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# **The ethics of electroconvulsive therapy**

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Cowardice asks the question- is it safe?

Expediency asks the question- is it politic?

Vanity asks the question- is it popular?

But conscience asks the question -is it right?

And there comes a time when one must take a *position*, that is neither safe, nor politic, nor popular; but one must take it because it is right.

*Dr Martin Luther King Jr. (In Shyne 2014)*

## **Abstract**

During the last forty years, there has been increasing interest in the concept of professional ethics, particularly in the area of medical ethics. Psychiatry as a medical speciality has been part of the process because it is deeply concerned with the view society holds and the ethical values that they place upon psychiatry. It is with this in mind that I have decided to address an ethical issue that exists within psychiatry, which is an intrusive psychiatric treatment. Electroconvulsive therapy (ECT) is arguably of this description. With the advent of anaesthesia and muscle relaxants, the traumatic effects of ECT have been reduced but serious side effects are still evident within the patient population receiving ECT. My position within this thesis is to claim that ECT is unethical and should not be used, (except in absolute emergencies). This claim is based on the knowledge that ECT is a treatment, which causes iatrogenic injury to the brain. Electricity is applied in such a way to provoke an epileptic type seizure or convulsion. The issue of whether or not ECT is morally and ethically justified as a practice or as a recommended form of treatment will be approached from a number of different theoretical positions.



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Dedicated to my father Ronald Ellison 24<sup>th</sup> February-16<sup>th</sup> June 2014 and my brother Stephen 19<sup>th</sup> April 1960-

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## **Chapter 1: Introduction**

*“My troubled thoughts prompt me to answer because I am greatly disturbed. ... Reproof which insults me and the spirit of my understanding makes me answer. ... I hear a rebuke that dishonours me, and my understanding inspires me to reply”.*

JOB: 20.2: (Holy Bible 2010)

### **Section 1.1: Opening Remarks**

Medical ethics examines not only violations of individual integrity in clinical practice, but also sanctions the available policies and legislation, which permits us to question medical practices. This point is important as accepted ways of practicing need constant vigilance in light of new perspectives of what is right and wrong within the field of psychiatry. As the above quote from Job illustrates new knowledge can be stimulated by exploration of the axiomatic incongruence between values and conscience, which can then be utilised to improve or alter practice. These opening remarks indicate the position I take within my thesis, namely that as a practitioner I am troubled by the use of electroconvulsive therapy (ECT) and wish to analyse this accepted practice in light of new knowledge within this field. I feel it is appropriate to outline to the reader the influences on this thesis from a personal perspective.

I was motivated to write this thesis on electroconvulsive therapy (ECT) by my considerable experience and first hand clinical hands-on care of patients suffering from severe mental health problems. The decision was prompted by my strong antipathy towards ECT as a treatment. This was a view I had developed through reflection and personal observation during my extensive professional experience. Despite presenting arguments for ECT within the thesis, I did not approach this issue as an impartial bystander; I firmly believed the clients within my care had been damaged by ECT. The intended aim was therefore to articulate my personal view that ECT is not a beneficial treatment. Also to challenge those pro-advocates, who offer evidence demonstrating that it is an effective and safe procedure, rather than to provide a more impartial starting basis and to then develop arguments for or against its use as part of a balanced analysis. Although I make no secret of my prejudice towards this treatment, my approach within this thesis has been to seek to reconcile my strongly held views with ethical concepts and to use academic analysis to elaborate and



communicate my position. It is through using these resources that this work takes the form of an ethics thesis; albeit one with a very particular approach to the way these concepts and analyses are employed and thereby creating a somewhat unorthodox approach to structuring the arguments it contains.

Beginning with the introduction in which I presented my reasons for condemning much - if not all - of the use of ECT, except in emergency situations, I went on to explore and challenge views of what constitutes an emergency. It was my belief that the only justifications which could be convincingly offered for the use of ECT was that of emergency treatment scenarios, which meant that presenting a challenge to our received views as to what constitutes an emergency in these circumstances was entirely warranted at the outset of the thesis.

The rest of the thesis is devoted to considering some of the arguments surrounding the use of ECT in a clinical setting and goes without saying that in order to argue against a particular position one must understand it. Thus, my readings of the literature, coupled with my professional experience, had to focus on the positive as well as the negative. As this approach was also intended to conform to some of the demands of reconciling my position with the use of ethical concepts and analysis in my thesis, it was necessary to consider evidence that supported the use of ECT. This means that I have included in the thesis not just evidence supporting my beliefs of the damaging effects of ECT but also some evidence put forward of beneficial effects. I raise this to emphasise that having reached a negative conclusion regarding ECT it was not because I simply “cherry picked” the negative studies and entirely ignored the positive but, rather, that the subsequent discussion of these arguments surrounding the use of ECT was presented with the intended aim of supporting a clear and strongly held view opposed to the use of ECT in all but emergency situations. This thesis is therefore very much an attempt to present one particular viewpoint of the use of ECT mediated through the use of ethical resources.

My first position statement is that ethics is an endeavour. It refers to ways of understanding what is good and right in human experience. It is about discernment, knowledge, and self-reflection, and it is sustained through seeking, clarifying, and translating. It is the concrete expression of moral ideals in everyday life. It is about meaning, and it is about action. Therefore, what can psychiatry, a field that specialises in understanding and strives to alleviate affective disorders, offer ethics, and therefore judgements on procedures such as ECT? Ethics undertakes the conceptual, logical, and normative analysis and justification of moral principles, values, virtues, and judgements. I concur with Wallwork who outlines that psychiatry offers very little with respect to such esoteric issues. He contends that the ordinary language of meaning of moral concepts and the logic of moral reasoning is contested, but that psychiatry offers a great deal at the practical level (Wallwork 2001). In psychiatry, ethics is about the use of specialised expertise to prevent and alleviate the suffering of mentally ill individuals. During the last 20 years, there has been an increase in the interest of professional medical and nursing ethics and none more so than in the area of psychiatry and mental illness<sup>1</sup>. I accept that ethics is an endeavour and that psychiatry has little to offer this concept. Then it follows that we as practitioners must challenge the accepted status quo.

In the area of psychiatry, ethics involves the use of specialised skills and expertise to prevent the suffering of mental illness and alleviate when possible their suffering. The validity of this point is down to the particular form of distress that the mentally ill suffer from. These include, the distortion of cognition, feelings, perception, and interpersonal behaviours that lead to an erosion in personal, professional and societal relationships. An ethical issue in psychiatry is to be examined within this thesis in the contexts between medical and paramedical practice parameters. The area of primary concern is the ethical use and in part legal enforcement of the administration of the operative procedure known as Electroconvulsive therapy.

My second position statement is that the use of electricity to cause convulsions, in the hope of improving a person's mental health, is one of the most controversial issues within psychiatry (Andrade, 2014). There are those who say that ECT is effective in depression, schizophrenia, and possibly other neuropsychiatric conditions (Andrade, 2014). The nub of the situation is that we do not know how ECT works. What also is evident is that we do not know what causes depression, schizophrenia and most of the conditions for which ECT is prescribed. Therefore, without a complete understanding of the etiopathogenesis of these

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<sup>1</sup> Hughes (2004); Fink (2001); Dowman et al. (2005); Bauer et al. (2007).

neuropsychiatric disorders, it is difficult to determine what action of ECT is therapeutic or if the iatrogenic action of ECT creates altered brain function. Therefore, we are prescribing a treatment of unknown action for disorders of unknown origin (Smith et al, 2014). This is a particular problem because ECT produces a large number of neurobiological effects; it is difficult to determine which effects are relevant and which are epiphenomena for what condition. Because we do not know its action, this brings me to the next problem; there is dissonance between explanations of action (Stein et al, 2004). Within this thesis, I will address the different explanations proposed as to how ECT may work. The rebuttal of these explanations are that it should be realised that when a change is demonstrated with ECT, we do not know whether it is corrective of pathology, compensatory, or merely irrelevant with regard to mechanisms of action for a particular outcome (Wysoker, 2003).

My objection to ECT is simplistic, given that the defining feature of ECT (modified, bilateral or unilateral) –is indicated in its name, as it consists in the electrical induction of a generalised seizure. The use of electricity to cause convulsions, in the hope of improving a person’s mental health, is one of the most controversial issues within psychiatry (Carney and Geddes 2003). Unlike any other treatment in psychiatry, ECT still arouses such passionate controversy after seventy years, on which supporters and opponents cannot even agree on its name. Proponents call it electroconvulsive therapy or ECT. They say it is unfairly maligned, poorly understood and is remarkably effective for certain mental illnesses (Miller 2007; Gass 2008; Eranti et al 2009). Critics call it by its old name: electroshock. They claim that it temporarily lifts symptoms on certain mental illnesses by causing transient personality changes similar to those seen in head injury patients: euphoria, confusion, and memory loss (Haglund & Essen 2003; Cyrzyk 2013; Stefanazzi 2013). My third position statement is to challenge the widespread acceptance of the consequentialist perspective. Supporters of ECT have defended it for consequentialist reasons on the grounds that it ‘works’. The problem with this argument is twofold: firstly, there are negative consequences to be considered, such as memory impairment; secondly, in an era of evidence-based medicine, claims about the efficacy of ECT are insufficiently supported. In light of these points, it may be questioned whether it is irrational to refuse this treatment. This is important in light of further objections that relate to the wider context of delivery of treatment. There are further arguments as to its use in that “decisions about ECT are fraught with social considerations in the sense that the treatment is often aimed at re-establishing norms of behaviour within settings that partly determine such considerations” (Clarke 1995.p.329). So what we need to establish is that are these arguments still relevant in 2015? Therefore , let us

question the term it 'works', what does that mean, what is the criteria for success? This treatment raises a number of concerns, which throughout the thesis I will address and will be arguing against its use. My final position statement is that I accept that in extreme circumstances where a patient is displaying suicidal ideations and the choice we are faced with is either death or ECT, then the use of ECT and life has to take precedence. However, they are extreme circumstances, which health professionals do not face on a daily basis. I will address the concerns utilising professional, ethical, and legal perspectives. My main argument will be based on the premise that here we have a treatment quite clearly involving iatrogenic injury to the brain (Versiani et al. 2011).

ECT as a treatment is argued in some quarters as effective but its side effects are hard to prove due to numerous ethical parameters. Pro- ECT advocates make the argument that the use of the treatment is beneficial because it is a short-term procedure and has been shown to have therapeutic effects within a number of mental illnesses. Additionally, some patients request it (the right to receive) rather than having to wait for the therapeutic effects of medication to take effect. Within the collection of data for this thesis, I encountered many pro-ECT people. Within discussions with numerous colleagues, I have even had it said to me that "...Critics of ECT suffer from ignorance and ex-patients who complain about its effects suffer from paranoid delusions and impede the progress of modern medicine" (Mental Health Discussion Forum, 2007). I have to emphasise that there are those colleagues who take a different view and question the validity and reliability of ECT. My argument against the use of ECT is the method is unacceptable because of the consequences on a number of levels, which are professional, ethical, and legal. The sole purpose of this thesis is to present a substantial and ethical position that ECT is unacceptable to use as the first treatment of choice in a number of instances when treating the mentally ill. I will outline the central arguments against the use of ECT and summarise the central arguments in this thesis, indicating the main challenges that I will address to support my conclusion.

Let me identify what is to come within this thesis. The ethical and rights based imperatives to be explored, include; its historical context, the legal aspects, right based imperatives of the patient which will include information presentation and communication of the health care providers, diverse cultural requisites, the review of new machinery, and pre and post ECT associated intra-disciplinary medical and psychiatric intervention. How the ethical framework of Principlism influences these imperatives, which become directed towards the patient, being brought to the foreground as aspects of patient autonomy and inclusion are

investigated through the issues of construction of consent and consensual decision-making. Issues of consent are complex particularly as different professionals have such contrasting views of the treatment itself, that it becomes difficult to agree what represents adequately informed consent. Even if one grants that the knowledge base we have on ECT justifies its use (which I refute) the ethical basis of ECT depends how closely the practical conditions of administering ECT conform to certain standards of medical care. Whether clear diagnostic criteria are practised (not just prescribed in the treatment manuals) in the use of the treatment and whether informed consent is obtained, and whether such consent includes information about possible cognitive effects following ECT.

I will address this point when psychiatric healthcare providers should ensure that patients' are fully aware of the range of options and choices available to them. This would seek to limit the impact of the 'last resort' rhetoric of which I address when discussing consent (Chapter 4.)

#### Section 1.2: Central arguments against the use of ECT

Ethical concerns have been raised about ECT since its inception in 1939, and psychiatrists are the first to admit that they do not know how or why ECT works, or what the convulsion, similar to a grand mal convulsion, does to the brain. However, they point to the fact that patients who have undergone ECT say it succeeds when all else - drugs, cognitive therapies, hospitalisation and others - have failed. (Mukherjee et al., 1994; Boodman, 1996; Fink et al., 1996). ECT was initially, used for a variety of psychiatric disorders, although throughout this thesis I will signpost readers to the fact that these efforts often proved to be ineffective and potentially harmful. My arguments will also show that this treatment damages the brain, resulting in memory loss and long periods of confusion and that this damage is greater than the damage sustained if mental illness is allowed to run its natural course. Memory loss is not surprising since the electrodes are placed and discharged directly over the temporal lobe, which is responsible for memory function. This is an important point in the ethical discussion of ECT and I will discuss this in more depth in a later chapter (section 2.5). My argument against the use of ECT will therefore have the following structure:

Premise 1: Moral agents, who have a duty of care to others, ought not to expose others to unreasonable risk (Athanasoulis and Ross, 2010).

Premise 2: Psychiatrists and other healthcare providers within psychiatry have a duty of care (a moral or legal obligation to ensure the safety or well-being of others.)

Premise 3: Electroconvulsive Therapy exposes patients to unreasonable risk of memory impairment and other side effects.

Conclusion 4: Therefore, psychiatrists and other healthcare providers within psychiatry ought not to prescribe and proceed with ECT as a form of treatment.

In recent decades, researchers have intensified efforts to establish the effectiveness of ECT and its indications, to understand its mechanism and clarify the extent of adverse effects. However, although extensive data exists in yielding substantial information in many treatments of mental illnesses, the safety and efficacy of ECT remains unanswered. This thesis will be devoted to supporting and providing evidence for these premises. Further to the chapters within this thesis, the conclusion brings me back to my overall argument that ECT is unethical and should not be used; except in extreme emergency situations.

### 1.3: Summary of the chapters

In chapter 2, I will address the historical context and birth of ECT, arguing that from its early inception and use that it was unethical. Firstly, ever since its inception the main arguments against its use have centred on the fact that it is not known how it works. Secondly, because of not knowing how it works, how can we ignore the side effects patients suffer from and verbalise to healthcare workers. Additionally, I shall seek to explore the question 'is psychiatry really a science?' and I also discuss professional practice and ethics. I shall debate a number of studies, which have discussed brain damage, due to technological advances, indicating that modern day machines are actually more dangerous than previous ones used. Following this to examine the premise Pro- ECT, proponents put forward that ECT prevents suicide and refute this claim. Lastly, to review the literature on placebo controlled ECT, addressing the claim that ECT is effective, when the literature on real versus sham ECT offers a different conclusion. Lastly the role of the anti- psychiatrists and the role they played within psychiatric clinical practice.

In section 2b, I will also address the arguments of how the Mental Health Act (1983) [revised 2007] sections 58 and 62 are used as a way to implement the use of ECT, often without the consent of the patient. In light of my ethical argument on how the Mental Health Act (1983) [revised 2007] is used to enforce the treatment of ECT. Therefore, my position will centre on how section 58 and section 62 are implemented to enforce ECT and how mental health legislation can override the informed wishes of the patient.

The application of the framework of Principlism within Psychiatry.

In chapter 3: I address 'The application of the framework of Principlism within Psychiatry '. My opening statement within this chapter restates my premise that moral agents, who have a duty of care to others, ought not to expose others to unreasonable risk. I make this statement by questioning the validity of the sole use of Principlism as an ethical framework. With particular focus on how by using this ethical framework, Principlism structures practitioners to consider utilitarianism in the decision making process. Although there are other theories that healthcare professionals use to enable them to rationalise their decision-making, Principlism tends to be the most favoured rights-based frameworks, which is also popular within psychiatry. However, I make the statement and give examples that Virtue theory would fill the gaps that the use of Principlism has created and would enable enhanced decision making for the psychiatric healthcare provider. I address the issue that mental health care professionals are constantly encouraged to re-examine the professional decisions they make by using the framework of Principlism, and why the principles that form this framework Principlism are used as guides for inoculation. With the use of the principles that make up the framework of Principlism, this theory ethically denotes a wrong action cannot be justified by a desirable action, and in the arena of psychiatric care is criticised by some healthcare givers. Due to its lack of ability to support the rights of individuals, (to determine what happens to one's body and the right to medical privacy). I will address the significant boundaries inherent in the framework of Principlism, which face mental health practitioners, when advising a patient that ECT is the best possible treatment or educating a patient as to possible alternatives.

In chapter 4: I will address the area ECT and informed consent, and argue that in numerous cases serious questions arise in the area of capacity to consent. In particular, I will question; at what stage, do health professionals agree that the patient is making a decision with cognitive and rational ability? The dilemma that arises is how far we go in keeping a patient informed. Giving information is synonymous with informed consent; my position is that true informed consent is never obtained, because practically no one would sign a truthful consent form of ECT (if any exists) unless coerced to do so. Defenders of ECT claim that informed consent is scrupulously obtained, but it is at present impossible to evaluate this claim properly. It then must follow that despite the importance of divulging the risks of this treatment in psychiatry, no study to date describing ECT consent forms used in different hospitals and outpatients units has ever been published.

However, I will consider the counter-argument to my last point in that the alternative to not consenting to ECT is the possibility of living with a debilitating mental illness. One of the main points I will address is whether those who give consent do so voluntarily and have the capacity to understand the information given to them.

In addition, information, which should be given in a format so that the patient can assess the risks, is not and informed consent is given lip service. My argument will also be centred on risk/cost benefits analysis; in that I believe that, the risks far outweigh any benefits that this treatment provides. The ethical and rights-based imperatives to be explored include the giving of information, its presentation, and communication, and pre - and post- ECT associated intra-disciplinary medical and psychiatric service intervention. These imperatives become directed towards the person, being brought to care arena, as aspects of subject autonomy and inclusion are investigated thorough the constructions of consent and consensual decision – making.

Lastly in the conclusion: This thesis will be devoted to establishing the truth of these premises and the position I have taken and the validity of my conclusion, which follows these premises. The conclusion, following discussion with the chapters, will bring us back to my overall argument that ECT is unethical because of the risks outweigh the benefits and should only be used in the most extreme circumstances. The issue of whether or not a psychiatrist is ethically justified for the practice of a recommendation for Electroconvulsive therapy can and will be approached from a number of different vantage points . I opened the thesis up with questioning the mechanism of action of ECT. It will be from the preceding discussions within this thesis I highlight that the question is quite complex, and that the answer is also complex, and that it needs to be broken down into many parts. For my thesis, I have chosen the route of possible explanations as to why ECT is prescribed, and why a psychiatrist might recommend this treatment, but then challenge these reasons and the premises they put forward. By doing this I will be better able to discuss the concomitant practical, moral and ethical considerations of ECT usage. I highlight a number of parts to give a clearer picture of my position when I address the many issues linked with ECT and the position psychiatrists put forward that it is their responsibility to extend the entire arsenal of their curative techniques. My belief is that the public demands’ protection from techniques or drugs which can be shown not to be safe and effective. In my final summing of my introduction, I refer to the work of an article I read over 40 years ago which I am convinced is still relevant in its message today. Giamartino (1974) wrote about ECT and the illusion of treatment and my thoughts mirror his thoughts of such a long time ago:

*“This illusion of treatment is an unconscious or possible conscious effort of psychiatrists to effect immediate cure by whatever means possible, even to the extent of utilising a treatment which has proven to be of little or unknown value for the disorder involved, to maintain the integrity of the professional and the patient’s desire for care. Electroconvulsive therapy fits the definition of this ‘illusion’ and upon this analysis should be*



*considered not only undesirable but also an ethically unjustifiable treatment in those cases where motives other than the welfare of the patient have influenced this choice of treatment.” (p. 1131)*

There are clear differences of opinion in what constitutes mental health treatment, and active public discussion is needed to translate ethical values in the use of ECT. It is hoped this process will stimulate debate in this area of practice leading to a review of this treatment. It is important to always identify the risks and involve ourselves within a clinical context to act in the patient’s best interests. Further development within this discussion will lead to greater sophistication, and a review of underlying ethical values as to why we use ECT needs to be examined explicitly rather than acted on implicitly.

#### Section 1.4: The Who, the Why, and the Where.

The relevance of this section in the introduction is to highlight the process of ECT and the personnel involved in its use. I believe awareness of these factors is paramount, because it gives the reader an insight into the framework and mechanics of treatment. This understanding will enable the reader to identify with the premises and arguments I question. The who, are for those patients for who ECT is a consideration are those patients who are acutely ill, and are said to require ECT frequently. ECT is the gold standard of treatment for most forms of depression and for those that have been refractory to other treatments. This standard also applies to those patients suffering from Delusional and Severe endogenous depressions, Acute Mania, the Schizophrenic syndrome of Catatonia, Parkinson’s disease, Neuroleptic Malignant Syndrome, Tardive Dyskinesia, Delirium and in Epilepsy (but with great caution). Particularly, indications for use differ vastly in existing guideline (NICE 2003). The why as to use ECT should be based on a thorough review of severity of the patient’s illness, medical indications and contraindications, and non-responsiveness to other treatments, the risks, and benefits of ECT in comparison to other treatment options and the patients’ preference of treatment modality and also, the why of treatment is evidenced by the wide variations in approved codes of practice internationally.

The where is an area where ECT takes place should be designated for the administration of ECT and for supervised medical recovery. These areas are often away from the ward environment in hospitals and sometimes located within day hospitals. However, because some patients with compromised cardiovascular status are prescribed ECT, cardiac conditions should be evaluated and monitored closely. This area should have the appropriate health care professionals available and should include equipment and medications that could be used in the event of cardiopulmonary or other complications from anaesthesia or the procedure. The

anaesthetist will insert an intravenous cannula, and a short acting anaesthetic is given to the patient.

Commonly used anaesthetic agents are methohexital, propofol, etomidate and sodium thiopentone (Eranti et al., 2009).

A short acting muscle relaxant (succinylcholine) will then be administered, which will reduce the physical extent of the 'motor seizure'. Electrocardiogram, pulse oximetry, blood pressure and expired carbon dioxide are continuously monitored throughout the treatment, while the cerebral seizure itself is monitored by dual channel electroencephalography (EEG). Electrodes are placed on the patient's scalp and an electrical charge is passed through the brain. The amount of electrical charge is determined by a stimulus dosing protocol as recommended by the Royal College of Psychiatrists. (2005). The aim of the stimulus dosing protocol is to establish the patient's seizure threshold and to titrate to an appropriate treatment dose to induce an adequate seizure. The patient is anaesthetised and muscles are relaxed to prevent injuries and minimise discomfort; the toes may twitch and become rigid, the patients jaw may clench (the anaesthetist will have inserted a disposable mouth guard to protect the patient's tongue and teeth); blood pressure and heart rate may transiently increase during the seizure.

The nursing role in ECT has evolved in recent years and now involves specialised nurses who liaise with the anaesthetist and the psychiatrist. The role is in three parts; the pre, during and the post ECT phases. The ECT nurse co-ordinates the service and is responsible for the management of the ECT clinic and care of the patient. While the actual administration of ECT involves predominantly the anaesthetist and psychiatrist, the nurse has a responsibility to address the psychological needs of the patient undergoing ECT.

On the day of the treatment, the nurse should be fully aware of the patient's present mental health status, their legal status and medical status. (Royal College of Psychiatrists [RCP], 2005). On treatment days the nurse co-ordinates the arrival of patients, checks legal status, consent and all relevant documentation. The nurse should assist with the operating of the ECT machine and confirm the specified dose and electrode placement prior to treatment. Once treatment is completed and the medical team is satisfied with the patient's condition, the ECT nurse transfers the patient back to the recovery room (RCP, 2005).

## **Chapter 2: ECT: History, Science, and Nursing.**

*“Those who cannot understand how to put their thoughts on ice should not enter into the heat of debate”*

*Friedrich Nietzsche: Philosopher and Author 1844-1900 (in Graham.2014)*

### **Section 2a.1: Introduction.**

This chapter will be structured into two sections, in section 2a I shall provide a historical overview of ECT and then to open a dialogue on what constitutes psychiatry and science, psychiatry and professional practice and psychiatry and ethics. After dealing with the issue of why I believe that the birth of ECT in its application was unethical my views and position continue with the statements that science and psychiatry have not progressed enough to give a clear indication of the advantages of the treatment of ECT. Lastly, I challenge the premise that ECT is effective when I offer my rebuttal by highlighting the literature on ‘Sham ECT’ and I also challenge the premise that modern day machinery is less harmful than its predecessors are. The controversy about the use of ECT in England and Wales in recent times has resonance with the past as it has polarised opinions as evidenced by discussions within the United Kingdom (UK) ECT Review Group (2003). In section 2b, I will examine and discuss the legal requirements that are essential for ECT to be given to patients who refuse it and the ethical considerations of this legal practice. I will also consider the issue of the use of ECT with suicidal patients and the legality of this practice.

To date there has been little critical exploration of the ethical issues that arise in professional practice. In particular, exploration of the link between the science of psychiatry to the physical outcomes of ECT treatment and how it affects the practitioner (Chakrabarti et al 2010). We cannot avoid these issues due to our advancement in providing quality care and as we inevitably act in ways that affect the well-being of others; we make choices, which may support or violate dignity and can infringe personal rights. Psychiatrists, because of their training and experience within psychiatry, who have the capacity to inspire progression but also the potential to repel progression, use various theories in their own way to capture the drama of psychiatry to justify the use of ECT (Kavanagh and Mcloughlin, 2009). More than any other medical speciality, for example cardiology, nephrology and gynaecology, psychiatric treatment and diagnosis are affected by the surrounding culture and society.

What then must follow that as cultural values and beliefs change within society, then how we diagnose and treat mental illness changes (Shorter, 2009). Specifically, psychiatry is unable to protect itself from various in-vogue treatments, such as the current vogue in diagnosing paediatric bi-polar disorder, and the constant changing of treatments that sweep back and forth such as the different uses of psychotropic medication (Klein, 2008). This is not to say that psychiatry is immune to progressive thinking, merely that the problems are highlighted because there are many competing theories and models of care, scholars and clinicians working in psychiatry find it difficult to disprove these ideas. However, the pro-advocates of ECT insist that this treatment is a recognised survivor as it has been used for over 75 years since its inception in 1938 and is the sole survivor among out-dated and deceased treatments like insulin shock, camphor, and Leucotomy Therapy (Ottorson, 1960). My first challenge is that -it has survived but it still falls into the realm of being a mode of treatment that changes in popularity, in so far that it is taken up with great enthusiasm for a brief period with exaggerated zeal. For example, within the decades of the 50's 60's and 70's its use was widespread, but less so in contemporary times. However, we see an upsurge in its use for the treatment of bi-polar and schizoaffective disorders rather than uni-polar depression (Gaylin, 2009).

#### 2a.2: Outline of sections.

In the sections that form the basis for this chapter, I will be making various points to advance my argument, to support my position and provide background information of the areas I discuss. To provide a more thorough explanation of these important positions, opposing explanations are discussed also. The reason for this chapter is it will also open up numerous points in developing arguments' within the thesis.

In the opening section 2a.3, I will start to discuss and examine the origins of ECT and the part it has played in history. This section starts with the historical context of work of Ladislaus von Meduna, predecessor to Cerletti and Bini, the creators of ECT and the crude historical beginnings of the therapy compared to what it is today. Its importance to the thesis is it gives me a platform to form my arguments from its historical discovery up to modern day.

In section (2.4), I will explore the nature of psychiatry within science, ethics and evidence based care in nursing. I discuss these concepts and explore why I believe these concepts are difficult to predict and for which, in reality, we do not have this understanding. In section 2a.5 I put into context the relevance and

viewpoint that the anti-psychiatry movement played within the late 1950s through to 1970s and the impact of these criticisms upon psychiatric care. These criticisms of psychiatry were launched by charismatic individuals who rejected 'coercive care' and attempts to lock up the rebellious, on the grounds that they were insane. These individuals played a major part on the development of doctor-patient care. The importance of this section is that by looking at the anti-psychiatry movement a rich understanding and nuanced account that highlights its important contribution to the history of psychiatry is presented.

Finally, in part 2a.6 I draw my thoughts together on the position I take and summarise the issues I have argued for and against solidifying my argument within this chapter that physically and legally there has been progress made but it remains unchanged ethically.

### 2a.3: Section: Ugo Cerletti and Lucino Bini.

This section of the thesis I believe is prevalent in a position to support my argument because it highlights the way that ECT was developed was unethical. In addition, the explanation regarding the invention of ECT sets the unethical standard which, to date, has never been truly addressed due to lack of empirical evidence. The two authors I identify are of importance to the overall theme of the thesis because not only were they were the two co-founders of the treatment of ECT but their scientific methods were highly questionable. The pro advocates of ECT argue that most discoveries could be deemed unethical by today's standards, but the consequences of their argument for ECT are unacceptable. The points they make are superficially correct – the consequences of their argument are worse than the benefit that they claim will follow. My position on why I believe their discovery on the application of electroconvulsive therapy was unethical is that they based their treatment on two mistaken beliefs. One was that seizures somehow protected the individual against suffering from schizophrenia, and the second was that disrupting the patient's memory was necessary for the cure

Following work by Von Meduna, (a scientist whose experiments with camphor oil on mentally ill patients) it occurred to him that instead of applying and inducing 'fits' by chemical means, such electrical methods may be technically acceptable. The idea of using 'cranial shocks' for the mentally ill would -emerge in 1938 with Ugo Cerletti and Lucio Bini in Italy. These two pioneers differed from others from the eighteenth century by deliberately using much stronger electroconvulsive shocks (Finger 2006). Cerletti, requested from the director of the slaughterhouse to experiment on the pigs, not wanting to try to kill the pigs but to keep them alive for

as long as possible. Cerletti endeavoured to find out the quantity of the current and length of time it had to be applied before death occurred (Cerletti, 1950). It became apparent to Cerletti that the more serious results (prolonged apnoea, sometimes lasting many minutes and sometimes death), appeared when the current was applied across the chest but was 'less' so when it was applied across the head. His findings in the Rome slaughterhouse convinced him that that application of electrodes to the head was both 'feasible and safe' (Gibson, 1971). He was now embarking on the transition of electricity by this method from pigs to men. The first shock treatment was given to an Italian man known as S.E; this potential subject arrived in the shape of a confused incoherent wanderer from Northern Italy, found by police in a Rome railway station. The subject was diagnosed as a schizophrenic as he was expressing incomprehensible gibberish made up of neologisms, paranoid ideas, and active hallucinations. His colleague Bini, together with an electrical engineer, devised the first electroshock box, which had two circuits: a direct circuit to measure the resistance of the patient's head (in ohms) and an alternating circuit to elicit the convulsion. Upon administering the shock, the subject gave a sudden jump on the bed with tensing of his muscles; then he immediately collapsed on the bed without loss of consciousness. The patient started singing aloud at the top of his voice, and then fell silent. Cerletti deduced from this that the voltage was too low bearing in mind that he had experimented on the pigs the previous day, so made arrangements for a repetition of the test. Then, understanding that the conversation was about him, the patient exclaimed, no longer in an incomprehensible jargon, but in clear words and in a solemn tone, "Not a second - deadly"(Cerletti, 1950, p. 84).

Bini suggested the repetition of ECT, many times a day led patients to a state he named 'annihilation'. Annihilation resulted in severe amnesic reaction, which was reported as a benefit for those suffering from obsessive states and paranoia. Cerletti in his findings presents an argument as to why ECT is viewed differently to other treatments and discusses that electroshock has been applied in a number of different illnesses. Recovery had been frequently reported in the cases of patients suffering from 'asthma' and there had been success in the treatment of 'psoriasis' and alopecia. However, I challenge their terminology, calling it 'annihilation' surely using a term that means to destroy (something or someone), or if we use the transitive verb: to cause to be of no effect, or to destroy the substance or force off. Were both these two people aware of the true power of ECT and inadvertently by saying that it resulted in severe amnesic reactions, were really trying to make us believe that the power of electricity was for the good of psychiatry?

Cerletti quotes Padre Dante: (c. 1265–1321) an Italian poet from the middle ages to emphasise his point:

*“Qual e colui che somniando vede,*

*E dopo il sogno la passione impressa*

*Rimane, e l’altro alla mente non riede...”*

*(Para XXX111, pp. 58-61)*

*(As he who while dreaming sees*

*And after the dream is over,*

*The emotion remains while the picture has faded away...)*

*(Cerletti, 1950, P. 94)*

When we question the ethics of watching this experiment, witnessing cognitive and behavioural changes, it was clear Cerletti was unresponsive when fellow researchers questioned its use. The conclusion one can draw from this is that on reading this quote from Dante, Cerletti adopted a single-minded approach detrimental to the care of his patient.

Let me conclude my position on why I have argued that ECT was unethical from its early beginnings. These treatments had all the hallmarks of a heroic medical discovery but let us stop there and look at what we are saying; when we talk of heroic treatments that medicine and science has given us, then ECT cannot be listed within that category. This treatment came about by giving cranial shocks and inducing a convulsion in a man without his consent. Cerletti and Bini showed no recognition in their written reports of what had occurred at the end of the eighteenth century. When doctors talk about heroic treatments, they were not referring to the forbearance of the patients on whom they inflicted treatments; the term rather implied that they were classed as heroes because of making a medical breakthrough. These breakthroughs were frequently done on patients who were often unable to consent or who adamantly refused. Let us be clear that in the 1930s, the patients’ views were of little account and psychiatric ethics played no part in the decision-making process. In modern day, the rights of the patients are more acknowledged and consent to ECT is necessary. However, there are

exceptions within the Mental Health Act (1983), [2007 revised] of which I address in part 2b when I discuss the law and ECT.

#### 2a.4: Psychiatry: Science, Professional Practice, and Ethics.

The focus of this section is that of the relationship between science and ethics in psychiatry and the influence these factors have on professional practice. This notion is considered the conceptual heart of the matter.

Ethics has been defined as the ‘the system or moral code of the individual, religion, group or profession’ (Robertson & Walter, 2014); science, with which psychiatry has strong links, is defined as a branch of knowledge concerned with establishing or systemizing facts (Thompson et al. 2000). Theoretically, science and ethics within psychiatry have been conceived of as two distinct and separate entities, almost anti-ethical insofar as science is descriptive and ethics is prescriptive or a science relying on validation; hence, ethics relies on judgement and science is concerned solely with ‘what is’ and ethics concerned with ‘what ought to be’ (Bloch & Chodoff, 1991). There are many scientific explanations put forward for scientific phenomena, the issue is how we can determine a good scientific explanation, and what weight we should give science in providing the answers in the world we live in. Consequently, here lies the nuanced conflict because the lines become less sharply drawn when the complexities of social reality are considered.

