

02 - 36.2 Ethics in Psychiatry

36.2 Ethics in Psychiatry

36.2 Ethics in Psychiatry Ethical guidelines and a knowledge of ethical principles help psychiatrists avoid ethical conflicts (which can be defined as tension between what one wants to do and what is ethically right to do) and think through ethical dilemmas (conflicts between ethical perspectives or values). Ethics deal with the relations between people in different groups and often entail balancing rights. Professional ethics refer to the appropriate way to act when in a professional role.

Professional ethics derive from a combination of morality, social norms, and the parameters of the relationship people have agreed to have. **PROFESSIONAL CODES** Most professional organizations and many business groups have codes of ethics that reflect a consensus about the general standards of appropriate professional conduct. The American Medical Association's (AMA's) Principles of Medical Ethics and the American Psychiatric Association's (APA's) Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry articulate ideal standards of practice and professional virtues of practitioners. These codes include exhortations to use skillful and scientific techniques; to self-regulate misconduct within the profession; and to respect the rights and needs of patients, families, colleagues, and society. **BASIC ETHICAL PRINCIPLES** Four ethical principles that psychiatrists ought to weigh in their work are respect for autonomy, beneficence, nonmaleficence, and justice. At times, they are in conflict, and decisions must be made concerning how to balance them. **Respect for Autonomy** Autonomy requires that a person act intentionally after being given sufficient information and time to understand the benefits, risks, and costs of all reasonable options. It may mean honoring an individual's right not to hear every detail and even choosing someone else (e.g., family or doctor) to decide the best course of treatment. Psychiatrists need to provide patients with a rational understanding of their disorder and options for treatment. Patients need conceptual understanding; the psychiatrist should not simply state isolated facts. Patients also need time to think and to talk with friends and family about their decision. Finally, if a patient is not in a state of mind to make decisions for himself or herself, the psychiatrist should consider mechanisms for alternative decision making, such as guardianship, conservators, and health care proxy. A young adult experienced a schizophrenic episode in which his religious fervor turned into psychotic delusions. After being involuntarily hospitalized because he

became suicidal, he insistently refused medication, claiming that his physicians were trying to poison him. His psychiatrist decided to respect his refusal of medication as long as his suicidal tendencies could be controlled. As his mental suffering became more intense, in 1 week the patient changed his mind about medication and agreed to try it. The therapeutic relationship with his psychiatrist deepened, and the patient left the hospital willing to continue with both antipsychotic medication and psychotherapy. Although not all cases work out so well, this one illustrates the benefits of negotiation about treatment even when hospitalization is involuntary. **Beneficence** The

requirement for psychiatrists to act with beneficence derives from their fiduciary relationship with patients and the profession's belief that they also have an obligation to society. As a result of the role obligation of trust, psychiatrists must heed their patients' interests, even to the neglect of their own. The expression of the principle is paternalism, the use of the psychiatrist's judgment about the best course of action for the patient or research subject. Weak paternalism is acting beneficently when the patient's impaired faculties prevent an autonomous choice. Strong paternalism is acting beneficently despite the patient's intact autonomy. Guidelines have been proposed for permitting beneficence to overrule patient autonomy; when the patient faces substantial harm or risk of harm, the paternalistic act is chosen that ensures the optimal combination of maximal harm reduction, low added risk, and minimal necessary infringement on patient autonomy.

Nonmaleficence To adhere to the principle of nonmaleficence (*primum non nocere* or first, do no harm), psychiatrists must be careful in their decisions and actions and must ensure that they have had adequate training for what they do. They also need to be open to seeking second opinions and consultations. They need to avoid creating risks for patients by an action or inaction.

Justice The concept of justice concerns the issues of reward and punishment and the equitable distribution of social benefits. Relevant issues include whether resources should be distributed equally to those in greatest need, whether they should go to where they can have the greatest impact on the well-being of each individual served, or to where they will ultimately have the greatest impact on society.

SPECIFIC ISSUES From a practical point of view, several specific issues most frequently involve psychiatrists. These include (1) sexual boundary violations, (2) nonsexual boundary

violations, (3) violations of confidentiality, (4) mistreatment of the patient (incompetence, double agency), and (5) illegal activities (insurance, billing, insider stock trading).

