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A historical perspective

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Introduction

This chapter on the history of psychiatric ethics builds on David F. Musto's initial chapter on the topic, which has been a fixture of *Psychiatric Ethics* since its first edition in 1981. Dr Musto (1936–2010) trained in classics and the history of science before he graduated in medicine and entered the practice of psychiatry. He was a celebrated author on the history of drugs and drug policy. His work (1) was known for avoiding polemics in an area where rhetoric and stubborn prejudice pose serious challenges. This careful, reflective attitude is characteristic of his chapter on the history of psychiatric ethics, the most recent appearing in the fourth edition of *Psychiatric Ethics*, published in 2009. Much of his chapter is retained in its integrity in this new revision, although some of the more detailed case studies (now slightly parochial, perhaps) are omitted in order to make room for more contemporary developments.

In general, this revision of Musto's chapter follows his chronological model of exposition and adopts his mode of organization into subsections within larger chronological divisions. Updates are interspersed throughout and, in a few cases, require pausing and looking back at earlier developments from the perspective of later times. Note that ethical themes manifest differently in different epochs and are typically not consistently or uniformly present in any one period. For example, humanitarian reforms and inhumane treatment sometimes exist literally side by side. This famously was the case with opening of the Quaker Retreat for Insane Persons at York in 1796 and the nearby York asylum known for its scandals, infamies, and abuses.

One area of Musto's 2009 chapter especially needs updating. Like its immediate predecessor, published in the third edition of *Psychiatric Ethics* in 1999, the later chapter makes no mention of the impact of social media and the internet on the practice of psychiatry and users of psychiatric services. These forces now arguably constitute an entirely new vector among the factors that shape psychiatry today. Indeed, the 'ecological niche' in which psychiatric illnesses now flourish and perish has been irreversibly altered by these developments (2). There are novel and important consequences for psychiatric ethics to consider among these issues. These include: new questions concerning diagnostic labels and identity and medialization of 'mental health and well-being', as well as possible bias, misinformation, and even corruption in consumer and professional education. Truth appears elusive and mercurial in this new 'wired' world, where social media is increasingly a turbulent agent of knowledge, power, and control. Consumers of psychiatric services are affected by these developments, as are psychiatrists and other allied health professionals.

In his 2009 chapter, Musto commendably warns of the risk of imposing our own terms and categories '… onto a historical record for which these terms are not entirely appropriate'. At the same time, the history of psychiatric ethics he provides has a Whiggish air to it and appears to follow '… a path of inevitable progression and improvement … which judges the past in light of the present' (3). We shall have occasion to read through his very brief account of the ethical critique mounted by antipsychiatrists like Thomas Szasz, which also cites postmodern critics like Michael Foucault. But his treatment of those authors and his treatment of their significance in the history of psychiatric ethics merits reconsideration in this age where even establishment psychiatrists increasingly side with 'survivors'. The frontiers and alliances of 'antipsychiatry' have been redrawn in ways that have yet to be properly articulated. Not only the constituency of antipsychiatry, but also its nature, have changed. Indeed, the term itself may have outlived its usefulness (4).

The rise of consumer freedom and autonomy that Szasz so vehemently wished for, together with the increasing social penetration of postmodern critiques of scientific expertise and objectivity advocated by Foucault and others, are no longer as marginal as Musto depicts them, as academic challenges on the fringes of psychiatry, but now largely constitutive of the lived experience in which the practice of psychiatry and the experience of psychiatric illness take place. Add to this the meteoric growth and globalization of the psychiatric industrial pharmaceutical complex, and it becomes evident that the present-day historical context of psychiatric ethics is very different from the one Musto originally described.

We return to these questions towards the end of the chapter after we consider a slightly modified version of Musto's insightful 2009 account of the history of psychiatric ethics, which takes us from Greco–Roman times to the twentieth and twenty-first centuries. A new emphasis in this revised version of that history is a concern with the ethical assumptions that underlie the rise of what Musto calls 'moral therapy', which is arguably more appropriately called 'moral treatment'.

The latter was based on the ethical assumption that despite the alleged 'observation' that the 'mad' were sometimes thought to behave more like animals than humans, they must nonetheless be considered human and, therefore, deserved to be cared for and treated as such. It is easy to overlook the significance of this shift in attitudes today. However, any thorough history of the emergence of ethical reflection in psychiatry must consider it carefully as many of the modern abuses associated with psychiatry still rest on a return to the assumption the 'mad' are somehow less than human—for example, the view that psychopaths are invariably 'monsters'. Indeed, early artistic and medical depictions of the 'mad' often emphasize and exaggerate features that are associated with violent animal ferocity and are thought to suggest subhuman degeneration, a view that actually achieved scientific status in the nineteenth century with the Degeneration (*dégénérescence*) theory of mental disorder proposed by Bénédict Augustin Morel and others. The link between crime, violence, and animality lies at the core of what has been called the 'Domestication Paradigm' of Madness by some historians of psychiatry (on which more below), despite the fact that we can now say with confidence that violence in the course of mental illness is far more often the exception than the rule (5).

Three factors underlying psychiatric ethical questions

Three factors underlie the ethical questions which at all times have preoccupied those delegated to help the mentally ill: the role of the therapist, the existence and nature of mental disorder, and the cultural, religious, and even political environment in which patient and therapist coexist. Since the 1970s these factors and the formal study of psychiatric ethics have been explicitly analysed and have become almost a new subspecialty. Before the mid-twentieth century, however, few such formal studies existed. This lack of attention is understandable, since the profession of psychiatry developed as a medical specialty only recently, and since for much of the last century the codes discussed and adopted for general medicine appeared to have served psychiatry well.