In professional practice, the psychiatrist or psychiatric nurse is obliged to act as a ‘double agent’ to accommodate conflicts between the patient, the healthcare worker and, in most cases, family members. When one considers that the psychiatric healthcare provider straddles the ambiguous line of science and the art of psychiatric care, dual attitudes towards their professional identity differ in both degree and quality. There is still the question about whether psychiatry is a science at all or whether it is a mechanism, which is just used to deal with humanistic interventions; it is not a science but a body of knowledge, which frees it from obligations that other sciences have (Conte & Karasu, 1992). Concern with the interface between psychiatry, science, and ethics is not a new concept; major controversies since Laing, Szasz and others (which I will address in 2a.4.5) have long pivoted upon the question of whether psychiatric illnesses actually exist and whether psychiatric care actually propounds any particular values, especially values that may be unethical or biased. Some believe it does not (McFarquhar & Thompson, 2008) and others point out its political and repressive nature by the very virtue of its existence (Sadock & Sadock, 2003).



#### 2a.4.1: Conceptual discussion: Psychiatry and Science.

Let me present my position by presenting my view of science within psychiatry by looking at the relationship between psychiatry and science, which are argued, are based on facts. When using ECT we have no clear idea of how the electrical discharges work within our neuropathic system. Therefore, science is the total of a great magnitude of mysteries not established truths (Singh & Singh, 2009). The problem whenever ECT is discussed is that the exact sciences do not encompass all of the truth but only exact knowledge that is binding to the intellect and universally valid is based on fact. Science does not have all the answers and traditional psychiatric risk assessment used in professional practice and management may not be up to the job (Hiven et al. 2010).

Chalmers (1999) in his book 'What is this thing called science' gives a nuanced interpretation of observable facts expressed as statements. He tells us that in normal linguistic usage, the meaning of 'fact' is ambiguous. It can refer to a statement that expresses fact and it can also refer to the state of affairs referred to by such a statement' ( p.11). He helps us understand by giving the analogy of mountains and craters on the moon. Here the facts can be referring to the mountains or craters themselves. Alternatively he makes the statement "...there are mountains and craters on the moon which can be taken as constituting the fact' (p 11). When it is claimed that science is based on facts, clearly that latter interpretation is appropriate. Having an understanding about the moon's surface is not based on and derived from mountains and craters, but from factual statements about mountains and carters. Now relating this to my argument on electroconvulsive therapy, those who base their argument that ECT works and is a fact, is an argument based on a false premise. Because of not knowing, how ECT works in a scientific manner, given that facts might constitute a suitable basis for science must be in a form of statements, the claim that facts are given in a straightforward way begin to look quite misconceived. Indeed, given the scope of finding an answer to the questions ECT poses, it could possibly be that science may never be up to the job of providing answers. Again, Chalmers (2008) has a position, which mirrors mine, he discusses and questions, both the fact that our perceptions depend to some extent on our prior knowledge and observation statements, which presuppose the appropriate conceptual framework, which indicate that it is a demand that is impossible to realise. "How can we establish significant facts about the world through observation of it, if we do not have some guidance as to what knowledge we are seeking, or what problems we are trying to solve" (Chalmers 1999 .p 13). It must follow then if I make the argument that facts based on ECT are not straight forward, reliable and valid, then they can be said to be

reversible and fallible. Following this then if we cannot accept this basis for scientific knowledge, then the knowledge based on it is equally reversible and fallible.

Therefore, can science be helped by the various theories of psychiatry? Firstly, let me define what I mean by a theory of psychiatry. A theory of psychiatry refers to a field of knowledge within medicine focused specifically on the mind, aiming to study, prevent, and treat mental disorders in humans. It has been described as an intermediary between the world from a social context and the world from the perspective of those who are mentally ill (Lester & Gask, 2006). While the focus of psychiatry has changed little throughout time, the diagnostic and treatment processes have evolved dramatically and continue to do so. Since the late 20th century, the field of psychiatry has continued to become biological and less conceptually isolated from the field of medicine. The discipline is interested in the operations of different organs and body systems as classified by the patient's subjective experiences and the objective physiology of the patients. (Lester & Gask, 2006).

Reznek (1991), when looking at theories of psychiatry makes claims in his book 'The Philosophical Defence of Psychiatry' that for psychiatry to be a science it must have a public and repeatable observational base. Psychiatrists have postulated illness entities to explain the problems encountered with their patients where these subjective accounts and phenomena have taken the form of hallucinations, distorted thought processes, and low mood. However, are these observable and if so in what form? This is an important question to ask because as Reznek (1991) points out, if the whole edifice of psychiatric knowledge depends on observation of given symptoms, it is from these that we judge that the patient is suffering from a mental illness. It is also from this that the search for causes, underlying nature and treatment can begin and therefore, psychiatry stands and falls on the foundation of observation of subjective symptoms. He goes on to say that while we cannot observe the mental states of patients' perceptual experience we can only observe from the behaviour that the patient is hallucinating. The observation is a hypothesis invoked to explain the behaviour of the patient. So if psychiatry has an observation base, it cannot lie in the subjective phenomena reported by the disturbed patients (Reznek, 1991). He continues that we do not have to find an observational base that is free of theoretical assumptions. All observational claims in science make theoretical assumptions, when scientists are measuring instruments, they hypothesise that these obey certain laws, thereby turning measurements into hypotheses? This can then be classed as a science (Lehoux et al. 2010).

Within psychiatry, we are in need of exact knowledge, which is universally valid, not knowledge that is based on presumptions as in the various theories of ECT. Varma (1989) articulates a similar thought when he says it is fatal to think that the scientific approach is the only one because most things do not lend themselves to the scientific approach. It may be preceded by exaggerated guesses but must be succeeded by unstinting critical enquiry. Additional to necessary analysis as to irrefutable conclusions from the existent state of knowledge, such critical enquiry and analysis is as important as the empirical enquiry itself and it may lead to further empirical enquiry that refutes these apparently irrefutable conclusions. This is the inevitable, inexorable process of scientific progress in psychiatry. It is Popperian refutation/falsifiability in action (Popper 1935/2004). This is the only valid way to add to the corpus of empirical knowledge. My position and the criticism I offer when discussing ECT based on science, while the scientific approach is not the only one, it is the only one which can be empirically validated and refuted and can therefore lead to progression of verifiable thought. This is how it transpired with the discipline of science down the centuries (McEwen & Willis, 2010). Therefore, it is critical that psychiatry, which claims to be science driven and a scientific discipline, does not lose sight of this. It either gives up the claim of being scientific or learns to follow the cannons of science. We develop the necessary tools for all things we believe to be important to be able to study them and do not comment on them until we have validated them. That is the essence of scientific approach; my point is that psychiatry cannot say it has done that when commenting on ECT. A true scientist will follow two cardinal rules; firstly, he will never unwillingly accept the worth of empirical evidence however damning to his/her favourite theories. Secondly and perhaps more importantly, for want of evidence he withholds comment (Singh & Singh, 2004).

Let me now enhance the psychiatric scientific discussion on the mind and the body. I make the claim that because ECT is a physical intervention, it will only be meaningful as a treatment for mental disorders if they too can be conceived as in some way physical, and that usually means as being correlated with brain states. I recognise that there are other positions in the philosophy of the mind that are not mind-brain identity theories, but reject discussion of these in-depth because discussing the efficacy of ECT would only make sense (placebo uses aside) in this context. If we make the point that the brain is part of the body then the question is what is the mind and what is the body? There has to be clear distinctions between structure and functions of both. Smith and Jones (1986) help me with this, by making the point that, "the leading idea of

what we have called the 'two component' picture is that we are a composite of two entities, one corporeal and one non-physical: and the presence of the second nonphysical component is essential if we are to function as thinking feeling human beings" (p 9). Let us use the correlation that the body is a house, it has bricks, walls, is used for shelter for people and appliances (Lehoux et al., 2010). Similarly, the body has a structure, the bone structure, which includes the neck, and thorax, torso and limbs. Its functions are numerous which include to think/sense (the head) to digest/evacuate/procreate (the abdomen and torso) and to move (limbs). Within the structure is the brain, which also has numerous functions but is connected to the body through a number of neuronal structures through the spinal cord, cranial nerves, and the neuro-endocrine system. Therefore, the functions of the body are included in physiology; similarly, the brain's functions are included in the entity called the mind. The brain (structure) is connected to the rest of the body, (structure) and the function of the mind is part of the brain which is a physiology of the body; therefore, is a disorder of the mind a disorder of the body or not? Actually, the question, which should be asked, is a disorder of the 'brain' a disorder of the body or not. This summary is attractively tidy, but it requires us to draw a sharp distinction between mental and physical properties. Therefore this distinction is not at all easy to draw cleanly , at least if we try to do it in a way that accords with our everyday intuitions about what counts as mental and what counts as physical (Smith & Jones, 1986). I move my position forward by now linking this to someone suffering from symptoms of a psychiatric illness. Those patients suffering from tactile hallucinations or nihilistic delusions are actually manifestations of a disorder of the brain and therefore, can be called disorders of the mind. Such disorders of the brain are connected to disorders of the body since the brain is dynamically linked to the body. Therefore, my point is how do we know what is going on in the mind, and then treat it with ECT if we cannot observe a physiological abnormality. The view that mental diseases stand in the same way of thinking as, say urinary problems stand in relation to kidney disease is at best superficially attractive. The argument runs along these lines: the human body is a biological machine composed of parts, called, such as the liver, lungs, heart, and brain. Each organ has a specific function but all are linked in a number of ways. When there is a malfunction with any of these organs and they fail, we have a disease, such as emphysema, hepatitis, and coronary heart disease. Therefore, if we define human problems as symptoms of brain diseases, even in the absence of any medically proven evidence, we can then treat mental diseases as if they were brain diseases. All bodily phenomena involve physiological correlates and all diseases, psychiatric illness included, involve pathological correlates (Kendal, 1993).

The aim is to crack the code for this brain neurophysiology and gain evidence of brain function in both health and disease and in this way; we 'may' reach the scientific goal of how ECT works and in what way. Put this way it starts to unravel the scientific question. As the brain is part of the body, a disorder of the brain is a disorder of the body, therefore what we term the mind is function of the brain, and a disorder of the mind is equally a disorder of the body. In other words, if science can become the monster of philosophy, biology can be the monster of psychiatry (Singh & Singh, 2009). My rebuttal to the pro ECT advocates is without profound insight; it appears your position is *invalidated* unless backed up with validated robust empirical evidence. We should also remember not to preclude any psychosocial correlates as well. Nevertheless, evidence is the only bedrock of any theory within psychiatry and that empirical data are necessary to construct a theory, which will also stand up to valid scientific scrutiny (Fabrega, 2005). This has been the case for centuries in biomedicine, which has given us countless tested and proven treatments; psychiatry cannot be any different especially when we commit so much to our professional practice (Fabrega, 2005).

#### Section 2a.4.2: Conceptual discussion on 'Sham' studies and ECT.

The gold standard for the establishment of the therapeutic efficacy of a treatment is the randomized placebo-controlled trial. Upon first blush, it may seem difficult if not impossible to design something akin to a placebo or sham control for a procedure like ECT. However, my position here is to refute the premise that ECT is a treatment, which benefits all patients by the nature of its application. To challenge the pro-advocates of ECT by presenting my claim that there is strong evidence that ECT superiority over sham ECT can only be demonstrated in a positive manner in the short term, and only 'marginally' long term but with serious side effects to take into consideration. There are numerous studies<sup>2</sup>, which support my claim that sham group positive responses to illness are often surprisingly high, which leads to questions about what the mechanism of improvement actually was.

Ross (2006) looked at a number of randomised prospective double blind, placebo-controlled trials. These studies varied in methodology but all involved the administration of real ECT versus sham ECT under double blind conditions. In the sham ECT condition, the patients' receive a general anaesthetic, are connected to the ECT machine, the button is pushed but no current is delivered. The patients have no way of knowing whether

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<sup>2</sup> Ulett et al (1956), Brill et al (1959), Sainz (1959), Harris and Robin (1960), Wilson et al (1963), Fahy et al, (1963), Lambourn and Gill (1978), Freeman et al (1978), Brandon et al (1984), Gregory et al (1985).

real or sham ECT was delivered. The sham ECT studies provided definitive evidence that real ECT is no more effective than sham ECT except over long-term use. However, the negative side of the cost-benefit analysis with real ECT is due to death, cardiovascular complications, and memory and cognitive impairment caused by real ECT. Associated with this is ECT's powerful placebo effect; sham ECT leads to improvement in patients levels of mental illness. If we are to base this treatment on scientific merit then the pro-advocates of ECT will find it hard to convince us of the value of ECT. A general sense of not having a firm scientific basis on which to base ECT use is discernible, but although clinically counter-balanced by the technologies dramatic effects it does not make a good argument for its scientific use( Wordage does not allow me to highlight all the studies but I will highlight two examples.) .

The Northwick Park trial (Johnstone et al 1980), published results with analyses of subtypes of depression as predictors, electrode placement was described as 'bifrontal'. In this study, 70 depressed patients were randomly assigned to real or sham ECT on a prospective double-blind basis. There were no differences in HAM-D (The Hamilton Rating Scale for Depression) scores between the two groups at the beginning of the study or at 1 and 6 months. There was a significantly lower HAM-D score in real ECT group at weeks 2 and 3 while the treatment was being administered. It concluded that although people receiving ECT were better in the short term, no differences were shown in the control group and the ECT group at one month and six month intervals. Analysis and conclusion of the results were to highlight that with intensive nursing and medical care patients could recover from the most severe depression without receiving ECT.

The 'Nottingham study' compared real ECT over sham ECT (Gregory et al. 1985). In the simulated group (sham ECT), the patient received everything that the group receiving real ECT experienced except the electrical charge causing the seizure. While there was improvement in the group receiving real ECT there, was also improvement in the group receiving the simulated ECT? So was it the electricity that created the seizure that caused the improvement or was it the thought of having the electricity and seizure that created the improvement? The researchers took it further by creating the seizure using flashing lights and the chemical flurothyl and patients improved as much as those receiving seizures from an electric current do. What was then shown was that the seizure and not the electric current created the therapeutic outcome and not the passage of electricity. The counter argument can always be made, for example, that the memory tests were

not sufficiently sensitive, that the autonomic regions studied were not sufficiently widespread, that the wrong biochemical constituents were assayed, the number of subjects was inadequate and so on.

However, the main argument put forward within the studies does not show there is a vast improvement in real ECT over sham; it does not support the conclusion that ECT is powerful and effective. Therefore, the counter claim and position the pro advocates put forward can be rejected on two grounds; firstly, their position contains errors in reasoning about cause and effect of ECT, the post hoc fallacy. Secondly, their position is based on faulty assumptions because they assume the patient's recovery is based on the treatment of ECT when it can be clearly demonstrated that it was not. Due to the refinement of research guidelines, a more up to date study is not available. In the absence of further research, it will remain the case that the effectiveness of ECT cannot be endorsed over sham ECT in the psychiatric literature.

#### 2.4.3: Conceptual discussion of ECT machinery.

Within this section, I wish to challenge the premise that modern day ECT is safer than its historical predecessors, and the view presented by those who advocate for a newer safer ECT service, that they are improving the wellbeing of the mentally ill. Increasingly the presentation of improved technical administration is a feature promoted by advocates for its current and expanded application. Advocates will point to three facts to support their claim in that unmodified ECT given cannot be compared to modified ECT (current techniques), firstly because modified ECT now involves pre-oxygenation, anaesthesia and muscle relaxation. Secondly, most animal studies used historically are in no way equivalent, in terms of voltage, seizure duration, or electrode size, to current ECT use in humans. Lastly, non-dominant unilateral ECT has a clear and marked advantage over bi-lateral ECT with regard to (cognitive) neurological deficits. They will point to those results, which have been favourable<sup>3</sup> without cognitive deficits and that the patient has recovered and point towards the nature and response in a variety of mental illnesses.

I concede it is important to note that many psychiatric conditions warranting ECT as a treatment are associated with cognitive deficits, and the range of the cognitive deficits can be diverse across several domains. As such, discussion of cognition should include the effects of untreated psychiatric illness as well as the potential for impairment following ECT treatment, which advocates will say is a rare phenomenon. Indeed,

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<sup>3</sup> Kirsch et al (2008), Turner et al (2008), UK ECT Review Group (2003), Feske et al (2004)

I have experienced at first hand the views from colleagues that cognitive damage occurring in patients with modified ECT is not an established fact. I disagree with their position, the evidence simply does not warrant such an opinion. The basis of my rebuttal to these claims are that although a number of issues surround ECT, perhaps the two most significant are the loss of memory problems and the transient nature of its therapeutic outcome. Patients will attest that they have problems with retrograde (distant memory) and anterograde (new memory). Therefore, no matter how rare such a phenomenon may be, it must follow that it is important to try to establish its etiology. Historically the extent of memory loss may have been overestimated, however the dismissing of memory loss by those who advocate for ECT is an argument not supported by evidence. The second major issue associated with ECT is the transient nature of symptom reduction, when the treatment stops, symptoms return for up to 50% of patients sometimes within days. Given our inability to explain how the treatment works, our inability to explain why it stops working is understandable. The question we should be asking is did it actually work in the first instance.

The next argument put forward by the pro-advocates of ECT is that the technique is now safer and much more sophisticated than that of the first machines developed by Cerletti and Bini. Yes, it is safer as we now have 'modified' ECT in which the general anaesthetic and muscle relaxant stops the patient thrashing about the bed and sustaining fractures. However, safe is not a word I would endorse, I would say that modern day ECT is more controlled with the balance of power with the anaesthetist and psychiatrist and not with the patient. Conversely researchers state that the use of recent techniques of modified ECT actually increase risk of complications. The use of general anaesthesia, oxygenation, and additional medications for delivery are thought to require higher voltages to induce the seizure potentially increasing the risk to the patient (Breggin, 1998, NICE, 2003).

The implication of the now discarded 'sine' wave machines which have been replaced by the 'brief pulse' machines hides a fact within its mechanism that makes me strongly question the ethics of using it. I also question the ethics of the actions of those using this new device, as only highly specialist personnel are allowed to operate this and are more than aware that danger lurks in the background of this new machine first devised by *neuropsychiatrist* Reiter and an electrical engineer Wilcox. A number of researchers started to question this 'new' machine and many are reported to have indicated, that there is a case that retrograde amnesia, constriction of arteries, and capillaries and other bio-chemical disturbances in the brain are caused



by the increased electrical current in the brain. It was now recognised that Reiter and Wilcox had created the most dangerous electroshock machine in history, completely discarding the minimal dosage, adequate convulsion precept of ECT (Cameron, 1994). I emphasise my point by saying the use of uni-lateral ECT (although hardly used) is actually more damaging than bi-lateral ECT, a point made by Cameron in 1994 when giving his paper on consumer misinformation to both American and English psychiatrists. To give or create a seizure on the non-dominant side of the brain actually causes more damage to that side of the brain. Lastly, ECT machines are by way of scientific advancement much more powerful than those used 50 years ago. Let me enhance my position by explaining where the scientific differences are:

- *The frequency is increased: Frequency is the number of pulses of electricity per second flowing past a given point. Although old 'sine' waves are wider than 'brief' pulses, they are emitted at a rate of 120 per second. Modern day 'brief' pulse machines emit up to 180 pulses per second of electricity making the electrical jolt stronger and more powerful to the brain. The seizure threshold is the minimum electrical charge that induces an adequate seizure. The aim of a stimulus dosing protocol is to establish the patient's seizure threshold and to titrate to an appropriate treatment dose to ensure an adequate seizure.*
- *The current is increased: Current can be defined as electron flow per second. Old machines delivered between 500-600 amps of current and induced a seizure. Modern day machines deliver between 700-900 amps to get the same result. The seizure threshold is the minimum electrical charge that induces an adequate seizure.*
- *Duration is increased: Duration is the amount of time the current flows through the brain; modern day machines are four to six times the maximum duration of older models*
- *Wave lengths can be increased: Modern machines can be adjusted, therefore leaving the door open for unethical use through higher and longer wave pulses*

(Feliu et al. 2008, p. 616)

I conclude this section by rebutting the arguments put forward that ECT is safer in the modern day than 70 years ago and reiterate that the arguments put forward by the pro ECT advocates is not supported by evidence. I disagree with the claim that new ECT machinery is safer and argue that the most up-to-date machine actually creates more 'internal brain damage' than previous obsolete machines and is a point made by Andre (2009). Therefore, no matter how much the pro-ECT lobby try to repackage the idea that modern day ECT is safer, their position is contradictory. The variances of ECT technique both in the United Kingdom and

within worldwide healthcare systems are coupled with contradictions in diagnostic conditions. There is operative administration differences in size of voltage applied, length of seizure requirements, in ranges from the placement of the electrodes, associated pharmaceutical prescriptions for pre-medication and additional drugs to make the seizure occur. These factors combine to create an information void where ECT advocates are not able to produce reliable, current national statistics on which to base their positions.

#### 2a.4.4: Conceptual Discussion: Psychiatry and Professional Practice.

The importance of this section is to present a position where I open up a discussion indicating that within psychiatry and professional practice nurses are expected to play an important role in the treatment of ECT. That they are involved in providing education both pre and post-operatively (Weiner & Falcone, 2013). The purpose of my literature review for this section was to determine the state of science in relation to nursing practice. My reason was that literature reviews are considered the *sine que non* of the gaps within science and its existing knowledge. This gives us direction for the next logistical step in our quest for further knowledge. From that, our understanding about the state of science in relation to nursing practice should bring about advances within our research, clinical and evidence based care. My concern is that there is a pro-ECT bias within numerous publications and books (Fink 2001; Dowman et al 2005; Bauer et al 2007) but an absence of those who challenge its use and of first person accounts (Johnstone 1999, Kershaw et al 2007). I start by providing an explanation put forward by the pro- ECT nursing publishers before I challenge their position. Within the nursing literature related to ECT, those in professional practices have several sub-themes. These include that ECT is effective in treating diseases of the mind, those who suffer from mental illness get better from having ECT, the cognitive side effects are not serious, and nurses need to understand what constitutes proper ECT practice, alleviate fear, and demonstrate proper knowledge and ethics (Daalen-Smith & Gallagher, 2011). Firstly, it is important to look at the differences between what constitutes diseases of the mind and mental illness; disease refers to objective pathology, illness subjective awareness of distress and sickness refers to a loss of capacity to fulfil normal social roles (Gelder et al. 2001). There is a difference between a disease of the mind and mental illness. It seems that any disease, which produces a malfunctioning of the mind, is a disease of the mind and need not be a disease of the brain itself. For example, arteriosclerosis, epileptic episodes, diabetic hypoglycaemia, hyperglycaemia, delirium and some confusional states caused by physical illnesses.

The term has been held to cover numerous conditions. However, what is required is what is defined as a disease. Boorse (1977) in his paper 'Health as a theoretical concept' first questioned 'is a disease anything that is inconsistent with health' (p542). He goes on to say if the axiom has any content; to address the fundamental problem in the philosophy of medicine then what is needed is to break the circle with a substantive analysis of either health or disease. He starts by stating health is a normal function, the absence of disease and practicable health roughly the absence of a treatable illness. He then makes the point that the influence of values on health judgements has usually seemed most potent in the area of mental health. Within his paper, he analyses health and disease within traditional physiological medical definitions. However, he does challenge the premise that healthy people are those who do not need medical treatment, and that all diseases are to be treated by doctors. By précising, numerous writers' views he gives a viewpoint on seven themes where he shows definitions in health, and shows that none by itself provides a necessary or sufficient definition of disease. His seven themes consist of one: value, where he says it is a desirable part of the mental welfare of the individual and views this concept as necessary for health. Nevertheless, he makes the point what happens when people are slow in reflex, short in height and unattractive, these conditions are not diseases; you could never distinguish them from diseases on grounds of disvalue alone. Secondly, treatment by physicians- it is often supposed that diseases are undesirable conditions that doctors happen to treat( p. 546) Thirdly, statistical normality- in clinical language, diseases, or pathological conditions are also called abnormal and healthy conditions normal( p 547). Fourthly, pain, suffering, and discomfort- Within his theme, discussions of health contrast with the pain and discomfort of illness. His challenge is that numerous conditions have been identified such as cerebral tumour, various forms of heart disease and breast cancer where there has been a complete absence of subjective distress. Therefore, right up to them being admitted into hospital or even death there was no reason to suspect illness as the person was classified as healthy (p. 547). Fifthly, Disability- he firstly makes the point that if all diseases cause physical suffering, perhaps any disease must at least tend at some stage to cause disability. His rebuttal here focuses on pregnancy, which he says is a painful, disabling, and unusual condition, which cannot count as a disease (p. 548). Six: adaptation- Here he makes the point that humans adapt to their environments, and that health is relative to that environment. However, unhealthy environments do not always give rise to unhealthy conditions and the recognition of diseases (p. 549). Lastly, seven: Claude Bernard and Walter Cannon first identified Homeostasis-the importance of homeostatic regulating mechanisms in body. Bernard looked at physiological processes as serving to maintain equilibrium in

the *milieu interieur*, while diseases processes were disruptions of the equilibrium. However many of life's functions are not homeostatic, for example, perception, locomotion, growth, and reproduction upset an equilibrium rather than maintain one. One would recognise why various equilibria are important to life without confusing homeostasis with the broader idea of normal functioning (p. 550). He concludes by saying all ideas discussed have in some fact some connection with 'normal' functioning and what we shall argue would constitute disease would tend to diminish health on all seven counts. It would appear that we have two senses of 'health', in one sense it is a theoretical notion, the opposite of disease. In another sense, it is a practical or mixed notion, the opposite of illness (Boorse, 1977). Although I agree with many of the points Boorse makes, I feel it is necessary advance his argument and challenge his premise on five (Disability) and apply this to the area of mental health. My belief is a disease is an illness when it is deemed serious enough to be incapacitating and debilitating. Mental illness refers to a wide range of mental health conditions, disorders that affect your mood, thinking, and behaviour. I will define the key terms for my argument because I believe they need deeper reflection to distinguish the nuanced differences, let me give examples to aid clarification.

Firstly, disease as an objective pathology - 'he is suffering from a brain disease'; secondly, illness as subjective distress - 'I am feeling ill, have a high temperature and am suffering from a fever' and lastly, sickness as an inability to fulfil a social role - 'I cannot come into work today because I am sick'. It is therefore possible to describe patients in any of the three terms as most patients suffering from diseases also suffer from illness and suffering. However, in psychiatry not all of these elements apply, because in some personality disorders only sickness applies (Mental Health Foundation, 1997). From the distinctions already provided further explanations are needed. Multiple sclerosis is a disease, a sickness and an illness (Lehoux et al. 2010). A disease since it has an objective pathology, an illness since there is a subjective awareness of distress and a sickness since it involves an incapacity to fulfil normal roles especially in the later stages of profound physical decline. Schizophrenia is a sickness; it is not always an illness and has yet to be proved a disease. It is a sickness since it involves an inability to fulfil societal roles, an illness because (depending on levels of insight) there is a subjective awareness of distress and not a disease because there is no universally accepted recognised objective pathology (Littlejohn, 2002). Therefore, when those in psychiatric practice state that ECT alters the disease process of mental illness, we need to unravel what belief they hold and if this belief is, research based or experiential. In addition, they have to prove in psychiatry that illnesses and sickness are also diseases or

they are open to criticism of their viewpoint. We live in a professional world where evidence based care is key; therefore, the ontology of evidence based care equates truth with the production of positive mental health changes in the individual. If it cannot truthfully do that, then all we are left with is very refined behavioural manipulation or 'spin' of the facts, which excludes as meaningless all the above questions. In fact, such a search is the very basis of scientific enquiry with psychiatry included. In answer to this statement, Shorter (2008) makes a valid statement 'You negate this and you nullify the very foundation of science' (Shorter 2008, p. 595).

The stance that pro-ECT advocates take is that they try to 'pick holes' in the objectivity and reality of physical illnesses which is a brave attempt at deflecting serious criticism away from psychiatry. My position and rebuttal to this is; it is hardly likely to stand up to any form of serious reflection for a disease will always need an objective pathology and a disease cannot be wished away by argument, a view also taken by Shorter (2008). When it does prove its diagnostic categories are diseases, then I believe psychiatry as a discipline will have truly established itself and anti-psychiatry will die a natural death. Having made that statement, I believe it is relevant now to address the stance of those who favour the anti-psychiatry view.

#### 2a.4.4.1: The Stance of Anti-psychiatry on Mental Illness and Treatment.

Following my concluding thoughts on psychiatry and professional practice, my viewpoint is that psychiatric diagnosis has weathered nearly a century of criticism. My viewpoint when discussing ECT is that it is in a contradictory position and can be considered unscientific. However, the healthy nature of any debate with proponents for and opponents against a stance, viewpoint, or theme, in any form, and its beneficial effects, are well known and recognised, within the psychiatric profession. The recognition of these debates within any discipline of science, including those of the medical sciences is immense. Yet, it would be unthinkable when dealing with anti-neurosurgeons, anti-paediatricians or anti-cardiologists but one could argue that these do not exist until something untoward happens and the science underpinning these specialities is on more solid ground compared to a treatment such as ECT?. However, this is the case for anti-psychiatry groups, who have pursued their beliefs and demand a more humane approach to psychiatry (Desai, 2005). Anti-psychiatry was established by David Cooper in the 1960s and was exemplified by Timothy Leary's famous quotation 'turn on, tune in, drop out'; the British genius for muffling dissent who also came to the rescue when, prior to the 1970

general election, helped bring about the lowering of the voting age to 18. The whole genre of clinical action was that large psychiatric Victorian institutions were beyond hope, being too tainted by their inflexible institutional codes of practice and therefore unable to promote any spontaneity in staff and patients alike (O'Brian et al. 2001).

This was in all, in essence, the position that the anti-psychiatry movement challenged, insofar as the logical status of mental illness, the intelligibility of madness, the dehumanisation of institutional care, a biological regime and the reframing of mental illness, as deviance. It is evident that the different forces from the anti-psychiatrist movement, even if they are not based on common theory or conceptualisation, have opposed the power exerted by psychiatrists over peoples' lives. One of their challenges was the psychiatrist's authority in diagnosing, involuntary detention for treatment, and the increasing medicalization of mental illness with ECT being one of these treatments. The antecedents of the anti-psychiatry movement can be traced back to the early 1950s when deep divisions occurred between biological and psychoanalytical psychiatrists.

Psychoanalytical psychiatry, which had exerted unchallenged control of the profession for decades, endorsed treatment that was subjective and dynamic. Biological psychiatry, which claimed psychoanalysis, was unscientific, costly, and ineffective (Reissmiller & Reissmiller, 2006). Conversely, society was starting to ask searching questions about compulsory admission into hospital, patients being coerced into the taking of high doses of neuroleptic medication, undergoing convulsive, and psychosurgical procedures. In the context of the social turbulence in the 1960-1970 era when criticism of psychiatry was emerging, came the counterculture group of psychiatrists. This rebellion came from within psychiatry that was influenced by the rejection of established authority. Overall, the task of the anti-psychiatry movement was to get psychiatry to take an existentialist approach in valuing human experience in preference to treating under a label within the dominant hegemony (O'Brian et al, 2001). They wanted mental health workers to focus more on the beliefs and values of their patients including the spiritual, political, and social-economic dimensions of their life experiences. Anti-psychiatrists did not just question specific coercive, custodial practices, they challenged the central concepts of psychiatry: its purposes, its basic doctrines of etiology and nosology, and the distinction upheld between traditional psychiatrists and psychiatric labels they attached under the umbrella of insanity and madness (Shorter, 2009).

It is important also that I make my position clear about as treating clinicians within mental healthcare we should be able to offer a definition of what mental illness constitutes and what it is we treat. Therefore before I endeavour to unravel the views of the anti-psychiatry body, let me build on the question of what constitutes mental wellbeing and mental illness (I addressed in science and psychiatry in section 2a.3), and build on the previous points made. On the face of it, this seems a strange question but if we cannot categorically say that mental illness exists why are we treating it with ECT in the first place? Within any scientific merit we should be able to define the object of our research and, as ethicists writing about mental illness, surely we should be able to provide a definition of the object of our investigation. So why is it difficult to accomplish these tasks?

It could be argued that the range of opinions and strong advocacy positions of what constitutes mental health from many psychiatrists and the impact these opinions have had have only served to give the viewpoint that we still do not know what constitutes mental illness (Desai 2005). If psychiatry requires to be understood, we need to recognise the enormity of the challenge and the need to meet the challenge effectively and levelly. If I play devil's advocate, I quite understand the anti-psychiatrist movement challenging a profession who cannot agree on the most important of issues like clear diagnosis of why a person suffers from a mental illness.

Subsequently, this approach was far too restrictive and, returning to my original question of what is mental illness, this anti-psychiatry concept on its own, it can be argued, does not help us in understanding what mental illness is, so more deconstruction of what we believe mental illness constitutes to be, is necessary. I find their attempt to discredit the position myself and others take that mental illness is linked to the association of labels challenging, especially when their line of argument dismisses neuro-chemical abnormalities found in patients with major mental disorders. Then recognise counter arguments they put forward, empathise with their stance on society's role, and confirmed by psychiatrists with the intent on coercion and controlling of individuals whose behaviour could be classed as deviant and who threatened society. This police officer's role was symbolised by the use of ECT, other treatments thought to cause serious harm, and the anti-psychiatrists campaigned vigorously against these treatments (Berlim et al. 2003). Put rhetorically, there are no psychiatric patients, society is the patient, and the psychiatrist himself is the symptom of the social disease (Singh & Singh, 2009). The basic argument of the anti-psychiatry movement is that psychiatric disorders exist because the psychiatric establishments exist. This is a serious but fundamentally flawed argument; you could actually turn it on its head and say the psychiatric establishment

exists because psychiatric disorders exist. We could actually say that the myth of mental illness and anti-psychiatry argument then go beyond their premises and therefore lead us to empty rhetoric. Moreover, in reality we should not overestimate the extent of the anti-psychiatry movement, as individuals within this movement had almost nothing in common except a deep criticism of psychiatry. They became an international phenomenon and I believe that at this point it is relevant to address 'collectively' the overall views of and fundamental positions of four anti-psychiatrists, which are Thomas Szasz (America), Ronald Laing (United Kingdom), Erving Goffman (America) and lastly Michel Foucault (France). <sup>4</sup>.

The main assailant of psychiatry in the United States was Thomas Szasz (1920-2012), he restricted the concept of disease to entities with defined anatomic, histological or biochemical substratum defending his position by arguing 'disease' means bodily disease ... The mind (whatever it is) is not an organ or part of the body. Hence, it cannot be diseased in the same sense the body can. When we speak of mental illness, then we speak metaphorically' (Szasz 1974.p.14). In summary, Szasz believed the labels given to mental disorders were no more than 'myths' or fraudulent impositions perpetrated by psychiatrists whose central intention was to protect and preserve their privileged professional status (Berlim et al. 2003). Szasz was opposed to involuntary hospitalisation and treatment of individuals; he believed that this practice was never in the patients' best interests, but only taken to control them on behalf of their families or the state. In the UK, the anti-psychiatric movement condemned the practice of psychiatry in its institutional practice in favour of community-orientated living. Its most prominent ideologist was psychoanalyst Ronald. D. Laing (1927-1989). In his writings in 1960 and his best seller 'The Divided Self' he saw mental disorders or at least schizophrenia as an understandable and even normal response of sensitive individuals to a mad world (Laing, 1960). He emphasised the importance of freedom and subjectivity over determinism, and believed that cure would occur when patients felt that they were free to make choices. He argued that patients with schizophrenia had a 'split' inside their minds and were 'playing mad' to avoid social responsibilities. Later he claimed, on the strength of a rather weak study, that schizophrenia was a product of disturbed families, which 'victimised' one of their group.

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<sup>4</sup> Because of space limits other relevant ideologues of anti-psychiatry will not be mentioned (as for example Franco Basaglia (Italy), Aaron Esterson (United Kingdom) and David Cooper (South Africa)).