Sexual Boundary Violations For a psychiatrist to engage a patient in a sexual relationship is clearly unethical. Furthermore, legal sanctions against such behavior make the ethical question moot. Various criminal law statutes have been used against psychiatrists who violate this ethical principle. Rape charges may be, and have been, brought against such psychiatrists; sexual assault and battery charges also have been used to convict psychiatrists. In addition, patients who have been victimized sexually by psychiatrists and other physicians have won damages in malpractice suits. Insurance carriers for the APA and the AMA no longer insure against patient-therapist sexual relations, and the carriers exclude liability for any such sexual activity. The issue of whether sexual relations between an ex-patient and a therapist violate an ethical principle, however, remains controversial. Proponents of the view "Once a patient, always a patient" insist that any involvement with an ex-patient—even one that leads to marriage—should be prohibited. They maintain that a transference reaction that always exists between the patient and the therapist prevents a rational decision about their emotional or sexual union. Others insist that, if a transference reaction still exists, the therapy is incomplete and that as autonomous human beings, expatients should not be subjected to paternalistic moralizing by physicians. Accordingly, they believe that no sanctions should prohibit emotional or sexual involvements by expatients and their psychiatrists. Some psychiatrists maintain that a reasonable time should elapse before such a liaison. The length of the "reasonable" period remains controversial: Some have suggested 2 years. Other psychiatrists maintain that any period of prohibited involvement with an ex-patient is an unnecessary restriction. The Principles, however, states: "Sexual activity with a current or former patient is unethical." Although not spelled out in The Principles, sexual activity with a patient's family member is also unethical. This is most important when the psychiatrist is treating a child or

adolescent. Most training programs in child and adolescent psychiatry emphasize that the parents are patients too and that the ethical and legal proscriptions apply to parents (or parent surrogates) as well as to the child. Nevertheless, some psychiatrists misunderstand this concept. Sexual activity between a doctor and a patient's family member is also unethical. An egregious example of a sexual boundary violation was reported in the Medical Board of California Action Report (July 2006) of a psychiatrist who had a 7-year affair with a patient who had schizophrenia. The doctor not only had sex with the patient but also had her procure prostitutes with whom he and the patient had group sex. He paid for their services by providing them with prescriptions for controlled substances and went so far as to bill Medi-Cal for these encounters as group therapy. The physician's

license was revoked, and he was also criminally convicted of fraud. **Nonsexual Boundary Violations**

The relationship between a doctor and a patient for the purposes of providing and obtaining treatment is what is usually called the doctor-patient relationship. That relationship has both boundaries around it and boundaries within it. Either person may cross the boundary. Not all boundary crossings are boundary violations. For example, a patient may say to a doctor at the end of an hour, "I have left my money at home, and I need a dollar to get my car out of the garage. Will you lend me a dollar until next time?" The patient has invited the doctor to cross the doctor-patient boundary and set up a lender-borrower relationship as well. Depending on the doctor's theoretical orientation, the clinical situation with the patient, and other factors, the doctor may elect to cross the boundary. Whether the boundary crossing is also a boundary violation is debatable. A boundary violation is a boundary crossing that is exploitative. It gratifies the doctor's needs at the expense of the patient. The doctor is responsible for preserving the boundary and for ensuring that boundary crossings are held to a minimum and that exploitation does not occur. A resident in psychiatry was admonished by her psychotherapy supervisor to never, under any circumstances, accept a gift from a patient. In the course of treating a young girl with schizophrenia, she was offered a Christmas gift (a cotton scarf), which she refused to accept, explaining as gently as possible that it was not permitted by the "rules of the hospital." The next day the patient attempted suicide. She experienced the resident's refusal to accept the gift as a profound rejection (to which patients with schizophrenia are exquisitely sensitive), which she could not tolerate. The case illustrates the need to understand the dynamics of gift giving and the transference meaning to the patients of rejecting (or accepting) the gift. The story (possibly apocryphal) is told of how Freud, who was an inveterate cigar smoker, was offered a box of difficult-to-find Havana cigars by a patient during the course of his analysis. Freud accepted the cigars and then proceeded to ask his patient to explore his motivations in offering the gift. Freud's reasons for accepting the cigars are more obvious than the patient's unconscious motivation for giving them, about which no information is available. Harm to the patient is not a component of a boundary violation. For example, using information supplied by the patient (e.g., a stock tip) is an unethical boundary violation, although no obvious harm may come to the patient. For purposes of discussion, nonsexual boundary violations may be grouped into several arbitrary (overlapping and not mutually exclusive) categories.