The dramatic changes in the scope of psychiatry since the Second World War, however, have brought ethical issues peculiar to it into sharp focus. Indeed, with its insistence on the inviolability of the voluntary consent of the individual, the Nuremberg Code of 1947 provided a new international legal basis for honouring and respecting the inherent dignity and autonomous self-determination of the individual. Article 1 of the Nuremberg Code states:

> The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved, as to enable him to make an understanding and enlightened decision. (6)

The Nuremberg Code led to international and national ethical and legal reforms and regulations that now form the basis for the study of medical ethics and its various branches, including, psychiatric ethics. In his 2009 chapter, Musto describes the relevant developments this way:

> As a result of these developments, psychiatrists have devoted more attention to ethical issues and professional standards than ever before, resulting in a string of new ethical codes and regulations specifically aimed at remedying ethical risks and abuses in the practice of psychiatry and allied institutions. The tragic abuse of medicine during the Second World War led to the Nuremberg Statement — rules for medical research — which was subsequently incorporated into the *Declaration of Helsinki*. In 1948 the World Medical Association promulgated the *Declaration of Geneva* and, a year later, the *International Code of Medical Ethics*, which was designed to be a model for national medical codes. These two texts are modern restatements of the Hippocratic Oath. Within psychiatry itself, the World Psychiatric Association adopted the *Declaration of Hawaii* in 1977. This was the first ethical code designed specifically for psychiatrists. It responded both to the misuse of psychiatry by the state in the former USSR and to the aggressive public health and paternalistic stances in Western psychiatry. Some national psychiatric associations have formulated their own ethical codes. The American Psychiatric Association, for example, adopted the *Principles of Medical Ethics* of the American Medical Association, and in 1973 produced a text, the *Principles of medical ethics* with annotations especially applicable to psychiatry. This text, unlike the *Declaration of Madrid*, does not advocate an essentially egalitarian relationship between therapist and patient. Rather, its emphasis—demonstrating its direct descent from Hippocratic tenets—is on the need for the psychiatrist to merit and maintain the trust of patients and other professionals alike. (7)

Some aspects of the development of these codes and regulations as they relate to psychiatry will be noted in this chapter. However, the primary aim of the chapter is much wider in scope and concerns the history of ethical issues in psychiatry more generally. Certainly, psychiatry has emerged as a medical domain of practice that requires specialized ethical attention, particularly in matters that regard the autonomy, or self-determination, of individuals seeking, or thought to require, psychiatric treatment, or participate in psychiatric research. This is because psychiatric illness is, by its very nature, sometimes thought to impair an individual's voluntary and informed consent. While this was initially thought to ethically permit overriding autonomy (because of mental impairment) by appealing to paternalism and considerations of best interests, new scientific evidence, combined with mounting ethical imperatives to promote and foster self-determination, mean that autonomy has now virtually eradicated paternalism as an ethical option. Admittedly and unfortunately abuses of paternalism still exist, and so any arguments based on paternalistic principles and considerations must be carefully nuanced and distinguished from such ethically unacceptable abuses.

A fascinating new ethical development in this area is that our social, legal, ethical, and clinical standards for what counts as being mentally capable to consent to psychiatric treatment appear to be changing. More precisely, persons who would once have been thought to be unable to consent because they are mentally incapable to do so, are now—using new modes of assessment, based on new assumptions—considered to be capable to do so (8). The new theoretical term here is *decision-making capacity* (9). In the language of capacity, the point is that historically our thresholds for counting persons mentally capable to make decisions concerning treatment and participation in clinical research, appear to be changing. Along with this, our conceptions of how and why persons entering psychiatric treatment or research should or should not be considered vulnerable are also changing.

Other historical novelties include the emergence of a new ethical vocabulary, including terms like *expert by experience*, *service utilizer*, and *neurodiversity*. Clearly, in recounting the history of psychiatric ethics we must be careful about imposing categories familiar to us, such as *informed consent* and *right to be treated*, onto an historical record for which these terms are not entirely appropriate. Nonetheless our historical inquiry must make some assumptions; in reviewing the past for the purposes of this chapter we will be looking for ethical concepts deemed pertinent by medical or other cultural authorities when the behaviour of a person was judged to be grossly abnormal and to require treatment or limitation of freedom. Social control in a broad sense could be justified as the theme for a study of psychiatric ethics. Social identity is another related theme that has also become increasingly important. A convenient starting-point is the Greco–Roman period.

Greco–Roman period

It would be an error to consider the *Hippocratic Oath* as representing Greek or Roman medical practice. The tradition of Hippocratic thinking was akin to Pythagoreanism, a school of thought with strict moral precepts whose tenets more resembled later Christian principles than the flexible mores of Hellenistic practices which, for example, condoned abortion and suicide (10, 11). The Oath does include, however, some of the earliest affirmations of confidentiality and the primacy of the patient's health (10, p. 6; 11):

> Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves. What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of the men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about. (12)

Insanity is not mentioned in the Oath. In the Greek world there appears to have been little legal provision for the insane, although Roman law did provide for trusteeship of an incompetent person's property and other restrictions of their rights. Mental illness and drunkenness were conditions that could decrease a defendant's criminal responsibility, although such decisions appear to have been made by judges without the advice of a physician or other expert on mental illness (11, pp. 125–8).

Treatment of the insane in the ancient Western world ranged from such harsh methods, described by Celsus (first century AD), as purgation, bleeding, beatings, and cold baths to milder policies advocated by Soranus (first and second centuries AD), which are similar to the moral treatment that flourished in the early nineteenth century: encouraging self-esteem for the patient, relative freedom of movement, and firm paternalistic 'judicious kindness' (12). Note that to employ the term *insane* in this context is itself an anachronism that belies the complexity and underlying ethical assumptions of considering the actual historical context of terms for which it is meant to serve as modern placeholder. While ancient Greek terms like *mania*, *melancholia*, *epilepsy*, and *frenzy* may appear to be relatively free of normative implications to the modern reader, this cannot be assumed. Later terms like *fools*, *idiots*, *innocents*, and *lunatics* certainly appear to be more normative in nature. *Insanity* also has its own history which goes back to early Latin writings.