It seems, like numerous others when we discuss myth and mental illness that I believe the problem lies with society's attitude towards such phenomena. What anti-psychiatry did was to reveal that there is a crucial value-element to how we judge the desirability of certain actions or beliefs that are socially constructed. This view has a familiar ring to it; many will recall Citizen Wolfe Smith, leader of the Tooting Popular Front (BBC 1977) and his embattled cry 'Come the glorious day brother'. The latter implied that on some far off glorious day, we would all see the only way, which was socialism, and be converted. Fantastic, to be certain of some things like Wolfe seemed to be about everything. I agree the anti-psychiatry arguments for this element were extremely persuasive but personally I find the discussion of myth unpersuasive and I am not convinced. Within a few sentences in a paragraph the critique moves from promoting the myth that works for people, giving them stress-free lives, ideological satisfaction and enlightenment to the assertion that it provides a growing army of psychiatric health care workers with employment and social sanctions rationale to forcible treat people from mythical illnesses (Clarke, 2009).

The dissent from sociological thought and perspective came from a sociologist from America, viz. Erving Goffman (1922-1982). His view was that psychiatrists used asylums as brainwashing machines to control disturbed individuals. His observations did draw serious attention to the provision of mental health care, and highlighted serious weaknesses. What he saw was individuals wasting their lives in the name of psychiatry like inmates in prison because of being institutionalised, a dubious medical speciality responsible for the very conditions it was supposed to treat and cure. However, the legacy left behind from the government's proactive willingness to push forward deinstitutionalization from the thinking of Goffman is still evident in the modern day. The process of deinstitutionalization has proven that asylums did perform important functions; deinstitutionalization has proven paradoxically that it helped perpetuate the stigma of those suffering from mental illness, by causing a record growth in the number of those mentally disordered homeless (Lamb & Bachrach, 2001).

Laing was much influenced by *Madness and Civilization* by the French philosopher and social theorist Michel Foucault (1926-1984), In *Madness and Civilization: A history of Insanity in the Age of Reason* (Foucault 1965), Foucault traced the social context of mental illness and noted that economic and cultural interests have always defined it. The work argues that conceptions of madness are not discoveries but cultural (legal, political, philosophical and medical) constructions of a given time and place, that vary from civilization to civilization

and time to time (Foucault 2006). One of the lasting features of Foucault's work is the way his histories challenge the historiographical pretensions of all who appeal to the "historical record", the way they have the historical record challenge itself. Here, the brief title History of Madness may be misleading. It can lead the unsuspecting reader to think that the text is a history of a particular "object" called madness. Yet part of the fascination exerted by this text is that it evokes something variously called madness, folly, insanity, precisely not as an object but as an something else called reason, and this, for a certain period and in a certain place (principally the seventeenth and eighteenth centuries in Europe) (Reissmiller & Reissmiller, 2006).

Although the mission of Szasz, Laing, Goffman, and Foucault was to get the psychiatric fraternity to view mental illness in a different light and question in a nuanced way custodial psychiatry, it was but a batch of radical departures, which has designated the counter culture of the 1960s and all which followed. Questions about freedom and being free, what is the true meaning of freedom? What is my true self? Do I really have choices? Am I free? Moreover, how do I become free? These questions were an everyday occurrence and were central to the then radical thinking of that generation. However, it is a quizzical link between social and legal changes and the counter-rhetoric of the then swinging sixties (Clarke, 1999). Bob Dylan said the answers were 'blowing in the wind' and if we were to embrace his meaning literally, there were no answers, or at least those that had been given were no longer good enough. The underlying argument put forward was, the different forces in the anti-psychiatry movement, even if they are not based on any common theory or conceptualisation, opposed the power that the psychiatrist and the psychiatric fraternity held over people's lives and what they saw as the lack of humane approach to care. The anti-psychiatry beliefs that endorsed the need and promoted the basic rights of the mentally ill are concepts that we cannot shy away from or disagree with and I hold that position. Nevertheless I will admit one serious objection remains for which I can see no adequate response namely Szasz's description of modern psychiatry 'inventing diseases' does not seem too farfetched in the ever expanding seamless scope of the current systems of what constitutes mental illness, adolescent anti-social disorder, communication disorder, neglect of child and premature ejaculation( DSM 4 and ICD 10).

Once again, let us return to the question 'what is a mental illness?' On the face of it, this is a strange question. Clinicians should be able to give a definition of the illness they are trying to treat. Surely mental health researchers should be able to offer a definition of the research they try to define. Finally, philosophers writing

about mental illness should be able to provide a definition of the object of their investigation. The childhood story of Humpty Dumpty illustrates my point. The problem lies in the Humpty Dumpty world of shifting, ambiguous, and idiosyncratic terminology. Humpty Dumpty: “When I choose a word it means what I choose it to mean” when it comes to defining the term mental illness or figuring out which conditions qualify, we enter back into Humpty Dumpty’s shifting world. Let me highlight this by giving two examples. “Mental illness refers to a wide range of mental health conditions — disorders that affect your mood, thinking, and behaviour” (MIND, 2014). “Mental illness is a term that is often used to refer to a wide range of mental health conditions that can be diagnosed by a health care professional” (DSM 4, World Health Organisation 2005). This is just two of many and what is a fact is that the diagnostic and statistical manual of mental disorders (DSM 4) is the American psychiatric association’s standard reference for psychiatry, which includes over 450 different definitions of mental disorders.

This, I argue, is a fundamental weakness in the whole field of mental health and the care of the mentally ill. Many crucial problems would be less problematic if it were possible to group or distinguish a definition of mental illness that really worked. Nosologists could use it to guide the decision-making process so that aspects of human distress and malfunction should be classified as mental disorder. The providers of care could use it when deciding whether to diagnose and treat and it would clear up the confusion in the legal system where matters of consequence often rest on whether a mental illness is present or not. However, before I look at the law and ECT let me pose the question will psychiatrists help to make psychiatric problems ascend from psychiatric illness to sickness to diseases and in doing so bring about the dismantling of the whole branch of psychiatry? As this section of the thesis concludes, we need to address other ideas for taking action and possible directions for future structure and maybe the quest for the answers lies in the ethics of psychiatry.

#### 2a.4.5: Conceptual Discussion- Psychiatry and Ethics.

My starting position in this section is firstly to look at how we increase the mental well-being of people and to prevent mental illness, and by whom should be given the role to define mental health. Bioethics play an important part in psychiatry, and the inter-link between psychiatry and neuroscience; the foray for the academics is to supply heuristic models and for psychiatrists to test them. They are heuristic assumptions (heuristic meaning serving to indicate, or stimulate investigation) and meant to reify these concepts of distress

that can be subsumed under the umbrella term of mental illness. However, being a good psychiatrist does not necessarily mean you will be a good bioethicist; we need the ethicist's detailed blueprinting, the clinician's practical implementation of care and the neuro-scientist's hardnosed verification. To ask the question whether mental illnesses are actual diseases or mere constructs confuses the number of questions posed about mental illness so maybe the numerous theories put forward about ECT can enlighten us to lay our marker down in the 'camp' of our belief. We cannot avoid the ethical issues that present within psychiatry or we inevitably act in ways that negatively affect the well-being of others, we will make choices, which in our efforts to help others may do the complete opposite by violating dignity and infringing rights. When delivering mental healthcare there has to be ethical thinking all of the time and it is widely construed to underscore the structure of our engagements with others as we think what to do, what to think and how to react (Levine et al. 2004). A contentious issue is the nature and nurture debate: acrimony and camp apart, for both sides there is much to integrate and assimilate from both viewpoints. Nature refers to all of the genes and hereditary factors that influence who we are, from our physical appearance to our personality characteristics. Nurture refers to all the environmental variables that impact who we are, including our early childhood experiences, how we were raised, our social relationships, and our surrounding culture. Therefore, if we take the viewpoint that genes determine and regulate behaviour and behaviour alters gene expression, then we can make the correlation that both are interlinked. The task of modern psychiatry is to unravel which determines what and to what extent (Singh & Singh, 2009). If we make the statement that absolute or perfect mental health is the absence of mental disorder linked to a positive wellbeing, then we can say that perfect mental health is the control of mental disorder, which results from optimal social functioning and personal equipoise. Every new step in the understanding and control of psychiatric illness must be a clear understanding over the previous, objectively verifiable and provide grounds for its refutation. Misuse is an inherent danger in any form, I agree also that disuse is due to a fear of misuse as in involuntary hospitalisation and the giving of ECT as a treatment, where the concern with misuse is giving rise to disuse and both areas need to be addressed. It is understood that the psychiatrist has a responsibility to society, true, but only as an adjunct to patient welfare and neuro-scientific verifiability. However, ethics also ensures that the psychiatrist does not become a convenient handle to enforce conformity to the above examples.

The sensible practice of neuroscience requires that health, illness and other features of the mind can be predictably altered by moulding and regulating the body (the brain). The sensible practice of ethics, on the other hand, requires the behaviour of the body (the embodied human being) can be controlled by changing actions of the mind (Hayry, 2010). Almost from the outset, ECT has been accompanied by a literature on how it works, during the 75 years of ECT history a wealth of theories regarding its mechanism have been put forward. Some are based on important aspects of the mechanism, some such as psychological theories based on pure speculation inspired by the prevailing psychodynamic theories for psychiatric illness and treatment of their day (Bolwig 2011). Wordage does not allow me to discuss these theories in-depth, but I have identified theories, which are congruent with nursing practice in psychiatry.<sup>5</sup>

Finally, if scientists make the claim within psychiatry that human actions are guided exclusively by the brain and the ethicists claim that human actions are guided partly by the mind, then their positions are drastically incompatible and professional practice within psychiatry. Having studied how science in its various forms plays a part, I come to the following conclusion. Any formulation of the mechanism of ECT will encounter numerous difficulties; it remains an unresolved issue whether ECT exerts differential effects or whether these obviously different disorders have common pathophysiological bases. Therefore, without the aetiology and pathophysiology, a theory of ECT cannot be complete. In short, the psychiatric fraternity is no nearer to having an understanding of the operative mechanism of the treatment than it did seventy-five years ago. As mentioned previously within my introduction, ECT is now widely practised and is safer than when it was first introduced. This suggests that there has been some understanding; however, some basic questions about ECT remain unanswered. There is a divergence between the views of the clinicians and those who receive ECT. Documentation shows practitioners focus on the effectiveness of the treatment, and the successful alleviation of disease and symptoms (Rose et al. 2003, Berg, 2009, Mangaoang & Lucey 2009, Tess & Smetana, 2009). Patients however prefer to speak about the overall benefits rather than the disadvantages and talk about the relief from illness rather than the cognitive and memory problems experienced. Clinicians point to the powerful nature of this treatment while consumers point to its negative consequences and uncertainties

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<sup>5</sup> (Meduna 1936); (Zur 1939); (Hemil & Walter 1942); (Cerletti 1950; 1954); (Ottorson 1960); (Abrams & Taylor 1974; 1976); (Fink 1978); (Abrams 1992); (Lebenson 1999); (Keltner & Boschini 2009); (Michael 2009); (Bolwig 2011).

(Benbow & Crentsil, 2004). Lastly, which of the myriad of post-ECT biochemical alterations in the central nervous system, individually or in combination, reflect the therapeutic effect? What these theories reflect, in their pursuit that they alleviate signs and symptoms of major mental illness, is the magnitude of the challenges facing the researchers and practitioners. If the current scientific theories are unable to determine how ECT works and what adverse effects it has, the scant evidence does little to increase public confidence in the treatment, which is a position point, put forward by the anti-psychiatry movement.

#### 2a.5: Conclusion.

This chapter provided me with the opportunity to argue a position and address the history of ECT, psychiatry and science, psychiatry and professional practice and psychiatry and ethics, in many ways the 1960s onwards was a watershed for psychiatry during which critics from both ends of the political spectrum besieged the speciality. I provided an analysis of controversial innovation of ECT, which then led me forward in my discussion on the advent of new machines used in ECT. Whilst dissent and the quest for the truth are germane in the discussion of ECT, healthcare professions in psychiatry struggle to come to grips with explanations and achieving resolution on its mode of function. I agree with the National Institute for Health and Clinical Excellence that there is a need for future clinical trials in ECT to develop deeper scientific understanding and reflect observer and patients rated assessments of improvement, the impact on cognitive function and deeper explanation of side effects. However, I presented a position and argued that the fact ECT even up to modern day cannot truly be classed as scientifically proven. As in the past ECT is a complex invention to untangle, so it is not surprising that many find it difficult to maintain a balanced view, especially since so many questions remained unanswered. However, these questions raised are all significant if we are to render a definitive opinion. I challenge the pro-ECT position, which champions the view that anyone with common sense, knowledge of basic, relevant scientific knowledge and a caring attitude would come to the conclusion that ECT is scientifically valid. Whilst attacking those like me who disagreed with their position and labelled us as biased and self-serving. The past abuse of ECT by psychiatry has extended to the manner in which it has been referred to in the psychiatric literature. With the scientists always presenting the argument on unfounded claims about ECT studies that the memory tests were not sufficiently sensitive, that the autonomic regions studied were not sufficiently widespread, that the wrong biochemical constituents were assayed, or that the number of subjects studied were inadequate. This chapter provided a brief historical account of the emergence of a categorical

medical view about mental illness and disorders of mental health. In recognition of the discussion on the conflict between psychiatry and anti-psychiatry, my view was and still is although I distance myself with many of the therapeutic implications of anti-psychiatry; I acknowledge there is a need to accommodate all possible viewpoints if it is able to enrich the concept and practice of psychiatry for human welfare. Szasz was perhaps the most vituperative but, as I have shown, he was not alone. In the final analysis, the debates over mind control and, given our current knowledge, it is not the scalpel and the electrode that need worry us, it is the word. It is not our brains, which we should be protecting, but our minds. The glib arguments of those, who under the umbrella of science without evidence and who manipulate the minds of the mentally ill are, I believe, the most dangerous. The menace to watch out for is not Dr. Frankenstein but the Wizard of Oz.

## **Part 2b: The Law and ECT:**

*“The aim of argument, or of discussion, should not be victory, but progress”*

*Joseph Joubert. French Writer 1754-1824 (in Gaiter &Gaiter 2012)*

### **Part 2b.1 Introduction**

The area of primary legal scope for this part of the thesis is the mental health service domain of England and Wales and the administration of the operative procedure Electroconvulsive therapy (ECT) in psychiatric settings.

I aim to present my argument within this chapter by critically reflecting upon the way mental health law has changed over the past 50 years. I cover sections 58 and section 62 of the Mental Health Act (1983), [revised 2007] because they are the prevalent sections that involve ECT. In this chapter, it will be discussed in ‘parts not sections’ to avoid confusion when I discuss sections of the Mental Health Act (1983), [revised 2007]. My primary concern is that certain sections of the Mental Health Act (1983), [revised 2007] create the potential for a patient to be given ECT against their wishes. This is a piece of legislation which is important to my claim that ECT is unethical and is a tool by which when applied can enforce ECT treatment. At this point I must make clear that the Mental Health Act (1983), [revised 2007] is an important piece of legislation preventing harmful actions, but some parts are problematic in regard of ECT. While the Mental Health Act has an important part to play in the care of the mentally ill, it should not be used as a tool to enforce ECT treatment without consent.

Once I have established the outline of the relevant sections and how they are used, I will look at the consequences of sections 58 and 62 in regards to ECT and patient care. Currently, physicians cannot administer ECT to a detained patient without seeking their consent or using the Mental Health Act (1983), [revised 2007] to justify its use. The position I hold will be in three key areas in sections 58 and 62, the criteria/claims for using ECT without consent are outlined as follows. Firstly, the sections claim that ECT saves lives by preventing the patient in an emergency going on to commit suicide. In cases where the patient is considered a suicide risk, the law dictates that treatment must be given (NICE, 2003). Secondly, the sections discuss how to identify a patient as dangerous so treatment has to be imposed. Lastly, the sections address the area of risk and how the Mental Health Act (1983), [revised 2007] solidifies the dominance of risk by providing a legitimising framework within which risk can be managed within psychiatric practice or they will continue to be misinterpreted.



An important consideration is whether mentally ill patients should be considered autonomous. These patients do not lack autonomy; however, they are not fully autonomous agents either. They are in the middle, which complicates the issue. Suicidal patients who fall under The Mental Health Act (1983), [revised 2007] still fall into this category. Even if included in the Mental Health Act (1983), [revised 2007], they can still be autonomous agents and therefore make decisions about their own treatment. Patients who are not autonomous are those who do not have the ability to show critical thinking ability, therefore, it is evident that they cannot display autonomous decision-making skills. The contentious issue is to prove that they cannot demonstrate critical thinking ability to a degree that they are not autonomous.

My intention is to highlight the changes that have evolved within mental health law to give a clearer picture in the later sections of the points I address and for which I have an opposing idea and present it to support my position. In this chapter, I introduce the ethical theory of Principlism (the bulk of the analysis of the theory of Principlism will be in chapter three) and start to identify how it is applied within psychiatry, identifying its positive and negative effects in the clinical area. Currently, two psychiatrists' agreement on using ECT is enough for its implementation. The argument that I highlight is the practical problems when requiring a judicial order, is this is an unreasonable ethical scenario that makes ECT available to the indigent and those that need timely treatment.

#### Part 2b.2: Summary of sections and arguments to be presented: both legal and ethical

In part (2b.3), I will cover the changes in Mental Health law and the impact of these changes on psychiatric patient care. This key point is important to my position because these improvements were to increase patient autonomy but they did not go far enough to allow the patient to be autonomous. How it brought a different perspective to mental health care. I briefly outline differences between the 1959 Act and the Mental Health Act (1983), [revised 2007] and identify ethical and legal key areas of change within the acts. In part 2b.4 I discuss others and mine arguments that centre on the right to receive treatment and, although I accept that liberties as rights should not constrain certain actions, I present discussion, points to further this topic with the aid of a case study.

In part (2b.5) I explore the right to refuse treatment and make my case opposing the practice of administering ECT to a patient on the grounds of their being 'dangerous'. In part (2.6), I discuss why I am targeting sections

58 and 62. To do this, I break down sections 58 and 62 and establish that despite these sections of the Mental Health Act, (1983, revised 2007) the violation of the principle of autonomy should not be permitted unless there is a need to prevent death and it is the last measure left open to healthcare professionals. I address this through the lens of Principlism and the basis of my argument is this is a section that enables the psychiatrist to enforce treatment in an emergency, but this emergency is a perception of the psychiatrist alone and often not all of the members of the healthcare team. Someone has to make a decision but my point is that consensus is far better than individual decision-making. An ethic that overrides refusal of consent, expressively interfering with the patient in physical and psychological terms and is legitimised by the Mental Health Act, seems paradoxical beyond the emergency. If the subject refuses consent for ECT in these circumstances- the legal, socio-cultural and ethics of the subject and identity are continually fore-grounded and needs further examination. Therefore, I explore the reasons for giving ECT in an emergency and challenge this position. Lastly in part 2b.2.7, (in parts 2b .7, part 2b.7.1 and part 2b.7.2). I will summarise my discussion around the use of the two main sections discussed and bring concluding arguments to close this chapter. In that although the new Act has provided more stringent and right based proposals for patients, its restrictive criteria has still not gone far enough for the rights of detained patients in that they are still subject to types of treatment and interventions which can be imposed without their consent.

#### Part 2b.3: Ethical and Legal perspectives – areas of concerns identified.

Let me motivate this section by giving a brief historical context. Because of the legal requirements that surround ECT, psychiatrists have found themselves in an adversarial contest in an effort to defend their decisions in the use of ECT when prior to the Mental Health Act (1983),[revised 2007] they had much more professional autonomy. In summary, changes have been implemented to allow patients' rights to be more freely expressed and recognised since the 1959 Mental Health Act. However, these changes still allow the use of ECT under the Mental Health Act (1983), [revised 2007].The indication from the legal guidelines within the Act is that the patient is otherwise incapable and in need of medical care in circumstances in which they have not declared an unwillingness to be treated prior to the onset of their mental illness. This gives the psychiatrists wide scope to 'treat'; the caveat being the treatments should always be in the patients' 'best interests'. This point now leads me where I highlight how the 2007 revisions to the Mental Health Act (1983) were implemented to give the patients more legal and ethical protection. I consider this change in legal and

ethical protection in relation to coerced treatment and poor treatment practice, but this consideration leads me to question whether the new Act still has omissions and question its usage. In 2007, the 1983 Mental Health Act was redrafted and came into being on the 3<sup>rd</sup> November 2008. This new version amended large parts of the 1983 Mental Health Act. Under the old MHA, detained patients had little opportunity to refuse treatment that their doctors believed necessary, even when those patients were capable of consenting or refusing treatment (Hewitt, 2009). Developing mental health legislation is a slow process; the now revised Mental Health Act (1983) has taken over four years to become legislation. However, to understand the evolution of care and rights and what triggered revising the 1983 Act we have to go back to the 1959 Mental Health Act. In the 1970s, treatment was already in a period of transition, moving towards community care and more effective pharmacotherapy. With the 1959 Act under review, it started to become evident that patients' lives were to be vastly influenced. It is at this point in time that the shape of the 1983 Act emerged. In particular on the issue of consent to treatment, an issue that was prominent in the 1983 Act but unmentioned in the 1959 Act (I will discuss the issue of consent in more depth in chapter 4).

The Mental Health Act (1983), [revised 2007] brought a different perspective on how treatment, including ECT, should be administered. The patient's primary nurse has a threefold duty to ethically, professionally, and legally liaise with the doctor to confirm that patients consent before each treatment. This should involve explaining again the nature of the effects of ECT, remembering that rumination, perseveration, memory disturbance, gloom about the future, mistrust of people and anger are all aspects of severe depression (Department of Health, 2008)

Although the Mental Health Act (1983), [revised 2007] seemed to make provisions relevant to psychiatric patient care and treatment for persons who suffer from a mental illness:

- It does not include a detailed consideration of the classification of persons who are to be compulsorily detained and treated. It also does not cover how they are to be detained and treated and the various appeals processes against the sections, (which have been applied) through the mental health tribunals in respect of their detention.

- It deals with the bureaucracy set up with the administration of this system, and places restrictions on the type of medical treatment that can be administered to various individuals suffering from mental illness.
- The Act also does not make clear in detail the care a hospital is obliged to give to its patients or the benchmark standard that is to be expected.

#### Mental Health Code of Practice (2008)

One must ask an ethical question here: if an Act can take away a person's liberty and has the power to treat that person against their wishes, then the Mental Health Act (1983), [revised 2007] should by all accounts make this crystal clear - I make the point it does not. Some sections of the 1959 Act did allow detention for treatment but consent to individual treatments was not considered as a separate issue. The Mental Health Act (1983), [revised 2007] did make changes in that area and recognised three categories of treatment: (a) those that required consent *and* a second opinion, (b) those who do not require consent or a second opinion and lastly (c) those who do not require consent, a point made by Taylor (1983).

There were distinct improvements in patients' rights between the 1959 Mental Health Act and the Mental Health Act 1983, where in occasional emergency or lifesaving situations treatment like ECT would only be administered with the consent of the patient. For ECT to be administered to a detained patient the patient must consent to the treatment and also the Responsible Medical Officer (or his consultant) must certify in writing that the patient understands what the treatment entails, its purpose and possible effects.

The ethical question I raise is what happens when none of the above can be achieved and the decision is taken away from the patient. In cases where the patient cannot grant consent, The Mental Health Act Commission, a controlling body whose role is safeguarding the rights of the patient, are contacted and an independent doctor is appointed to see the patient. This independent doctor can then certify that, although the patient has refused to consent or is incapable of consenting; in their professional opinion, the ECT may take place. I claim that in these cases, the patient is *lawfully but questionably* given ECT. Although the Mental Health Act (1983), [revised 2007] laid out clear guidelines about how the procedure must be followed it gave no guidelines as to how judgement of patient capability or competence should be made. In regard to ethical determination of

capacity, my first concern centres on the patients undergoing a treatment that I argue from a position of experience as doing more harm than benefit. My second ethical concern is the patient's right to refuse treatment: a patient cannot refuse treatment if he or she is severely ill and unable to participate in the decision-making process.

#### Part 2b.4: The right to receive treatment.

In chapter one, I introduced the issue of the patient's right to receive a treatment which has become a major ethical and legal issue, which is often determined within our British judicial system. Here, more in-depth I discuss the moral and human right to receive treatment within our country with the aid of a case study. It is of importance to the theme of this thesis because it gives an understanding of the basis of the moral mandate to care and how concepts of care are constructed additionally revealing the origins of intrusive ideological aspirations in the socio-economic and socio-legal domains. The explicit statements from UK government social policy directions emphasise the ethical, legislative, and regulative mandates in respect to the liberties, rights and diversity of people and their experience. The communicative process of treatment for both subject as "patient" and healthcare professionals is also an internal process for each individual placed in the contested arena of best interest and necessity. In exploring this position it can be said that liberties as rights should not constrain the action of others (Ruthen, 2006).

However, when a person's wishes are unknown, such as in the case of someone suffering from a severe mental illness, proxy decision-makers try to project what the person's choice would be and what better promotes the rights of that person. However, my position is that we cannot hold something as a positive good unless we know it to be good and without harms. Thus, we cannot hold the use of ECT as a positive good unless it causes no harm. However, I recognise the counter argument to my position in that we hold many things to be good that are still harmful. For example, many forms of surgical intervention can be classed as harmful and yet we consider it good because the overall benefits outweigh the harms. However, I refute this position on applied reasoning for ECT because there have been numerous researches and experiential papers written on surgical intervention with proven cause and effect which cannot be said of ECT. Before I address the issues on good and harm, I believe an ethical analysis of our present psychiatric practice will give us a clearer picture of our present impasse. The theory of Principlism is needed here to help us understand an upsurge in

the interest of the application of ethical principles. The four principles of beneficence (doing good), non-maleficence (not doing harm), autonomy (self-governance) and justice (equality of opportunity), Beauchamp & Childress, (2009) are widely accepted within psychiatry (Ottoosson, 2004). The four principles are useful conscience keepers for medicine, but they need the utilitarian's detailed blue printing; the clinician's practical implementation; and the scientist's/researcher's hardnosed verification coupled with the activist's constant surveillance (and of course a well primed legal system too)(Singh & Singh 2009).

I have been involved in many debates when the question is posed "what should the psychiatrist do when the patient immediately requests ECT and flatly refuses other forms of treatment?" Some patients who know the risks and side effects are prepared to accept this to achieve what they believe is a "quick fix". These patients are acknowledging the seriousness of using such a treatment, hoping for fast results instead of using patience until medicine and therapy produce the same results but over a longer period. I will now consider the following case.

#### Case study 1.

*A 39 year-old woman was informally admitted with recurrent severe depression and had been hospitalised on four occasions in the last four years. Her depressive symptoms included early morning insomnia and an inability to concentrate. The latter symptom was very problematic as she was a concert pianist who had become unable to concentrate on her music and when this was evident, she suffered suicidal thoughts and ideations. Previous treatment of ECT at the psychiatric hospital had provided relief from her illness (but only on a temporary basis) and a return to being able to perform. The patient refused all forms of other treatment and requested ECT.*

In the case study above, would it then be unethical to withhold ECT from someone consenting to it, but who refuses to be involved in any other form of treatment, which could be said to be less invasive than ECT? If we apply the utilitarian social philosophy to this example then we could accept that in this case, ECT is a good choice and it would be unethical to withhold ECT. We must consider that the patient for financial reasons could not wait for the benefits of other therapeutic interventions, such as anti-depressants or psychotherapy, to take place. ECT advocates should re-examine the harms against benefits ratio. Psychiatrists are empowered to give ECT to save lives, such as in cases where a patient is suicidal, but I argue the reverse side of the coin is that ECT arbitrarily kills brain cells; the treatment's inherent danger suggesting at best a balance between

benefit and harm (Panton, 2001). Unless withholding treatment would be life threatening, the principle of beneficence achieves priority over respect for autonomy, and a paternalistic position is adopted to ensure treatment. Just as competent patients have the right to accept, abstain, or discontinue an offered treatment; incompetent patients and those who request it have the right to receive what they believe is the most effective treatment (Ottoosson, 2004). However, the counter argument regards treatment, which is futile. Let me approach this from a different angle and address the position put forward by physicians that offering treatments that are said to be futile is not obligatory. The determination of medically futile treatment is an ethical dilemma. Medically futility is generally defined as a treatment or clinical interventions that are not likely to result in benefit to the patient or produce the expected outcome (Tera & Powell, 2012). At this point, I agree with the position of the healthcare providers, and it might be seen as violating the principle of non-maleficence if patients concluded that they were expected to choose futile options. It is true that a patient has a right to make certain demands on health care providers, those demands, however, are limited (Brieva et al. 2009). A patient under normal circumstances does not have the right to demand that physicians provide treatments that are not indicated. Following this then the patients do not have the moral right to demand treatments that the medical community has judged to be without benefit. Physician – determined treatment futility encounters a number of reservations, since it is difficult to predict with absolute certainty that any treatment is futile, such a determination generally involves a value judgement. A patient may not demand unnecessary surgery, for instance, and claim that he has a right that his physician provides it. Therefore, the question of patient autonomy only makes sense after it is determined whether the care is medically appropriate. The issue of patient autonomy must be put-off until after a discussion of futility and cost containment. At that point, the argument is likely to be moot. Cost containment suffers a similar fate as do's patient autonomy (Paris, 2010). All things being equal, cost containment should not create a legitimate basis upon which to refuse care to a specific individual. This basic premise may not be true, however, in cases where no good is to be generated by the health care expenditure. In a world where health care resources are scarce, it would seem irresponsible to "waste" money on treatments that have no reasonable hope of benefiting patients. Therefore, the only cost containment issue to consider will hinge on whether the care in question is truly "wasteful". In order to settle that question, we must consider whether the care is futile. At this point, the question to be asked is; why should patients have the right to demand treatments that will not work? They should not. No one expects physicians to render care that is "physiologically futile", that is, care that will not

provide the benefit sought by the patient. If we make the point that, there are only two substantive reasons for doctors not to provide treatment that they judge as futile-either based on judgement that treatment would harm the patient, or on the basis, that providing treatment would harm others.

It is here I challenge the proponents of ECT in so far, if the healthcare providers are questioned on their position about the efficacy of medical treatment, does an ethical as well as pragmatic concern influence their decisions. Working on the basic premise for the provision of healthcare implies there is an illness and a subsequent improvement in health, a return to wellness or recovery from illness from injury (Pope, 2009).

Alternatively, it could be argued that because these decisions regarding relative treatment futility have to be based on available scientific literature, a representative societal group who have had ECT should make them.

Unfortunately, at present, there is no such group, and it is necessary to use existing structures to deal with current problems. Therefore in returning to the point that a treatment is futile if it does not improve a patient's condition, then I can present an opinion that ECT is futile because firstly of a lack of relevant data as to its effect and also many patients often need numerous ECT treatments over a number of years. A point I made when I addressed the sham ECT-real ECT arguments (Section 2a.4.2) Physicians have a fiduciary obligation, and have taken a professional oath, if harms of treatment are excessive, physicians risk maleficence, it must then follow physicians must exercise clinical judgment based on scientific data when declaring treatments futile. Surely, there is a need to clarify between specific treatments that are medically ineffective, yet might still provide perceived benefits to patients; but physicians should also not dictate nuances of care for their patients. This argument is worth exploring but wordage does not allow me to do so.

In the case study above, the interpretation I present is the decision to offer ECT could be seen as ethical, humane, well within the psychiatrists' rights, and importantly felt as beneficial by the patient. However, administering ECT even in this seemingly ethical scenario raises questions about the psychiatrists' violation of patients' rights and transgression of ethical standards. My position on patients who request and then receive ECT is that it should be based on health promotion and presentation of the true scientific facts, which the psychiatrist cannot provide. Therefore, ECT should only ever be given where the risk of suicide is the alternative option; however, the case study above has shown that the effects are short acting and the patient needed re-admission on different occasions. The fact that psychiatrists cannot provide true scientific facts' but the ethical question remains should a patient have a voluntary right to ECT? One of my major concerns is



whether we should be willingly offering a dangerous treatment even if patients request it. The assumption of a supposable but straightforward a decision leading to action between ECT and suicide prevention is erroneous, however as it is purported to be in the patient's best interests, this makes the way ECT works, in an emergency or otherwise, of critical importance.

In summary, in a legal context, a patient can and has a right to request ECT as a treatment and is not contravening any rule or law. The patient who exercises their voluntary rights is said to increase their self-worth and make them more amenable to care and treatment. When this patient's mental status was good, she fully understood the implications of her consent to ECT, but when her mental status was poor, one could argue her mental state was compromised, as she clearly did not fully understand the seriousness of her present circumstances. The key issues centre on who should decide, who is entitled to choose, and most crucially, who is competent to decide. By offering ECT or not encouraging alternative treatments, are we fully entering into 'autonomous choice' (empathising lack of coercion) or authentic wish (empathising consistency of choice)? The pro ECT advocates will present the view we should be clear that those patients who are incapable of understanding do not meet the standards required to be considered autonomous. In rebuttal, my view is that we are not addressing all the issues that centre on 'autonomous choice' of a treatment, which has harmful effects. At times there has to be competent refusals of treatment from patients that psychiatry must learn and respect.

#### Part 2b.5: The right to refuse treatment.

Ethical concerns related to ECT become more complex when we address the ethics of the right to refuse ECT. This right to refuse treatment was expressed by the 19<sup>th</sup> century philosopher John Stuart Mill.

*"...In the conduct of human beings towards one another, it is necessary that general rules should for the most part be observed, in order that people may know what they have to expect; but in each person's concern, his individual spontaneity is entitled to free exercise. Considerations to aid his judgement, exhortations to strengthen his will, may be offered to him, even obtruded on him, by others; but he himself is the final judge. All errors which he is likely to commit against advice and warning are far outweighed by the evil of allowing others to constrain him to what they deem his good" (Mill, 1963).*

If the Greatest Happiness Principle were nothing but the aggregate of each person's happiness, leaving people free even to cause harm for themselves we still would be maximizing happiness. If each of us knows better than anyone else what causes us pain and pleasure, what causes the happiness or suffering of the majority of people does not necessarily cause the happiness or suffering of a minority of individuals that, for whatever reason, does not have the same feelings of the majority. In other words, even though humankind has an objective criterion, an accumulated knowledge to decide what causes suffering and which pleasures are more valuable in society, society does not know what each individual feels. Thus, society cannot impose its views on individuals, forcing them to renounce their pleasures, on pain of not maximizing happiness, which would go against the Greatest Happiness Principle (Riley, 1991).

The point Mill was making and the interpretation by Riley is that the decision-making of the individual should rest with them solely. He lays out that respecting decisions should be observed and should not be interfered with by other third parties. For Mill, his position is the prerequisite for the rich and diverse development of humanity is the freedom that enables each individual to seek out and explore his or her own particular 'path of life' which one would argue is the right to refuse treatment you believe is detrimental to your health. Mill also believes the only source of potential within society for continued human development is contained in the creativity and spontaneity of individuals: thus the liberty of the individual, expressing the most fundamental characteristic of human nature, is at the heart of Mill's social and political philosophy (Mill, 1963). If I escalate this discussion and bring it back to clinical practice I identify (but I am not always in agreement with) the position of psychiatrists who are reluctant to agree to the right to refuse treatment. The right to refuse treatment is related to the notion of 'competence, which sometimes was linked to individuals considered dangerous by society. Some psychiatrists believe that some individuals with mental impairments, specifically psychotic symptoms, may refuse treatment due to lack of awareness and/or understanding. Therefore, having 'poor insight' is the precursor to dismiss/overlook their decision. Yes, poor insight is a key factor but poverty of discussion with the individual is disturbing and requires rectification (Rudnick, 2002).

