Abstract: Since the beginning of the 21st century, ethics has been at the core of the practice of psychiatry. This paper discusses the basic principles of ethics that are relevant to psychiatry and focuses on recent developments in ethics, particularly since 1960. Further, it revisits notions of deontology and codes of ethics and discusses how these regulations can be made relevant to psychiatric practice through clinical ethics consultation services. Finally, two specific issues are highlighted: the teaching of ethics to residents and the relationship of psychiatrists and residents to the pharmaceutical industry.


Key Words: ethics, deontology, principles, autonomy, clinical ethics

Ethics is a crucial element at the core of psychiatry practice. Because psychiatry purports to understand, treat and work with the whole person, humanistic and ethical considerations are (or should be) integrated with all the theoretical and practical aspects of our profession (1).

Historical Considerations
Pellegrino discussed the four successive metamorphoses of medical ethics (2). First, the Hippocratic tradition (up to the early 1960s), influenced by Greek philosophy, was grounded in fundamental ethical principles: do good; avoid evil. It condemned abortion, euthanasia and patient–physician sexual relations. Its essential idea was “phronesis,” or practical judgment, as the guide to therapy and in accord with the principle of primum non nocere (first do no harm). The second period was influenced by the social upheaval and the new philosophical questioning, which took place at the beginning of the 1960s. Since then, medical ethics has been defined mostly by utilitarianism and principality (3). This latest approach is grounded in four principles: autonomy, beneficence, nonmaleficence and justice. However, there is no hierarchy in the practical consideration of those principles at the bedside, and the application of this approach remains problematic. The third anti-principalist period, which began in the early 1980s, was characterized by a critical review of those principles. It emphasized “ethics-based virtue, caring, experience, or casuistry or a return to theological and biblical sources as the only reliable grounding for medical morals” (2). The current and last period, which began in the early 1990s, is characterized by skepticism and nihilism. In the current context, with its lack of consensus on metaphysical issues, it seems difficult to avoid reconsidering essential anthropological aspects of personhood to reestablish a foundation for ethics and a respect for the dignity of psychiatric patients (4,5).

Ethics and Deontology
Deontology refers to a theory or study of duty or moral obligations. Ethics is the science that studies human behaviour in relation to values, principles and moral norms. Deontology is enshrined in codes and regulations, but ethical concepts are at the core of such endeavours. Codes of ethics are therefore essential to our practice as psychiatrists; they reflect who we are and who we want to be for ourselves, for our patients and for society.

Codes of ethics for physicians usually cover the following topics: considering the well-being of the patient, honouring the profession and its traditions, recognizing one’s limitations and the skills of others, protecting patient secrets, teaching and being taught, using our integrity and professional ability as our only advertisement and setting a value on professional services in a responsible manner.

The Canadian Psychiatric Association has published annotations to the Canadian Medical Association Code of Ethics (6–8). These annotations concern special considerations that respect the psychiatric patient, such as patient rights and choices, continuity of care, personal morality, clinical research, medical research reporting, need to address the public, cooperation with other...
professionals in patient care and the responsibility of psychiatrists while testifying in court (6,7).

Codes can help foster a healthy environment for physicians to fulfill their ethical commitment to professional roles.

**Teaching Clinical Ethics**

For many psychiatrists, ethical principles may seem foreign to daily practice and to their concern for patients. Clinically based ethics services may help bridge this apparent dissociation. In 1984, Mark Siegler, an internist, set up the Center for Clinical Medical Ethics at the University of Chicago. This centre provides training programs for health professionals (mostly physicians) to deliver bedside consultations in ethics at the request of the treating physician (or team). The proposed grid for analysis of clinical cases is organized hierarchically around four elements: 1) indications for medical intervention; 2) patient preferences; 3) quality of life assessment; and 4) all relevant external factors (role of the family, confidentiality, costs of care, allocation of scarce resources, research and teaching needs, and any other legal or social considerations) (9). Clinical ethics services have been established in university teaching hospitals, psychiatric facilities and community hospitals; these services help psychiatrists manage difficult ethical problems in their daily work. Psychiatric residents also benefit from these services. For example, an elective rotation in clinical ethics for psychiatric residents has existed in the McGill network since 1994 and offers a three-month experience supervised jointly by the hospital clinical ethicist and by an academic psychiatrist with expertise in ethics.

Since the early 1990s, after the Royal College of Physicians and Surgeons of Canada (RCPSC) officially included ethics as a topic on specialty exams, teaching ethics to residents (and psychiatrists) has been a more pressing issue in Canada. An ad-hoc subcommittee of the Royal College Committee on Biomedical Ethics worked for three years to develop teaching modules for each of the main disciplines; namely, internal medicine, surgery, psychiatry, obstetrics-gynecology and pediatrics. The subcommittee created 10 modules, which were circulated to postgraduate training directors of the 16 medical schools in Canada. Their feedback was included, and the RCPSC published the modules in 1999 (10). You can view these modules on the RCPSC Web site at http://rcpsc.medical.org. The psychiatry topics include consent, capacity, substitute decision-making, confidentiality, resource allocation, involuntary hospitalization, transference and counter-transference, suicide, sexual impropriety and research ethics. Each module is built around a clinical vignette, a lesson plan with relevant questions to consider, a bioethics bottom line (a summary of relevant principles and theory on the topic), and useful references. I invite psychiatrists and residents to peruse this site and invite residency program directors in psychiatry to use this material in their particular training programs.

**Relation with the Pharmaceutical Industry**

The increasing need for private funding to compensate for decreasing public support for teaching and research in our university programs; more aggressive detailing by pharmaceutical representatives, with frequent industry-sponsored events open to psychiatrist and residents alike; and other factors have created a climate wherein ethical issues abound (11). Recent reviews have highlighted potential and real conflicts of interest and have suggested avenues for change. One recommendation calls for staff to make special efforts to abide by the regulations of existing codes, regulations and guidelines, thereby creating a positive modelling reference for residents. Another recommendation involves residency programs developing guidelines for residents to help them deal with ethical problems in a practical and realistic manner. Such an attempt, recently completed at McGill, was discussed in 2001 at the national meeting of residency training directors and presented at the American Psychiatric Association meeting in 2001 (12).

Considering the patient’s best interest still remains the guiding principle that can inspire our codes and regulations. These principles can protect physicians from undue influence by the industry and help them maintain focus on serving patients through solid science.

**References**