Psychiatry today is beguiled by the question of how to label instances of mental illness in nonstigmatizing ways, resorting to more or less neutral terms like *disorder* (13). It is important to recognize that this was not always the case. In some historical contexts, psychiatric terms unabashedly wore their ethical credentials on their sleeves, sometimes precisely to stigmatize and discriminate. To complicate things, many of these terms as they are used today—*mania* for example—do not at all mean the same thing now as they did in earlier times (14, 15). 'Insanity' is a rather gross and oversimplified term in this context, although its practical merits sometimes outweigh its historical deficiencies, as is hopefully the case in the present discussion.

Just as a range of restraints on freedom can be identified in these early approaches to mental illness, so the causes advanced for insanity extended from divine intervention to organic or natural factors. When ethical issues are drawn from this period, the vague edges of the definition of insanity, and various responses to it, make firm statements about these issues difficult. Clearly, for those who were treated medically, evidence suggests that harshness of the treatment or limitations of freedom were the prerogative of the physician, and that the patient and his family had little to say about either. Furthermore, the major determinant of the form of therapy depended on the custodian's faith in a particular school of medicine, or perhaps in a lack of faith in any medical treatment and, instead, a dependence on religious intervention.

The marks of insanity typically were simple: strange behaviour that did not have a likely explanation from the observer's point of view. Sometimes, but not always, the behaviour was violent, suicidal, or homicidal. Bizarre explanations from the patient would only confirm the judgement of the family or other authorities. Treatment might be painful or harmful, but the physician administered it with a clear conscience because his theory of medicine required certain courses of action. In these instances ethical problems may exist for us, but did not for the confident physician or the patient's faithful custodian or, perhaps, even for patients themselves. The random manner in which those considered insane received care continued for centuries until more formal and elaborate systems evolved, first with hospitals and, much later and only since the twentieth century, with the varieties of care possible when a large mental health profession exists.

The Middle Ages and the Renaissance

The Middle Ages brought no medical advance to the insane; rather, the major influence on attitudes towards the mentally ill emanated from religion. For example, the Prophet Mohammed revealed that the insane are the beloved of God and especially chosen by him to declare the truth. This attitude, taken with the founding of hospitals in the Moslem world and establishment of an enlightened medical profession, suggests that Islam was disposed towards humane care of the ill. Because of the Prophet's statement, the status of the patient was elevated to at least the same level as that of the therapist, a rare event in the history of psychiatry (15, p. 5; 16).

Jewish tradition, as stated in the *Talmud*, portrayed the insane as victims of a disease, not of possession (15). Christian religious orders provided humane, though limited, treatment for the deranged, but outside the monasteries Europeans had diminishing resources for care as the Roman Empire was gradually eroded. The ensuing anarchy apparently was responsible for an increase in gaolings, beatings, and torture among the insane. Compounding their misfortune, schisms among Christians led to an increase in the maltreatment of patients by equating deviant opinions with demonic possession and heresy (17, p. 17). Among competing religious factions little concern was shown for the rights of heretics whom we would now consider sane, and certainly no more concern was shown for those whose disordered fantasies and opinions were thought to be the product of heresy. Yet it would be unfair and misleading to suggest that European Christian attitudes towards the insane were uniformly characterized by a belief in demonic possession which had to be rooted out by the most severe methods. Towards the end of the Middle Ages, hospitals for the mentally ill were founded; humane physicians and caregivers did exist; and their numbers were to multiply in the sixteenth and seventeenth centuries (15, pp. 16, 17).

At the same time, legal care for the insane seems to have been in some specific instances balanced and thoughtful. This is the conclusion of Richard Neugebauer (18), who studied judicial records regarding 'natural fools' and those judged *non compos mentis* in England from the thirteenth to the seventeenth centuries. These records do not support the accepted belief that the era was cruel and dominated by demonological explanations of mental retardation and disorder. There was a growing pattern of reasonable distinctions between congenital and temporary conditions, protection of the property and interests of those judged incompetent, and a disinclination to be punitive or cruel.

In monastic hospitals the insane received good care, in keeping with the dictum of St Benedict that 'care of the sick is to be placed above and before every other duty' (19). With suppression of the monastic orders in Protestant countries and confiscation of their property, care of patients suffered. Still, even taking into account the existence of a few hospitals and of legal protections, the Middle Ages offered only a random and unpredictable response to insanity. The ethical context in which decisions were taken was the religious tradition of the locality. This could mean emphasis on charity and understanding, or it could justify severe measures if demonic possession were suspected. It is probably reasonable to generalize that during this time a person with bizarre behaviour and beliefs was seldom classified as a 'patient', and, moreover, that no broad consensus existed for what we think of as humane treatment. The low level of institutional and public health care for all health or social problems meant that the overall quality of treatment for the mentally ill would be as low as that for other illnesses, such as leprosy and communicable diseases.

The seventeenth century to the French Revolution

The two centuries preceding the French Revolution were a period of increased hospital building but no significant improvement in caring for the mentally ill. The traditional religious view of mental illness was progressively balanced by advances in anatomy and physiology which suggested that it was the product of organic change. Humane treatment, however, seems to have been related more to culturally inspired responses than to organic explanations of disordered behaviour or beliefs. An assumption that a lesion in the brain or other part of the body caused mental illness brought contrasting treatment, usually invoking opposite or contrary considerations or mechanisms (hot versus cold, for example). Powerful and destructive therapies were justified on the grounds that they were required for the correction of specific lesions, while milder treatments were advocated because of the belief that strenuous applications would impair the natural capacity of the body or mind to heal the lesion and restore health.

