Dinesh Bhugra and the WPA on the lack of civil rights of psychiatric patients (Bhugra 2016).

The process of stigmatization has four key components (Mehta and Thornicroft 2010): (1) Labeling of personal characteristics which are noticed as deviant, (2) stereotyping, which is linked to undesirable characteristics, (3) separating, by differentiating between the “normal” and the labeled group, (4) status loss and discrimination, by excluding the labeled group.

Stigmas against people with mental illness can contribute to negative therapeutic outcomes as well as to developing self-stigmatization and contributing to reduced self-esteem. They exist in different sociopolitical systems all over the world, and seem to be even more pronounced in developing countries. Although these kinds of stigmas have a long tradition, the attention to stigmatization and discrimination against people with mental illness is quite a recent phenomenon.

Such societal discrimination means that psychiatrists have a particular responsibility and a moral imperative to act in a certain way. The Madrid Declaration states: “Psychiatrists shall ensure that people with mental illness are presented in a manner which preserves their dignity and pride, and which reduces stigma and discrimination against them.” Indeed, psychiatrists have the socioethical obligation to draw attention to the discrimination experienced by mentally ill people in many areas of society. Often, patients are not capable of asserting their rights, or they are afraid of
appearing in public out of fear of ridicule and ostracism. Where necessary, psychiatrists must also ensure that adequate conditions are created for mentally ill people of the same standard as those for people suffering from physical illnesses. This applies to both actual medical care and social (re)integration (Schneider et al. 2012). For the latter to be successfully achieved, it is crucial to dismantle misguided assumptions and prejudices within society and to counter the often considerable rejection of mentally ill people by helping to develop antistigma campaigns.

Resource Allocation and Equality of Access in a Global Perspective

Another social injustice is that not all people have equal access to psychotherapy and psychiatric treatment. It must be the societal goal of organized psychiatry to work toward ensuring equal access and equal allocation of resources (Engelhardt 2009; Hoff and Hinterhuber 2011; Kious 2015). It is undeniable that in many industrialized nations, more financially lucrative patients (usually privately insured) receive treatment more easily and/or quickly than other sufferers. The global discrepancies are even greater. Katz et al. (Katz et al. 2014) emphasize: “Global psychiatry stands apart from other areas of health care when it comes to ethical considerations for at least six distinct reasons:

1. There is a paucity of resources to enable and support psychiatric care abroad and a greater demand for psychiatric health care professionals relative to other fields of medicine.
2. Longitudinal treatment is usually necessary for successful psychiatric care.
3. Psychiatry inherently places more emphasis on care rather than cure.
4. The effects of mental illness are often intangible.
5. Language barriers are more imposing on psychiatry than on other areas of health care.
6. Culture, spirituality, and other belief systems have an effect on psychological ‘mindedness’.”

Thus, the international organizations of psychiatrists and the global health community should insist on equal, unimpeded access to psychiatric treatment.

According to the Madrid Declaration (2011), psychiatrists should be “concerned with the equitable allocation of health resources” and “advocate for fair and equal treatment of the mentally ill, for social justice and equity for all.” At this point, we should emphasize that those barriers to access currently in place not only constitute the withholding of necessary therapeutic treatment, but also represent social discrimination.

Conclusion

Suitable ethical concepts are needed to achieve acceptable outcomes in cases of ethical conflict. “Principlism” is a particularly popular concept among clinicians. This approach is based on four simple principles, which are derived from common morality and can form a normative standard for decision-making processes.
Representatives of the psychiatric profession are faced with particular ethical challenges. Psychiatrists and psychotherapists are primarily bound by their treatment mandate – that is, to diagnose, maintain, and restore the health of their patients. They are also assigned an important social and/or regulatory role. Both their activity as practitioners and their social/regulatory functions raise ethical issues.