Business. Almost any business relationship with a former patient is problematic, and almost any business relationship with a current patient is unethical. Naturally, the circumstance and location may play a significant role in this admonition. In a rural area or a small community, a doctor might be treating the only pharmacist (or plumber or couch upholsterer) in town; then when doing business with the pharmacist-patient, the doctor tries to keep boundaries in check. Ethical

psychiatrists try to avoid doing business with a patient or a patient's family member or asking a patient to hire one of their family members. Ethical psychiatrists avoid investing in a patient's business and collaborating with a patient in a business deal. Ideological Issues. Ideological issues can cloud judgment and may lead to ethical lapses. Any clinical decision should be based on what is best for the patient; the psychiatrist's ideology should play as little a part as possible in such a decision. A psychiatrist who is consulted by a patient with an illness should tell the patient what forms of treatment are available to treat the illness and allow the patient to decide on a course of treatment. Naturally, psychiatrists should recommend the treatment that they feel is in the best interest of the patient, but ultimately, the patient should be free to choose. Social. The particular locale and circumstances must be considered in any discussion of the behavior of an ethical psychiatrist in social situations. The overarching principle is that the boundaries of the psychiatrist-patient relationship should be respected. Furthermore, if options exist, they should be exercised in favor of the patient. Problems often arise in treatment situations when friendships develop between the psychiatrist and the patient. Objectivity is compromised, therapeutic neutrality is impaired, and factors outside the consciousness of either party may play a destructive role. Such friendship should be avoided during treatment. Similarly, psychiatrists should not treat their social friends for the same set of reasons. Obviously, in an emergency, a person does what a person must. Financial. For psychiatrists who practice in the private sector, dealing with the patient about money is a part of treatment. Issues surrounding setting the fee, collecting the fee, and other financial matters are grist for the mill. Even so, ethical concerns must be observed. The Principles advises the doctor on such matters as charging for missed appointments and other contractual problems. Ethics complaints against doctors are frequently precipitated by financial issues; thus, the doctor must recognize the power that these issues have in the therapeutic relationship. Because the psychotherapeutic relationship is so much like a social relationship—the office looks like a living room; the doctor wears regular clothes; some patients might, without recognizing it, assume that a friendship exists that forgives payment of a fee. When the bill is presented, feelings, even though they are unconscious, are ruffled. The idea that psychiatric services are dispensed in a contractual context cannot be sufficiently emphasized. Early in their careers, psychiatrists are often reluctant to discuss fees openly out of a sense of

embarrassment over discussing money or a sense of protecting the patient. How an ethical psychiatrist handles the situation when a patient temporarily or permanently runs out of money is important. Many options are available—some more problematic than others. The psychiatrist can certainly lower the fee, but caution is needed because a fee lowered to the point where the treatment is not somehow being compensated may evoke countertransference resentment. The number of patients being seen at a reduced fee is a similar consideration. Running up a bill can also be a problem. Is there an expectation of eventually being paid? Is the hypertrophic bill a sham? The frequency of sessions may have to be altered. Any psychiatrist who sees private patients will definitely face these problems. Confidentiality Confidentiality refers to the therapist's responsibility not to release information learned in the course of treatment to third parties. Privilege refers to the patient's right to prevent disclosure of information from treatment in judicial hearings. Psychiatrists must maintain confidentiality because it is an essential ingredient of psychiatric care; it is a prerequisite for patients to be willing to speak freely to therapists. Violating confidentiality by gossiping embarrasses people and violates nonmaleficence. Violation of confidentiality also breaks the promise that a psychiatrist has explicitly or implicitly made to keep material confidential. Confidentiality must also give way to the responsibility to protect others

when a patient makes a credible threat to harm someone. The situation becomes complicated when the risk is not to a particular individual, such as when a doctor is impaired or someone's mental state adversely affects his or her performance of a dangerous job, such as police work, firefighting, or use of dangerous machinery. Erosion has also arisen from the demands of an insurance company for detailed information. Patients must be told that information may be released to insurance companies, but they do not need to be warned that information concerning abuse of a child or threat to themselves or others needs to be reported. Various settings exist in which patient data can be used to some degree. The general rule for doing so is to disclose only that information that is truly necessary. In teaching, research, and supervision, patients' names or information that might allow others to identify them should not be unnecessarily released. In ward rounds and case conferences, in which patient material is presented, attendees should be reminded that what they hear should not be repeated. Confidentiality endures after death, with the ethical obligation to withhold information unless the next of kin provides consent. A subpoena is not automatic license to release the entire record. A psychiatrist can petition the judge for an in-camera (private) review to define what precise information must be disclosed. Ethics in Managed Care Psychiatrists have certain responsibilities toward patients treated in managed care