Mild treatment, though, appears to have been rare in the great hospitals that were built before the French Revolution. There is however the exception of hospitals administered by religious orders, like the famous *Hospital de los Inocentes* (Hospital of the Innocents) founded in 1410 in Valencia Spain, which is said to '… have spread like wildfire through the entire Iberian Peninsula during the fifteenth century and shortly after through American Spanish speaking countries (20). At the same time, the rise of the sciences stimulated new explanations for the body's functions: mechanical, physical, and chemical theories challenged the Galenic tradition of four humours whose balance brought health. New theories fostered new regimens: strong medicines, bleeding, purgation, and blistering competed with methods such as isolation, beatings, and instilling fear. Faith in theory continued to outweigh empirical considerations based on the actual effects of the patient's treatment. In general, eighteenth century therapists considered their task difficult and in need of rough procedures.

The American and French Revolutions gave a new importance to the individual in terms of his rights in the secular order. This importance rivalled the religious tradition of immortality and equality before God. In the late eighteenth century, particularly in France, mental illness was considered the result of a wrongly ordered society: the patient was the victim of an exploitative social environment. The attitude that placed blame on society exonerated the ill person; it also suggested that care could take on a social form and promoted optimism as to the outcome—at least in the heyday of revolutionary fervour. The prevailing intellectualist view of mental disorder promulgated by John Locke, that 'madness' was the result of faulty associations among ideas and in relation to things in the world, was soon joined by Philippe Pinel's affective view that wayward passions, too, could serve as both causes and symptoms of madness. In fact, Locke himself was far more aware of the existence and role of passions in affective disorder than many accepted interpretations of his intellectualist view of madness typically allow for (21).

Pinel, so often honoured for removing the chains from patients, was not totally original in his efforts, but he did adopt and promote more humane attitudes than his predecessors (22). The basis for his action in the 1790s was faith in the Revolution and one of its corollaries, the expectation that an improved society would result in fewer patients and great improvement in those already interned. He did not abolish authority over his patients—in fact, he was quite firm and paternalistic—but he believed that communication with them in as egalitarian a manner as possible was in keeping with the spirit of the French Republic, and beneficial to their health. Pinel was confident that few restraints were necessary if patients were treated with fundamental regard to their individuality and self-respect.

Inspired by Locke and his main expositor in France, Etienne Bonnot de Condillac, Pinel also played a major role in establishing psychiatry as an evidence-based scientific discipline. Many of his contributions sprang from better opportunities for systematic empirical long-term observation and data collection. He provided empirical evidence that mental disorder was often periodic and curable, and often healed on its own, and that aggressive prior treatment often compromised recovery and even harmed patients. This is possibly one of the first carefully documented evidence-based statements of the basic principles of the modern recovery movement and the existence of iatrogenic harm in psychiatry, including the evils of 'polypharmacy'—a term that Pinel himself appears to have created for that purpose. In order to avoid biased results, Pinel even went so far as to exclude patients from his main clinical studies who had been treated outside his hospital. Typically, their prognosis for recovery was practically nil due to the irreversible harms inflicted by previous treatments. The evidence-based manner in which Pinel identified and documented the occurrence and risks of iatrogenic harm in psychiatric treatment marks an ethical awakening that is insufficiently recognized in the history of these matters.

In contrast, George III of Great Britain, who suffered a relapse of his mental condition in 1788, received traditional rugged care and close restraint because his physicians were determined he should receive the best care that their theories commanded: wild behaviour required a strong antidote. This assumption and interventions of this kind of 'moral management' were rather different than those of the moral treatment advocated by Pinel, although they shared some similarities (23, pp. 206–28). Even the King could not escape what we would today consider cruel treatment. Whatever anxiety the physicians felt about the King's response to their care, their consciences were untroubled. Pinel was equally at ease when he moved in the direction of more benign treatments; in both instances the physician had virtually absolute control over his patient. It is interesting to speculate whether this 'moral authority' (*ascendant moral*) possibly contributed to treatment success through a placebo effect.

Benjamin Rush, the father of American psychiatry, introduced improvements for patients under his care at the Pennsylvania Hospital in Philadelphia. As usual in the movement towards less confining treatments, reformers faced the problem of the hyperactive and threatening patient. Rush, whose own son was a patient at the hospital, devised restraints like the 'tranquilizer chair', which allegedly prevented movement that could cause further damage to the patient. An important goal of the intervention was to ensure that necessary restraint and treatment created no unintended or undesirable effects.

The nineteenth century

In the nineteenth century, ethical formulations for the medical profession were promulgated in many countries. In 1803, for example, Dr Thomas Percival published a formal statement on medical ethics. Percival's immediate goal was the establishment of a code of ethics and etiquette for the Manchester Infirmary, in order to reduce controversy among the attending physicians. His comments, however, on mental patients in asylums such as existed on the Infirmary grounds, reveal the tension between humane care and the need to preserve order. Percival writes:

> The law justifies the *beating of a lunatic, in such a manner as the circumstances may require*. But it has been before remarked that a physician, who attends an asylum for insanity, is under an obligation of honor as well as of humanity to secure to the unhappy sufferers, committed to his charge, all the tenderness and indulgence compatible with steady and effectual government. And the strait waistcoat, with other improvements in modern practice, now preclude the necessity of coercion by corporal punishment. [Percival's italics] (24, p. 126)

Although he wished to be kind, he believed the physician with special knowledge of the insane could take actions that might appear harsh to young and uninformed physicians. 'Certain cases of *mania*', he wrote, 'seem to require a *boldness of practice* which a young physician of sensibility may feel a reluctance to adopt.' When this occurs, the novice 'must not yield to timidity, but fortify his mind by the councils of his more experienced brethren of the faculty'. Yet Percival could not let his advice admit of too severe an interpretation, for he warned that 'it is more consonant to probity to err on the side of caution than of temerity'. Repeatedly, these advocates of humane care faced the problem of keeping order in hospitals and regulating the admission of patients. Percival strongly favoured strict inspection of asylums for proper care and for assurance that no one was admitted without a certificate signed by a physician, surgeon, or apothecary. He emphasized the provision for writs of *habeas corpus* and other legal protection of hospital inmates. Here then are two aspects of care of the insane in which ethical problems arise: whether detention is justified, and (if it is) whether care given during detention is as humane as possible.