Every competent adult has the right to refuse unwanted medical treatment. This is part of the right of every individual to choose what will be done with his or her own body, and it applies even when refusing treatment may cause death. The ethics of considering ECT for those patients incapable of making a decision involves the concept of '*parens patriae*'. The ethical dilemma that confronts psychiatrists is when the patient's ability to

make a rational decision is compromised by the cognitively impairing nature of their disorder. Also even if sectioned, the treatment has to be given because the mental illness impairs the ability of the patient to properly consent.

If the patient is not subject to the Mental Health Act, or if the treatment team feels that the use of the mental health laws would be inappropriate, the next question is whether the patient is competent to refuse treatment. The standard notion of competence to consent to treatment includes four components: the ability to express a choice; the ability to understand the information involved; the ability to appreciate the personal relevance of this information, and the ability to reason logically in decision-making (Grisso & Appelbaum, 1998). In most circumstances, the law recognises that a competent person may refuse medical treatment, even if that decision is “not sensible, rational or well considered” and even if refusal will likely lead to death or serious injury.

The notion of competence to consent to treatment refers also to competence to refuse treatment, although the threshold for the latter is considered by some to be higher, as the risks of refusing treatment may be greater than the risks of consenting to treatment, at least for serious illnesses (Buchanan & Brock, 1989). Admittedly, others have disputed the validity of this difference in threshold for competence (Danner -Culver & Gert, 1990). What has become practically the standard notion of competence to consent to treatment includes four components: the ability to express a choice; the ability to understand the information involved; the ability to appreciate the personal relevance of this information, and the ability to reason logically in decision-making (Grisso & Appelbaum, 1998). Therefore, if a patient’s decision to refuse treatment is clearly and unambiguously competent, or their legalised advance directive is clearly and unambiguously valid and applicable, then health professionals should honour the patient’s decision. Healthcare professionals use the qualifier “probably” here because, even in these situations, which I believe will be very rare, there are still ethical and legal arguments against giving effect to a decision to refuse treatment that needs further consideration.

#### Part 2b.6: Conceptual discussion on why I am targeting sections 58 and 62.

Section 58 of the Act applies specifically to treatment for mental disorder. Treatment for physical disorders is outside the remit of the Act and can only be given in the absence of consent if it can be justified under the Mental Capacity Act (2005)

Here, I question the choice to 'treat without consent' which is complicated and cannot be made lightly. Where the patient is unable to give consent, they should receive ECT under common law rather than the Mental Health Act (the accepted legal position following the Bournemouth case (R. v Bournemouth, Community and Mental Health NHS Trust, 1998)).

Because of changes in the law relating to mental health over the last 50 years psychiatrists' decisions to treat a patient suffering from a mental illness with ECT have changed. Although the patient's rights have become more evident, the amount of information expected to be given as recommended within the Mental Health Code of Practice (2008) has increased. Consent to treatment is required for both informal and detained patients, and the circumstances in which ECT can be given without consent to detained patients are limited by sections 58 and 62. In the case of detained patients, consent must always be obtained for the treatment of ECT [Section 58 (1) (b)]. Once the patient has consented to ECT the responsible medical officer completes form T3 (which was formally known as form 38) to satisfy that the patient is capable of understanding the nature, purpose, and likely effects of ECT, and has consented to it. Additionally, a patient signs a standard consent form, agreeing to the administration of a general anaesthetic in order to carry out the treatment of ECT. The consent form and form T3 are kept in the medical notes so that they can be readily retrieved when the treatment is given.

#### Part 2b.6.1: Ethical concerns that surround section 58.

The position I take here is the importance of looking at section 58, through the lens of the law and how it influences psychiatric patients. Firstly, one of the criteria, which legally sanction its use within the section, is that the patient is a danger to themselves or others. If a patient is suicidal and/or homicidal, they can be detained and treated with ECT after three months within a hospital. This strategy approach to risk prediction and determination raises some serious psychological and behavioural challenges for those working within the mental health system. My second ethical concern is that a Registered Medical Officer certifies that the patient is competent and able to consent when, in fact, the whole procedure actually denies the patient the opportunity to demonstrate their competence. The patient does not give consent; it is the Registered Medical Officer certifies competence without requiring that the patient signify that his or her authority has been sought and obtained.

Firstly I will identify my concerns about detaining and treatment of ECT within the Mental Health Act (1983, revised 2007) and look at how the use of section 58 has the potential to be used. I open up in this section of the thesis by making the point that most societies have provisions governing the involuntary treatment of people with serious mental disorder. Two broad approaches to mental health legislation have been identified (Peele & Chodoff, 1999). Both require the presence of a mental illness. In the first instance, there must be an additional need for treatment, which might be in the interests of the person's health or safety, or the safety of others. Secondly, there must be evidence of risk or danger in addition to the mental illness. In this section I argue that neither formulation is satisfactory and highlight that today's mental health legislation discriminates against the person with a mental disorder. Presently mental health law addresses two questions in order to process detention and care but my viewpoint is that the questions asked are the wrong way round. Firstly, they ask if the person has a mental illness. Then, they ask if they are dangerous. Addressing them in this order inevitably leads to treatment of people with mental disorder on a different basis than those of the rest of society (Bartlett, 2011). However, the questions may be answered differently if answered the other way around. The question of dangerousness can be approached in the same way for all people, despite the presence or absence of mental illness. The disorder then becomes a factor in determining how to handle dangerousness. It follows then, if the first question is negative, and then there is little justification for compulsory admission and compulsory treatment. This analysis then opens up where my position lies and is a most helpful contribution to the analysis of risk. However, it is important to return to the legislation I highlighted earlier to have an understanding of how the legislation within this part of the thesis gives understanding that the patients can be detained and treated based on the disorder, even though the degree of the disorder is not sufficient to warrant intervention. The Mental Health Act (1983), [revised 2007] presents the government's position and from this gives me the opportunity for me to enable mine. The functionalist stance recognises the risk determination process as being one which can prevent hazardous outcomes from occurring, or at least to reduce and minimise the impact of risk on others. One of the key foci in the Mental Health Act (1983), [revised 2007] is the question of risk posed by the patient primarily to others; a result of both the social and political impetus within the reform process of the Mental Health Act (1983), [revised 2007]. Whilst 'dangerousness and risk' are not explicitly stated as grounds for compulsory admission and treatment involving ECT 'it is necessary for the health and safety of the patient or the protection of others persons' ... (My emphasis).

This act seeks to find the elusive balance between protecting and facilitating the individual's autonomy whilst providing a legitimate framework for the wider public right to protection. However, following the Mental Health Act (1983), [revised 2007], risk assessment and management have become explicit concerns of the civil commitment process. Consequently, a patient's risk to either the self or others forms a significant part of the mental health decision to engage the civil commitment procedures (Department of Health, 2012). Yet the mental health legislation neither defines risk nor delimits the factors relevant to it, and this forms the basis for many professional problems and difficulties on decision making of psychiatric care. National Health Service risk assessment tools provide some guidance on what constitutes risk, but how reliable, valid and professionally rigorous they are is a matter for the health care providers. Bartlett (2010) makes the point that 'decision-makers' operate on their own experience and base their decisions of how dangerous patients have turned out in the past. The NHS Mental Health Trust risk definitions seek to position the particular organisations apropos the conception of risk to themselves or society within an abstract sphere of possible risk assessment and management protocols. Such broad-brush definitions seek to define what the risk is, to the extent that risk is deemed a legitimately acceptable process in decision-making yet leaves sufficient scope for wider professional discretion in individual cases (Thomas -Glover 2011). Unfortunately, while such definitions clarify the '*abstract*' concept of risk, what actually constitutes a '*risk factor*' in clinical practice is left up to the decision-makers to determine in accordance with their professional judgement and experience.

In consequence, the department of Health's risk framework shows that decision makers often go beyond the 'clinical' when assessing and determining risk, this approach mirrors the Department of Health risk framework (Department of Health, 2007). This guidance relates to three areas of risk: violence (including anti-social behaviour and offending behaviour); self-harm; or suicide, and self-neglect. The Mental Health Act (1983), [revised 2007] judicial framework "then provides the scope to legitimise any potential arbitrariness that may flow from the decision making process" (Thomas-Glover 2011. p.596). I challenge this process of applying this section because it has already been identified that the relevant ingredients that suggest a patient poses a risk to self or others are not defined by an exhaustive list of factors within the Mental Health Act (1983), [revised 2007] or associated Mental Health Code of Practice (2008), which define risk to self or others with an exhaustive list of relevant factors. Instead, risk is often determined by an individual's decision-makers discretion. Therefore, in this way, someone sectioned under the Mental Health Act (1983),[revised 2007] may never be certain about which aspects of their diagnosis, characteristics, or circumstances; a decision-maker

has deemed relevant material. Decision-makers are free to identify and attribute weight to any factors that they believe are relevant to a patient's risk profile.

If we break section 58 down, we can see that it appears to discriminate against protection of the self when making a decision that relates to a patient's safety as it refers repeatedly to refer to '*protection of others*'.

People with mental disorders are unique in being liable to detention and treatment because they have been assessed as presenting a risk to others without committing an offence to others.

Let us assume for a moment that dangerousness can be 'reliably' linked to an individual's mental disorder and further that some form of 'treatment' will reduce the risk. If the patient has capacity and rejects ECT because he or she does not regard the treatment as in their best interests. Can we say that danger to others provides an ethically acceptable reason for involuntary treatment? The Expert Committee (1999) offered a tentative 'yes', but also recognized an inconsistency with the fundamental principle of respect of autonomy. It must then follow that if we impose ECT treatment under these circumstances then no health interest is being served and protection of the public is the sole interest. It might be tempting to make the case for a 'best interests' argument—if people with a serious mental disorder (with capacity) commit a serious offence, they would probably be viewed in a disadvantaged position. However, a mentally healthy person at risk of committing a violent act is not acting in their own best interests, and should therefore be likely to preventative detention and treatment; few (I believe) would accept this. Best interests here are not 'health related' best interests. On the other hand, there is an ethical concern, which allows Mental Health Trusts to detain, and treat people for something they have not done or even plotted to do but merely might do. It is a rather serious challenge to decide what a person might do when they are not actually conspiring or planning a misdeed. The fact that a person could or might do something wrong does not warrant acting against that person and treating them against their will. I concede that the obvious exception is when there is concrete evidence that a person is plotting to commit a crime. However, these issues are already covered by law, so what would seem to be under consideration would be categorising people without adequate evidence that they are plotting to commit crimes and to be treated with ECT under the Mental Health Act (1983), [revised 2007]. On the face of it, this would seem unacceptable. If I was to try to analyse the reasons given by those who favour giving ECT under a section of the Mental Health Act (1983), [revised 2007]. One obvious argument would be to justify using coercive powers against those with mental illness, before they commit a crime or even plan a crime is to argue

that certain mental issues are themselves adequate evidence. Therefore it is reasonable to assume that the person will engage in a crime even though nothing they have done meets the imminent danger to themselves or others threshold. On an abstract level, this does have a logical appeal in that it makes sense to treat for a condition before it manifests itself. If a person objects to medical treatment for a physical condition then one could argue that a person should be able to do the same for a dangerous mental health issue. The rationale is that the person who refuses treatment for a physical issue is only endangering himself or herself but the person, who refuses treatment that, can result in violence against others, then they are putting others in danger without their consent and he or she does not have the liberty or right to do this. Hodgins & Muller-Isberner (2004).

If we move into the realm of the concrete however, the matter becomes more problematic. My position statement (in part 2a) was mental health science is lagging far behind, the physical health sciences (I am using the popular rather than philosophical distinction here). As such, using the best mental health science of the day to give a prediction of how a person is likely to engage in violence (in the absence of evidence of planning and past crimes) will typically result in a prediction that is questionable. Therefore to use the Mental Health Act (1983), [revised 2007] as a coercive power against the person based on dubious evidence would not be ethically acceptable. After all, a person should only be denied liberty on adequate grounds and such a prediction does not seem strong enough to warrant such an action. If preventative detention and treatment (using ECT) is to be allowed for the mentally ill 'solely' on the account of danger to others, so should it be for all of us otherwise it amounts to discrimination against those with a mental illness. Dangerousness is a social construct; it is not a psychiatric phenomenon and thus it is a perversity to assume competence on behalf of psychiatrists to assess individual cases. Studies have shown that psychiatrists err on what can be considered as the 'safe side'.<sup>6</sup> The potential for civil liberties through an unwarranted removal of liberty then becomes evident (Price, 1994). Driven by concerns about public safety and the control of violence within our society, the United Kingdom has moved towards the present situation of the principle of legalised control of the mentally ill. The Mental Health Act (1983), [revised 2007] might be characterised as the iron hand fitted with a velvet glove of legalism and expressed in a rhetoric of psychiatric care. What has been identified are that the relevant ingredients that suggest a patient poses a risk to self or others are not defined by an exhaustive list of factors

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<sup>6</sup> Mullen (1997), Taylor & Gunn (1999) Hodgins & Muller-Isberner (2004).



in legislation or the Mental Health Code of Practice (2008). It must then follow that our society has not yet reached a point of moral sensitivity sufficient to make treatment decisions and only by placing compulsory treatment on a firm ethical basis are patients who fall under this umbrella protected from powerful societal forces.

My second area of concern is the issue of consent, (I will revisit consent further in chapter 4). This term derives its moral force from the principle of autonomy, and that autonomy is most suitably demonstrated by the patient's capacity to act freely. The first essential point in explaining section 58 and its implementation within the use of ECT as a treatment is that information given can only be given in probabilities due to the lack of sufficient empirical evidence around its use. The provision of section 58 acts as a safeguard in that certain forms of treatment shall not be given to the patient except when the patient freely consents. Alternatively, if an independent medical practitioner has certified that the patient is incapable of giving his or her consent or that the patient should receive the treatment even though he or she has not consented to it.

The philosophy of care for 'treatment', and particularly for the interests of this section 'emergency treatment' - is stated in the imperatives of Part IV of the Mental Health Act (1983), [revised 2007] ECT currently comes under the auspices of section 58A of this part of the Act. Here, the Secretary of State reviews individual cases and has powers to include or exclude treatments where treatment requires consent or a second opinion. In the accompanying Code of Practice (2008), capacity, consent, necessity, and best interest are considered. This controversial aspect of capacity and consent carries into legal argument the debates surrounding so termed "incapacitated compliant patients" and whether the Mental Health Act (1983), [revised 2007] is an appropriate tool for the provision of treatment, or provides any appropriateness or protection for people liable to be detained in such circumstances. Section 58 treatments may be prescribed in the person's best interests under the common law doctrine of necessity (Code of Practice 2008; Mental Health Act, 1983 [2007 revised]).

Explicitly, treatment is required to be; necessary to save life or prevent deterioration or ensure an improvement in the patient's physical or mental health; and in accordance with a practice accepted at the time by a reasonable body of medical opinion skilled in the particular form of treatment in question (Bolam v Friern Hospital Management Committee [1957] 1 WLR 582). When it was first implemented, section 58 violated the above principle. It was supposed to support the principle of autonomy, but did not do so. Let me

give clarification of this section to show how the principle of autonomy was violated so that a clearer picture arises to the ethical point I make regarding its use.

If the person is capable of understanding the nature, purpose, and likely effects of the treatment and consents to it, the Responsible Medical Officer (RMO) has to certify in writing that understanding and consent are present. Alternatively, if the patient is not capable of understanding the nature, purpose, and likely effects of the treatment and therefore cannot consent to it, then a doctor is appointed by the Mental Health Act Commission to give a second opinion. The appointed doctor must consult two people who have been professionally involved in the patient's medical treatment, one of whom must be a nurse and the other can be either a doctor or a nurse (NICE, 2003). If psychiatric drugs have been given to a detained patient for three months without consent, section 58 of the Mental Health Act (1983), [revised 2007] says an independent doctor must consider whether the patient should continue to receive them or not. This doctor is sent by the Mental Health Act Commission (M.H.A.C. 2009) and is called a Second Opinion Appointed Doctor (S.O.A.D.). If a patient does not consent to Electroconvulsive Therapy (ECT), section 58A says it cannot be given, although if he or she is not capable of understanding its nature, purpose, and likely effects, and a SOAD agrees that it is appropriate for the treatment to be given, it can be given without consent. However, if the patient has previously made a 'valid' advanced decision (see below) refusing ECT which is applicable to the treatment in question, then the ECT cannot be given, even if he or she does not understand its nature, purpose and likely effects at the time that the treatment is being proposed. In addition, ECT cannot be given if this would conflict with a decision of an attorney appointed under a Lasting Power of Attorney, a deputy appointed by the Court of Protection, or by the Court itself. My concern is that Section 58 as described in the above paragraph may result in a situation in which a patient makes an autonomous decision but it is a decision not accepted by the medical fraternity, then the decision is ignored or classed as irrelevant. Decisions made by patients are often labelled as irrational if the individual did not have sufficient information to make a decision. The doctor who suggests that the patient who states "I'm refusing ECT because I am not having no-one putting electricity inside my brain" was suffering from irrational fears is incorrect, as that is exactly what was going to happen to that patient. On a professional level, it appears that ECT treatment bias overrides the beliefs of the patient and it is ethically wrong in that patient autonomy is considered irrelevant.

#### Part 2b.6.2: Ethical concerns that surround section 62.

Section 62 of the Mental Health Act can be used to administer treatment without consent in an unethical manner. Firstly, let me explain the difference between section 58 and section 62. Section 58 deals with treatment requiring either competent consent or a second opinion by a Registered Medical Officer. It applies immediately to ECT and drug treatments given beyond three months. It cannot be imposed if it is proven that a 'valid' directive by the patient has been stated not to receive ECT. Alternatively, Section 62 discusses 'urgent treatment,' and the requirements of section 58 do not have to be followed when urgent treatment is required. Therefore, forced emergency treatment with ECT can still be given without consent even if the patient is capable of understanding the treatment. If a mentally ill patient does not consent to ECT, then a second opinion appointed doctor is sought from a medical practitioner appointed by the Mental Health Act Commission. This doctor interviews the patient and consults with the responsible medical officer and two other members of the multi-disciplinary clinical team caring for the patient, one of whom must be a nurse and the second someone other than a doctor.

The doctor appointed by the Mental Health Act Commission (2009) will decide if the ECT treatment is necessary and if the patient is capable of understanding the nature, purpose, and likely effects of the treatment. If it is felt that ECT will alleviate or prevent deterioration of their condition, the doctor completes a T4 (formally known as form 39) which is retained in the patient's case notes in the same way as form T3 (formally known as form 38) At this point, treatment occurs against the wishes of the patient. While it may seem straightforward, Section 62 gives a false impression as to its use (Emergency Provision of Care). This provision serves the purpose of allowing the terminology to change to intensify measures to be used in order to save the life of the patient'.

Section 62 applies to 'urgent,' non-consensual treatment which may be given with or without the patient's consent or to a patient not capable of giving informed consent allows for treatment which is necessary to safeguard the patient's life. I wish to explore the level of probability that the patient's life needs saving, and suggest treatment should be given based on this probability. Firstly, consider the direction given to practitioners from the Mental Health Code of Practice (2008) on medical treatment for mental disorders under the Mental Health Act (1983), [revised 2007]. It gives specific direction regarding treatment given without patients' consent.

Section 62: 23.22.

It is an emergency only if the treatment is immediately necessary to:

- save the patient's life;
- prevent a serious deterioration of the patient's condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed;
- alleviate serious suffering by the patient and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard; or
- prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.

Section 62: 23.24.

In addition, force may be used (whether or not the patient objects), provided that:

- The treatment is necessary to prevent harm to the patient; and
- The force used is proportionate to the likelihood of the patient suffering harm and to the seriousness of that harm.

Mental Health Code of Practice (2008)

In looking at points one and two in 23.22 and point one in 23.24, the terminology used states the word 'necessary' to prevent harm. Therefore, we must take into account levels of probability that a treatment is necessary to prevent harm to the self or others, which are not stated but inferred, and also take into account the level of probability (of self-harm and possibly suicide) which is that the patient will be a distinct and present danger to themselves or others. However, this use of terminology would require a very 'lax' and accommodating interpretation of the word probable. Surely the terminology would have to accommodate the meaning 'more necessary than not' or 'more probable than not' because on the face of it there is a 50% chance the patient will be a harm to themselves or others, and 50% they will not.

Considerations of probability of a suicide risk might include factors such as; the age of the patient, his or her expectation of discounting suicide, the expected quality of life, the likely response to treatment and the

degree of probable resistance of his or her objection to being given ECT and being put on a Mental Health Act section in the first instance.<sup>7</sup>

There are a number of studies, which support the view that ECT can be a life-saving therapy and improve the quality of the patient's life (Prudic & Sackheim, 1999; Munk-Olsen et al. 2007, Thirthally et al. 2009, Phutane, 2011). The common dominator in all of these studies is that symptoms of 'suicidality' would be reduced and ECT was specifically recommended in patients with mood disorders in which suicidality was a main feature. However, a beneficial effect on 'suicidality' is not the same as a beneficial effect as suicide. Yes, it may decrease or help prevent suicidal behaviour, presumably due to its effectiveness in treating the illnesses characterised by suicidal symptoms, but I present the position it does not prevent suicide. One of the most common reasons cited by healthcare providers for performing ECT is that it prevents suicide. The report of the 1985 NIH Consensus Conference states that 'the immediate risk of suicide' that cannot be managed by other treatment, 'is clear indication for the treatment of ECT'. Further, within these guidelines, ECT should be used to "gain fast and short-term improvement of severe symptoms after all other treatment options have failed, or when the situation is thought to be life-threatening" (NICE, 2003). Although ECT is not considered a treatment for suicidal thoughts *per se*, it may dramatically decrease suicidal behaviour, presumably due to its effectiveness in treating the illness characterised by suicidal symptoms. In patients with severe affective or psychotic disorder, many texts and expert groups specify suicidality as a particular indication for the use of ECT over other treatments (Andre, 2009). The rationale is that the onset of clinical response may be quicker and likelihood of improvement more certain with ECT relative to other treatments. The presentation of ECT as a treatment of last resort, which prevents suicide or is only for those with profound levels of distress is common within the literature and used as counter argument by those who advocate for ECT.<sup>8</sup>

My rebuttal to this claim is these are the kinds of arguments that represent the rhetorical devices, which are used by advocates to minimise its negative impact and to justify its legalised use within a biomedical framework. Fisher et al (2011) enhances my point and also presents the argument that last resort rhetoric is unhelpful since it is not clear what level of distress or risk is required for someone to warrant 'last resort'. ECT is not expected to achieve improvement in all patients. Rarely do studies show improvement rates with ECT

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<sup>7</sup> Mental Health (Care and Treatment) (Scotland) Act (2003); ECT Survey (2002); Department of Health (2005); Mental Health and Learning Disability (Northern Ireland 2005).

<sup>8</sup> Reisner (2003); Middleton et al (2010); Sienaert (2011); Fisher (2012).

alone above eighty percent of people treated, the treatment outcomes for those people where ECT was not viewed as beneficial may arguably be unclear (Experts by Experience, 2005). The researchers reviewed the literature on ECT and suicide and concluded that these findings do not support the position of those who advocate that ECT exerts short and long-range protective effects against suicide'. In fact, there is no proof that ECT prevents suicide. Some critics suggest that there is anecdotal evidence that the confusion of memory loss after treatment even precipitates suicide in those suffering from mental illness. What we should be doing is asking the question can ECT increase the risk of suicide. They point to Ernest Hemingway who shot himself in July 1961, days after being released from a psychiatric facility where he had received 20 ECT treatments. Before his death, Hemingway had complained to his biographer A.E Hotchner, 'What's the sense of ruining my head and erasing my memory and putting me out of business'. In their book Shorter and Healey (2007) like many others, (National Collaborating Centre for Mental Health (2010), C.Q.C. (2010), they base much of their support for ECT on the claim that it prevents suicide. They cite five studies to support their claim. One study is incorrectly cited twice with different authors. This is the Metrazol study (Ziskind, 1945). Therefore, the actual number is three. In addition to the other study from the 1940's described above Huston & Locher (1948), they cite Avery & Winokur (1976) and a National Institute for Mental Health (NIMH) study (Kellner et al. 2005). The NIMH study is not a study of suicide, it is a study of '*thinking about suicide*' (which might be justified on the ground that completed suicides are a rare event and difficult to investigate without large samples).

However, let me challenge the counter argument that the risk of suicide is reduced during ECT treatment. ECT usually takes place in hospitals under strictest guidance and supervision especially for those patients diagnosed as suicidal and displaying suicidal ideations. Indeed these are precisely the extreme sorts of cases – acutely suicidal patients in hospital who have stopped, eating, drinking, and communicating, that are highlighted to make the case for ECT. I argue if these severely depressed/psychotic inpatients are given ECT and do not kill themselves or attempt to kill themselves whilst in hospital, how we can be sure it was the ECT rather than the medical and nursing care they received that saved them, we cannot. The presentation of preventing suicide I accept as a criterion and I also accept this as an ultimate goal, but I reject their methods for reaching this goal and the methods they propose to reach that goal. The reference to ECT effectiveness in illnesses characterised by suicidal symptoms is a 'red herring'. The utilitarian argument would present the view (which can be said to be taken by most psychiatrists) that mental illness on many occasions requires the

temporary suspension of liberty for the benefit of the patient and society. While this is not an incoherent position, it seems a deeply unattractive one.

Yes, I concede with the counter argument of the pro ECT stance, the removal or reduction of the risk of bodily harm is a recognised benefit. However, my challenge to their position, which advocates for the use of section 62, is that the Act should outline what is considered serious bodily harm. It seems unlikely that the minimum level of anticipated harm could be set higher (i.e. that it refers only to injury more severe) than that which passes for grievous bodily harm in criminal cases (Durham, 1988).

Psychiatry's stance is the suffering imposed by having an acute episode of mental illness will justify the treatment and outweighs the lesser grades of bodily harm as they see it. However, if the psychiatric viewpoints stance portrayed is suspected of bias, then let me make my point in another way.

Let us suppose (*per impossible* but for the sake of argument), my patient (who shall be referred to as a male patient, but only to avoid an excess of gender –signifying pronouns) is faced with two alternatives. Firstly, imagine that he is exposed to a 50% chance of fractures of the tibia and fibula (a broken leg) with all its potential complications. My patient has now the choice to have his leg treated or not, but if not he faces the inescapable possibility of his lifestyle being drastically changed.

Secondly, imagine that he is exposed to the 100% chance of an acute episode of mental illness with most of its hazards. The mental illness would run its course if untreated, but the client refuses treatment, and is therefore treated with ECT within section 62.

In the acute stage of his mental illness, he becomes objectionable towards family, friends, and work colleagues, making absurd accusations and grandiose claims. My logic is that most people would choose a broken leg, but this is still inconclusive in my argument that mental illness is sufficient justification for compulsory treatment. What needs to also be taken into account is that I question the treatment can be justified because it is 'necessary'. The patient has no choice, he already has the mental illness, and therefore the greater evil of having a mental illness is necessary to treat and to impose treatment than having a broken leg and being treated. If the risk of mental illness and serious self-harm is justification for compulsory treatment because it is necessary, should the serious consequences of not treating a broken leg, blood occlusion, gangrene and possible death, also lead to compulsory treatment? My point therefore is that magnitude and probability of serious self-harm to self and others through mental illness is a greater evil than

those suffering from a physical complaint. It is evident to note that where there is a risk to the patient, a measure of subjective judgement is allowed, but that when there is a question of dangers to others or an express threat, only an overt act or discourse of action can serve as evidence.

The problem with this provision to apply section 62 is that it can be argued that in the modern day no patient fits the first condition that ECT is a lifesaving treatment. Although we speak of ECT as a lifesaving measure like defibrillation to start a heart that has stopped or the need for an antidote of a fast killing venom from a poisonous snake, we do not or should not portray it as the sole lifesaving measure and 'necessary immediately'. What should be the case at that point and for that particular patient is it is the safest and most practicable. It is always possible to defer the death of a patient by immediate admission and custodial care, good medical and nursing intervention, but to put this treatment in the same category as for example emergency defibrillation the arguments conclusion does not follow the justification. Whilst Deontology and Utilitarian theories differ in their coherence, complexity and comprehensiveness, their differences may lead to similar moral judgements and recognise the same contexts. Whichever theory we apply, the outcome is unwanted treatment, which is unacceptable.

This unwanted outcome may occur when the utilitarian considers some of the use of the indirect consequences of an act, and when the deontologist acknowledges that the use of some moral principles (e.g. beneficence) requires that we determine its likely outcomes. The changes within the Mental Health Act (1983), [revised 2007] do give more liberty to patients and provide a more stringent and restrictive criteria for detaining mentally ill patients. In this chapter, I have argued that within the Mental Health Act (1983), [revised 2007] there is a given and legalised option that enables psychiatrists to use ECT as a treatment of a first resort and not last resort. I understand that psychiatrists are faced daily with the dilemmas that mental illness brings but those dilemmas should be given full exploration and are not easily solved (which is the position a number of psychiatrists present) with the use of section 62 unless it fully fits the criteria of life and death.

#### Part 2b.7: Conclusion

In part 2b in summary, the Mental Health Act (1983), [revised 2007] still adopts a position of ethical imbalance of a rights focussed approach of the patient as against the benefits the legislation portrays and argues for the overwhelming benefits of society. The changes that occurred from the 1983 Act to the revised 2007 Act do not



follow the premises, which were the driving force that change was needed to give more rights to the psychiatric patient. (Hilton 2007). These premises and the subsequent accepted practices created by sections 58 and 62 give rise to questionable consequences. The ethical issues I have addressed relating to the right to treatment, the right to refuse treatment, the competency and capacity of psychiatric patients and the use of the Mental Health Act (1983),[revised 2007] to enforce treatment have all become major issues to consider within psychiatry. I have to acknowledge that ECT has been found to be a short-term effective treatment in certain psychiatric conditions but I still have professional concerns, as to how many other treatments it has reduced or illuminated due to issues of expediency<sup>9</sup>. The ethical and, I would suggest legal issue is that complete documentation of the clinical conditions, medical evaluations, course of treatment is lacking within our psychiatric profession. My belief is that ECT should be peer-reviewed and more research carried out to assess its use and over-use, and cases where it has been used and classed as 'non-respondent' to determine whether ECT should ever have been a consideration as a treatment.

Let me reiterate my position, It is often difficult to achieve a balance between the complex issues the Mental Health Act (1983),[revised 2007], the patient's rights, the need to treat and duty of care. Such balances have, and still do present serious dilemmas. If the patient is deteriorating rapidly, expressing suicidal ideations and is in an emergency then decisions need to be made immediately. However, this is not always the case and ECT in some cases is used as a first choice treatment rather than a last resort, (a discussion I present again in chapter 4 when I address consent and ECT).

The ethics of giving ECT to involuntary patients will always be an on-going argument and the ethical issues, which I have argued, relate to its questionably proven effectiveness and its side effects. If a patient is to have their liberty taken, away as in the case of the use of section 58 then it can be argued that, the treatment should be effective and free of harmful side effects. One of the highest values is personal freedom, liberty according to Mill (1963) and to have that taken away then the benefit should be high, and the risks very low (Seedhouse, 2009). This argument will be always in the spotlight due to the controversy that surrounds it and our legal system will always be on hand to scrutinise benefits and risk, as scientific evidence cannot rule out the possibility of brain damage (unproven) and other recognised side effects (unexplained). The judicial system

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<sup>9</sup> Andre (2008); Berg, (2009); Chakrabarti et al (2010).

directed by the government needs to be more involved in increasing the medical profession's accountability to the area of professional and clinical ethics, standards of practice and public accountability, especially as they pertain to involuntary patients and the use of ECT.

### **Chapter 3: The application of the framework of Principlism within Psychiatry.**

‘...It is doctrine that moves the world. He who takes no position will not sway the human intellect’

William Thayer Shedd: American Theologian. 1820-1894 (in Gomes 2003)

#### **Section 3.1: Introduction.**

In this chapter, I appraise and review the ethical framework of Principlism with particular focus on how this framework influences mental health care and in particular the treatment of ECT. I present my position that one certainly has to admit that a convincing ethical theory must have practical application. On its own, the framework of Principlism does not fit the bill when we are dealing with dilemmas within psychiatric clinical practice. Principlism is the term employed by Beauchamp & Childress (2009) to describe the dominant conceptual framework used in bioethics, a framework based on the balancing of four ethical principles: non-maleficence, beneficence, justice, and autonomy. These four principles, often known as the 4P's, are the cornerstone of Beauchamp and Childress's principle-based ethics. In psychiatry, ethical decisions are often made overtly or covertly with the ethical principles of this theory in mind.<sup>10</sup> Clinicians use Principlism to resolve ethical dilemmas at the bedside (Kennedy, 2004; Loewy & Fitzgerald, 2003; Mohr, 2010) but this use often functions in a way that undermines a nuanced assessment of clinical ethics cases.

Here, I do not argue against the theory of Principlism itself, but rather against the influential trend within clinical areas of psychiatry to use the framework of Principlism as the sole decision making framework.

Principlism has positive aspects that are often used in the field of mental health, but it is not always an applicable theory to use in psychiatry as a standalone theory. When applying Principlism to psychiatry as a standalone theory, standards within the theory often conflict, but are important principles used in examining courses of action. I argue that these conflicting standards within Principlism would be complemented by using another ethical approach known as Virtue ethics. Virtue ethics is person rather than action based: it looks at the virtue or moral character of the person carrying out an action, rather than at ethical duties and rules, or the consequences of particular actions. The general concept behind 'Virtue ethics is that it focuses on what the individual should choose for his/her own personal inward behaviour (character) rather than the individual relying solely on the external laws and customs of the person's culture, and if a person's character is good then

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<sup>10</sup> Riecher et al (1991); Pymm et al. (1999); Burke (2003).

so ought the person's choices and actions be good. Baggini and Fosi (2008) (I will address this in more depth when I look at the importance of the virtue of ethics in section 3.7 and 3.8). Principlism as an ethical framework does not give us a formula for resolving matters of value such as in the debate around implementing ECT and when attempting to apply the principles and in other areas for example in the use of restraint. However, it does help us to see the problem for what it is, rather than misperceiving it as no more than a reflection of inadequate science, and leads to a recognition of teamwork. This shared decision-making provides balance, creating an evaluative basis of good practice in clinical psychiatry. Bioethics links medicine, psychiatry, and philosophy by providing an overlap between philosophical theory and medical advance (Warnock, 2007).

The roles of both can be interchanged under active surveillance, but expertise in one area is not generalizable to expertise in the other. Being a good psychiatrist does not mean some can be a good philosopher of ethics and vice versa. Transgression of expertise may be counterproductive unless the basic tenets of psychiatry are followed. My viewpoint is that Principlism can be helpful in adhering to these tenets, but must be complimented by virtue ethics, which I would believe, address any violations within decision-making. Certain aspects of the application of Principlism, in particular the trend to privilege the principle of respect for autonomy over the other three ethical principles, create conflict and unique problems within psychiatry and in the context of mental illness.<sup>11</sup> The conflict is vitiated by the effects of the mental illness, such as psychotic behaviour where the patient often has no insight into their illness, on the patient's capacity for autonomy and the scales are tipped towards beneficent obligation to relieve the patients suffering. These problems within psychiatry and the dilemmas they create are often around behaviour control, diminished decision-making capacity due to psychosis and involuntary treatment, of which ECT is one example. By using this theory in an approach to mental illness, these dilemmas can be easily couched in terms of prima facie professional and ethical conflicts of the autonomy of the patient to choose as against the need of the healthcare professional to alleviate symptoms (the need for beneficence) and not to do harm (non-maleficence). These are obligations of the healthcare professional that few would argue against but difficulties arise in the interpretation of what constitutes 'good' and 'harm'.