settings, including the responsibilities to disclose all treatment options, exercise appeal rights, continue emergency treatment, and cooperate reasonably with utilization reviewers. Responsibility to Disclose. Psychiatrists have a continuing responsibility to the patient to obtain informed consent for treatments or procedures. All treatment options should be fully disclosed, even those not covered under the terms of a managed care plan. Most states have enacted legislation making gag rules illegal that limit information about treatment provided to patients under managed care. Responsibility to Appeal. The AMA Council on Ethical and Judicial Affairs states that physicians have an ethical obligation to advocate for any care that they believe will materially benefit their patients, regardless of any allocation guidelines or gatekeeper directives. Responsibility to Treat. Physicians are liable for failure to treat their patients within the defined standard of care. The treating physician has sole responsibility to determine what is medically necessary. Psychiatrists must be careful not to discharge suicidal or violent patients prematurely merely because continued coverage of benefits is not approved by a managed care company. Responsibility to Cooperate with Utilization Review. The psychiatrist should cooperate with utilization reviewers' requests for information on proper authorization from the patient. When benefits are denied, it is important to understand and follow grievance procedures carefully; return telephone calls from review agencies; and provide documented, solid justification for continued treatment. With the advent of managed care and the need to send periodic progress reports and documentation of signs and symptoms to third-party reviewers to pay for treatment, some psychiatrists may diminish or exaggerate symptomatology. The following case report and discussion illustrates the ethical difficulties psychiatrists face in dealing with managed care. Mrs. P admitted herself to the hospital because she was afraid she might kill herself. She was experiencing a major depressive episode, but she improved markedly during the first weeks on Dr. A's ward. Although Dr. A believed that Mrs. P was no longer suicidal, he thought she would benefit greatly from continued hospitalization. Because he knew that Mrs. P could not afford to pay for hospitalization and that the insurance company would pay only if the patient was suicidally depressed, he decided not to document Mrs. P's improvement. He noted in the chart that "the patient continues to have a risk of suicide." Does Dr. A engage in a form of deception? Yes, he intentionally misleads by what he writes and what he omits writing in the chart. Although what he writes is true in

some literal sense, his statement is misleading in the context of treatment. Mrs. P is not suicidally depressed in the way that she was. What Dr. A omits from the chart is also deceptive. Whether a particular omission is deceptive depends, in part, on the roles and expectations of the people involved. Not telling a colleague that one dislikes his tie is not a deception. It is simply tact unless the role or relationship involves the expectation that one offers a candid opinion. Dr. A's case is different. His professional role is to document the patient's course and the expectation is that he will note any significant improvement. Thus, his failure to document Mrs. P's progress accurately is a kind of deception. The second and more difficult question is whether deception is justified in this instance. The answer to that question depends on the reasons for the deception, the reasons against it, and the alternatives available. The reasons for this deception are obvious. Dr. A's aim and primary obligation is to help the patient. He believes that Mrs. P would benefit greatly from continued hospitalization that she cannot afford. He may also believe that it is unfair for the insurance company to refuse to pay for inpatient treatment of nonsuicidal depression and that his deception rectifies that unfair practice. Important reasons also exist against this deception. The first concerns honesty and social trust. It is a good thing if people can rely on what others say and write. Without some honesty and trust, many social exchanges and practices would be impossible. Deception, even for beneficent purposes, has real potential to damage social trust. A risk exists that deception may damage people's trust in the profession of psychiatry and even patients' trust in their psychiatrists. Damage to trust may, in turn, compromise treatment. The second reason concerns future medical treatment. If Mrs. P seeks medical treatment in the future, the physicians who attend her will read the misleading notes. If they believe that the notes are an accurate account of the previous treatment, they may suggest an inappropriate treatment for the present problem. Even if they have doubts about the accuracy of the notes in her chart, they are deprived of an accurate history and report. In either case, the prior deception can hinder treatment. The third reason concerns obligations and coverage policies. Dr. A seems to ignore the obligation that he has to the population that is covered by the insurance policy. He shifts a burden onto this population by forcing the insurance company to pay for treatment that it did not agree to cover. Perhaps the insurance company should pay for inpatient treatment in cases such as Mrs. P's; perhaps its policies are unreasonable and unfair. However, Dr. A's deception does not challenge the insurance company and pressure it to change its policy, nor does his deception encourage patients and their families to contest the company's policies. The use of deception simply circumvents, in an ad hoc way, a policy that should be challenged and discussed. Dr. A also seems to ignore his obligation to future patients. By introducing an inaccuracy into the chart, he compromises the value of medical records research. His deception works, in a small way, to deprive future patients of the benefit of research that relies on medical records.