Often the adoption of ethical codes in the nineteenth century was related to the advent of professionalism, whereby standards were set for members of a professional organization who were distinguished from physicians or laymen outside the organization. Medical etiquette was a prominent feature of these codes, which regulated procedures for consultation, details about fees, and relations with fellow physicians. Through statutory laws and third-party payment procedures, society later would begin to control aspects of practice that physicians had first governed through internal professional standards. But in the 1800s, especially in the United States, professionalism was not a concern of the state, and jurisdictions had few or no licensing powers. So many schools of medical practice existed that the need to distinguish among them became a matter of pride for their adherents, as well as a source of economic advantage. Thus physicians established a variety of medical associations, each of which set codes of conduct and standards.

When the American Medical Association was founded in 1847 its members adopted a code of ethics based on Percival's work (25). The Association did not become a powerful medical organization until the twentieth century, but its code of ethics is representative of mid-nineteenth-century concerns about proper clinical practice. The first section stresses the physician's high moral obligation, the need for secrecy, and the requirement that a physician see a patient through to the end of his illness—whether to cure or to death—balancing hope with realistic warnings to the family. There followed a long section, entirely missing from Percival, entitled 'Obligations of patients to their physicians'. The patient should choose a properly trained physician, provide all relevant information, follow the regimen prescribed, and, after recovery, 'entertain a just and enduring sense of the value of the services rendered him by his physician' (25, p. 444).

Later sections of the code detail courtesies of physicians to one another and the qualifications of a regular physician. The title of the last chapter is 'Of the duties of the profession to the public, and the obligations of the public to the profession'. The relationship of physicians to coroners, guidelines for dispensing free service, and the need to educate the public regarding quackery are stated; yet, in distinction to the detailed treatment in Percival's work, there is no discussion of medical practice within hospitals, and the only reference to insane asylums is in a list of various institutions in which medical authorities must have an interest, such as hospitals, schools, and prisons.

Hooker's contribution

In 1849, two years after adoption of the American Medical Association code, Worthington Hooker, a Connecticut physician, published what is recognized as a pioneer study of medical ethics in the United States, *Physician and patient;*

or, a practical view of the mutual duties, relations and interests of the medical profession and the community (26, 27). The titles of the chapters, 'Skill in medicine', 'Popular errors', 'Quackery', 'Good and bad practice', 'Influence of hope in the treatment of disease', 'Truth in our intercourse with the sick', and 'Moral influence of physicians' reflect his ethical concerns. Two chapters, 'Mutual influence on mind and body in disease' and 'Insanity', particularly merit our attention. Hooker, like Percival, advocated removal of the mentally ill to a retreat, and reliance upon a 'regimen, or the regulation of their occupations and amusements, bodily and mental, and very little indeed upon medicine'. Hooker deplored the practice, which he admitted was widespread, of intentionally deceiving the insane, or any other patient. He recommended early treatment, and that its costs should be shared by the town and state of the patient's residence.

On the subject of how best to determine whether a person is insane Hooker approved of the French system, in which a committee of experts made the decision after an examination conducted over several days. This despite the fact that this French legal initiative to introduce the expert opinion of psychiatrists into the courtroom initially had very mixed results. The problem was that the experts disagreed. This, for example, is what happened with the first French efforts to decide questions of mental capacity in the courtroom by resorting to the diagnostic category of 'monomania'. Originally introduced by Pinel's famous student Jean Étienne Esquirol, monomania soon fell into disrepute after enjoying a wave of popularity (28, pp. 162–96; 29). This series of events sowed the seeds for a crisis of confidence in the authority of psychiatry in the courtroom, an issue that arguably persists to this day.

Dr Hooker had sought to introduce expertise into decisions regarding insanity, and this is by and large what occurred in the century after his advocacy. He saw application of knowledge by professionals as increasing the rights of the committed and reducing error during commitment procedures. It is worth noting that he did not favour waiting until an overt, dangerous act had been committed before acting on behalf of the community and the patient. He was unaware of the present-day argument that cultural bias might distort professional judgement, or that reserving the decision about confinement entirely to medical practitioners might abridge legal protection for the patient.

From healing asylum to human warehouse

For several generations thereafter few issues other than the justification for commitment and the humaneness of care were raised regarding psychiatric patients. Such currently significant concerns as the ethics of behaviour control can be dissected away from the practices and concerns of 1800, but only with difficulty. The rights of the committed patient were few, and the primitive state of what we might call the psychiatric profession of the time meant that treatment consisted chiefly in admission to a hospital and residence there until reversion to a normal state, improvement, withdrawal by relatives, or death.

The chief question for those who worried about the quality of care was how to conduct a paternalistic relationship kindly, effectively, and efficiently. Personal attention to a patient was expensive, and required great devotion on the part of individual caregivers and hospital authorities. Attempts to make contact with patients through close, kind supervision, mutual respect, and a wholesome environment—moral treatment—could not survive waves of pessimism about the curability of mental illness, the overloading of caregivers with patients, and the degradation of hospitals to the status of human warehouses. These conditions obtained in the mid-nineteenth century in many countries. Attention to ethical questions suffered as the possibility of substantial reform declined (30).

Superintendents of American institutions for the insane, who formed an organization in 1844 (later to become the American Psychiatric Association), argued especially for the right to make most decisions about their patients, from commitment to the way the hospital was organized. This body, antedating the American Medical Association, testifies to the special role these physicians had assumed within the profession. Increasingly isolated from medical practice in general, the superintendents saw themselves as experts in a field too often neglected financially, misunderstood by the community, and requiring extraordinary powers of insight and judgement. Harassed by patients' complaints of maltreatment and wrongful commitment, the superintendents were more concerned to protect themselves from legal encroachment than they were about the veracity of these accounts.