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<sup>11</sup> Gillon (2003a).

This is a question which I will be preoccupied with when I identify the use of Principlism within psychiatry and how effective it is in the decision making process of the treatment of ECT.

If we agree that, the purpose of healthcare ethics is to inspire questions and examine what would be the ethically right action in health care situations, demanding a choice between at least two undesirable alternatives. Let us say then that ethics deals with the construction of criteria for judging people's behaviour. The reasons I offer to accept my view of psychiatric healthcare ethics, is that within clinical practice arguments exist where we are in need of utilising principles and theories, which make distinctions on the value laden concept of 'quality of life'. My concerns are that by solely using this framework or allowing its dominance to prevail we are in effect providing an ethical cookbook for the mental healthcare providers. There is an ongoing problem within psychiatry as to who is best placed to make decisions for those patients with severe mental illness. When patients lack the decision-making capacity and no surrogates are on hand to advise or instruct, practitioners need to consider what is deemed in the patient's best interests as their course of action( I will discuss the best interest's issues in Chapter 4 section 4.7.1).

In psychiatry, various theoretical orientations and treatment approaches coexist or compete with each other and have done for a number of years.<sup>12</sup> Since each theory purports itself to be the most productive in the treatment of mental health care, each theory also has its critics, a point not lost by Reiter-Theil (1992). Within the discussion of contemporary ethical issues surrounding ECT, Hoffman (1985) explained that the use of ECT highlights the conflict between a scientific psychiatry and a modern society, a situation still prevalent today. Ethically though there has progress to find a compromise between the patients' autonomy and the protection of the patient and others from harm, however, there are some serious problems with this approach. Therefore, what is it that crystallizes my disquiet regarding some of the thinking within psychiatry by some of the healthcare professionals concerning the use (perhaps misuse) of ethics and in particular the framework of Principlism to ground out professional decisions and behaviour?

My concerns are twofold: 1/ that we may be using this framework as a punitive tool and 2/. Using it as a stand-alone framework, does not uncover the ethically problematic issues within psychiatric practice. My worry regarding the latter is that unless we are prepared to uncover these issues and engage in a serious and

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<sup>12</sup> Lutzen and Norden (1993); Breeze (1998); Heffern and Austin (1999); Dickenson and Fulwood (2000).

sustained discussion we will remain in a dormant state at the expense of patient care. My belief is that it would be beneficial to highlight how this framework is used within psychiatry and the difficulties that those people who have used it have encountered. Within any argument, it is in the interests of fairness to address the pros and cons of the subject matter. This thesis is no different so I will now address the criticism levelled at Principlism and those who defend it, over the use of other theories.

### Section 3.2: What is the most favourable ethical framework for psychiatry?- Is there one?

In this section, I shall address what makes up the four principles and address the distinction between them before then looking at their feasibility within psychiatry. This challenge is significant because in the absence of a reliable distinction between the principles, I would not be able consider the strategy of argument to challenge Principlism as a sole dominant framework within psychiatry. Ethical concerns about the psychiatrist's role and functions have dogged the profession for at least three centuries (Bloch & Pargiter, 2002). In my view, psychiatrists must respond to ethical challenges as moral agents. The task, however, is complicated by the lack of a coherent framework for ethical decision-making, a conclusion buttressed by two points. First, rationales and methods used to resolve ethical questions differ radically, and secondly contradictory ethical theories may generate irreconcilable tension for the clinician. Campbell et al (2005) sees psychiatric ethics as having a special status in biomedical ethics given the effect of mental illness on autonomy. They argue that psychiatric ethics should adhere to three basic tenets of autonomy, beneficence and non-maleficence: using validated methods to return the patient to proper functioning as a responsible and self-directed individual; refraining from any treatments which are harmful and preserving the distance between psychiatrist and patient by acting without an 'emotional entanglement'. They appear to have little time for academic debates about the relative merits of one ethical theory over another, arguing, "Patients should not be adversely affected by such Olympian struggles among the demigods of the medical pantheon" (Campbell, 2005 p.6).

There are many ethical theories that provide tools for thinking ethically within psychiatric practice, such as virtue ethics, feminist, phenomenological, Kantian deontology, utilitarianism, communitarianism, liberal individualism, social contract theory, the ethics of care, casuistry, and countless others, which compete for our attention and approval. Alternatives or supplements to Principlism abound, and a detailed description of all potential ethical theories is beyond the scope of this thesis. Donnelly (1994) made the point that despite their

different labels and tenets, these competing theories all point in the same direction: “reconnecting medical ethics with both the more general perspectives of philosophy and the particularities of medical practice” (p.142). However, despite criticism (Danner-Clouser & Gert 1990; Hanford, 1993) Principlism based on ‘the four principles’ is generally regarded as the most accepted and popular approach.<sup>13</sup> In the next section, I examine Principlism through a short account of its history, a breakdown of its framework, a summary of its critiques and supports, and a discussion of its application to psychiatry including the treatment of ECT.

### Section 3.2.1: Historical overview of Principlism.

Principlism, was introduced by Beauchamp & Childress (2009) in the 1970s in an attempt to reconcile the divergence between utilitarian and deontological models by linking moral decision-making principles subject to change (e.g. in light of new scientific findings) rather than to universal rules. The four principles when developed were as a comprehensive starting point for normative standards of conduct in biomedical contexts (Beauchamp, 1994). Although never presented as a comprehensive ethical theory, the four principles were later adopted by other health professions (Beauchamp & Childress, 2001). Additionally, Principlism was adopted by other professions such as the law, social and behavioural sciences, politics, and economics (Pellegrino, 2002).

Principlism as a theoretical approach to ethics is often traced back to the Belmont Report (1979) which addressed the protection and safety of human beings in biomedical and behavioural research. The Belmont Report (1979) did not state specific reasons for its choice of principles: they were simply “among those generally accepted in our cultural tradition” that “are” particularly relevant to the ethics of research involving human subjects (Hughes and Fulwood, 2005). The Belmont Report was written by the National Commission for the Protection of Human Services of Biomedical and Behavioural Research (1979). Part of the reason for its existence was due to past deplorable acts in research and to protect human subjects in clinical research from this point forward. To understand Principlism, it is useful to have an understanding of an earlier approach to principle-based decision-making, which was called the Georgetown mantra,<sup>14</sup> which specifies respect for

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<sup>13</sup> Hewitt-Taylor, J. (2003). Hine, K. (2011) Richardson (2002) Gordon et al (2011).

<sup>14</sup> Principlism has been called “the Georgetown mantra” because both authors were at Georgetown University's Kennedy Institute of Ethics when drafting the first edition of their book of *Principles of Biomedical Ethics* (1979).

autonomy, beneficence, non-maleficence, and justice as the basic principles of biomedical ethics. Principlism has been said to offer the lure of calculability and predictability therefore giving the notion of commensuration. Commensuration is the method of "...measuring properties normally represented by different units, with a single common standard or unit" in order to "make decision making easier by ignoring aspects of the problem" (Evans 2000, p. 32). Principlism is a form of commensuration in that it simplifies a complicated process. The tenets of Principlism were created to enhance calculability and to simplify ethical decision-making. While simplicity may be efficient, often the medical community finds a commensurable set of decision-making principles to be useful, however the patient on the receiving end of this decision-making tool may not share this view.

As Parker (2009) notes, overly abstract and basic principles are too broad when compared with principles derived from facts factual assumptions and people's personal circumstances. This approach tends to abstract individuals from their particular social context and deflects attention from the larger social, economic, and cultural forces that shape their lives. These factors must be taken into account alongside the basic concepts of Principlism and the Georgetown Mantra, especially when treating the patient with ECT. In ECT treatment, the patient's feeling can and often are an afterthought and they become a passive recipient of care. However, we must remember to consider the effect of severe mental illness on a patient's ability to participate in the decision-making process. The premise in using this framework is that it will be possible to suggest core values, which are based on the four principles. My rebuttal is however, these values cannot be put to use without considering the patient's context. Thus, we must consider other theories and choose from other medical approaches. Depending on which of the four principles takes priority in a given situation, we can choose from a range of theories (Pellegrino & Thomasama, 1988,) to an elevation of individual autonomy (Harris, 1985). Principlism posits that widely held principles, too general in quality to address the particulars of diverse circumstances, at least provide a starting point for moral judgment. When the principles are used in biomedicine, it is often necessary to ensure that the principles are applied uniquely to each case.

Beauchamp & Childress (2009) call this process of narrowing a principle's scope to make it action guiding "specification". Specification involves fine-tuning the scope of the principle by increasing information about the specific situation (what time, where, what persons are involved and so forth) (Ebbesen, 2011). Each principle is *prima facie* binding, which means that 'it must be fulfilled unless it conflicts, on a particular



occasion with an equal or stronger obligation' (Beauchamp & Childress, 2009). If the principles conflict they can be justifiably overridden, meaning that none of the principles are absolute. In tandem with other guiding information, such as relevant empirical data or consistent clinical observations, the framework offers an approach to moral deliberation that adheres to commonly agreed upon rules but permits flexibility in interpreting their intent. By embracing tenets of both utilitarian and deontological theories, Principlism can lay claim to a broadly based foundation (Fricker & Guttenplan, 2009).

### Section 3.3: Return to the Conceptual Discussion on Principlism.

The normative and objective standards of what came to be termed 'Principlism' provide 'moral compass points' in differentiating right from wrong (Pellegrino, 2002.p.661). Rules of practice can be formulated from the four principles, including not only ideas of medical benefit, but also truthfulness, confidentiality, fidelity and privacy, which are then interpreted within specific contexts to develop their meaning, limits and application (Beauchamp & Childress, 2009). Clinical, contextual, narrative, hermeneutical, casuistical, virtue, feminist and phenomenological ethics (to name only a few of the leading contenders) now compete for our attention when making ethical decisions within healthcare.

Once these principles have been established, the practical activity then becomes that of specifying how the principles are to be used in specific situations and balancing the principles with the other competing moral principles. In using this approach, every moral decision will be dilemmatic in that the agent will be to some degree either morally right and morally wrong under a single principle. There will be two or more competing moral principles and the agent will not be able to fulfil one or more moral principles without violating or competing with one or more other moral principles. Dilemmatic decision-making is not unusual when making pluralistic social decisions (LaFollette, 2014). Textbooks and a wide body of literature <sup>15</sup> have given currency to the usefulness of these formal principles in dealing with case analysis. It should be noted, however, that these "formal" principles might have different expressions in different cultures or institutional environments.

Autonomy, for example, although univocal in grammatical sense is different in an Islamic society and a secular community and, while highly appreciated in some regions of the world, may have a different value in others. The same holds true for justice and beneficence. This caveat does not imply relativism, but suggests that some

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<sup>15</sup> Robertson and Walter (2007) Macklin (2003) Page (2012)

degree of cultural sensitivity is essential for an adequate understanding of the contents of each formal principle and the details of its impact on a particular society (Gordon, 2011).

Beauchamp & Childress's (2009) approach to the problem of relativism is one of the most widely discussed in biomedical ethics, and over the last 32 years has influenced many scholars, physicians, and moral philosophers worldwide. Their most recent work, the 7<sup>th</sup> edition of *Principles of Biomedical Ethics* (2009) outlines their original four universal prima facie principles, noting that these admittedly 'do not constitute a general ethical theory' but nevertheless provides a framework of norms with which [one] can start in biomedical ethics (Beauchamp & Childress, 2009, p 16).

Beauchamp & Childress (2009) discuss particular ethical problems in the 7<sup>th</sup> edition, and while they insist that a balance must exist between guiding tenets (Gordon 2011), they divide the discussion of these problems into four sections based on the pillars of Principlism —autonomy, non-maleficence, beneficence and justice (Tomlinson, 1998). In the 7<sup>th</sup> edition, the authors provide an expanded and more nuanced account of their history and method, which is intended to dispel criticisms of their version of 'Principlism'. Their success at this goal will be addressed when I look at key criticisms of Principlism. Firstly, however, I will summarize the arguments in support and criticism of Principlism.

#### Section 3.4: Support and Criticism of Principlism.

Let me start this section by advancing an experiential observation, which will enable me to highlight my position here: healthcare professionals are taught to trace out the consequences of their choices and to recommend to patients those courses of action. This then should provide the best risk-benefit ratio. That is the best chance for attaining good outcomes and avoiding or minimising bad outcomes. I make this statement because it is a core element in the training of doctors and nurses. Within my experiential background, I have seen little evidence of various types of ethical decision-making strategies explored in any great depth, and this includes Principlism. Many individuals have published papers on the four principles approach and discussed the approach in public arenas of which I will now highlight some. The importance of doing this is that I believe it will give a better overall view of the use and workings of Principlism. Due to space and word constraints I can only give a snap shot of these discussions and papers and cannot enter into in-depth analysis of how it addresses nuances of moral problems. However, having highlighted some of these discussions I will challenge

them make clear my position, which I reiterate in my hypothesis. The argument put for by the pro Principlism population and principle-based ethics advocates that when approaching moral dilemmas, physicians consider the four core principles of Principlism. I recognise the merits of Principlism but I see virtue ethics as an important component when addressing psychiatric dilemmas and propose that Principlism and virtue ethics make a credible combination in psychiatry.

First, I address Gillon's (2003) paper on the principle of autonomy, which is widely regarded as *primus inter pares* among the four principles, although Beauchamp & Childress reject this particular view. Gillon (2003) argues that respect for autonomy should hold a primary place among the four principles. In psychiatric care and clinical medicine, respect for autonomy dictates that patients with decision-making ability have the right to voice their opinion when addressing treatment preferences and pathways of care (Tsai, 2008). Gillon embraces a Millian understanding of autonomy, understanding it as a deliberate self-rule; the ability and tendency to think, to make decisions for oneself about the way one wishes to lead one's life based on that thinking, and then to enact those decisions (Gillon, 2003). According to Gillon, the other three principles (can be reduced to) respect for autonomy, beneficence and non-maleficence towards autonomous moral agents presupposes respect of these agent's even when they chose to refuse lifesaving medical interventions (Azzetsop & Rennie, 2010). Gillon also takes an autonomy centred approach to justice, arguing that responding to people's needs justly will require respect for those people's autonomous views. These include autonomous rejection of offers to meet those needs; and, to conclude his praise for autonomy, Gillon writes that respect for autonomy contingently builds prima facie moral requirement to respect both individually and cultural moral variability (Gillon, 2003).

While I agree with Gillon that not all autonomy-based approaches to bioethics take the explicit and extreme form, autonomy continues to be treated implicitly as a primary value in many controversial psychiatric decisions. Considerable theoretical discourse exists concerning the importance of autonomy in relation to the remaining principles and how to apply those principles within medical ethics. Several authors respond mainly to specific case information and change the importance of the ethical principles based on the situational information in each case<sup>16</sup>. Contemporary readings often accept a 'Millian version' of autonomy that is

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<sup>16</sup> Landau and Osmo (2003) Westin and Nilstun, T (2006)

associated with self-seeking attitudes. This approach to respect for autonomy refers to the capacity to act on needs, wants, or wishes. Since a person's action is informed by instrumental reasoning it constricts the scope of reason so that the subject to any desire or disposition that happens to endorse at the time one acts (Gillett, 2008). Let me build on Gillett's viewpoint and bring it back to psychiatry. Autonomy based ethics should place the responsibility for medical decision-making predominantly in the hands of the patient. I say predominantly because it does depend on cognitive ability and the capacity to make those decisions. This raises the descriptive question of whether this conception accurately reflects how clinical decisions are made. As well as the normative question about whether a conception should (or should not) function as a universal ideal.

Autonomy based bioethics has a tendency to distort the relationship between individuals and the world. On the one hand, it exaggerates the power and range of individual agency; furthermore, it underestimates the impact of society, culture, and environment, both on the individual and on health (Azzetsop & Rennie, 2010).

Macklin (2003) agrees with Gillon supporting the claim that there is soundness and utility in the principles. As an example, he considers the importance of respecting autonomy in the case of a Jehovah's Witness refusing a lifesaving blood transfusion. The Jehovah's Witness, makes a choice based on a reasonable cost/benefit analysis as defined by his religion. He decides that the harm of receiving the transfusion and being denied "eternal salvation and is greater than the harm caused by refusing the transfusion and ending his mortal life on earth" (Macklin 2003, p 276). This situation is very different from a situation in which a patient does not and cannot understand the risks/benefits treatment of ECT. Consider the ethical framework that Principlism's encourage us to accept when addressing the issue of ECT. Who is the psychiatrist answerable to, the patient, himself, or society? If the psychiatrist has a moral obligation to act in a beneficent manner, to promote autonomy, be non-maleficent and act in just and equitable way. Can they act appropriately when trying to measure the unknown outcome of ECT gives us "when determining the likelihood of an array of potential good and bad outcomes" (Macklin, 2003 p.277). However, if the framework of Principlism is intended help clinicians choose an objectively moral procedure, and then there is a question of justification of use on what this theory is supposed to do and how it helps with dilemmas within psychiatry. This is where the shortcomings of Gillon's autonomy centred conception of bioethics become the most obvious .I challenge the viewpoint that Principlism can be applied as a singular framework in all situations, especially within psychiatry. Tensions are

created between the principles when clinicians face moral dilemmas, and psychiatry has become over reliant on respecting autonomy. In an increasing culture of self-determination, the concept of autonomy is gaining momentum, as the cornerstone of good psychiatric practice. However, counterarguments (and criticism) explore the merits of this ideology on in-patient psychiatric care. The basis of these counterarguments is that patients are disadvantaged by an overzealous focus on autonomy as they may exercise a right to make a poor choice, which leads to subsequent harm (Harnett and Greaney, 2008). Beauchamp & Childress both acknowledge the source of John Stewart Mill and Immanuel Kant as a source of their autonomy principle. Beauchamp & Childress regard autonomy as one of the four principles, and ascribe this principle to Kant, who according to them, 'argued that respect for autonomy flowed from the recognition that all persons have unconditional worth, each having the capacity to determine his or own destiny' (Beauchamp & Childress, 1994, p125). Undoubtedly, Kant does offer such an argument: but whether it can be used to support the principle of patient autonomy is open to doubt. What I believe is needed here is to see what Kant meant by autonomy, and why he thought it must be respected. Kant's definition of autonomy is that: 'Autonomy of the will of property of the will by which it is a law to itself (independently of any property of the objects of volition)' (Kant, 1997 p47). Therefore on the basis of that definition, he then states the principle of autonomy as 'to choose only in a way that maxims your choice are also included as universal law in the same volition' a principle which he calls 'the sole principle of morals, (*ibid*).

Matthews (2000) when discussing the work of Kant makes the point that for Kant, then, a person is choosing autonomously when he chooses something, not as a pure act of will, based on impersonal general laws. "I choose to perform an action or to bring about a state of affairs autonomously, when I am making my choice not myself, as a particular individual with particular individual contingent desires and wishes but as a rational agent" (Page 60). The Kantian argument is not that human choices are worthy of respect because they are free, in the sense of being the expression of the agents own desires and conceptions of good. They are worthy of respect, and are genuinely autonomous, only if they are not constrained even by the agents own desires or conceptions of the good: if they are based on recognition of what is objectively as such, as determined by universal moral principles (Matthews, 2000). It follows then that we can deduce from this that Kant's conception of autonomy differs in respect from that employed by modern ethicists, and so that Kant's argument for respect for human worth cannot be used to justify the modern principle of 'respect for

autonomy'. When making treatment choices, the patient's concern would be receiving the treatment, which will produce the desired result, which may not necessarily, be the one required by universal law. The following example will distinguish the differences between Kant's conception of autonomy and how it is used within modern psychiatry.

A patient suffering from Bi-polar disorder refuses her medication because the side effects are more traumatic to deal with than the illness itself. Not taking her medication could cause problems at work, as she is a company director who makes decisions involving high levels of financial acumen. In such a case, believers in respect for patient autonomy would argue that her wishes be respected. However, the impact of that decision has consequences not only for herself but also for her colleagues within the company. The modern principle for respect for autonomy in this case would imply we respect the patient's wishes, but Kantian principles would imply the opposite. In the Kantian sense, the patient would not be acting autonomously, but rather simply expressing her feelings about the adverse effects of the medication, which she feels are intolerable. Nevertheless, if Kantian arguments cannot justify the claim within psychiatry that patient autonomy (in the modern sense) should be respected, are there any arguments that can? Given these general considerations, the argument for respecting patient autonomy is therefore more Millian than Kantian. The Millian argument for respecting autonomy is utilitarian: it is in the best interests of society as a whole that individuals should make decisions about their future, including decisions about their medical care including objection to treatment that does not promote their wellbeing. Beauchamp & Childress acknowledge the differences in that Mill emphasises that individuals should be permitted to develop in the literal sense and according to their personal convictions; whereas Kant emphasizes that autonomy is based in deciding on the base of pure reason (Matthews, 2000). (I will pursue this point in more depth in the next section to highlight the problems of utilising the framework of Principlism within psychiatric settings). Historical reasoning for admission to a mental hospital was that the person was out of their mind, of unsound mind, or was a lunatic (Monat, 1940). We have moved away from such terminology, but the fact remains that patients are often unaware that they are ill and lack insight when they have a psychotic type illness. On another note, if we believe that patients need treatment and care because they make irrational decisions, we must first address rationality. What is rational to one person is far from what another would deem rational, but just because an individual would rather refuse treatment than suffer the side effects does not make the decision irrational. Yes the person's

thinking may be classed as distorted or exaggerations of inferential thinking, it can be argued that this does not render them unable to make autonomous decisions. Deviations from the norm are not necessarily illnesses, so how does restriction of autonomy of the patient prove to be positive within this situation? I emphasise this point from the work of Dworkin who said "...if the autonomous man cannot adopt his motivations *de novo* he can still judge them after the fact. The autonomous individual is able to step back and formulate an attitude towards the factors, which influence his behaviour". (Dworkin, 1976, p24).

So consider my last point, many psychiatric disorders are paradigm examples of what we label 'mental illnesses where the person suffers from some degree of cognitive disability'. If we move the argument forward that all those involved within healthcare, including other relevant professionals I have worked with like the police and social services, can be said to have a duty to help these people. A mentally ill person's right to refuse treatment is found 'unintelligible' of irrational form. Alternatively, is it right to restrict, manipulate or totally dismiss autonomy to act in a beneficent manner to impose treatment if the patient sees nothing distressing about their condition and would rather live with it than endure the negative side effects of varying mental health treatments. The link between all the criticisms when using Principlism within psychiatry is that it offers the psychiatrist or healthcare worker a method of reasoning but not guidance on how to deliberate the *prima facie* conflicts of the method. This is particularly true when key issues of autonomy are involved. This is now an issue I will address in the next section.

### Section 3.5: Conceptual Discussion of how Principlism is linked to psychiatric practice.

In this section, I highlight how the four standards of Principlism are used in practice. I begin with a question: in what area in psychiatric decision-making scenarios does the over reliance on autonomy occurs? Firstly an observation: When dealing with patients that suffer from disruption of cognitive ability, healthcare workers start from the position that they believe the patient has a loss of autonomy and is incapable of decision-making. Clinicians see the patient as making decisions that they might not make if they were not governed by their illness, and this leads these providers to believe they have justification for imposing treatment. They would take the stance they are justified to apply treatment for patients whose ability to maintain their own safety is compromised. Seedhouse's (1988) analysis of autonomy supports this view, considering autonomy to be something that must not only be respected but also created. Seedhouse contends that autonomy is an

individual characteristic, an ability, or quality that can be enhanced. Seedhouse suggests that healthcare workers endeavour to create autonomy for patients, and that this is not synonymous with granting patients absolute choice. Absolute choice would involve the opportunity for recovery, and possibly sufficient development of autonomy, in order to enable the patient to exercise greater choice. Seedhouse does acknowledge that there is a difficulty in determining at which point creating autonomy takes precedence over respecting autonomy.

Considering examples of these issues creates a route into allowing for the applicability of Principlism to psychiatry. I must begin by noting the relative absence of psychiatric literature in the bioethics field. Pockets of ethical issues are to be found in the psychiatric and ethical literature, but the everyday ethical problems faced by doctors and nurses are not given adequate or realistic consideration. Beauchamp & Childress write extensively about high profile issues such as euthanasia and abortion, yet psychiatry is only mentioned briefly. Beauchamp & Childress (2001) give a clear reflection of the everyday difficulties encountered in the practice of mental health care, a point made by Fulwood (1995), yet no less than a third of the problems described in their appendix of case histories are psychiatric. Psychiatry is in the precarious position of having an aging paradigm of practice rooted in old customs, beliefs, and knowledge that has been recalcitrant to the adaption and incorporation of new knowledge and new realities of psychiatric clinical practice (McCabe, 2002). The juxtaposition of an aging paradigm that poorly matches new evidence based realities or research findings leaves the profession with seemingly incompatible knowledge structures, which constantly divides the psychiatric profession when we search for the most proficient way of treating the mentally ill. Therefore, my position here is to say ethical theory and reasoning do not alone solve dilemmas within psychiatry, but they can provide a framework to clarify the many issues, which can arise. So following this statement, I reflect on questions of the framework of Principlism when used in psychiatry. Under what conditions is it morally permissible to impose risk on psychiatric patients, and under what conditions? If guided by Principlism, will one identify and perform the objectively moral action? Will the decision to use ECT be justified and consequently the action that flows from that decision be justified? When considering the effectiveness of Principlism in the decision-making process around ECT, I will keep these questions in mind. Healthcare ethics aims to inspire questions and examine ethical options in health care situations, often demanding a choice between at least two undesirable alternatives.



Involuntary treatment of ECT is one of the most controversial aspects of psychiatric care and has been subject to varying legislation (chapter 2b). While there has been progress towards finding a compromise between the patient's autonomy and the protection of the patient, serious problems remain in this area. I am concerned with the use (perhaps misuse) of Principlism as a basis for professional decisions surrounding ECT. Unless we are prepared to uncover these issues and engage in a serious and sustained discussion, we will remain in a dormant state at the expense of patient care. Within my literature search, I uncovered three authors who used Principlism within psychiatry and discussed its application. Campbell (2005) looked at the reliance of the four principles of biomedical ethics within psychiatry, and Robertson et al. (2007) addressed the overview of principles-based ethics within psychiatry and their value when considering the clinical and social context of ethical dilemmas within psychiatry. Lastly, Harnett & Greaney (2008) who within their clinical practice tried to contextualise the principle of autonomy by reviewing ethical dilemmas experienced by healthcare workers in psychiatry when balancing autonomy against the other three morally justifiable ethical principles.

Campbell (2005) promotes the use of philosophy within mental health, claiming that it offers more solutions and helps reduce reliance on the simplistic solutions that the four principles provide. This is not because philosophy offers solutions to some of the dilemmas, but because it demands coherence and honesty in the arguments used to defend specific healthcare policies and clinical procedures, a demand that Principlism alone does not make. Campbell applied three 'rules of reasoning' to some concepts and controversies within mental health: dangerousness, responsibility, and treatability. He first writes about dangerousness, he uses a patient suffering from anorexia nervosa as his example. In this case, the patient is a danger to themselves due to their self-harming tendencies. He argues that in self-harm situations, "the ghost of John Stuart Mill still haunts us. Mills robust defence of liberty led him to want to restrict the freedom of individuals to act only on those actions that threatened others" (Campbell, 2005 p.1009). Campbell believes that dangerousness is not limited to violent actions towards others, and that the actions of people who engage in self-harm are determined by illness, not by autonomous free choice. He recognises that the framework of Principlism is inadequate in instances that involve extreme physical situations, these would include patient refusal to stop self-harming behaviours when considering the variables of mental lucidity and the patient's right to self-determination. Lastly, he discusses treatability, asking if Principlism can help with the question 'is there a treatment for mental health?' However, he quickly realises that this questions requires a definition of health. This he cannot provide

due to the conceptual debate on definitions of illness, disease, and health. In his attempt to use Principlism to aid with dilemmas in psychiatry, he makes the following points: Principlism oversimplifies the important issues and that it only opens up new ways of thinking. He believes that it is the diversity of the ethical theory which gives the discipline its strength, and that we should use a range of theoretical analyses to compliment Principlism like the virtue ethics approach.

In Harnett and Greaney's work (2008), they make the point that psychiatric healthcare is currently influenced by Principlism, focusing on the fact that this is a 'normative approach' to ethics. A normative approach is a branch of moral philosophy that applies ethical language and moral theory to a situation to determine what one 'ought' to do (Fox & De Marco, 2001). The authors discuss the concept of autonomy between the patient and healthcare provider, but I found that the authors prioritize autonomy over the other three principles for example when considering detention, restraint, consultation on care, consent, best interests and administration of medication. The authors aim to show that current psychiatric practice places significant value on autonomy without sufficient discussion of its moral worth under specific conditions. They claim that the principles of beneficence and non-maleficence are only utilised in support of involuntary or coercive treatment and that these principles fundamentally underpin the ethos of current mental health legislation, for example the use of 'rapid tranquillisation' (Harnett & Greaney, 2008). In keeping with my own viewpoint, the authors note that promoting autonomy is problematic if the patient is violent, while promoting beneficence or justice may result in restraining patients against their will for the benefit of others (restraint is an issue I will address later in section 3.6.1). As Gibson (1993) described in his account of a moral dilemmas, this is a situation where one must choose between conflicting values, neither of which result in an ideal outcome. Harnett and Greaney conclude by saying that mental health care providers are required to decide whether respecting a patient's autonomy takes priority over beneficence and non-maleficence. While autonomy is to be respected, it is not an absolute principle to be upheld at the expense of others. Robertson et al. (2007) consider the application of Principlism in a specific scenario, discussing a 42-year-old schizophrenic female who insists on giving a kidney to her son who has been on dialysis for ten years. While she does suffer from delusions, she understands the concept and significance of kidney transplantation. The authors write that principle –based ethics is a useful tool in many situations, and is often more articulated than other ethical frameworks. However, they use this case study to show that Principlism is not ideal for every situation. The authors look at how each principle

applies to the situation. First, they consider autonomy, asking whether the patient has the capacity to give informed consent. They note that autonomous choice is a dimensional construct and can only be considered in regards to specific tasks at specific points in time (Dworkin, 1986). However, they also note that Principlism appeals to doctors because it reduces the ethical dilemma to an issue similar to diagnostic assessment. Their belief is that Principlism will help them address the possibility that in this scenario, the mother's delusions interfere with her decision-making skills. In certain psychiatric situations, such as the one at hand, respecting the principles of beneficence and non-maleficence may in certain circumstances mean failing to respect a person's *autonomy*. For example, it may be necessary to provide treatment that is not desired in order to prevent the development of a future, more serious health problem. Although the mother in this case wishes to save her son's life, the future possible complications of kidney removal paired with her questionable mental state must be taken into consideration when making a decision. Physicians are expected to refrain from causing harm, but they also have an obligation to help their patients. Ethicists often distinguish between obligatory and ideal beneficence. Ideal beneficence comprises extreme acts of generosity or attempts to benefit others on all possible occasions. Physicians are not necessarily expected to live up to this broad definition of beneficence. However, the goal of medicine is to promote the welfare of patients, and physicians possess skills and knowledge that enable them to assist others. Due to the nature of the relationship between physicians and patients, doctors do have an obligation to 1) prevent and remove harms, and 2) weigh and balance possible benefits against possible risks of an action. However, to the patient it is much more salient because her view is she will save the life of her son.

When considering an act of non-maleficence physicians should not provide ineffective treatments to patients as these offer risk with no possibility of benefit and thus have a chance of harming patients. In addition, physicians must not do anything that would purposely harm patients without the action being balanced by proportional benefit. Because many medications, procedures, and interventions cause harm in addition to benefit, the principle of non-maleficence provides little concrete guidance in the care of patients. Where this principle is most helpful is when it is balanced against beneficence. In this context, non-maleficence posits that the risks of treatment (harm) must be understood in light of the potential benefits. Ultimately, the patient must decide whether the potential benefits outweigh the potential harms.

Psychiatric healthcare providers involved in the case of the schizophrenic woman and her son are encountering one of the most common ethical dilemmas: balancing of beneficence and non-maleficence. This balance between the benefits and risks of treatment and plays a role in nearly every medical decision when, physicians give patients the information necessary to understand the risks and benefits in order to make a decision themselves. Ultimately, the patient assigns weight to the risks and benefits. Nonetheless, the potential benefits of any intervention must outweigh the risks in order for the action to be ethical. Lastly, the authors look at how the principle of justice applies to the same scenario. The surgeon's viewpoint is that he is reluctant to recommend the living donation of a kidney by a psychiatric patient. However, if we are to argue for the principle of justice, psychiatric patients must be afforded the same entitlements as any other person. Again, the authors note the difficulty of applying the principle when the person's cognitive capacities are compromised. As in the case of Campbell (2005), they advise we should use a range of theoretical analyses to compliment Principlism like Virtue ethics.

In conclusion, let me present a viewpoint brought about by reflection on these authors discussion on psychiatry and the issues they raise. Their view on Principlism oversimplifying issues and that it is not always easy to utilise in clinical practice is something I can identify with. But one very basic and very strong argument against the sole use of Principlism is that, psychiatry is far too complex an area of medicine for Principlism to be anything other than the most simplistic of guides to ethical reasoning. Therefore, it becomes essential to supplement it with a view that is more grounded and nuanced approach such as Virtue ethics in order to avoid over-reliance on a simplistic framework. Therefore, the implication being (and something I will discuss later in section 3.7 and 3.8) that a good virtue ethicist will know when the ethics framework of Principlism is too limited.

### Section 3.6: The Role of Principlism in ECT.

Compulsory ECT treatment is a clear example of a case when two or more principles apply and conflict. For example, if a severely depressed patient is in need of treatment, we have an ethical duty to act in a beneficent manner to save the patient's life, even when this involves overriding the principle of autonomy. Ideally, ECT treatment will allow the patient to function in everyday society, but any side effects of the treatment are not discussed in advance due to the patient's mental state. When considering involuntary use of ECT, we must

balance the demands of these principles and determine which are stronger given the situation in each individual case. The problems associated with applying beneficence may be obscured when we use involuntary treatment and compulsory detention. Deprivation of liberty is a maleficent act, yet the patient gains protection from harm and necessary clinical services. Does applying Principlism to the debate around involuntary use of ECT make the treatment ethically acceptable? I believe that it does not. In fact, Principlism is unhelpful because healthcare professionals are expected to respect both beneficence and autonomy simultaneously. To use ECT without consent would infringe respect for autonomy, but refraining from treatment would infringe beneficence, a point made by Leung (2002). The principle of respect for individuals and the values they pursue and hold is central to the ethical conduct within nursing and medicine and therefore all patients should as a matter of principle be autonomous. Another reason Principlism is difficult to use when considering the use of ECT as a treatment is that ECT has the capacity to diminish the patient's ability to make cognitive rational decisions, or their autonomy. By the healthcare givers, arguing from a beneficent perspective it influences an important ethical area, which is the principle of autonomy. The question which then begs to be answered is by acting in a beneficent manner without acknowledgement of a known side effect are we then reducing the capacity to be autonomous? As an analogy consider the treatment 'leucotomy,' now called 'lobotomy', which is the surgical operation of cutting some of the nerve fibres in the frontal lobes of the brain as a treatment for intractable mental disorders. History and science has proved that this treatment exacerbated the mental illness (El-Hai, 2005; Persaud, 2005). Lobotomies were done with the best intention in a beneficent manner, but in many cases reduced patients to a level of non-cognitive function. Principlism offers little help because of the possible lack of ability of the individual to make a decision because of mental illness. Honouring all four principles for the patient would be unachievable because they are unable to make an autonomous choice because of their illness or diagnosis given by others.