Whether the deception is justified depends on both the weight of the reasons for and against the deception and the available alternatives. One alternative is to tailor the chart. Another alternative is to describe Mrs. P's response accurately and to discharge her to outpatient care. However, a third alternative exists. Dr. A can accurately document the patient's course and can recommend continued hospitalization. He can petition the insurance company for coverage. If the insurance company decides not to approve further inpatient care for the patient, Dr. A can appeal that decision. This alternative is more time consuming, and nothing guarantees that it will succeed, but it avoids all the problems associated with the use of deception. Impaired Physicians A physician may become impaired as the result of psychiatric or medical disorders or the use of mind-altering and habit-forming substances (e.g., alcohol and drugs). Many organic illnesses can interfere with

the cognitive and motor skills required to provide competent medical care. Although the legal responsibility to report an impaired physician varies, depending on the state, the ethical responsibility remains universal. An incapacitated physician should be reported to an appropriate authority, and the reporting physician is required to follow specific hospital, state, and legal procedures. A physician who treats an impaired physician should not be required to monitor the impaired physician's progress or fitness to return to work. This monitoring should be performed by an independent physician or group of physicians who have no conflicts of interest. The Office of Professional Medical Conduct (OPMC) in New York State regulates the practice of medicine by investigating illegal or unethical practice by physicians and other health professionals, such as physician assistants. Similar regulatory agencies exist in other states. Professional misconduct in New York State is defined as one of the following:

1. Practicing fraudulently and with gross negligence or incompetence
 2. Practicing while the ability to practice is impaired
 3. Being habitually drunk or being dependent on, or a habitual user of, narcotics or a habitual user of other drugs having similar effects
 4. Immoral conduct in the practice of the profession
 5. Permitting, aiding, or abetting an unlicensed person to perform activities requiring a license
 6. Refusing a client or patient service because of creed, color, or national origin
 7. Practicing beyond the scope of practice permitted by law
 8. Being convicted of a crime or being the subject of disciplinary action in another jurisdiction
- Professional misconduct complaints derive mainly from the public in addition to

insurance companies, law enforcement agencies, and doctors, among others. New York State has established a program called Committee for Physician Health (CPH) in which impaired physicians receive appropriate treatment for their condition without losing their medical license as long as they comply with a treatment program. For example, a physician addicted to opioids or alcohol might be hospitalized to safely withdraw from the drugs and then move to a sober house for further rehabilitation that would involve intensive individual and group psychotherapy, mandatory supervised drug testing and careful oversight by CPH. The physician must be compliant for 5 years during which time he or she may gradually return to practice under supervision. The program has rehabilitated many physicians successfully.

Physicians in Training It is unethical to delegate authority for patient care to anyone who is not appropriately qualified and experienced, such as a medical student or a resident, without adequate supervision from an attending physician. Residents are physicians in training and, as such, must provide a good deal of patient care. Within a healthy, ethical teaching environment, residents and medical students may be involved with, and responsible for, the day-to-day care of many ill patients, but they are supervised, supported, and directed by highly trained and experienced physicians. Patients have the right to know the level of training of their care providers and should be informed about the resident's or medical student's level of training. Residents and medical students should know and acknowledge their limitations and should ask for supervision from experienced colleagues as necessary.