With regard to ensuring respect for patients’ self-determination, a distinction should be drawn between autonomy as a right and autonomy as a capacity. The right to make autonomous decisions is absolute, while actual capacity for self-determination may be limited. If capacity for self-determination is lacking, the therapeutic measures – as far as possible – should be aimed at restoring this capacity. Otherwise, treatment has to be in the best interest of the patient and should not be provided against the patient’s will, unless withholding treatment would risk the life of the patient or any third parties. Coercive measures and forced treatment are therefore only ethically defensible when persons who are incapable of self-determination concretely and significantly put their own or others’ health or life at risk, and when this cannot be avoided by any other means, in particular targeted attempts to convince patients of the risky nature of their behavior and their need for treatment. The welfare of third parties must not take precedence over the welfare of the patient, as treatment for the exclusive welfare of third parties or the general public is ruled out. The moral prerequisite for such coercive measures is that a patient’s refusal of treatment is an expression of their mental illness and not of their autonomous free will. Coercive measures taken by doctors must appropriately reflect an assessment of the expected benefits and harm. Consideration also needs to be given to the fact that avoiding coercion may also constitute failure to provide vital assistance. Therefore, the procedure must be determined and justified according to the individual circumstances, based on thorough medical, ethical, and legal knowledge.

Geriatric psychiatry presents particular ethical challenges. These relate to the ability to give consent, resource allocation, elderly suicide, and end-of-life care. As far as they are able, psychiatrists should go beyond simply providing adequate treatment and actually work to overcome social injustices (striving to achieve fair access to treatment and patient empowerment).

Another area with significant potential for ethical conflict is research on or with psychiatric patients. Many research ethics issues arise as a result of role conflicts between the physician as therapist and the physician as researcher. There is a fundamental risk of patient abuse, and of corrupt behavior by drug trial investigators who accept personal financial contributions. The potential risks to the person involved should not be disproportionate to the potential benefits of the research. External research on persons incapable of consent should therefore be subject to strict conditions.

Another increasingly important field for psychiatry – genetic research and population genetic approaches – also contains ethical pitfalls. The psychiatrists involved should allow for the fact that the implications of genetic information are not limited to the individual patient, but can also have detrimental effects on his/her family. Population genetic approaches not only raise issues of confidentiality and data protection, but also the issue of informed self-determination. Participation in this type of screening process must not be declared as an individual obligation, but at the
most as a moral imperative. Furthermore, the subjects must be able to withdraw from
the study without giving reasons.

In all the above areas of conflict, it is possible to draw on ethically relevant tools
for decision making in difficult clinical situations – clinical ethics consultation and
advance healthcare directives. Clinical ethics consultation gives practitioners the
chance to reflect on their own practice by including a facilitator trained in ethical
decision-making processes who is not involved in treating the patient concerned.
This contributes to best practice training. Special advance directives that are more
procedural and participatory and specifically relate to application in psychiatric
contexts are playing an increasingly important role. These should strengthen both
the therapeutic alliance and participatory decision making and help to reduce
instances of coercive measures in psychiatry.

The ethical problems surrounding neuroenhancement are fundamentally different
from the situations described above, because this is not a matter of treating ill
patients but of “improving” the cognitive performance or mental state of healthy
individuals. In this context, respect for individual self-determination collides with
the principle of doing no avoidable harm (nonmaleficence). Given what we know
today, medication for merely enhancement purposes must be regarded very critically.
Neuroenhancement measures go beyond the actual task of the psychiatrist, as they
are not part of the treatment mandate.

More than almost any other medical field, psychiatry is characterized by diverse
social contexts and interactions. This can be seen very clearly by looking at the past.
A particularly heinous example of moral misconduct was the involvement of
psychiatrists in the “euthanasia” program of the Third Reich. It is not only an ethical
imperative to systematically reappraise these historical events, but also a profes-
sional and political necessity. This reappraisal must be consistently driven forward,
as the DGPPN has been doing since 2009.

The manifold evidence of the stigmatization of mentally ill patients also creates a
moral imperative to act. Psychiatrists must advocate for the social integration of their
patients and make sure that people with mental illness are presented with dignity.
Antistigma campaigns are an important measure in this regard. It is also necessary to
work for equal and unrestricted access to psychiatric treatment, which should be
attributed the same social value as physical treatment.

All of the above demonstrate the high normative demands on psychiatry in both
clinical and social contexts. Living up to these demands requires heightened aware-
ness of ethically relevant problems and implications, and of how to impart ethics
knowledge and skills in continuing professional development.

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