Reiter-Theil (1992) provides support for my argument; she makes the point that according to autonomy, a treatment should only be applied if a person is willing to accept it because of adequate information given and competency to decide. She emphasises that non-maleficence and beneficence represent the same dimension but both can be harmful at the same time. The two principles constitute a risk-benefit analysis frequently necessary for a good medical decision; if the risk-benefit analysis favours a particular treatment, it is ethically right to recommend the treatment to the patient. In special cases, e.g. a risk of death or suicide, it can be

ethically justified to intervene without the patient's knowledge or consent. The sole use of Principlism as a theoretical framework is therefore not justified to hang this decision on. The question I pose is can a certain procedure like ECT be judged ethically right for one person but have negative consequences for others, and whose interests are served best, society's or the individual?

Let me add another variable to support my argument at this point. A leading concept in the bioethical literature on the involuntary use of ECT is the concept of adhering to the 'least restrictive alternative option'. Since 2005, it has been one of the mainstay principles within the Mental Capacity Act (2005) (when addressing capacity decision-making issues) and requires that the patient be treated in the least restricted way when considering their physical and mental wellbeing. What does 'least restrictive' mean in the context of care – it means that healthcare providers should always look for and use the least 'invasive' pathway of care therefore reducing anything detrimental to the patients'. This concept holds that when several approaches for treating the mentally ill are available, the least restrictive option should be chosen. The basis for this concept is found in considerations of the rational relationship of means and ends (Freedman, 1987). My position is that given the restriction of liberty and lack of acknowledgement of autonomy, intervention in the life of another is inherently wrong. Justification of interference must show that no other method would cause less interference. I argue that as one among several treatments, ECT fails this test for two reasons. The first is whether the problem has been correctly identified. I argue that, for those of unquestionable lack of insight, the idea of least restrictive misses the point. For the psychiatric patient, whose inability to express a coherent choice or reaction in any way in which they are treated, not the least restrictive way, the most beneficial should be chosen.

My belief is that the second is more relevant. How is restrictiveness to be identified and judged?

Restrictiveness is not a natural and simple measurable quantity, but some form of combination of factors, which can work at cross-purposes. In the cases of the depressed patient who are treated by ECT, by close observation and possibly psychiatric medication. A case can be made for any of the possible rankings of those alternatives in terms of intrusiveness or restrictiveness. A defensible ranking would need to follow from an in-depth examination of the values involved. What is it about restrictiveness or intrusiveness that we find objectionable? Would it be for example, the number of times individual choice is overlooked? (Freedman, 1987). Alternatively, the significance of the choices is lost on the patient. My conclusion is therefore that no

purpose of clarity is solved by papering over the main issues of basic values by resorting to the formula of least restrictive option decision-making. To give my argument more credence I move away temporarily from the discussion on the ethics of ECT, and use a different analogy, by looking at the use of physical restraint. I do this because I want to highlight a different clinical problem that picks out the difficulties when utilising the theory of Principlism within a psychiatric clinical setting.

### Section 3.6.1: Restraint.

My starting position statement here is by its very definition, restraint is incompatible with the principle of autonomy, as far as it involves restricting a patient limiting their freedom in some way against their will. It is therefore impossible to use the principle of autonomy, as unilateral decision making by clinicians is that the patient is 'out of control' and in need of external control and the patient lose their voice in the decision-making process. The conflict posed by the use of restraint in psychiatry is an eloquent example of the conflict between divergent views and principles, all of which equally deserve within their own merit. The issue is that the decision to use restraint takes place under a veneer of an appeal to have respect for autonomy. Yet this is impossible for a number of reasons, so the processes of consent and patient decision-making are put into place to make it seem as if the patient's autonomy is in some way being respected is simply a smokescreen for what is really happening. This is a central criticism of the way Principlism is not being applied properly in psychiatric practice. However, this is a criticism of the application of Principlism, not Principlism itself. What I argue is that by practising a restraint within ethical practice through the lens of the four principles, it leaves professionals in terms of conflict between the ethical principles within a complex and multifaceted problem. This decision making process requires the clinician to make a judgement about the effect of the pathology on a patient's behaviour and not a decision judgement about the authenticity of a patient's physical and mental make-up. The unfortunate necessity of physical restraint sadly is part of psychiatric and learning disabilities nursing that all nurses find troubling. Others include the use of seclusion, rapid tranquillisation, and the use of covert medications. Having worked in an extremely volatile environment where I needed to be part of a team to initiate restraint, there are times when physical restraint is the only possible course of action open to the caregivers. I have discussed the issue of risk (in chapter 2b.6.1) and I return to it when discussing restraint because it puts both patients and practitioners in a clinical quandary. Staff members are morally obligated to

keep the patient from being a risk to them or other patients despite putting the restrained individual at risk from the restraint itself (Mohr, 2010).

McCain & Kornegay (2005) make the point that decisions have to be made along utilitarian lines in so far that restraint is sometimes necessary and is justified in that it benefits more patients. They contend that restraint is designated to meet the needs of the greatest number of people at the expense of the individual. Muir-Cochrane & Holmes (2001) make a number of assumptions that give weight to their argument that need to be challenged. Firstly, it is generally accepted safety needs and therapeutic considerations for the individual, and others on the ward must be balanced against the rights of the individual. For this contemporary argument, I agree with Myers (1990) who suggests that valid reasons must exist for the use of restraint and it is the nurse's moral and legal responsibility to use the least restrictive means when dealing with potentially destructive behaviour. It is not to be used as a treatment of violent behaviour without just cause. The ethical key is that this measure should always be able to demonstrate that the level of force applied in the restraint does not exceed the violence it was intended to control. The correct course of action may not be clearly defined and arguments may exist that would challenge either decision. The dilemmas posed by the use of restraint in psychiatry are an eloquent example of conflict between divergent values (or principles) that are equally deserving of respect (Berghmans, 2012). These principles can be considered as "prima facie" duties, in agreement with Ross (1939) who, in seeking to reformulate the typical Kantian deontological principle of ethics, drew a distinction between prima facie or conditional duties and actual duties (O'Neil, 2005). Prima facie duties are the primary principles of the moral life: self-evident, intuitive, instantly recognisable, and imperative. Actual duties, on the other hand, are currently present or effective obligations. Prima facie duties should always be respected, though this may occasionally be impossible, mostly because of conflicts between equally prima facie values. When this happens, criteria must be found to decide whether a violation is justified. In the case of physical restraint, it is obvious, that freedom (autonomy) may conflict with therapeutic aims (beneficence) as well as with the duty to protect the patient from risk to him/ herself or to others (justice) (Petrini 2013). Yet Beauchamp & Childress (2009) propose a reference grid to help the clinician decide, when there is a conflict between principles- when a violation of one or more of these principles is justified.



According to Beauchamp & Childress (2009), a violation may be justified provided that

- The moral goal that justifies the violation has a realistic chance of being achieved,
- The violation of an obligation is necessary in the specific circumstances, meaning that no other morally preferable alternatives are available,
- The violation is of as little significance as is compatible with achieving the goal,
- The agent attempt to minimise the effects of violation.

(p.69. 2009).

In contrast to the Principlist approach, let us also consider an alternative approach the principle of double effect, another principle that can be applied, albeit in a soft touch manner, to the issue of restraint. This principle comes into play when an act is performed towards a proposed 'good' outcome, (treatment, risk prevention and patient safety) also has one or more undesirable effects (violation of autonomy, and absence of consent). The principle of double effect has already entered the philosophical and ethical arena and has been debated and revisited widely in the recent decades (Aulisio 2003). Although in recognition of this principle but not discussing in-depth, the principle of double effect is an act performed with good intentions, (such as therapy, risk management). However, it also has the ability to have harmful consequences (which in the issue of restraint is the restriction of the person's freedom and movement) is morally acceptable only if three conditions are met:

- The harmful effects are not intentionally pursued;
- The harmful effects are not the aim of the act, and the good effect is not a direct cause and effect result of the harmful effect;
- The intended good effect is as great or greater than the harmful effects and proportionate to them.

Boyle (1980)

So opening up the discussion to protect my position on this issue, I put forward a view to question the Principlist approach, when considering restraint it may be prudent to combine the two mentioned approaches above for the benefit of patient safety and care. If it is therefore necessary to consider other frameworks, it

must then follow that this highlights a problem when initiating the principles of Principlism solely in the area of restraint, and when there is a violation of one or more ethical principles. At the core of Western morality is the basic belief of individual freedom; it must then follow that respect for autonomy is a reflection of that morality and is based on the right to privacy and self-determination.

Mohr (2010) makes the point that two fundamental components of autonomy are liberty: the right to self-determination without interference or controlling interference from others and agency: the capacity to make decisions and intentionally act upon them. Firstly let me ask you to consider/imagine that a patient suffering from a mental illness was given a directive (for their own good) and did not comply, were then threatened with restraint, the decision to co-operate would be non-autonomous because it is based on coercion (i.e., credible threat difficult to ignore). Similarly, manipulation can result in a non-autonomous act. Secondly, my point is also imagine that to accomplish a specific action or behaviour such as the caregiver provides, the caregiver limits or withholds information that the patient would be able to process. For this reason, the patients are asked to declare their consent, (to be put into a restraint hold) and caregivers are obliged to disclose the nature of those procedures and the inherent risks. There is no or little positive good (act of beneficence) and definitively doing no harm is not evident (Non-maleficence) as the actual restraint holds themselves are painful. By its very definition, restraint is incompatible with the principle of autonomy, as far as it involves restricting a patient limiting their freedom in some way against their will. In addition, it could be classified as medical malpractice and negligence if a clinician imposes a careless or unreasonable risk on a patient. Providing a proper standard of care that avoids or minimises the risk of harm is supported not only by our commonly held moral convictions but by the laws of our society as well. In a professional model of care one may be morally and legally blameworthy if they fail to meet the standards of due care. The principle affirms the need for medical competence and it is clear that medical mistakes occur, however this principle articulates a fundamental commitment on the part of the healthcare professionals to protect patients from harm (Dimond, 2008). The crux of the conflict in the treatment of ECT could be argued to be that the healthcare provider feels it is necessary to treat the clinical condition, while its effects and side effects are not acceptable to the receiving party. Both viewpoints are incompatible so which one should take precedence? Can another principle solve the conflict? As often is the case, autonomy looms large in this dilemma. I also add another concern to consider for my position: To articulate the prima facie conflict there appears a tension

between the issues of autonomy and non-maleficence and beneficence. The patient's capacity to make decisions has to be balanced with the need to respect his wishes. Is there a practical way of assessing the value of these principles once the boundaries of obligation to care are determined, or should doctors and nurses be concerned about what benefits and burdens apply when applying this theory? Ethical questioning begins with identification of a problem, a difficulty, a possible harm and bioethical writings often incorporate rather than scrutinise the assumptions behind the practices. It is therefore impossible to use the principle of autonomy, as unilateral decision-making by clinicians, is that the patient is 'out of control' and in need of external control and the patient loses their voice in the decision-making process. Precipitating this cycle is often a directive from the caregiver to the patient and on the face of it 'never' in the patients favour, and autonomy although (you could say) not totally absolute is under assault here within a clinical setting (Mohr, 2010). Before adopting such radical measures all less radical therapeutic options, that have some chance of success should be explored. Healthcare providers have an ethical duty to give information; this obligation is also valid for restraint. Clearly, this is not always possible, particularly if the patient is not able to comprehend the information given in severe circumstances. What must then follow is that the professional relationship between caregiver and patients becomes unequal. The idea of compliance as an expectation from patients strengthens and underscores inequality. (Petrini 2013). The expectation of compliance, as opposed to patient engagement in their treatment pathway is the antithesis of respecting autonomy. Having said this, I have to agree with a specific point when we address the counter arguments and I have experienced this on a professional and personal level. It is that the healthcare givers themselves have a right to expect to be safe and to have the tools at their disposal to assure this and that their charges are protected against bodily harm. Therefore, in the absence of less coercive tools being available, they are forced to breach patient autonomy at times when there is no alternative and it is unavoidable. My next point I wish to focus on is the argument put forward by the caregivers that restraint is a treatment, and it benefits the patient.

When addressing the principle of beneficence, can we honestly call the act of restraint a treatment? In order to establish the proportionality (between the need for and the application of restraint) each individual case should be assessed and all relevant circumstances (e.g. age, mental capacity etc.) needs to be considered (Petrini, 2013). The principle of beneficence confers a moral obligation on the caregivers to act for the benefit of their patients. Clinicians are rarely able to produce benefits without creating additional risks or incurring

costs. As a result, to act with beneficence they must act only when the benefits warrant the risks and costs associated with a particular procedure or action, for example, is the safety of others compromised, and does this justify restraint procedure (Bigwood & Crowe, 2008). Following that beneficence must be constrained by autonomy to prevent the rights of the patient from being subjugated to their medical needs or the medical needs of others. Caregivers want to provide care that they believe be in the best interests of the patient but must acknowledge patient preference (exercising autonomy). This now highlights an interesting dilemma and raises the challenging question of whether the caregiver's primary obligation is to act for the patient's medical wellbeing and welfare, or to promote their autonomous decision-making.

Beneficence usually requires specific action on the part of the caregiver, which includes weighing up all the available options to facilitate the maximum benefit for the patient (Mohr, 2010). Therefore having said all that, with respect to those actions, they should be therapeutic and be part of a well-being care pathway: otherwise, patients would not need caregivers. They could get better on their own and heal themselves. Following through this line of reasoning now requires me to ask the question whether restraint is therapeutic.

Parenthetically, although the number of institutions and clinical environments I have worked in call the various holds 'therapeutic holds', simply naming them therapeutic does not make it so, and to do so in that euphemism has the capacity to convince outsiders that it is something which it is not (Berrios & Jacobowitz, 1998). The argument and evidence that restraint is therapeutic is unconvincing and a massive analysis from a number of sources concluded there is no evidence to say it benefits the patients (World Health Organisation, 2005). The physical and psychological effects have been well documented within the psychiatric literature. Potential adverse effects of restraints increased with psychotropic medication, and the risk is increased when the patient is held in the prone position for prolonged periods (Laursen et al. 2005; Nielson, 2005).

Examining the use of restraint against the principle of justice is problematic and the question of justice is a difficult conundrum when patients are detained against the Mental Health Act (1983) [2007 revised].

Commitment to psychiatric units on the grounds of public safety necessitates thinking about justice as encompassing patients and the public good. It follows that in such instances, consideration of justice issues becomes very different from those in maintaining psychiatric units and hospitals. Therefore, can the four principles help us with this unique situation where psychiatric healthcare professionals are left with the decision to restrain or not. There is a paradox to consider in that the right action to take may be in fact wrong.

When viewed through the lens of Principlism, the practice of physical restraint can be argued to violate the four principles, which underpin the numerous healthcare professional codes of ethics. However, in some instances within psychiatric healthcare, restraining a patient is unavoidable and is actually the morally correct procedure to take within the given circumstances. The dilemma of restraint highlights that in certain circumstance restraint is justified because of the lack of alternative procedures to detain certain individuals who pose a risk to themselves or others (Berk et al. 2008).

Following the issues, I have raised in restraint I now illustrate that balancing principles, which Beauchamp & Childress (2009) advocate, is problematic, and offer a charge that they do not succeed. They make the point “if principles conflict they can be justifiably overridden which is the act of ‘balancing’ (meaning that none of the principles are absolute). Balancing principles tells about their weight and strength when balancing two principles, one principle is infringed by another” (Beauchamp & Childress, 2009, p15). They go on to make the point that “... physicians acts of balancing, and specifying ethical principles often involve ‘sympathetic insight humane responsiveness’ and the practical wisdom of evaluating a particular patients’ circumstance and needs” (Beauchamp & Childress, 2009, p22). Balancing Judgements and Solving Conflicts. So if the premise by Beauchamp & Childress is that ‘balancing’ is best suited for reaching judgements in individual cases , then the question has to be does balancing provide us with justification for carrying out these acts? I illustrate my contention that balancing is an act of inarticulate intuitions and an array of circumstances need to be addressed before it’s taken that we use balancing and there is a need for its justification. Different ways can be used to enable more in-depth analysis of this clinical case when using a Principlist strategy: (1) to make additional specifications and (2) to make use of the method of balancing (Gordon et al 2011).

#### 1. Additional specifications.

By applying additional specifications, the Principlist tries to solve the conflict between (a) differing principles (e.g. non-maleficence and beneficence or (b) differing interpretations of one principle (e.g. autonomy).

If the psychiatrist utilises the specification of beneficence, they would take the line of argument that, restraint could well be unacceptable and pursue other pathways of care. Therefore, if the evidence is that restraint is not of therapeutic value, and therefore questionable tools in the armamentaria of the caregivers within mental health, it is timely at this point to question whether restraint violates the principle of non-maleficence. Returning to using the framework of Principlism as an assessing tool, I question what direction Principlism takes us, when I address how restraint comports with the use of the principle of non-maleficence.

## 2. Balancing.

This places the psychiatrist in a situation where he now has to choose between respecting an individual's autonomy over his own professional autonomy and the codes of practice he has to follow. The four principles approach endorses a systematic way to deal with such conflicts, which is to balance conflicting specifications<sup>17</sup>. Professional autonomy needs to be shown the high level of respect it deserves, however there are cases of when respect for a patient's autonomy prevails. The issues I have raised within the use of restraint have highlighted a grey area in utilising Principlism as a sole framework and its incompatibility for solving clinical dilemmas. When I reflect on the use of restraint it follows that there is significant disagreement about the proper balance between contending obligations, the failure to give reasons justifying that balance may be problematic. However, the moral controversy centres on differing judgements about what the proper balance should be. Simply to assert that one of the obligations constitutes a good and sufficient reason for overriding the other, begs the question by failing to give any reason on behalf of the balancing judgement, which has been made. Balancing therefore is not a tool or method of justification: it marks the end of reasoned justification as a tool of moral reflection (Ebbesen & Pedersen, 2007).

In fairness Beauchamp & Childress themselves do not, give reasons justifying the balancing judgements, which they make in support of their positions on particular issues. They simply assert them. As they acknowledge 'Respect for autonomy ...has only *prima facie* standing and can be overridden by competing moral considerations ...The principle of respect for autonomy does not itself determine what, on balance, a person ought to know or do or what counts as a valid justification for constraining autonomy' (Beauchamp & Childress 1994, p.126). Finally if we follow the reasons given by Beauchamp & Childress (2009), that when using balancing in an ethical situation, the general idea is not to reach absolute certainty, which is impossible, but just to approach it. Therefore, my counterargument is the recourse to 'balancing', does not answer my question with a reason for justification. It answers it by assertion of which is taken to be obvious to moral common sense. Then the criteria are not really criteria for balancing, what they are, is criteria for comparing differing courses of action, with the one which entails the least infringement of norms, without regard to which norm is the weightier.

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<sup>17</sup> Beauchamp & Childress (2009).

In conclusion, to this section, I return to my original question. Can the four principles help us with this unique situation where psychiatric healthcare professionals must decide whether to restrain a patient? While a helpful framework at times, the concept of choosing restraint when it violates Principlism cannot help with dealing with what is classed as a serious dilemma. Treatments that affect the patient's integrity and psychophysical resistance may be administered only with the purpose of procuring a tangible clinical benefit or the alleviation of patient suffering. Restraint is an explicit violation of Human Rights, (Human Rights Act 1998) as it impairs freedom and dignity of the patient. Despite this, it is necessary at times. The four-principles approach has a number of limitations in psychiatric practice. It assumes that patients will either have capacity to be autonomous or only lack autonomy for discreet periods. In defence of Principlism in general, Beauchamp (2003) writes that people from different cultures share some moral rules. The examples he uses for these moral rules are, 'Tell the truth', 'Do not kill', 'Rescue persons who are in danger', and 'Do not steal'. These moral rules are not implemented in the same way in all cultures; however, the norms themselves are cross-cultural. There is a connection between these rules and the more general principles. For example, the moral rule of 'Tell the truth' is justified by the principle of autonomy, the rule of 'do not kill' is justified by the principle of no-maleficence. The rule of 'Rescue persons who are in danger' is justified by the principle of beneficence and lastly 'do not steal' is justified by the principle of justice. One rule can be justified by more than one principle; hence, there is a non-linear connection between the rules and principles (Ebbesen, 2011).

Applying Principlism to the dilemmas encountered in the use of restraint and ECT may actually lead patient's lives to worsen, therefore firstly the moral rule of 'Telling the truth', justified by autonomy, I question how is this possible when the truth of how ECT actually works is still unknown and the psychological damage caused by restraint is also unknown. Secondly, 'Do not kill', justified by the principle of non-maleficence, research evidence has shown that ECT kills off healthy brain cells (Abrams, 2002; Braddock, 2014), and I would put forward the view that restraint virtually kills the therapeutic relationship between patient and clinician. Thirdly, 'rescue persons who are in danger', which is justified by the principle of beneficence. And lastly, I am yet to be convinced by proponents that the premise that using a treatment like ECT which is still to be 'scientifically' proven or to be holding down a patient in the prone position is doing positive good. What is not discussed is how autonomy should be conceptualised when patients are in long-term psychiatric care, and

where patients are compulsorily detained, autonomy is a concept that needs to be expanded and refined when thinking about patients with chronic dependency needs.

Either to claim that actions that we normally consider distasteful are not in fact distasteful in the circumstances of politics or to say that they are indeed wrong, but that it is sometimes right to commit wrongful actions. Surely, these are human traits of a virtuous person, which I offer is the physician, who find the wisdom to find the right actions in the specific role of alleviating suffering of the mentally ill.

### Section 3.7: The Benefits of Virtue ethics.

In this section, I argue for a strong –action guiding approach, which will I believe will complement the theory of Principlism for contemporary nursing in psychiatry. There have been many debates as to whether dilemmas within psychiatry when faced with unique circumstances in clinical practice can solely rely on one ethical theory. Psychiatry needs an ethical framework that can capture the complex moral dilemmas inherent in practice, but it also needs a framework that provides a model of ethical practice. The sort of complementarity framework that I believe is needed is to balance philosophical principles and virtue ethics into an intersecting relationship enabling a wider range of decisional making skills. The theory virtue ethics is designed to link with Principlism, which they contend, is a mix of objective rules or Principles and subjective character traits, a method they labelled ‘judgement within limits’ (Block & Green, 2006, p 7). Their model is a combination of mind and heart that tries to complement each other in attempting to resolve difficult moral dilemmas. While recognising problems in both theories, Bloch & Green assert that they can, in combination provide a sound moral framework ‘based on conceptual compatibility and synergy’ (p 8). From the outset, I recognise that one of the more recent developments in moral philosophy has been the recognition of the place of caring or emotional bonds between persons. The status of ‘ethics of care’ theory remains indeterminate but although I recognise its merits as a substantive moral theory, it does not form part of my argument when I discuss Principlism and Virtue ethics.

I will utilise the work of various authors on virtue ethics and I argue that the moral virtues and a strong (action guiding) version of virtue ethics develops virtue based relationships and a virtue based approach within psychiatry. The latter is characterised by three features: 1/ exercising the moral virtues such as compassion; 2/ using judgement; and 3/ using moral wisdom, understood to include at least moral perception, moral



sensitivity and moral imagination (Armstrong, 2006). To highlight my position as to why I believe virtue theory can complement and address the problems associated with using Principlism solely as a framework, for dilemmas in clinical practice. I believe clarification is needed on this point. I reject the sole use of the framework of Principlism because of the possibility of healthcare providers making decisions, which are too dependent on the principles. These four principles are too far removed from a model of holistic care so therefore I offer virtue theory, as a supplement to address the problems identified within Principlism theory. When we address the issue of ethical decisions and adopt a philosophical stance here, I return to the complexity of decision making within psychiatry. Again, I use the examples of dilemmas faced in psychiatry like a patient being restrained, receiving psychotropic medication, or being given the treatment of ECT.

However, the first question that must be asked is, 'what is a morally good decision? So that it is seen to impact on healthcare with positive consequences.

The healthcare provider may make the decision based on what they feel the consequences of withholding information or full disclosure of the treatment of ECT to the patient. This may be in terms of predicted harm, side effects, and distress to the patient, or effects on their autonomy and decision-making capabilities (Hodkinson, 2008). However, there are difficulties with this approach (Principlism) I highlighted earlier within this chapter and are well-rehearsed criticisms of outcome-based frameworks. These include difficulty of predicting consequences, both in the short term and long term; whether the healthcare provider is able to make decisions about what is important to the patient based only on the patient's own values. Having the rightness or wrongness of actions embedded in the consequences of those actions increases the level of uncertainty in decision-making. This is because being able to predict consequences in an absolute sense is difficult. The best that can be achieved is to accept that there may be a range of consequences with some being more probable than others are. Hodkinson (2008) indicates deontological approaches cannot resolve moral conflicts and so the psychiatrist is denied an available remedy.' Utilitarianism is seen as too difficult to calculate benefits and risks and demands an impartiality that healthcare providers would find difficult to achieve. Both Deontology, a respect for autonomy and utility, a measurement of consequences, are seen as theories' that do not help psychiatric healthcare providers in clinical practice. Let me return to the problems I identified and points made earlier in that the framework of Principlism is useful in deliberating psychiatric ethics when dealing with dilemmas in clinical practice. The approach Principlism takes it that it integrates well

with a number of aspects of clinical issues, but lacks guidance in how to deliberate the prima facie conflicts of the method; particularly where the key issues of autonomy is involved. Regardless of the instrumental value of Principlism, it suffers from a lack of substantive theoretical background (Robertson et al. 2007). Healthcare providers in psychiatry may be able to overcome this problem by employing the approach of virtue ethics. There is considerable scope for values not to be shared in psychiatric practice. It is important; therefore, that psychiatric ethics should be open to this possibility. One of the problems of Principlism is its implicit acceptance of a biomedical model, which takes for granted that diagnosis is value-free. In psychiatric practice, this is not the case. The person displaying aggression who requires restraint, the patient with psychotic depression who needs psychotropic medication or the patient suffering from Bi-polar disorder and prescribed ECT may or may not require enforced detention. Therefore, the four principles can readily fail to account for the clinical decision that most people would be inclined to accept as correct. "In fact the four principles can either seem too indeterminate or even so completely irrelevant as to be otiose" (Hughes & Fulford, 2005 p 1005). My viewpoint is that virtue ethics provides a useful tool to complement the shortcomings I have just discussed within principle based ethics. I endorse this point, because it focuses on the moral character of the individual and that a morally good decision can be made by utilising character traits or behavioural dispositions such as kindness and honesty.

Therefore, I start this section by promoting the discussion that in looking at the qualities that makes up the virtuous person we can see these character traits are reflected in the patient –client relationship. However, the first question should be what are virtues? A virtue is a trait of character, which is good for that person to have. Consider the ethical concepts of tolerance, generosity, integrity, honesty, sincerity, and kindness, which make up the traits of a good person. Even though perhaps most of them can be put into the form of an adjective and applied to actions, (a tolerant action; a generous action and so on) the focus of virtue ethics is on traits of character of person (Mizzoni, 2010). Ancient Greek philosophy (Irwin, 1999) provides an early account of the roles of the virtues in human lives, understood in terms of human nature, the good life for humans, and the notion of human flourishing. The central question posed by Aristotle (1998) in *The Nicomachean Ethics* is 'what is the good life for man?' Crudely, his response was living the life of virtue according to reason and desires. In book two of *The Nicomachean Ethics*, Aristotle states that the soul consists of three kinds of things; passions, faculties and states of character. Aristotle believed virtue is neither passions nor faculties' all that

remains is that [the virtues] should be states of character (Aristotle, 1980 p 28). He distinguished between moral and intellectual virtue. The latter was taught through instruction and was split into scientific knowledge (*episteme*) intelligence (*nous*) technical skill (*techne*), wisdom (*sophia*) and practical wisdom (*phronesis*). Conversely, moral virtue was acquired through exercising the virtue, 'moral virtue comes about as a result of habit' (Aristotle, 1980 p 28).

The emphasis is on the word 'habitual'. Taking honesty as an example, someone who is honest on certain occasions- perhaps when it is convenient to be so- does not possess the virtue of honesty. Within the Aristotelian view, the honest person is always honest. For Aristotle, the actions of a virtuous person spring from a steady unchangeable character (Armstrong, 2006). The principled healthcare provider asks; how ought I to act. The healthcare provider acting from a principled position recognises certain rules or maxims as guiding. These rules or maxims provide morality of doing (Mayo, 1993). However, the virtuous healthcare provider asks; who ought I to be? The healthcare provider having this disposition lives an ethical life through cultivating virtues or character traits that would have them described by others as being a 'good person'. The virtues are embedded character traits, which are held to be societally valuable such as truth telling, trustworthiness, honesty, and kindness. Practical wisdom relates to how the virtues are applied or enacted. Virtue ethics is about an individual of good character doing the right thing. By incorporating virtue ethics it enables healthcare professionals, patients and significant others, to place value or added weight on a particular principle to find a balance and rationale for decision-making. A virtue ethicist Rosalind Hursthouse had already addressed this issue when she made the point that this is virtue ethical characterisation of 'right action' because the rightness of the action is explained in terms of virtue and not the other way round. Most of the theoretical weight is therefore borne by the account of virtue provided in the theory. To unpack this account of right action, we need to know what the virtuous agent would do. We need to have an account of virtue that will give us some way to approach this issue (Hursthouse, 1999). Hursthouse herself adopts a broadly Aristotelian account (with some qualifications) On Aristotle's account of virtue she asked questions on what qualities that made up a human being. She believed that virtue ethics is concerned with character, prior to action, so it asks the question 'How shall I live?' before it asks the question 'What shall I do? Secondly, virtue ethics focuses on *eudaimonia*, that is wholeness, or human fulfilment (Aristotle [350BC] 1976) rather than on specific decisions about right actions. Thirdly virtue ethics sees morality as learned ways of being, which are a blend of reason and emotion, the so-

called 'habits of the heart' (Campbell, 2005). Therefore, virtue ethics is not episodic: it is interested in the narrative of an individual's life viewing this as a quest for excellence, in human experience, a quest for those things that are of intrinsic value (MacIntyre, 1985). The advantage to healthcare is the approach is that it can explain the relationship between human motivation and ethical conduct. Most of us want to live a good life and become better persons. Virtue based ethics provide a clear link between natural human desires for happiness and self-improvement and moral conduct. Principlism based approaches have difficulty showing the relationship between ethical conduct and motivation since following ethical rules may not be in our best interests (Resnik, 2012). Kant (1964) argued, for example, that ethical conduct consists in doing our duty, for duties sake, but how many people have such pure motives? Most people act morally for a variety of reasons, including fear, of punishment, shame, or guilt (Cahn & Markie, 1998).

The good person of moral excellence has the dispositional character traits of virtue and this trait produces good acts: just as a good watchmaker produces a high standard watch, which is fit for purpose, a good nurse will deliver a high standard of care, and a good person will behave well in all circumstances. The intellectual component of the trait suggests that moral virtue or excellence of character and the intellectual virtue, practical wisdom can be taught and that people can develop moral expertise (Begley, 2006). It then follows that virtue ethics emphasises that the quality of the action produced is affected by the integrity and competence of the moral agent. If the agent is corrupt, the action is likely to be corrupt. If the moral agent is incompetent in either a practical or a moral sense then the action is likely to be less than satisfactory. If you lack skills or the necessary competence to perform a particular act (e.g. give an injection) then it would be morally irresponsible and unjust to patients to subject them to your incompetence. There are close links between virtue ethics and professional competence and these moral obligations and principles are imposed upon people who work in a number of roles, nursing being one of them, e.g. obligations that are laid down by the Nursing and Midwifery Council (2008). One might think that, while there is no doubt, there is much to be done on the details- such as identifying and ranking the virtues important in nursing. There cannot be much wrong in principle with applying virtue ethics to nursing (Holland, 2010). One of the most common criticisms of virtue ethics is that it is circular in character: that is by being virtuous- exercising traits I have mentioned, one is a morally good person, but, to be morally good, one needs to be virtuous. Another criticism of virtue ethics lies with the emphasis on one's character and the kind of person one ought to be- both of which are culturally and

socially embedded. For this reason, virtue ethics is criticised as being too vague with little ability to guide actions (Begley, 2006). Obligation- based ethicists argue that the virtuous person will have no idea what to do in a particular dilemma, because they argue that virtue ethics fails to come up with any rules for conduct. Indeed the main critique of virtue ethics as a moral philosophy in psychiatry is that it seems to have impractical expectations of individuals and places the individual amidst a potentially disabling psychodynamic process of identification with the idealised ethical superman (Dyer, 1988). Virtue ethics has been proposed as a foundation of psychiatric ethics, with some argument that the sole virtue of phronesis can provide for ethical behaviour in psychiatry, or at the very least inform prescriptive codes of ethics in psychiatry (Held, 2006). However, and here is an important premise in the argument from the proponents of competing philosophical frameworks to virtue ethics theory, all virtue ethics normative rivals can also account for the fact that healthcare providers should have kindness as a virtue. For the act-utilitarian, 'act kindly' is a rule of thumb that tends to maximise utility; for the indirect utilitarian, it is a rule that would maximise utility if adhered to generally; for that Kantian it is universalizable maxim, or the implied imperative to treat others as ends-in-themselves; and so on. In fact, that a putative normative theory failed to render the injunction to be kind would figure in a *reduction ad absurdum* argument against it (Holland, 2010). Whilst I recognise these claims, my rebuttal is that whilst they are traditional criticisms of virtue ethics, these criticisms do not fatally undermine the coherence of virtue ethics. Hursthouse (1999) agrees with my thinking in that people have access to a whole range of virtues and within that structure of these virtues, there is considerable moral guidance. I shall now defend the coherence of virtue ethics further. As moral professionals, those working in psychiatric healthcare should advance opportunities for persons with mental illness to understand their illness, manage their illness, and try to engage fully within society.

According to the school of virtue, ethics 'good people will make good decisions' and ethical behaviour is what good or virtuous people practice (Oberle, & Raffin- Bouchal, 2009.p 11). Virtue ethics suggests that actions are right when they stem from good character, or the disposition to be just benevolent, or courageous in situations where someone is in need of help. Proponents of virtue ethics suggest that the complexities of life defy the formulation of or adherence to externally imposed principles (Bennett, 2010). Within this ethical framework, the accumulation and synthesis of experiences, maturity, practical wisdom and the influence of exemplars guide action (Begley, 2006). Rules are therefore, not part of virtue ethics; it is about the virtuous agent and personal development (Pellegrino, 2002). In thinking about virtue ethics, it is important to

distinguish between two positions: the replacement view and the augmentation view (Cahn & Markie, 1998). According to the replacement view, virtue theories should replace principle approaches to morality. What it means to act morally is to practice virtue, not to follow moral principles or rules. According to the augmentation view, virtue theories should supplement but not replace principle-based theories, of which I am a believer. The augmentation view is not controversial, because most theorists agree that moral theories should include an account of moral virtue. For Kant, virtue is a useful by-product of acting morally. By following moral rules, we develop the disposition (or strength of will) to continue following moral rules (Kant, 1964). For Mill, seeking virtue is a worthwhile pursuit because it contributes to one's own happiness and the happiness of others, and therefore promotes utility (Mill, 1963). In his book *After Virtue*, Alastair MacIntyre challenged the dichotomy set up in contemporary moral philosophy between *deontological* and *teleological* theories, and suggested that virtue ethics represents a bridging third way within ethical theory, which has been neglected in the debates between deontology and teleological utilitarianism. Here in this next section I address that very issue, I put forward a view that yes it cannot only bridge but compliments and supports decision-making when faced with dilemmas in psychiatry.