To the extent that an asylum attempted moral treatment, an uplifting and healthy environment was created for the patient. One could hardly find fault with trying to improve the conditions of patients, the authorities believed; and if better conditions did not exist, the cause lay in inadequate financial support from governments, not with the managers of the asylums. What in this context is referred to as 'moral treatment' is an approach to the care and treatment of the mentally ill that is typically traced to the humanitarian reforms initiated by Pinel in France and William Tuke in England. The two reformers could not be more different. Pinel was a medical scientist of international fame. Tuke was a wealthy Quaker tea merchant dedicated to providing nonmedical care and comfort for mentally ill members of his community. It is generally agreed that while moral treatment was a largely successful therapy in its early beginnings and through its Golden years, it eventually collapsed—a travesty of itself—under the weight of impossible demands, unrealistic expectations, and lack of adequate financial support, which led in turn to a self-defeating therapeutic pessimism that differed markedly from the optimism that had fuelled its early days (31). The term *asylum* accordingly shifted in meaning. Originally intended to refer to specially designed institutions meant to medically treat and protect the mentally ill from the pressures of the outside world and their own wayward flights and delusions, the term soon began to connote sordid 'museums of madness' from which no one ever escaped (32).

Experimenting with new procedures

While the psychiatric profession and the mental hospitals in the United States were becoming established and stimulating a body of law and precedent regarding the care of the ill, increased experimentation with new procedures and operations raised other ethical questions within the profession and among the laity. Three instances of what we today might consider abuses of research in Ohio, Maryland, and Ontario led to harsh criticism from physicians in North America and Great Britain. It is noteworthy that the condemnation came first and strongest from peers, illustrating the alertness of professional self-regulation. These experiments were not representative of contemporary treatment. On the other hand, one should be aware that the high-minded aspirations of asylum superintendents in fact probably did not reflect the reality of day-to-day existence in mental hospitals. Published reports and admonitions are not good guides to the routine practice of psychiatry.

The Ohio experiment was published in the eminent *American Journal of Medical Science* in 1874. Dr Roberts Bartholow studied the effect of stimulating the exposed surface of a patient's brain electrically through her ulcerated skull. A few days later the patient died, but Dr Bartholow denied that the experiment was related to her death (33). However, the *British Medical Journal* criticized his procedure and conclusions (34). The editor was reaffirming Claude Bernard's comment in his introduction to the study of experimental medicine:

> It is our duty and our right to perform an experiment on man whenever it can save his life, cure him or gain him some personal benefit. The principle of medical and surgical morality, therefore, consists in never performing on man an experiment

> that might be harmful to him to any extent, even though the result might be highly advantageous to science, that is, to the health of others. (35)

In a reply, Dr Bartholow tried to justify his actions, but acknowledged that the procedure was injurious to the brain, and he stated that he would not repeat such an experiment (36, p. 101). Reports such as that of Bartholow became a refrain in the antivivisectionist literature as examples of experimenters meddling with the bodies of poor patients while observing great caution towards fee-paying patients. The antivivisectionists saw a similarity between charity patients and laboratory animals: they opposed experiments on both, and sought to arouse the public through dramatic reports (37).

In 1897, Dr George Rohé, superintendent of a Maryland hospital for the insane, reported on his research of operating on female pelvic organs in order to relieve insanity. He based this treatment on such diagnoses as hysteroepilepsy melancholia, puerperal insanity, and mania, and claimed a recovery rate of about one-third (38). Similar operations were reported by Dr A. T. Hobbs of the Asylum for the Insane at London, Ontario (39). In general, female patients were especially susceptible to being selected for novel and untested cures because of their sex, often with horrific consequences (40) Indeed, it is only relatively recently that considerations of gender have emerged as a major issue in both the history of psychiatry and psychiatric ethics, and the development of codes and regulations (41–43).

In looking back over the nineteenth century—keeping in mind that we are considering, rather narrowly, antecedents to the modern psychiatric profession—we see that the growth of mental hospitals and the increase in their inmates, the decline of genuine moral treatment, and a deterioration in the relations between physicians and patients were all evidence of an atmosphere of pessimism about the ultimate cure of mental illness. This pessimism, in spite of advances in understanding syphilis, alcoholism, and other specific causes of mental illness, overshadowed ethical concerns, and caused them to appear unimportant.

Despite progress in the recognition that ‘madness’ was not tantamount to inhumanity, the nineteenth century still saw its share of cases where patients who displayed bizarre behaviour were relegated by some caregivers to a less than fully human status. Even reformers like Benjamin Rush described such patients as animal-like and fit for being ‘broken’ like wild animals. This animalistic view of mental illness and disorder was certainly not new to Rush. It existed and persisted for centuries, fuelled by fear and prejudice based on the manner in which persons suffering from mental disorder are often ‘observed’ to break accepted rules of behaviour through violent, or indecent, or seemingly incomprehensible acts. Of course, these ‘observations’ are generally exaggerated, taken out of context, and biased by selection. Nevertheless, despite their weak empirical base, they explain the persistence of this ‘domestication’ paradigm for explaining and treating mental disorder (44).

The domestication paradigm and its assumptions revisited

As previously discussed, the ‘mad’ had been perceived as little more than humans reduced by illness or degeneration to the state of wild animals, and accordingly were ‘treated’ as such. A key premise underlying this view is that because of their disorder, the ‘mad’ no longer have souls and, consequently, are not truly human beings deserving of dignity and respect. Regarded, merely as wild animals that needed to be tamed, controlled, and subdued, they were subjected to beatings, starvation, incarceration in freezing dungeons, and the attempt to instil fear and terror as modes of social control in the guise of medical treatment.