Physician Charter of Professionalism In 2001, a movement to clarify the concept of "professionalism" was begun by the American Board of Internal Medicine. A set of principles called the Physician Charter of Professionalism was developed, which describes what it means for physicians to perform at their

highest and most ethical level. Table 36.2-1 lists the principles and commitments of professional behaviors in the Physician Charter of Professionalism to which all physicians (including psychiatrists) are expected to adhere. Table 36.2-1 Physician Charter of Professionalism

A summary of ethical issues discussed in this section is presented in a question-and-answer format in Table 36.2-2. Table 36.2-2 Ethical Questions and Answers

Military Psychiatry Psychiatrists in the military face unique ethical problems because confidentiality does not exist under the military code of conduct. A 19-year-old white single man, new to military service, presented with a history of periodic episodes of anxiety when taking showers in groups with other men. He identified himself as gay and recognized that his anxiety was related to his fear of

acting out his sexual impulses, thus risking court martial and dishonorable discharge, if he is ever discovered. The psychiatrist was faced with a dilemma: whether to report the soldier to his commanding officer (as he was obliged to do under the military code) or to protect the soldier from acting on his impulses that would place him in danger (in keeping with the medical ethic to do no harm). After discussing various options, he and the patient agreed on the latter option. A diagnosis of anxiety disorder was made, which allowed the patient to receive an honorable discharge on medical grounds based on a recognized psychiatric disorder. No record of his homosexual orientation was made. **Health Insurance Portability and Accountability Act** The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 to address the medical delivery system's mounting complexity and its rising dependence on electronic communication. The act orders that the federal Department of Health and Human Services (HHS) develop rules protecting the transmission and confidentiality of patient information, and all units under HIPAA must comply with such rules. The Privacy Rule, administered by the Office of Civil Rights (OCR) at HHS, protects the confidentiality of patient information (Table 36.2-3). Table 36.2-3 Patients' Rights under the Privacy Rule

REFERENCES Blass DM, Rye RM, Robbins BM, Miner MM, Handel S, Carroll JL Jr, Rabins PV. Ethical issues in mobile psychiatric treatment with homebound elderly patients: The Psychogeriatric Assessment and Treatment in City Housing Experience. *J Am Geriatr Soc.* 2006;54(5):843. Cervantes AN, Hanson A. Dual agency and ethics conflicts in correctional practice: Sources and solutions. *J Am Acad Psychiatry Law.* 2013;41(1):72–78. DuVal G. Ethics in psychiatric research: Study design issues. *Can J Psychiatry.* 2004;49(1):55–59. Fleischman AR, Wood EB. Ethical issues in research involving victims of terror. *J Urban Health Bull N Y Acad Med.* 2002;79:315–321. Green SA. The ethical commitments of academic faculty in psychiatric education. *Acad Psychology.* 2006;30(1):48. Kaldjian LC, Weir RF, Duffy TP. A clinician's approach to clinical ethical reasoning. *J Gen Intern Med.* 2005;20:306. Kipnis K. Gender, sex, and professional ethics in child and adolescent psychiatry. *Child Adolesc Psychiatr Clin North Am.* 2004;13(3):695–708. Kontos N, Freudenreich O, Querques J. Beyond capacity: Identifying ethical dilemmas underlying capacity evaluation requests. *Psychosomatics.* 2013; 54(2):103–110. Lubit RH. Ethics in psychiatry. In: Sadock BJ, Sadock VA, Ruiz P, eds. *Kaplan & Sadock's Comprehensive Textbook of Psychiatry.* 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:4439. Marrero I, Bell M, Dunn LB, Roberts LW. Assessing professionalism and ethics knowledge and skills: Preferences of psychiatry residents. *Acad Psychiatry.* 2013;37(6):392–397. Merlino JP. Psychoanalysis and ethics-relevant then, essential now. *J Am Acad Psychoanal Dyn Psychiatry.* 2006;34(2):231– 247. Parker MJ. Judging

capacity: Paternalism and the risk-related standard. *J Law Med.* 2004;11(4):482–491. Roberts LW. Ethical philanthropy in academic psychiatry. *Am J Psychiatry.* 2006; 163(5):772. Schneider PL, Bramstedt KA. When psychiatry and bioethics disagree about patient decision making capacity (DMC). *J Med Ethics* 2006;32:90–93. Simon L. Psychotherapy as civics: The patient and therapists as citizens. *Ethical Hum Psychol Psychiatry.* 2005;7(1):57. Strebler A, Valentin C. Considering ethics, aesthetics and the dignity of the individual. *Cult Med Psychiatry.* 2014;38(1):35– 59. Wada K, Doering M, Rudnick A. Ethics education for psychiatry residents. *Camb Q Healthc Ethics.* 2013;22(04), 425–435.

Revision #1

Created 2026-01-04 19:52:32 UTC by Omar Ayman

Updated 2026-01-04 19:52:32 UTC by Omar Ayman