### Section 3.8: Virtue theory and Principlism -how do they complement each other?

Even if I have succeeded in motivating the question as to how well Virtue ethics is relevant in psychiatric nursing decisions, a detractor might say I have only made a case for its merits and not how it can complement Principlism. You might even find those who ask the question of integrity, 'Which approach should health-carers in psychiatry take-the virtue approach or the principle based approach?

Therefore, in this section I, attend to that criticism and address the advantages of using both theories in conjunction for the benefit of those suffering from mental illness. Virtue based ethics and the Principlism approach are complimentary because they focus on different aspects of ethical conduct. Although virtue based approaches and principle-based approaches can complement each other, I have identified their strengths and weaknesses that do affect their ability to serve as conceptual frameworks for promoting integrity. Building on my earlier points that a principle based approach stresses the importance of moral rules, while virtue based ethics approaches emphasises moral character development, which are essential in healthcare promotion and decisions. There is a typical structure: firstly identify a moral sphere of a psychiatric nursing dilemma then

secondly define and apply the virtues relevant to that decision and act accordingly to those virtues, discussing the implications of certain virtues relevant to the dilemma when utilising the Principlist approach (Holland, 2010). Following rules does not interfere with the development of moral character, nor does character development preclude the following of rules. Indeed one might argue that one of the ways that we develop virtue is by understanding and following moral rules. For example, you are asked various questions about ECT, the rule will be 'don't lie' repeatedly, this will develop into a habit and they will become more honest in their answers (Seedhouse, 2009).

Principlism as a framework does not allow for a consideration of the specifics of the situation or of moral character and reasoning of the individuals involved. There is a danger that adhering to moral absolutes (such as truth telling) in all cases may do more harm than good (Begley & Blackwood, 2000). However, it is possible to imagine other situations involving unknown consequences where the dynamics are so complex that an absolute rule is unhelpful. Virtue ethics provides an alternative, because it focuses on the moral character of the individual and on their practical ability to use their practical wisdom (Hodkinson, 2008). This section argues that the philosophical approach of virtue ethics is of value in terms of providing guidance and working alongside the theory of Principlism in decision making within a psychiatric clinical environment. However, in terms of not only providing guidance and support to decision making with Principlism, but to help reflect on how decisions are made and the moral character of the individual involved. Therefore let me summarise my points if the proponents of Principlism were to challenge my position and ask what the merits of virtue ethics are and how can they complement Principlism. They are as follows; firstly, this approach accurately reflects the language of virtues and vices e.g. 'fair', 'well' and 'care' that health-carers use on a daily basis (Armstrong et al. 2000). Secondly, this approach places a firm emphasis upon the crucial role played by emotion including moral remainder, (Hursthouse, 1999) in the moral lives of patients' and nurses. Thirdly, this approach makes pivotal the importance of using judgement and moral wisdom to enable psychiatric health-carers to make morally good choices and decisions with patients' in different circumstances (Armstrong, 2006). Lastly, this approach places a firm emphasis upon moral education, e.g. the importance of morally (and clinically) good role models, e.g. (Lutzen & Barbosa da Silva, 1996; Parsons et al. 2011). That is, a psychiatric healthcare provider who strives beyond reciting of ethical principles, but also responds virtuously – all of which is essential for ethical decisions those are good and right. To recall my previous arguments, some of the

normative work can be done by adding the virtue ethics approach. While obligation based theories focus primarily on the notions of moral rightness and wrongness, the virtue approach focuses upon 'goodness and badness'. In other words, it is enough for it to secure a role in decision making within psychiatry, and in my view the distinctiveness of decision making in psychiatric nursing as a moral domain can be retained.

### Section 3.9: Conclusion.

This section has argued that the philosophical approach of Virtue ethics is of value, not only in terms of providing guidance when dealing with dilemmas in psychiatry, also how to act and how it can complement the use of the Principlism, of which its shortcomings I have identified. It is important to clarify that my argument within this chapter was not about the theory of Principlism but the use of the framework of Principlism. Healthcare providers often assume that they know what is in the patient's best interest and almost invariably define that best interest according to what might be the best outcome, or far worse, they might decide best interest according to their own personal values. I have no quarrel in using the framework of Principlism but the concerns I have are that the moment we start to only use Principlism as the sole theoretical framework in psychiatry it then takes on the mantle of superiority over other applicable theories. My aim was never to find answers 'but' to challenge assumptions that Principlism is always best placed to direct us on quality psychiatric patient care. As soon as we start entering the autonomy versus other principles debate, we set aside our ability to recognise other ethical viewpoints that other theories give us. However, it then follows these viewpoints may not always be easy to address but are essential to afford the patients all their ethical rights, and not be selective in what is given to them. I have also argued that with the use of Principlism, it has the ability to impose values of the healthcare providers whereas in effect it should achieve the opposite of imposing the values of the patient. Mental health care is in a precarious position of having an aging paradigm of practice rooted in its historical knowledge and beliefs. This has been recalcitrant to adaptation and incorporation of new realities of clinical care. The juxtaposition of an aging paradigm that poorly matches current practice realities leaves psychiatry with seemingly incompatible knowledge that seemingly divides our profession. Principles are guidelines for action, not rules of conduct (Hodkinson, 2008). Only we as moral agents can grapple with the facts of each patient case profile to determine the appropriate course of action. To be able to deal with real-life moral quandaries we can utilise the framework of Principlism, but must compliment it by using sound reason, good judgement, and display virtues of character. Several forms of



treatment make it difficult for the patient to hold or act on any values at all. ECT comes within that category.

Then it is, by identifying the limitations of what Principlism gives us within psychiatry that I hope gives way to a broader outlook of how we address ethical issues. Healthcare providers may be able to overcome this problem by employing a method of critical reflection in the light of other competing ethical theories such as virtue ethics. "It is important to be able to reflect more deeply on how decisions are made and the moral character of the individual involved" (Armstrong, 2006. p 298).

Healthcare providers may be able to overcome this problem by utilising all that is good with Principlism, but also overcoming its shortfall by linking in another theoretical approach, which is Virtue ethics. This sharing of the two theories leads to the importance of decision-making, thus giving a balance of evaluative perspectives as a basis of good mental health clinical practice in this area. Many people expect applied ethics to be helpful in resolving concrete moral problems and are disappointed when they do not fulfil the expectation (Hoffmaster, 1994). A natural response to that disappointment is to turn from moral principles that seem to general and far removed from the problems to engage in decision-making, which is subjective and not always beneficial for the patient. It has to be recognised that virtue –based approaches and principle-based approaches can complement each other but do have distinct strengths and weaknesses, which in isolation affect their ability to serve as conceptual frameworks in healthcare decision-making. By using Principlism and Virtue ethics in conjunction, it provides a venue in which the relationship between ethical theory and ethical practice can be pursued in an extended, comprehensive, and one hopes, ultimately productive clinical practices.

## **Chapter 4: Consent and ECT.**

*"Volenti non fit injuria:"* "A person is not wronged by that to which he consents."

(Terence Ingman 1981)

### Section 4.1: Introduction and Chapter outline.

The goal of this chapter is not primarily to resolve the conflict between consent and the mentally ill who are prescribed ECT. Rather, I aim to highlight problems related to the violation of consent and the validity of gaining consent from a person with limited understanding due to mental illness. In addition, from a number of conceptual viewpoints I address the following question: 'can genuine informed consent for ECT exist if healthcare professionals 'play down' both the harmful effects and unknown evidence for how the procedure works? Informed consent is a lively ethical issue, debated frequently in both general medicine and psychiatry. It should be noted that I am using the term 'informed consent' as synonymous to 'ethically valid consent'. Informed consent has been termed 'valid consent' by writers such as Beauchamp & Childress (2011). Valid consent is usually taken to incorporate three elements in that it is informed, voluntary and the patient is competent to consent, I will also address the related but significant problem of determining patient capacity to opt for ECT. I question the position taken in psychiatry that it is morally appropriate to treat patients who have given consent based on a minimal amount of information given by the healthcare provider. The Royal College of Psychiatrists (RCP, 2013) indicates that it is morally permissible to forcibly treat psychiatric patients with ECT in order to preserve their best interests, restore their autonomy to enable their mental health and cognition to improve decision-making, and because they are a danger to themselves or others (RCP, 2013). These views reflect the National Institute for Health and Care Excellence (NICE, 2003) guidelines as well. I disagree with the above claim and argue that this viewpoint is ethically and clinically questionable. This chapter shows the weakness of NICE and the RCP's position and examines why their reasoning fails. The argument they put forward respects the duty of beneficence towards others while not fully recognising the equally important tenet of autonomy. The psychiatrist's position rests on choosing an appropriate, informed process for ECT, which hinges on one's interpretations of available literature regarding the safety and effectiveness of the procedure. Due to personal interpretation of literature, different psychiatrists are likely to have widely discrepant views concerning 'appropriate' informed consent. For patients who have lost a portion of their decision-making skills due to mental illness, where are the limits of informed consent? The concept of consent

may take on different meanings depending on whether the approach is medical, legal, philosophical, or ethical and whether it is given for the benefit of a third party (Beloucif, 2013). Beyond the previously addressed issue, regarding the lack of empirical knowledge on the mechanism of action of ECT lays the concept of the 'implications of consent'. If a mentally ill person lacks the ability to understand the implications of ECT, a truly autonomous decision cannot be made and consent cannot be gained. In addition, if an overt or covert threat of involuntary treatment is present, then there can be no truly autonomous decision made. This point has been recognised and documented by authors working within this specialised field of psychiatric healthcare.<sup>18</sup> (A point I discussed in chapter three).

When examining informed consent within psychiatry, it is evident that a number of assumptions are made when determining whether to use ECT. Firstly, the patient giving consent to the treatment that there is a reasonable chance of the patient getting better. The second assumption is that consenting to the procedure will not impose excessive risk to the patient. Lastly, it is assumed that consent is gained every time, as consent given at the start of treatment should not be the final exchange on the issue and should be re-examined repeatedly. These problems with communication can be overcome and there are ways to communicate all that which a reasonable person would wish to know. These assumptions must be challenged to examine whether consent within ECT is actually possible. I argue that gaining informed consent for ECT is not possible, and explore this point by asking and answering a series of questions throughout the chapter. Questions addressed are as follows: Has an explanation of ECT been given? Is it understandable to patients, and has it been understood by patients? Who is recommending ECT and why is it the treatment of choice? How much information has been given on the risks and benefits of both anaesthesia and the treatment itself? Lastly, have any other alternative treatments been proposed? After addressing these questions, I conclude that patient information needs to improve, as existing guidelines and practice falls short of the ethical dictum of patient autonomy. Lastly, it must then follow that a patient who lacks sufficient knowledge about the potential risks and benefits of a proposed treatment should not be expected to accept or refuse treatment or to be held fully responsible for the decision and its consequences. In the following section, I examine what I believe constitutes a violation of consent within psychiatry, which I believe will open doors of discussion on the law, paternalism, and best interests.

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<sup>18</sup> Breeding (2000); Ross (2006).

#### Section 4.2: Violation of consent within psychiatry.

Consent is often violated within psychiatry in a number of ways, and these violations have consequences. I build on work done by John Breeding (2000), who explains the many ways in which informed consent within psychiatry is violated. I refer to Breeding's work because he became a world-renowned speaker on 'electroconvulsive therapy survivors' and his book *The Wildest Colts make the Best Horses* (1996) is a forceful challenge to the use of stimulant drugs with millions of children. Informed consent is violated when healthcare providers minimize the risks of ECT, when ECT is used as the treatment of choice before safer methods, and when the patient is vulnerable to coercion.

My first argument revolves around the mind-set of denial and minimisation of the harmful effects of ECT. By ignoring these risks, many within psychiatry claim that ECT is a safe procedure and that the benefits far outweigh the risks. The American Psychiatric Association (APA, 1990) states that the death rate for ECT is "approximately one per 10,000 patients treated" but goes on to say that statistics collected by the Texas Mental Health department between 1993 and 1996 show that the rate is 50 times higher. In the United Kingdom, the statistics parallel the Texas study (Eranti & Mcloughlin, 2003). The ethical downside of not being able to answer truthfully to any question posed by a patient receiving this treatment regarding mechanism and long term after effects, and in recent years, the question of permanently disabling memory loss following ECT has become a concern. Although post-ECT amnesia has generally been demonstrated to be transient, this report raises the possibility that in occasional instances, the patient may experience permanent memory loss (Andre, 2009). We need to ask, is there sufficient evidence about such memory loss to require psychiatrists to inform their patient of this possible consequence of ECT? At what level of statistical frequency does it become necessary to mention such a risk to a patient? Does the sharing of such information constitute a risk in itself? The dictum now in English law imposes a duty on the doctor to inform his or her patient of real risks inherent in the proposed treatment. Firstly my argument about 'inherent risks' is that these risks are often played down unless a patient specifically asks about a particular risk. The doctor is obliged to give a full disclosure (to disclose all the details of a problem, which are known) and the onus is on the healthcare provider and not with the patient (NICE, 2003).

Secondly, I argue that informed consent exists in name only. In reality, often-minimal information is given and guidelines for the administration of ECT are routinely and systematically violated. ECT has become the treatment of choice for a number of psychiatric conditions instead of being last resort after less invasive treatments have been tried (Ottoosson & Fink, 2004). Thirdly, ECT should only be considered when alternative pharmacological and/or psychotherapeutic treatments have been given an adequate trial without efficacious response. Lastly, more research data exists on the efficacy and side effects of pharmacological and/or psychotherapeutic treatments than the efficacy of ECT (NICE, 2003). Because of this, benefits and risks are more difficult to calculate when considering ECT than when considering pharmacological and/or psychotherapeutic treatments. When a patient is non-responsive to other treatments, factors such as the severity of the illness, its natural course, and the risk of other treatments worsening the course (for example, anti-depressant medications precipitating a manic episode) need to be taken into account.

My third argument takes into account the vulnerable position that patients find themselves in when considering ECT. The thorny issue of coercion can play a part when healthcare providers consider the ethical obligation to provide patients with enough information to make an informed decision. Healthcare providers should provide all information relevant to a patient's current situation, addressing the treatment in question and their condition in general.

We must consider how much information is sufficient and if a lack of information is a type of coercion, some would propose that just enough information is given to 'get the patient to say yes'. However, decisions are made from professional perspectives and most are done in an unbiased way. The art of gaining consent is not to give too much information, creating an 'information overload', but to gauge how much information is needed to make an informed choice. In any caring relationship, healthcare providers are trying to 'get the patient to trust the healthcare providers in order to deliver treatment and care. My viewpoint mirrors Andre (2009) in that patients who are prescribed ECT often are reluctant to ask about alternatives. Therefore, because of the severity of their illness, and not posing relevant questions the tendency to prescribe ECT first is increased.

#### Section 4.3: Conceptual Discussion: Distinguishing the legal and moral concepts of informed consent.

To validate my argument surrounding informed consent, it is necessary to distinguish between the legal doctrine of informed consent and the various moral principles of informed consent. ECT and informed consent has been treated as a moral principle in biomedical ethics, but we cannot conflate this role with the legal understanding of informed consent. Within the UK, legal principles of informed consent were created by the courts dealing with battery and with medical malpractice within the context of negligence of the law.<sup>19</sup> I am primarily concerned with the justification and ethical ramifications of informed consent as a moral principle. The justification, which I give, constitutes a partial justification of a legal principle, but a full justification will not be discussed here due to space constraints. Following that statement, whether in its legal or moral manifestation, a principle of informed consent will provide that, with certain exceptions, a patient is not to be subjected to a medical procedure, including tests and experiments, unless the patient knows the relevant facts concerning the procedure and consents to the procedure in light of that knowledge (Gunderson, 1990). This concept is almost impossible to achieve within psychiatry when dealing with issues of consent around ECT with mentally ill patients. However, to make this claim we must pursue the question of what actually constitutes consent.

Consent is defined as “to give permission” and “acceptance or approval of what is planned or done by another” (D.O.H, 2009), I mention frequently the term of ‘valid informed consent’. For consent to be valid there is a basic tenet in the law of trespass that, to consent to a medical intervention, the patient should know in broad terms in a ‘full disclosure’ format, outlining what is involved and to be expected. For informed consent to be ethically valid, it must be maximally autonomous, which occurs when there are no apparent defects in a patient’s ability to control desires or actions, their reasoning, or their ability to understand the information upon which their choices are made (Harris, 1985). A theme in this chapter is the concept of *coercion* and its implications for informed consent. Patients suffering from a mental illness should not be singled out as different for the very nature of their illness, but this often occurs when they are coerced into ECT treatment. The voluntary aspect of consent is meant to ensure that patients are not coerced into participation and are free to withdraw from treatment at any time. Within psychiatry, patients with mental

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<sup>19</sup> Kennedy and Grub (2000); Mason and McCall (2006); Dinmond (2008); Brazier and Cave (2011).

illness are particularly vulnerable to *coercion because of the severity of their illness* and often have had no or little experience in exercising their rights. Whilst researching for this thesis, I came across two authors who were looking at this problem within their own countries. Jacob & Rajan (1991) made the point that: ECT has been given a special status among treatments and hence requires special consent according to the law of the Mental Health Act (1983), [revised 2007]. Although informed consent and true voluntarisms are ‘ideals’, they are rarely attained as such decisions contain an element of coercion ranging from subtle to overt (Jacob & Rajan 1991.p. 576). Informed consent to any medical treatment represents a mutual agreement between the practitioner and the patient, the validity of this agreement requiring that the consent be informed, rational, voluntary and competent (Fisher, 2002). Many psychiatric patients have been placed in a vulnerable position where they are unable to understand the potential risks, benefits, and alternative options to ECT and have been subjected to coercion. Numerous articles have been written about coercion in psychiatry,<sup>20</sup> and a number of authors make the point that coercion is justified in order to prevent disorientation, to protect the patient from harm, and to protect others (Kaltiala-Heino et al. 2001; Cowman et al. 2001; Olsen, 2001). Those who coerce patients argue that their actions are justified because they are doing something to the patient in the name of therapy or treatment. The use of coercive treatment violates the two universal principles of liberty and autonomy. Liberty is defined as the condition of being free from restriction or control, and the right and power to act, believe, or express oneself in a manner of one's own choosing (Bloch & Chodoff, 1991). Respect for autonomy is grounded in liberty because the healthcare provider accepts the obligation to do good for the patient, but the patient is an autonomous agent who defines what is best for them. In forced or coercive treatment, liberty is denied by restricting the patient's choice. Due to experience and training, a psychiatrist can state that they are in a better position to predict a patient's prognosis. Nevertheless, it is a thin line between prognosis and future judgements of value and possible mental states of the patient, on which they base this better position to prescribe a treatment with unknown long-term effects. Earlier, I posed the question of whether valid consent can be achieved from a mentally ill patient for ECT. As shown by this discussion of coerced treatment, true consent must be voluntary—the patient must choose freely without the overt or covert pressures from others affecting the autonomy of the patient. I will therefore confine the use of

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<sup>20</sup> Not used: Dolan (1997); Erikson and Westrin (1995); Haglund et al., (2003); O'Brian and Golding (2003); Taxis (2002).

conditions necessary for informed consent to those patients who are unable to make an informed decision because of their mental illness, rather than mentally ill patients who refuse ECT logically and with sound mind. Staden and Kruger (2009) suggest the following conditions be put in place.

- A mental illness should not prevent a patient from understanding what he/she consents to.
- A mental illness should not prevent a patient from choosing decisively for/against the intervention.
- A mental illness should not prevent a patient from communicating his/her consent (presuming that at least reasonable steps have been taken to understand the patient's communication if present at all).
- A mental illness should not prevent a patient from accepting the need for medical intervention.

The key point is that patients must receive relevant information to enable choice. In certain situations when the patient refuses or is unable to give consent or sign the consent form, it becomes necessary for the treatment to be given against the patient's wishes. In cases like these, a second opinion doctor will assess the patient. If they feel that the treatment is warranted then the treatment will be given, irrespective of the patient's views. I argue that ECT is often used without consent too soon; before the patient is extremely suicidal or so physically debilitated that, he or she may die from uncontrollable behaviour or medical complications if treatment is not initiated (Kradecki & Tarkinow, 1992).

#### Section 4.4: Conceptual Discussions: Systematic analysis of the concepts of consent.

The importance of this section is to highlight the different versions of consent, with different theorists using different meanings to defend their position. When Miller & Wertheimer edited their latest version of the *Ethics of Consent* (2009), many asked if the medical community really needed another book on informed consent (Dresser, 2011). Miller & Wertheimer (2009) answer was yes for two valid reasons; firstly, 'despite considerable literature on consent in different contexts, there is surprisingly little systematic analysis of the concept of consent and the moral and legal work that performs it' (Miller & Wertheimer, 2009, p 5). Secondly, they point out 'those bioethicists sometimes write as if the concept and principle of informed consent was first developed for their purposes (Miller & Wertheimer, 2009). These authors offer an analysis that expands the conventional view that valid consent is the element that makes an action morally permissible. In their view, valid consent transactions must be 'morally transformative' (p. 79). To meet this standard, consent



transactions must incorporate more than valid individual consent. The background conditions for a transaction determine whether the consent is morally transformative. In Miller & Wertheimer's book, Joffe & Truog extend this 'fair transaction' concept of consent. They claim it is the physician's fiduciary obligation that constitutes the background condition for a morally transformative consent to medical intervention. Through exploring the fiduciary of the doctor – patient relationship, Joffe and Truog (2010) develop an approach to discerning which medical decisions require individual patient consent and which decisions physicians may defensibly make without consulting their patients. In Kuflicks (2010) work on 'Hypothetical Consent,' Kuflick's explores two areas in which consent is used to justify medical decisions. One is treatment decision making for incapacitated patients where the substituted judgement standard is often invoked to support a choice to administer or forgo a particular medical intervention (Kuflicks, 2010). This is similar to when surrogate decisions are made for those with mental illness in the 'best interest' of the patients. Secondly, Kuflicks described is the 'thank you theory of medical ethics' in which a health intervention is imposed on the grounds that an individual will later appreciate and 'retrospectively consent' to that intervention. In my view, the underlying argument against this concept of what Kuflicks presents is, I have (and concede to this point in my experience) been presented with patients who consented and say that ECT has been beneficial for them, at the initial outset. However, only for them to return to ill-health and state apparent side effects, which far outweighed the treatment and illness for what they were treated. It must follow from this that positing the existence of a 'beneficial treatment' of unknown action raises as many problems as it purports to solve, and so the argument to use ECT or not leaves us in no better position than when it found us.

#### Section 4.5: Conceptual Discussion: The Quality of Consent and Autonomy.

In this section, I hope to recognise the significance of a person's authority over his or her own body, which is central to moral reflections around consent regarding ECT. A patient should be allowed freedom of choice over his or her mind, which is central to maintaining personal integrity. Here relevant moral considerations can be gathered under three general rubrics; firstly, the authority to be secure against unauthorised touching or battery; secondly a liberty interest and an acknowledgement of the value of autonomy and thirdly a general patients best interests concern (Cherry, 2010.p 789). I highlight two main arguments that have predominated in previous years and receive respect to this day. The first concept concentrates on free actions, and was advocated for by Faden and Beauchamp. These authors focus on autonomous actions and characterise

autonomy in terms of a liberty model, in which an agent acts autonomously only when he or she acts intentionally, with understanding, and without controlling influences (Faden & Beauchamp, 1986, p. 238). These authors outline how they derive the standard of informed consent from the principle of respect for autonomy, which they describe as the principle that 'persons should be free to choose and act without controlling restraints imposed by others' (Faden & Beauchamp, 1986.p.8). As a rebuttal, I argue that the analysis given by Fadden & Beauchamp fails to take into account the difference in roles between the patient and the physician, especially within psychiatry. Firstly, the psychiatrist is forced to divulge information, which he or she may believe is better, undisclosed, such as recognised side effects of ECT and the unknown mechanism of action. Second, if the patient decides to withhold consent, this may compel the psychiatrist to actively pursue other avenues and refrain from engaging in alternatives. Fadden and Beauchamp's argument fails to justify a principle of informed consent based on autonomy. This is because the principle of autonomy they provide fails to account for the fact that informed consent should increase the autonomy of the patient by restricting the autonomy of the physician (Gunderson, 1990). In addition, their argument allows physicians to perform procedures on patients when consent obtained has been gained but when the patient has not been given complete information about the treatment or procedure (Gunderson, 1990). Full information would enable the patient to make his or her wishes known. I return to Miller & Wertheimer as an alternative to the above theories. They believe that 'autonomous authorisation' is not ideal and it does not do justice to transactional fairness and present their 'fair transaction' model of consent. Although the 'fair transaction' model applies clearly too clinical research, many of its principles can be utilised within psychiatry. In their explanation of the 'fair transaction' model of consent, they discuss the function and value of consent from a narrative perspective. Their reasons are that consent, when valid, is a transaction between two or more people that generates 'moral transformation'. A major function of consent is to 'make permissible conduct that would be impermissible' without consent (Miller & Wertheimer, 2011, p. 203). Their next point is that consent should be 'morally transformative' by virtue of creating rights and obligations. Any adequate theory of consent must provide guidance as to when a person's token of consent is valid and when it is morally transformative. Consider the following example: if a (healthcare provider) *coerces* B (patient) or *deceives* B about a material issue relating to a transaction between them (honesty about ECT), then B may express consent, but that consent will not be valid. It then becomes obvious that B's mere expression of consent is not sufficient to render A's action permissible. Their view is that 'morally transformative' consent not only must

protect the patient's rights and interests of consenters, it must give those who solicit consent fair notice of what they need to do in order to gain valid consent and therefore avoid wrongful interaction with others (Miller & Wertheimer, 2011, p. 204).

Attempts to qualify the word 'consent' with terms implying that the subject has to have a full and proper understanding of a proposed treatment first appeared in 1946 with the appearance of the Nuremburg Code on medical experimentation. The code outlined fundamental principles aimed at the protection of human subjects for the first time in history, and included the prohibition of research on children or incapacitated adults. The Nuremburg Code (1946) details what information patients' must be given for a person to know if he or she is to give consent: a full explanation of the nature and duration of a procedure, as well as sufficient knowledge and comprehension of the elements of the subject matter. A patient must also be aware of purpose, method and means, inconveniences, and possible hazards and effects upon their health or person (Nuremburg Code, 1946). The code clearly articulates the requirement on the part of the person making the decision. Other examples of abusive practices, which violate informed consent, show parallels to the discussion I put forward about ECT used in an experimental way. In 1932, the Tuskegee Syphilis Study began (Moon 2008). Two hundred black men diagnosed with syphilis were never told of their illness, were denied treatment in the interests of human experimentation, and were used as human guinea pigs to examine the disease. All subjected died from syphilis, and their families never told that they could have been treated. In 1940, 400 prisoners in Chicago were infected with Malaria in order to study the effects of new and experimental drugs to combat the disease. Nazi doctors, later on trial at Nuremberg (1947), cited American studies to defend their own actions during the Holocaust. Consider the following paradox: it can be argued the effectiveness of ECT has been demonstrated within limited populations: non-consenting patients and those whose consent may not be valid. However, for the research hypothesis to validate the findings and to demonstrate effectiveness, a key variable, which is lack of information to validate consent, could not ethically be included, due to the lack of empirical evidence. Therefore, ECT ethically should not be carried out on this group of patients. Why, because also it is questionable whether individuals with mental illnesses are the best judges of their own best interests, bringing together long standing moral and jurisprudential considerations that establishes as an authority over themselves to make important decisions of this nature. Such a judgement 'recognises the difficulty as to what it means to choose correctly in a secular, moral pluralistic society' (Cherry, 2010, p. 791). It must follow that such a judgement recognises the dilemma of the divergent understanding

meaning of beneficent action. Because of the different understandings of the good life and what, actually counts as doing that which is good, general bioethics cannot simply comprehend beneficence as the 'Golden Rule' (Cherry, 2010, p. 791). I move on now to the second conception of autonomy that has prevailed in the field, addressed by, Gerald Dworkin. Dworkin characterises autonomy in terms of an authenticity model in which persons are autonomous when their first order preferences are in line with their rational second order preferences. His definition of informed consent is derived from a principle of autonomy as 'the capacity to reflect upon ones motivational structure and to make changes in that structure' (Dworkin, 1988, p. 108). Any justification of a principle of informed consent must consider the fact that patient autonomy sometimes conflicts with the autonomy of the physician and that principles of informed consent secure the patients autonomy by limiting the autonomy of the physician. I challenge Dworkin's position on respecting autonomy between the physician and the patient when he discusses first and second order preferences. Dworkin characterises autonomous persons as persons who have the capacity to reflect critically upon their first order preferences to enable a decision within second order preferences (Dworkin, 1988, p. 109). Dworkin's definition of consent does not address what it means to respect a person's autonomy. When we prevent a patient from acting on his or her first order preferences, which correspond to second order preferences, formed under critical reflection, we diminish autonomy. Similarly, we diminish autonomy when we treat a patient in a way that reduces that person's capacity to reflect critically on their preferences. Here, there is a conflict between the autonomy of the psychiatrist and the autonomy of the patient: the patient fails to consent to the ECT, which may thwart the psychiatrist's first order preferences, just as the psychiatrist may thwart similar preferences of the patient by failing to secure the informed consent of the patient (Gunderson, 1990). It would seem that Dworkin's conception of autonomy does not provide an adequate basis for a principle of informed consent because it fails to account for the way in which principles of informed consent give preference to the autonomy of the patient.

#### Section 4.6: Conceptual Discussion: Consent, Assent and Critical Engagement: Professional and Inter-professional relationships.

The relationship between a patient and their healthcare provider creates issues around consent that have implications for effective healthcare. In a successful patient-provider relationship, both the patient and provider should collaborate in a continuing process intended to advance the patients best interests, both in their health and their right to self-determination. Although it is still a matter of controversy, consent is central

to patient-provider relationships as well as central to healthcare overall. While this may seem good in theory, I highlight weakness of this relationship and claim that there is tension between theory and practice relating to informed consent in the patient-provider relationship. This has given rise to a lack of clarity about and application of theory to practice. I believe (as do others)<sup>21</sup> that this prevailing thinking about patient-provider relationships, especially within the arena of mental health care, is flawed. Two things are of particular interest when considering consent. The first is why some people may be looked at as being unable to give consent, and the second is the phenomenon of medical paternalism. I start by looking at the issue of assent to treatment, which states that if a conception of autonomy is accepted, then treatment decisions ultimately remain with the patient. Before the use of modified ECT and the use of muscle relaxants with ECT, persons who sustained fractures and other injuries during ECT brought several lawsuits. The allegations were that the patient was negligently managed during ECT or was not given full facts. In the case of *Bolam v Friern H.M.C.* [1957], Mr Bolam was diagnosed as a manic-depressive and prescribed ECT. Unknown to Mr Bolam was that the treatment could cause seizures and that the likelihood of fractures was very high. Restraints were available, but were not given to Mr Bolam and he suffered severe fractures of the pelvis, after which he sued the hospital. The doctor failed to tell a patient about the risk of fractures being sustained in the course of ECT, but the judicial system held that he could not be criticised if he was acting within current medical practice. Following Justice McNair's direction to the jury, Mr Bolam lost the case. A critical passage in the judge's direction regarding the amount of information provided to the patient was as follows:

*"The doctor is not guilty of negligence if he acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in that particular art ... Putting it the other way round, a man is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion which would take a contrary view" (Bolam v Friern Hospital Management Committee [1957] 1 WLR 582, in Griffith and Tengnah, 2008, p.86).*

The courts took the view that fractures and dislocations were acceptable as inevitable risks of ECT. If proper indications for the use of ECT were present and standard precautions were taken, the injured person had no grounds for complaint. Moreover, the courts in ECT cases were unwilling to apply the doctrine of '*res ipsa*

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<sup>21</sup> Appelbaum et al (1982), Reisner (2003), Sreenivasan (2003), Fetterman and Ying (2011), Gazdag et al (2012).

*loquitor*' a rule, which permits a plaintiff's cases to go to the jury even though the plaintiff does not introduce expert testimony relating to the defendant's alleged negligence.

The most striking manifestation of this was in the change, which came about in *Chester v Afshar* (2004). Carol Chester underwent a spinal operation that carried a 1%-2% risk of *cauda equine syndrome*. After she developed the syndrome, it was established that she had been warned of the possibility. The court voted in her favour. The surgeon appealed, but by a majority of three to two, the House of Lords upheld the decision. The defence argued that even if she had been warned she still would have had the operation. However, in this case, the traditional rule of causation (which would have required the claimant to show that she if she had been warned, she would not have undergone the operation) was waived, as the majority of the judges felt that the right to self-determination was fundamental. Self-determination, or the right of every person to decide or determine the course of his/her life, is a presumption of English law and a critical value of nursing. In a healthcare context, self-determination means that every competent adult has the liberty to consent or refuse a medical treatment (ibid). The self-determination of health care consumers is intrinsically connected to informed consent policies, procedures, and practices of healthcare providers. Informed consent is the ethical doctrine and legal procedure that embodies the value of self-determination and provides necessary action. Informed consent has become a more stringent requirement in the provision of health care in recent years (Maclean, 2005). There is a great deal of debate over what exceptions should be made, what information must be given to the patient, and when a patient is competent to provide informed consent (Gunderson, 1990). How these disputes are settled depends on how the principle is justified. Further, different arguments justifying principles of informed rely on the different conceptions of autonomy (Beauchamp, 2009). Many find it difficult to agree as to what represents adequately informed consent (Reisener, 2003). Clinical psychologists, psychiatrists other healthcare professionals are currently working towards ensuring that patient-led research provides that consent procedures and consent forms give a true reflection of up to date data. Ensuring that what healthcare providers tell patients adequately reflects findings from studies would help make sure that ECT patients gain an array of different perspectives.

Space does not allow permit me a full discussion of these factors but it is worth noting that these complex concepts can be made accessible by using such simplistic terms. Therefore, let me quickly challenge a position that psychiatrists put forward in the 'last resort argument' where they feel that ECT is the last hope that the

patient has left in their care. By making this statement, what they are actually saying is in fact that by ECT being a last resort treatment, we are actually taking away the patients' power and forcing them into a decision out of desperation. However, it is not clear how 'last resort' is defined or what level of distress or risk someone should be experiencing to warrant a 'last resort'. Believing ECT is a 'last resort' impacts on patients' perceptions of their choice to consent, as in the study by Johnstone (1999). The premise is that patients felt unable to decline ECT because of the belief that other options had been exhausted. This represents an implicit pressure to agree to ECT. If we do not accept the premise of this argument, we do not have to accept its conclusion, no matter how clearly the conclusion follows from the premise. My rebuttal is what then becomes of patients, if they are one of those, who do not respond to ECT if this is their 'last resort'? Therefore, I personally do not accept their arguments' conclusion because it does not follow from its premise. Why, because mental illness is not a terminal illness, therefore terminology like 'last resort' takes away hope and should not be used. We can research and look for treatments as long as the patients necessitates, often over tens of years.