In contrast, therapies based on the provision of comfort, care, and consolation are grounded in the ‘observation’ that, despite their afflictions, the mad are still human. Believing this to be the case, the Jesuit reformers in fifteenth-century Spain and later Quaker reformers of the eighteenth century tried to do away with the use of chains and cruelty. A legendary example of this alternate paradigm of care for the mad was inspired by the seventeenth-century Quaker religious reformer George Fox, who encouraged his followers to look for ‘that of God’ in everyone, a view that reverberates through his grandson Samuel Tuke’s famous 1813 account of the York Retreat noted above.

The history of humanitarian reform in the treatment of the mentally ill often focuses on the accomplishments of Pinel, among other clinicians and scientists, yet his medicalized humanitarian moral treatment did have different ethical and political origins than, say, the moral treatment practiced at William Tuke’s York Retreat, and the ultimate outcome of these different secular and religious interventions was very much comparable in its success, as were their methods (45). William Tuke was in effect an early ‘antipsychiatrist’ of sorts, although his Retreat did have a doctor on staff, actually also a carefully chosen antipsychiatrist himself. Pinel was aware of the Retreat at York and was apparently rather embarrassed by the medical success of its lay methods, calling it ‘the English secret’ (*le secret des anglais*). On the other hand, Samuel Tuke is careful to pay homage to Pinel’s accomplishments in his *Description of the*

Retreat, and to credit and honour Pinel for his introduction of the expression 'moral treatment' (*traitement moral*).

The history of moral treatment suggests that the origins of the antipsychiatry movement and the ethical motives that inspire it go back quite a bit farther than is usually thought. Pinel, a medical doctor, who tried to warn and guard his patients against the terrible iatrogenic harms inflicted by current psychiatric treatments was much like established modern day psychiatrists who criticize the profession because of concerns about overtreatment often with ineffective or harmful drug therapies, over-medicalization, as well as widespread fraud and corruption in the pharmaceutical industry (46). He even went so far as to say, 'It is an art of no little importance to administer medicines properly, but it is an art of much greater and more difficult acquisition to know when to suspend or altogether to omit them' (47). Indeed, it can be argued that while it was once an indispensable ally of psychiatry, medicalization may now be an enemy, as psychiatry risks scientific dilution and trivialization by assuming too much responsibility for the ills of everyday life.

It is also worth emphasizing that the term *moral* in 'moral treatment' (sometimes referred to as 'moral therapy') is highly ambiguous in these historical contexts, possibly leading to confusion and misunderstanding over the ethical nature of many of the interventions in question. The situation is nuanced and complex. Generally, the term *moral* in these writings refers to treatments that are psychological and mental rather than purely physical (45). At the same time, some of the interventions themselves have a decidedly ethical character, such as the provision of kindness, the encouragement of autonomy and promotion of self-esteem—as well as the condemnation of unethical behaviours that are thought to fuel and underlie mental disorder (47). In reflecting on the role of moral treatment in the history of psychiatric ethics, it is important not to overlook these facts. *Moral* in this context does not necessarily mean or imply *ethical*. For example, questions of diet and the prescription of hot and cold baths are important elements of moral treatment, though there is nothing especially ethical about them. So are gardening and cooking, engaging in the production of artefacts, and taking walks or participating in games.

To sum up, moral treatment was a psychological therapy, though not a pure one. Note also that in many cases, it would be inappropriate to call it a 'talking therapy', though it did target and deal with psychological states, as well as physical states. Finally, an interesting feature of moral treatment is the manner in which physicians sometimes resorted to theatrical ploys and re-enactments, often based on deception, as part of therapy (48). On the whole, we should be careful of attempting to classify moral interventions—and even moral treatment itself—into a sharp dichotomy contrasting ethical and nonethical characteristics. We must be watchful not to read our contemporary concepts and categories into the history of psychiatric practice and its ethics. The sharp and largely artificial positivist distinction between normative ethical matters of value and descriptive matters of fact that is so characteristic of later Western thought is not obviously present in many of the historical episodes recounted in this chapter.

The twentieth and twenty-first centuries

Crisis of confidence in psychiatry's authority

The crisis in confidence in the authority of psychiatry that began with the monomania fiasco in the early nineteenth century has worsened significantly with the blatant misuse of psychiatry in the service of totalitarian states in the early and mid-twentieth century, that undoubtedly shook public confidence in the profession. The extensive use of psychosurgery throughout the developed world for certain diagnoses between 1935 and the mid-1950s also served to weaken confidence in psychiatry. During this period, for example, approximately 30,000 patients (as a conservative estimate) received lobotomies and related procedures in England, Wales, and the United States alone (49). Growing opposition to these interventions and the development of new psychotropic drugs brought an end to this first wave of psychosurgery, but we are presently in a second wave in the case of mental disorders like major depression and anorexia nervosa (50, 51). However, unlike the moral outrage that greeted the early use of psychosurgery, there seems to be little public concern over the new varieties of psychosurgery and methods currently in vogue, though their ethical merits are hotly debated by professionals. Certainly, public concern with such methods lags far behind the misinformation and fear that still surrounds the use of electroshock treatment as it was famously depicted in the 1975 comedy-drama film, *One Flew Over the Cuckoo's Nest*. This despite the proven safety and relatively high degree of effectiveness of this therapy when properly administered (52).

Perhaps the deepest crisis of confidence that psychiatry faces today is the troubled status of psychotropic drugs, the 'magic bullets' that were initially supposed to assure the psychiatric profession its own special status as a scientific medical discipline. The effectiveness of many of these drugs compared to placebo and the consequence of this for the assessment of their relative risks and benefits is a major issue in the area (53). Many of the drugs in question were allowed onto the market by regulatory processes that are now recognized to have been flawed due to bias by the absence of negative studies (54). While there have since been improvements to the evaluation process, other problems, such as fraud, corruption, and deliberate misinformation in the production and marketing of drugs, have created considerable challenges for the public image and status of psychiatry as a legitimate scientific discipline. The current opioid epidemic is a case in point, where both the drugs responsible for addiction and those used to treat it, form an astonishingly profitable centripetal circle for both drug manufacturers and the medical establishment (55–57).