I have emphasised that ECT has to be a major consideration when the only avenue left open for the patient is death. This I have emphasised is the rare occasion where death is likely without ECT (for example, a depressed patient who refuses to eat or the patient is actively seeking a suicidal act), therefore my choice is either life over death, in this case I will always choose life. The obligation of securing consent arises both to meet the appropriate standards of care (negligence) and to avoid liability in battery (trespass to the person) (Mason & McCall, 2006). Even if it were possible to ensure that disclosure could be neutral, 'this will not solve the problems that arise from misunderstandings' of information (Schneider, 1998, p. 59). While the information may be disclosed in a non-directive way, it will not necessarily be received in that way. If information is misperceived, then the patient's ability to make a rational decision is effectively undermined. If autonomy involves some degree of rationality, rather than self-determination, and if healthcare professionals have a duty to respect patient autonomy, 'then this should require some attempt to enable the patient to understand the information disclosed'; autonomy requires knowledge not information' (Maclean, 2006). It is the role of the healthcare provider to assess the patient's understanding and avoid their misunderstanding of information given.

#### 4.6.1 Patient Capacity.

This section examines whether the current legal test for capacity protects the autonomous patient or gives too much leeway for paternalistic action. Unless a psychiatric patient is truly incompetent because of the severity of their illness, non-consensual psychiatric treatment violates the foundational principles of medical jurisprudence and secular bioethics. The weight of this moral and jurisprudential tradition establishes patients as an authority over themselves and as the presumed authoritative judge of their own best interests in deciding what clinical care is beneficial for them (Cherry, 2010). The legal concept of capacity is that touching a patient without consent is recognised as battery or assault (Kennedy & Grub, 2000). For consent to be legally valid, it must be given freely by someone with decision-making capacity. It follows that when a competent patient refuses treatment, under law; their decision must be respected, even if it appears irrational or could place their life at risk (Halliday, 2009).

The Mental Capacity Act (2005) states that a patient must be presumed to have capacity unless there is evidence otherwise. This statute provides guidance on assessing capacity and acting in the best interests of those who lack capacity with the fundamental aim of ‘balancing’ rights of the potentially vulnerable with their protection. The act makes it clear that if a patient is considered to lack capacity following assessment, they should still be involved in the decision-making process as far as possible; thus enhancing their ability to exercise autonomy. There may be doubt over a patient’s capacity if the functioning of the mind or brain is impaired or disturbed in some way. To conclude that a patient lacks capacity to consent or refuse treatment, it must be shown that the patient is unable to understand, retain, and/or weigh the costs and benefits of the information regarding a potential treatment (Mental Capacity Act, 2005).

The provisions of the Mental Capacity Act (2005) represent a triumph of the right to self-determination over the paternalistic stance taken by doctors. However, the Mental Capacity Act (2005) is not rigorous enough to protect those who suffer from mental illness. The Mental Capacity Act (2005) plays second fiddle to the Mental Health Act (1983) [2007 revised] because a patient can undergo treatment without consenting if their capability to decide on treatment is compromised by an irrational belief. The Department of Health Guidelines on consent to examination (2009) state that when a decision, which appears irrational, is based on a misconception of reality, it can be concluded that the patient is unable to comprehend the information and therefore lacks capacity. However, the “irrationality” of decisions and even “misconceptions of reality” are largely subjective, and some personal or religious beliefs may seem unreasonable to a doctor but make perfect



sense to the patient. A patient who has demonstrated capacity in previous decisions may state, that 'I don't want ECT; it destroys my personality and takes away my part of my soul. I want to leave this world with everything I came into it with' can be argued is able to pass the test for capacity and has a valid point where their healthcare is concerned. The middle ground is to recognise the relevance of both the patient's autonomy and the ethical and legal judgement of the healthcare provider. This requires that consent be seen as both a state of mind and an act of communication (Malm, 1996). The doctor's duty is to 'balance' requirements necessary to allow a patient to exercise their autonomy with the need that the duty is reasonable (Maclean, 2005). Autonomy should provide the driving force behind consent and should demand that the doctor give particular attention to the patient's informational needs.

I understand the position healthcare providers put forward when discussing 'balancing' and margin-for-error approaches, which allow that the patient is legally competent to make a decision. One drawback of the balancing approach to competence, according to Checkland (2001), is that it leaves no room for incompetent wishes that should nevertheless be respected (p.35). Whatever qualities of a person lead us to respect their autonomy does not disappear when the patient becomes legally incompetent. In proposing the 'balance model' Eastman & Hope (1988) argue in favour of a 'trade off' between considerations of competence of the patient to decide whether or not to do a procedure. What Eastman & Hope claim is that as the danger of a procedure increases, the patient must be increasingly competent for their decision to be respected. They also suggest an outside agent, such as a doctor, judge, or close relative should determine the consequences because their views have an 'ethical significance'. It is based on the syllogism: If treatment were beneficial, it would be unreasonable to refuse it. Competent patients' do not make unreasonable decisions; therefore, the patient is not competent (Maclean, 2005).

There are two main problems with the above argument. Firstly, what the doctor sees as beneficial may not be seen as beneficial from a patient's view. A patient who admits to having relief from acute depression after ECT but loses part of their capacity to remember may have a different viewpoint than their doctor. There is a stark contrast in viewing a treatment, which gives some relief from their mental illness and loss of function of memory. The second problem is that 'competent' patients do make wrong and sometimes unreasonable decisions. As Maclean (2005) says, 'if we were all perfectly rational agents then all our decisions would be correct and reasonable' (p. 285). However, having perfect rationality is unrealistic; all that should be expected of a patient is 'minimal rationality' (Cherniak, 1986). Essentially, 'minimal rationality' requires that only some

decisions match with the agent's value and belief system. Incompetence would not follow from an isolated irrational decision. The position that psychiatrists put forward is that mentally ill patients are not able to consent freely because of the nature of their illness, but I refute this claim. Having a mental disorder does not necessarily prevent a patient from accepting their illness and their need for psychiatric care/intervention. Many patients, including those suffering from psychotic illnesses, do accept their illness. While some may not realise the full extent of their illness, they can still give informed consent. If the patient's *acceptance* of the need for a medical intervention is not prevented by their mental disorder, is a condition *necessary* for informed consent. If any patient were to agree to treatment when they did not believe that the treatment was warranted or necessary, this would cast serious doubt as to whether that patient had actually given informed consent.

My defence here is as follows; consider a severely depressed patient who has been prescribed ECT and suffers from *Cotard's delusions*, which means they believe that they are already *dead*. Because of this, they consider treatment to futile. The patient understands that they are consenting to ECT, and communicates their decision to proceed at the advice of their psychiatrist. This patient meets the three conditions necessary for informed consent to ECT. However, they would still not be capable of giving informed consent. The capacity to make decisions is required for someone to give informed consent, but informed consent requires more than capacity to make decisions. It requires that the mental disorder does not prevent 'actual understanding' of treatment, rather than a mere capacity to understand (Staden & Kruger, 2002). Following this, note that the incapacity to give informed consent extends to incapacity to give informed consent for medical interventions. Consider a patient who agrees to a medical intervention for a life-threatening condition, but their mental illness prevents them from understanding the nature and purpose of the treatment/intervention. This prevents them from communicating their consent, despite all practical steps to help them understand. One would be mistaken to claim that the patient's *assent* to the intervention would constitute valid informed consent. Due to their mental disorder, they do not meet the conditions necessary for informed consent.

O'Neil (2000) opens up another avenue for consideration when she discusses the reasoning model of consent and patient empowerment, which involves advocating for oneself to participate maximally in significant decisions. I will not address recognitional and constructive models of consent due to space constraints, but both have their advantages and disadvantages. That said patient disempowerment is an issue when discussing

consent. A reasonable compromise would be to examine O'Neil's position—that one's individual ability to reason must be judged against, ends, norms, or commitments that are accessible to others (O'Neil, 2000). O'Neil's position is that reasoning is defective when reasoners misjudge or misunderstand information. She emphasises the role of patient empowerment and makes the point that the purpose of the consent requirement is to provide 'reasonable assurance that the patient ... has not been deceived or coerced' (O'Neil, 2000, p. 26- 27). In her later work, O'Neil is quick to admit that the mere signing of the consent form may not in itself provide reasonable assurance, but does point out that this model of rationality allows an individual's decision to be challenged. If respect for autonomy means assisting the patient to make the best decision, then a duty to respect autonomy requires the patient's decision to be challenged (O'Neil, 2002, p. 5). O'Neil's position varies over time. In 2000, she says we are to assure enough information is used so as not to deceive or coerce the patient into signing the consent form. However, in 2002 she makes the statement that '... the inclusion of excessive or technical detail ... will eventually overtax even the most energetic and undermine the possibility of informed consent (p 60.) I challenge the latter viewpoint, as some patients wish for more information than others do, and the amount that an individual patient can comprehend varies. O'Neil says that by challenging the patient decision and presenting alternative options, the healthcare provider may facilitate reflection. Furthermore, although the notion of best decision must be determined by the patient's subjective values, the patient may still make an irrational decision, which might be corrected by the physician. O'Neil accessible ends model requires a patient's irrational decision to be confronted and rational argument used to reach a position that is mutually accessible. O'Neil's model does not require the assessor to agree with the person's decision, but the assessor should appreciate that someone with different beliefs could make such a decision (Maclean, 2006). O'Neil highlights a further problem in her discussion of the 'opacity' of consent: suppose that a patient consents to a procedure, A which logically entails B and has the consequence C. If the patient, for whatever reason, cannot understand the connection between A, B, and C, they have not given informed consent to B or C. While these connections may be obvious to healthcare provider, these providers should not assume that a patient would make the same connection. In the Alder Hey case, for example, some parents consented to the retention of tissue from their children but did not believe they were consenting to the removal of organs (Royal Liverpool Children's Hospital, 2001, O'Neil, 2003).

Therefore, my position is that patients may retain decisional capacity even if they are somewhat impaired. Informed capacity requires more than mere capacity; it requires that a mental disorder does not prevent 'actual' understanding of what is being consented to (rather than a capacity to understand). Whichever model of rationality is adopted, respect for a person's autonomy requires the healthcare provider to challenge an apparently irrational decision in an attempt to reach a more rational choice. Arguably, it also requires an apparently rational decision to be challenged. However, some decisions require a choice between options where more than one choice is rational. This position still reflects the argument that autonomy provides the driving force behind consent and demands the healthcare provider address the patient's informational needs. I take my lead on the last point from Maclean, who has written numerous works on the legality of consent. Having a decision based on empirical evidence, which supports the decision-making process is important when determining what people should do. The law supports decisions based on 'fact'. This means that empirical evidence is the only way of discovering what information should be disclosed (Maclean, 2005). It would perhaps limit the patient's self-determination and undermine their autonomy if the doctor's duty was limited to disclosure of rationally required information. As the mentally ill patient may not be fully able to understand everything, their informational needs may be irrational. In these cases, it becomes less helpful to try to constrain them by rational normative judgements. Whilst autonomy is still a valid principle, patients should be entitled to decide how much autonomy they wish to exercise. Although the Mental Capacity Act (2005) has laid down guidelines for capacity and competency, a more consistent approach to determine these standards should be put in place by psychiatrists to determine these standards. I believe that by shifting the burden of proof from patients suffering from a mental illness, mental health professionals believe they are safeguarding the best interests of the patient. However, they are actually denying the rights of the patients both legally and ethically.

#### Section 4.7: Conceptual Discussion: Consent, Paternalism, and Best Interests.

Mental health care involves restraints on the actions and decisions of patients. These restraining practices are often justified by paternalism, seen as being for the patient's own good. I challenge the paternalistic position of healthcare providers. This challenge also involves the traditional paternalistic treatment of mental illness, which involves limited autonomy and thus limited capacity consent. *To recap*, a patient's incapacity to give informed consent to one intervention should not be assumed to imply incapacity to give consent to all medical

interventions. A mentally ill patient incapable of giving consent to their asthma treatment may still be capable of giving consent to their schizophrenia and vice versa. Decisions are often made for the mentally ill sometimes without ethical justification, which leads to treatments including ECT being given to the mentally ill that they have specifically refused. Mental Health Act (1983), [revised 2007]. Paternalism is a system by which an authority attempts to supply needs or regulate conduct of those under its control in matters affecting them as individuals as well as in their relations to authority and to each other. An analysis of paternalism involves the concept of limitation on the freedom or autonomy of an agent. As often is the case, the first question to address is whether the concept itself is normative or descriptive. Is the application of this concept a matter for 'empirical' determination so that if two people disagree about the application to a particular case they are disagreeing about some matter of fact or of definition? (taken from Plunkett & Sundell, 2013) or does their disagreement reflect different views about the legitimacy of the application in question?

I suggest the following conditions as an analysis of X acts paternalistically towards Y by doing (omitting) Z

1. Z (or its omission ) interferes with the liberty or autonomy of Y
2. X does so without the consent of Y
3. X does so because Z will improve the welfare of Y (where this includes preventing his/her welfare from diminishing) or in some way to promote the interests, values, or good of Y.

(taken from Plunkett & Sundell, 2013)

Condition 1 is the hardest to capture. Clear cases include withholding relevant information that a patient has a right to have or imposing unnecessary requirements or conditions on a patient. Let me highlight the problems by presenting the following case.

#### Case study two

*Sally, a 52 year-old employed woman with a long history of recurrent depression who had never been prescribed medication, was voluntarily hospitalised with a psychotic depressive illness. She agreed to ECT without seeming to pay much attention to the explanation of the treatment. Because she was not paying much attention, the psychiatrist proceeded to give a brief outline. The treatment was given with no attention to detail regarding any risks or side effect, or the possibility of receiving an alternative treatment. After reading and signing the informed consent, the patient remarked, "it doesn't make any difference any way because this*

*is all over for me, I am dead.” This voluntary patient would probably have consented to any procedure, because of the acute severity of her illness, so did she truly understand the treatment, the effects, and side effects, to which she gave permission?*

The second condition above is meant to read as distinct from acting *against* the consent of an agent. This condition implies that the agent does not consent, nor do they refuse treatment. They (Sally) may for example, be unaware of what is being done to them. The third condition can also be complicated. There may be more than one reason for interfering with Y. In addition to concern for the physical and mental welfare of Y (Sally) there may be concerns for how Y’s action may affect third parties. In order to decide on the above issues, one must decide a normative issue; e.g. does someone have a right to some information then the concept is not purely descriptive. Ultimately the question of how to refine the conditions, and what conditions to use, is a matter for philosophical judgement (Coons & Weber 2013). The stance I take from an ethical and legal position I have stated previously (earlier in this chapter) is that valid consent within this psychiatric scenario is not possible. I have also argued that healthcare providers demonstrate paternalism seldom looking at differing alternatives in decision-making. Miller & Wertheimer (2009) enhance the discussion by saying that paternalism does not always involve interfering with someone’s liberty of action; sometimes it involves deceiving another for their own good or withholding information from them. However, the question remains, what does paternalistic interference entail and how does it occur within psychiatry?

It is important to distinguish between what Feinberg calls ‘soft paternalism’ and ‘hard paternalism’ (sometimes referred to as weak and strong paternalism). Soft paternalism is the view that only conditions under which state paternalism is justified is when it is necessary to determine whether the person being interfered with is acting voluntarily and knowledgeable. A soft paternalist believes it is legitimate to interfere with the means that agents choose to achieve their means. Soft paternalism operates to restrict conduct only when the agent’s decision-making is judged non-voluntary or non-autonomous. In contrast, hard paternalism involves restricting the freedom of persons who are substantially autonomous to protect them ‘against their will, from harmful consequences even of their fully voluntary choices and undertakings’ (Feinberg, 1986, p. 12). Hard paternalists believe that people may be mistaken or confused about their ends, and it is legitimate to interfere to prevent them from achieving those ends. Strong paternalism is considered harder to justify than weak

paternalism, and some authors (e.g. Beauchamp & Childress, 2009) have even argued that weak paternalism does not require ethical justification.

I reject the acceptance between strong and weak paternalism and hold that all actions involving the use of authority to override a patient's choices are coercive, even if those choices are not autonomous. Whether a coercive action has, a paternalistic justification depends on whether or not that action can be justified in terms of prevention of harm. Some would argue that paternalism justifies psychiatric medical intervention to prevent harm. This is countered by the principle of autonomy and each person's right to be a self-determining individual. However, the principle of autonomy was limited by the self-harm principle, therefore giving justification to paternalists to intervene in order to prevent harm to self and others. That said I hold that the use of coercive actions towards substantially autonomous patients cannot be justified by making an appeal to beneficence. Acting under the guise of the patient's 'best interests', requires the clinician to make a judgement about the effect of a pathology on a patient's behaviour and not a decision judgement about the authenticity of a patient's physical and mental make-up.

Additionally, (and to reiterate from chapter 2b) we must address the need to defend others from harm. Dangerousness is often a trump card in decisions on hospitalisation to psychiatry, and patients can be hospitalized if they are deemed a 'danger to others'. However, dangerousness is not specific to any one psychiatric diagnosis. In rebuttal, I note that one must be cautious: mentally ill patients are not a significant danger to others until proven otherwise. While somewhat rhetorically phrased, the moral point is clear: just as criminal guilt must be proven, not assumed, a psychiatric patient's significant danger to others must be proven not assumed (Cherry, 2010).

#### Section 4.7.1: Best Interests.

Firstly, let me address the premise of the 'best interests' argument. Dawson (2005) breaks down "best interests" into objective and subjective accounts. Objective is to be "explained in terms of maximising the individual's welfare, wellbeing, or good" (p. 195). Dawson (2005) notes that an action is only classed as 'best' if the action would be most beneficial for the patient. In contrast, subjective accounts of best interests refer to the decision an individual would come to if they were able to make a competent decision (Loewy & Fitzgerald, 2003). It has been long established that when a patient lacks decision-making capacity and there are no

guardians or recognised surrogates available, decisions are made with the patient's best interests in mind. Buchanan & Brock (1989) make the point that any decision is driven by the competence to make that decision. A patient may be competent to make the required decision under certain circumstances but lack competence to make a decision under different circumstances. I argue that the idea that informed consent should be prioritised above 'best interests' rests on the claim that a patient has privileged knowledge as to what constitutes their best interests. Healthcare providers who challenge this premise and who actively demonstrate paternalistic behaviour, base their position around three points: Firstly, the patient lacks non-medical information, in so far their lack of medical knowledge places them in a position of inequality. Secondly, the patient's decision is influenced by cognitive biases and thirdly, the patient poorly judges the risk element in their decision. Taken together, these arguments hold that the patient is not always the best party to make a decision, as the patient's ability to make a decision that protects their best interests can sometimes be compromised. This group of people also go on to say that in the majority of cases there is no reason to question a patient's decision. However, there is a presumption that patients with mental illness lack the competence to make decisions, and thus their decisions are often not respected. Buchanan & Brock (1989) go on to say that, the benefit of the best interest's decision should bring about a 'net' benefit to the patient. However, this alone is not sufficient, as treatment results also need to be greater than the option of the patient suffering. While many people with a mental illness lack rationality and the ability to make a judgement, there is a growing realisation that these people are capable of considered judgement. Buchanan & Brock (1989) say that decisions in the patient's best interests should take into account quality of life judgements and consider the ways in which a proposed treatment affects the patient's life. If a patient is deemed incompetent to give or refuse consent to clinical procedures, what criteria do others use to decide on the patient's behalf? Who should decide, by what criteria they should decide and what the limits of surrogate decision-making are. Healthcare professions need to develop a more nuanced approach to balancing the demands of informed consent and duty of care. An autonomous agent cannot be expected to investigate all information before accepting it as truth. However, one should have good reason for accepting any source of information. The more authoritative the source, the more believable the information (Hogarth, 1987). No matter how credible the source, the patient is still free to believe or not believe the information supplied. Before the Mental Capacity Act (2005), the problem with determining capacity to believe was similar to that of determining capacity for understanding, it depended on unobservable and inferential mental processes rather than on



concrete and observable elements of behaviour. At this time, law courts were filled with overly optimistic and often morally empty and evasive rhetoric, which did not serve as a beneficial benchmark in the interests of patient care. Since the Mental Capacity Act (2005), authors have developed a hierarchy of guiding principles for surrogate decisions. Some of these include advance directives, substituted judgement, and best interests. Advance directives are considered a decision about the care a patient wants to receive if they become unable to make a decision in the future. Substituted judgement occurs if no valid expressions of the patient's wishes are available. Then, decision-makers would try to judge what the competent person would have decided. When deciding what is in a patient's best interest, we have to consider the problem of 'moral imagination' in decision-makers. What criteria do the decision-makers use when trying to imagine what the patients would have chosen? When considering ECT, can the healthcare professional set aside his or her own interests and acting beneficently for the welfare of the patient? This situation is especially relevant if healthcare providers have known the patient for a long period and come to a conclusion that they believe is reflective of the patient. If ECT is directed towards a patient with severe depression and suicidal ideations, then it could be argued that this treatment is in the best interest of the patient. However, I have noted in previous chapters that ECT irreversibly damages brain tissue, so what is in the patient's best interest may not be as clear as it seems. Consider the analogy of a patient who has a brain tumour and needs an operation that may involve damaging further tissue but is necessary to save the patient's life. Here, an objective view of best interests is that surgery is justified, because in the end we save the patient's life. The patient may suffer from minor brain damage rather than an early death.

ECT is different in that doctors are not taking out diseased brain tissue, which would otherwise continue to kill healthy brain cells. ECT actually kills off healthy brain tissue, (Ross, 2006) but in principle saves the life of the person by lifting the person's mood to reduce suicidal ideation. Whereas not removing a tumour will almost certainly lead to the death of the patient, not treating a depressed individual with ECT does not have the same certainty. In addition, when removing a tumour, doctors know what the outcome will be. This is not the case with ECT, as we scientifically do not understand its mechanism of action in the brain (Loewy & Fitzgerald, 2003). Moreover, ECT should not be an option if their depression could be relieved in other ways. This determination requires the doctor or nurse recognising the patient's best interest to make a judgement about the effect of their illness on their behaviour as well as understanding what the patient would prefer. The

answer lies in deliberation and prioritisation of ethical principles, which should be taken on a case-by-case basis in a more nuanced model of medical decision-making.

Lastly, we must address the limits of surrogate decision-making. Does the question 'are our patients under-protected' need to be addressed? When investigating the limits of surrogate decision-making, the central question will be whether we should have a moral system in which there is intense, close ethical review in research protocols and choices should be respected. When the courts and a detailed patient's history conclude that the patient's mental capacities are intact, there comes a point that any decision to refuse treatment should be respected. Therefore, if there is a principle that operates to raise the threshold level of mental capacity required for legal competence, therefore the operation of that principle may be limited at extremes of capacity and gravity (Buchanan, 2004). The practical consequences have not been described systematically; most decisions have often not reached the courts, and those that do not always describe the court's rationale. However, it is most frequently proposed that the good of acting in the patient's best interests always has to be *balanced* against another good, that of respecting the same patients autonomy. According to the '*balancing*' justification for proportionality, capacity is either a measure of how much autonomy someone has, or a measure of how much value should be attached to respecting that autonomy (Eastman & Hope, 1988). As a result, the threshold level of capacity required for legal competence should rise as the consequences become more serious. Numerous writers<sup>22</sup> refer to the threshold varying with seriousness of a proposed treatment and what is at stake for the patient. However, the consequences of any one decision are different from the next. Under the balancing approach, the same psychiatric patient can decide whether to take medication, but is denied the right to decide whether to undergo ECT (Buchanan, 2004).

Central to the argument of determining capacity to consent is the information given to a patient in regards to what is at stake if a procedure does not result as planned. It follows that the balancing approach appears to place a peculiar burden on the process of seeking consent when dealing with the mentally ill. In conclusion, any measurement of capacity is subject to error, even modern legislation decisions. These errors are disrespectful to the autonomy of the mentally ill. Surely, a balancing approach has to establish what needs to be balanced, which must include an honest and thorough explanation of the risks and benefits of a procedure.

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<sup>22</sup> Fadden and Beauchamp (1986); Buchanan and Brock (1989); White (1994); Wilks (1999).

#### Section: 4.8. Conclusion.

My goal questioned whether ethically valid consent is achievable when considering ECT for the mentally ill. I challenged a number of assumptions put forward by those who argue that current practices for gaining consent for ECT are legally and ethically sound. Despite the fact that ECT may improve a patient's state, there may still have been a lack of honesty in the method of gaining consent through minimisation of the side effects and process itself. By not telling patients about alternative treatment methods long-term effects, the consent process imposes excessive risk to the patient. All individuals have the same protection under the law, even if they are placed under a section of the Mental Health Act (1983), [revised 2007], and patients should be allowed to make decisions concerning their care and treatment. Throughout this chapter, I have shown that the issue of consent and personal patient choice is far from resolved. Valid consent is an essential pre-condition to administering ECT, and an essential element of consent is a meaningful assessment of the patient's capacity to consent un-coerced. Lastly, the problem of communication between patients and providers can be overcome, and there are ways to communicate all that which a reasonable person would wish to know in an accessible manner. To accomplish this goal, healthcare workers must investigate a more nuanced approach to medical decision making. With respect to obtaining consent for ECT, every patient should be fully assessed to demonstrate that they are able to participate in the consent process. It is not ethically appropriate to address the issue of from the mentally ill if the full facts of ECT are not provided. If consent is gathered without the appropriate information given, it is a dismal failure in respect of autonomy.

## **Chapter 5. : Conclusion: Final thoughts.**

‘Opposition comes to those who have taken a position’.

Reginald Gatsi - Pastor

Throughout this thesis, what I have argued for is not a general critique of psychiatry or the many personnel who work within it but against the use of a particular treatment, which is Electroconvulsive Therapy. The conclusion of this argument is “Clearly, Electroconvulsive therapy which will continue to be used within psychiatry in its present form is unethical”. Until there is scientific and technological advancement the use of Electroconvulsive Therapy as a treatment for mental illness is highly questionable, its prescription and its new machinery is dangerous in its modern day format and should not be used except in extreme emergency circumstances. The viewpoint I take is that if ethics had been a factor when ECT was discovered and applied to psychiatry, ECT would have been abandoned or prohibited. As society becomes increasingly high tech, we might plausibly argue that psychiatry and medicine will similarly develop and advance, but that is not reflected in the present day. Nonetheless, the validity of the author’s argument depends on the idea that psychiatry and medicine has not advanced as rapidly as technology. A treatment that can cause such devastation, while producing such limited and questionable results, has no place in the practice of medicine and psychiatry. At best, ECT offers a very poor trade-off – potentially irreversible brain damage and mental dysfunction, in exchange for the docility and temporary emotional blunting or euphoria that result from the damage.

Within my thesis, I made a number of points to support my main argument and it is very important for me to clarify my supporting arguments and my approach to psychiatric healthcare when I challenge ECT and to distinguish them from other similar seeming conclusions.

Firstly: Central to the argument lies the premise which the proponents of ECT base their position on, which is that relief from acute mental illness is in their best interests, and therefore good (which I agree with ) so the justification of using ECT as a treatment is perfectly right given these circumstances (Which I disagree with).

Ambiguity and vagueness are the enemies of analytical philosophy and consequently applied ethics within healthcare. The medical use of ECT presents an integrated spectrum of clinical, ethical, and legal problems. The salient points within this thesis are that ECT is an iatrogenic treatment which has the ability to cause brain

damage, manifested in forms of severe and often permanent loss of memory and should not be used (except in absolute emergency circumstances)

Secondly, I have not argued about the role of ethics in decision making in the prescription of ECT, because there is an important role for ethics to play in psychiatric clinical dilemmas and the emerging field of healthcare ethics within psychiatry. The implication of the arguments I have put forward in this thesis is not that bioethics should not be a consideration factor, but one of major concern. The conclusion to be drawn is that ethics in future development has a large part to play when considering using ECT as a treatment.

Thirdly, I have not argued for not using the ethical theory of Principlism. In fact I happen to think Principlism has merits which can be seen to utilise established moral ways of thinking. There are still many questions that arise from the unresolved tension between clinical care and patient rights coupled with legally binding treatment decisions based solely on claims to 'therapeutic efficacy'. I have argued that one ethical theory is not to be advocated over another, but a combination of Principlism and Virtue theory is needed to address the wide expressions of professional and clinical practice in psychiatry. The unique quality of psychiatric ethics is that it pulls us on the one hand into clinical conceptual analysis; and on the other hand, it pulls us in the direction of the contradicting nature of diverse and disputed values that society places upon us. This thesis has argued that the philosophical approach to Virtue ethics is of value, not only in terms of providing guidance regarding how to be, but also how to act. This perhaps may be an unsatisfying conclusion to those who favour the theory of Principlism against those who favour virtue theory; but my position is that for the benefit of patient care what we can achieve by implementation of both sets of principles is justified action and a morally right action. While doing so, it will at least set an achievable standard, while allowing room for evaluation (criticism and reward).

However, returning to my main thesis argument, as in the past, ECT is still a most complex intervention to untangle, so it not surprising that it is difficult to maintain a balanced view, particularly as so many questions remain unanswered. Whatever is claimed and counter claimed in the ongoing scientific debate of ECT, and particularly while our understanding of the healing and transcendental potential of brain/mind is still incomplete. Neurophysiological knowledge is in its infancy regarding this treatment's precise mechanism of action. Science has not yet given us a definite answer as to how it works and the reasons for the side effects of this treatment. When I questioned the

relationship between psychiatry and science, I am reminded of Dworkin's statement on the role of scientists in the processes of social change, offered in her book *Life and Death*. Extrapolating from her statements concerning battered women:

*Social scientists find a pattern of injury and experts describe it...They are listened to respectfully, are often paid to give evidence in legal cases. Meanwhile, the voice of the victim still has no social standing or legal significance. She still has no credibility such that each of us-and the law-is compelled to help her. (p.45)*

With the voices of individuals and political movements continuing to enter the debate on the administration and efficacy of ECT, coupled with further possibilities of further in-depth involvement from legal frameworks in compelling socio-cultural change "those of us who are not jurors have a moral obligation to listen 'p.47)

However, a significant gap exists in what information and what perspectives are being given to patients, it is often only the pro-ECT viewpoints that are communicated, only the pro-ECT research (limited and unsubstantial it may be) which is cited and only pro-ECT perspectives, themes and ethics which are given a voice. A gulf is seemingly apparent from positions of peoples' experiences of the affects and efficacy of ECT, situations of consent or refusal, and those involved in the administering and administration of the process. Yet little literature is available viewing the effects of involvement in ECT administration and surrounding processes for individual staff, staff teams, carers, families, friends - the social milieu of relationships and personal and professional interfaces, whether they be in the clinic settings or beyond.

The methodologies from trauma-based perspectives coupled with the fact that the people subjected to ECT and the mental health system are both the expert witness and, for an alleged ECT medical research "industry", the personal evidence that is appropriated to drive this "industry". Alternate evidence-bases assertively challenge the widespread adherences of state-endorsed medicalised practise to prescribed hierarchies of method. Retaining prevailing structures of evidence recognition that predispose the extrapolation of certain medical/scientific models for ECT's functional efficacy and placement in a diagnostic and operative setting mean limiting possibilities for fully informed debate, and collaborative research (Ruthen, 2006).

Advocates of ECT will give many explanations and reasons to rationalise its use. ECT has been so strategically repackaged that other professionals often condone the use of it even with the most controversial client groups (Jones & Baldwin, 1992). An important and subtle feature of the maintenance of the dominant power positions of healthcare providers is the possession of a body of knowledge that structures how mental illness is understood and treated. Although exceedingly complex and painful, this discussion is necessary, and possibly increasingly, so as the debates about ECT and all the issues attached to it becomes challenged within professional, legal, and ethical circles. However, for such debates to be meaningful, the much more complex issue of healthcare provider –patient relationship, needs to be meaningfully addressed. The changing influence of power paradigms is not easy, but needs to be addressed if patients are to have more of a say within their psychiatric care pathways, commensurate with their desired level of involvement in decision-making. It has become increasingly clear to the author this must be a subject open to discussion. Avoiding it is not only detrimental to the wellbeing of the psychiatric patient, but also to that of our profession and its place within psychiatry and medicine.

To the pro-ECT advocates I set down a challenge, what is needed is a more balanced representation of ECT's controversial nature, prescription, side effects and outcome, if healthcare providers wish to profess that they are acting from a position of knowledge. However, here is where I underscore my position, when I state ECT in my view is here to stay; there is a need for the pro and against ECT professionals to work together. The validity of a position which finds something intrinsically and unanalysable distasteful about ECT cannot be questioned. However, neither can it be supported (Freedman, 1987). It is imperative that the patient referred for ECT makes an informed decision whether to accept treatment or not based on information and not perceived ideas or unreliable accounts. Specifically, the author assumes that since research into ECT has decelerated as technology has improved the pattern of ECT use will be continued with no empirical knowledge to provide its evidence base. For those who say such an assumption is unwarranted; many trends reverse direction entirely or eventually. My rebuttal to this is that the present research does not reflect this, your argument relies heavily on assumptions of which without research your position is weakened, and you could argue presently gives an invalid conclusion.

In my section on the law and ECT, I have not argued that psychiatry is irrelevant to the law and ethics, I agree anyone committing dangerous acts of place, and person whilst suffering from acute mental illness needs to be treated. I did not argue against the Mental Health Act (1983) [2007 revised] to enable this process of admission. What I did argue against was using the law to enforce ECT treatment especially when we cannot even answer the question how strong is our presumption that relief from the mental illness is achievable. Following this, the argument I pursued was the real ECT and sham ECT debate. My position was since there is no demonstrated benefit from real ECT compared to sham ECT, except during the time the treatment is being administered. Since the difference is modest and since ECT has associated morbidity and mortality, those who advocate for it and wish to continue prescribing it should undertake an adequate empirical study of the effectiveness of ECT. The burden of proof that ECT is safe and can be prescribed ethically without long-term side effects lies with the advocates. In the absence of such a study, whatever its outcome, the sham ECT literature supports the conclusions that real ECT is no more effective than placebo ECT (except during the time the treatment is being administered), and that ECT will repeatedly endorsed due to custom and practice.

I would suggest that consent forms should be adequately designed and state, there is no difference between sham ECT and real ECT and during treatment, the difference is modest. It is difficult to understand how anyone would give meaningful consent without this information being given to him or her. Psychiatry raises fundamental questions such as those linked to the definition of the person (Seedhouse, 2009). Therefore, in the quest for harmony in the relationship between psychiatric patients and healthcare providers, tensions on all sides between means and ends need to sustain recognition. If healthcare providers wish to project the premise of practising from dominant power positions then this must be from possession of knowledge that structures mental illness and treatment and not from subjective value judgements. The position of subjectivity only encapsulates what is wrong with psychiatry and will receive sustained criticism. The implication of the arguments I have put forward in this thesis is that, it is vitally important that emphasis is placed on all areas where knowledge is underdeveloped and addresses all the psychiatric medical issues not just one part. Let us



recognise the challenge, to accommodate all possible viewpoints and enrich the concept and practice of psychiatry for human welfare. Although exceedingly complex and painful, this process is necessary and possibly increasingly necessary. Additionally, in other areas of psychiatry, like rapid tranquillisation, seclusion, restraint, forensic care and the care of the attempted suicidal patient. Given these examples and the countless questions, debates and unresolved ethical quandaries, it has become increasingly clear to the author they must be subjects open to discussion. Avoidance is not only detrimental to the wellbeing of the psychiatric patient, but also to our profession and its place within psychiatry and medicine. This thesis has sought to find a position in a transitional domain between the differing perspectives, because the importance is at the centre of the discussion remains the unique human person who is mentally unwell.

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