Combined with these challenges to the profession is the relentless progression of medicalization. As psychiatric diagnoses continue to explode in scope and numbers, medicalization has turned from a welcome ally of psychiatry into an enemy that ought to be feared (46). On this argument psychiatry faces either trivialization (virtually any mental discomfort counts as a psychiatric illness) or absurdity (everyone is in need of psychiatric treatment). Earlier ethical worries about cosmetic psychopharmacology that we are changing or denying our humanity (58, 59) have been supplanted by the worry that we may be on the way to obliterating or losing the mental capacities that make us human, like sadness (60). In this debacle, the battle lines of antipsychiatry are being redrawn. What has changed is that the critics of psychiatry now include numerous prestigious established psychiatrists and medical scientists, including a former chairperson of the *Diagnostic Manual of the American Psychiatric Association* (DSM) and a former editor of the *New Journal of Medicine* (61, 62).

Psychiatry in the age of social media

Over the last few decades, widespread consumer advocacy, facilitated by social media, appears to be transforming how medicine and psychiatry approach the diagnosis and treatment of some mental disorders, even questioning their existence. The diagnosis of 'homosexuality,' the elimination of Multiple Personality Disorder, and the celebration of Borderline Personality Disorder and Anorexia Nervosa are examples of such consumer-led challenges to the edicts of establishment psychiatry (2). A more recent and telling example concerns the diagnosis and treatment of transgendered individuals and so-called conversion therapy (63, 64). In a dramatic historical reversal, consumers, and not the psychiatric establishment, have at times become the new arbiters of ethical power and practice in psychiatry. These are not simply changes at the level of the 'message', but also pertain to the 'medium' in which discourse takes place. In a significant way we are now far beyond the tumultuous riots and illegal departmental 'sit-ins' that marred the growth of psychopharmacology in the mid-twentieth century (65). Today such battles are largely fought and won online, not in the streets. Fraud and impersonation are also a constant worry in this new cyber world.

Currently, public discourse in matters of psychiatric ethics is generally conducted by innumerable social media interest groups and platforms (66). Some provide a forum for retaining diagnostic labels that have been abandoned, while others serve to lobby for adoption of new diagnostic labels that do not presently exist. Websites sometimes promote lifestyles that affirm personal roles and identities that other websites vehemently denounce as sick and pathological. Various behaviours and therapies are alternately celebrated or condemned. Meanwhile, all of this takes place in a world where traditional modes of expertise and authority are more problematic than ever and online 'likes' and 'hits' constitute an unprecedented measure of power and influence. Psychiatric ethics and practice are not exempt from the rampant promotion of autonomy and the right to personal opinion and self-determination that underlie many of these developments. Nor are they exempt from the challenges of 'fake news' and the unsettled state of scientific expertise and authority in areas of social concern, such as climate change and so-called alternative health therapies.

Perhaps most intriguing and somewhat worrisome in all of these developments is the increased growth and promotion of the ethical principle of autonomy and self-determination—now apparently meant to apply at all costs. No doubt, a historical correction of a massive sort was required after the horrors and abuses of the past, when persons who were deemed mentally ill were all too often stripped on their autonomy, arbitrarily and unilaterally declared mentally incapable or unfit to consent to or refuse treatment, and denied any significant role in their care. The history recounted in this chapter shows that there has been much ethical progress in this area, though sadly pockets of prejudice and abuse still exist. The discovery that the promotion of autonomy might also have an educational dimension whereby it may increase the ability of some persons to exercise greater control over their healthcare decisions is also something we should be careful not to underestimate. At the same time, it might be wise to guard against the projection of exaggerated hopes and capacities for autonomy in the case of some individuals affected by mental disorders (67). In this respect, the recognition that 'loss of control' during some stages of mental illness may compromise decision-making capacity to consent to treatment, or to participate in research, appears to be turning into a rare commodity.

For example, we may claim for ethically laudable and valid political reasons, that persons suffering from mental disorders should be deemed mentally capable to make their own health care decisions, even when their decision-making capacity is very likely impaired by their disorder. But that does not make it so. Paradoxically, there seems to be a great resistance to undertake the required sort of clinical research to better assess such situations (68). Loss of control and incapacity are proving to be increasingly elusive and mercurial in this new ethical age where autonomy always seems to have the first and last word. Addiction, for example, is apparently a choice and no temptation is ever totally irresistible (69–71). Similar problems arise in the case of decision-making capacity to consent to or refuse treatment in the case of severe and enduring anorexia nervosa (72). In both cases, there seems to be an erosion in the scope and application of the notion of vulnerability and the appropriateness of paternalistic interventions. Recently, some organizations concerned with the rights of persons with disabilities have begun to address such issues from a broader perspective, challenging the view that decision-making capacity (or 'mental competence') is necessary for informed consent, a proposal that certainly merits careful consideration (73) Nowhere are these considerations more evident than in recent debates on the role of decision-making capacity in physician, or medically assisted, suicide (74).

One of the major areas of controversy in this last debate centres on the extension to mature minors and persons diagnosed with a mental illness of the legal right of mentally capable adults to choose one's own time and manner of death. Such an extension is presently under consideration in some Western jurisdictions, like Canada (75), while it is already a reality in others (76). In a recent declaration on the ethics of euthanasia and physician assisted suicide, the *American Psychiatric Association* recently ruled that 'a psychiatrist should not prescribe or administer any intervention to a non-terminally ill person for the purpose of causing death' (77). Without pronouncing on the truth or soundness of this declaration, it is worth stating that impaired capacity has not proved to be a major obstacle to this extension of the law in the jurisdictions where it already exists. Despite critics and detractors. Theoretical and practical questions about the clinical assessment of decision-making capacity and, in particular, on what counts as an appropriate threshold for capacity should play an increased role in these debates. Whether this shall come to pass is currently a pressing issue in the ethics of psychiatry.

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