

## The Ethics of “Ethics”: Black and White or Shades of Grey

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In historical understanding, ethics is an aspect of morality or a normative branch of moral philosophy. Morality concerns contrasts between right and wrong conduct, and because many of the world's religions tend to express themselves in these terms, morality is often approached by reference to religious beliefs and authorities. However, the rise of modern ethics concerned with developments in biology, particularly human biology and health care, known as bioethics, is essentially fact-based, rather than faith-based, and non-religious in that it excludes reasoning based on supernatural or divine agency.

Modern bioethics, which includes the ethics of mental health care, is old enough to have a history, but young enough that many whose initiatives and writings founded the field of bioethics are still contributing to its literature. In 1999, Warren Reich, an observer of the evolution of bioethics, recorded how in the 1960s the Vatican invited Catholic theologians and philosophers to consider church teaching on contraception, sterilization and abortion. Their proposals for liberalizing reform were rejected, however, since in 1870 the Catholic Church voted to approve the doctrine of papal infallibility, meaning that no papal pronouncement delivered ex cathedra could later be faulted or contradicted. Reich noted that “The theologians, who were the first ethicists working in bioethics, cut their teeth on contraception/sterilization and abortion debates and in a very real sense, much of the great energy that was turned toward bioethics around 1970/71 was energy that was diverted from the then-increasingly futile church debates on fertility control” (Reich, 1999).

Modern bioethics, unlike religious doctrine, is secular, pluralistic, empirical and argumentative, rejecting narrow orthodoxy and duties of obedience to authority. Bioethics often embraces a spectrum of approaches, on acceptance that there can be different ways of reaching decisions by reference to the priority given to competing ethical principles and levels of ethical analysis. These range from person-to-person ethics (microethics) to group or population-based ethics (macroethics), including administrative or bureaucratic ethics (mesoethics), and may transcend national or jurisdictional boundaries to consider wider environmental or ecological concerns (metaethics/megaethics). Bioethical discourse has flourished to such an extent that proponents of religious preferences have come to claim participation under the guise of advancing bioethics, making their religiosity of approach and appeals to emotion and supernatural influence under the name of bioethics, as the existing U.S. President's Council on Bioethics does.

The tension in ethics comes from the need to maintain sound ethical principles and also to endorse practices that work well. Sometimes, effective practices require compromises of principle and consistent applications of principle can be at the cost of efficient or effective practices. For instance, medications to treat schizophrenia can produce wanted effects, but eligible patients may decline to take them regularly. Medications' effects of maintaining patients' functioning in their communities may be gained by compromising patients' autonomy of choice on taking them. Respect for the principle of patient autonomy in consumption of medications may entail patients' periodic involuntary admission to care because they do not take appropriate medications and present an apparent danger to themselves or others.

This tension raises the issue of whether there are practices that are overwhelmingly correct and should never be compromised, that is, whether some principles present black and white options, and whether there can be ethically legitimate compromises of principle to produce desirable, protective effects. That is, whether the part-black, part-white application of principles produces shades of grey.

### Black and White

A key ethical practice that should always be observed and never allowed to be violated, which emerges from the ethical principle of respect for persons, is non-discrimination. Recipients of mental health care warrant the same respect due to other persons. They should not suffer disadvantage such as stigma, because of their past, present and/or prospective mental health status and treatment. This is a principle of practice that is sadly often violated as amply illustrated in the findings and narratives presented in the Final Report of the Standing Committee on Social Affairs, Science and Technology of the Senate of Canada (the Kirby Committee Report) “Out of the Shadows at Last,” released in May 2006.

A history of demeaning abuse of patients with mental illness, such as was once expressed in involuntary sterilization, has not ended. Its modern expression is in the lack of these patients' equal access to employment, community housing and even health care itself. The Kirby Report publicizes the voices of mental health service consumers and their family caregivers who explain the lack of respect and the unequal, discriminatory treatment and stigma that patients with mental illness and their families suffer in access to

both private and public services, including institutional and community services, schools, homes for the aged, and in, for instance, police and prison care.

Discrimination against mental health patients is a clear violation of ethical principles, not only of respect for persons but also of the duty to do good (beneficence) and to avoid harm (non-maleficence, or Do No Harm), and of the duty to act justly. It is also a violation of human rights, expressed in the laws of many countries and in leading international human rights treaties. Attitudes and practices that discriminate against and stigmatize mental health service recipients show the clear distinction between unethical and ethical conduct.

## Shades of Grey

Medical treatment, at both the clinical and public health or population levels, often requires judgement to be exercised in assessment of benefit-to-risk ratios. At times, the prospect of achieving wanted results is offset by the risk of causing inadvertent harm. For instance, the confidentiality of health care patients is important to preserve and beneficial in that it encourages patients to make the full disclosures to health service providers that allow providers to identify optimal treatments and care strategies for patients. Where patients present risks of causing injury to others or to themselves, however, strict observance of their confidentiality may expose others, and the patients themselves, to avoidable harm.

Warning others, such as family members, of mental health patients' liability to cause harm to others or to themselves, is not discriminatory. For instance, persons unfit to drive motor vehicles, and those liable to spread contagious infections, are liable to suffer comparable restrictions that limit their rights to confidentiality. Persons who live alone and are mentally disposed to neglect themselves, for instance in nutrition or hygiene, or to attempt self-injury or suicide, may have others appropriately warned of their disposition. The price of added safety is the compromise of confidentiality, but this trade-off may be ethically acceptable.

Consent to treatment can similarly present difficult ethical trade-offs. Courts applying non-discrimination principles have ruled that when mentally competent patients who declined to take particular medications become incompetent, they cannot be forced to take the medications they refused when competent. That is, they have the same rights to autonomy and physical or bodily integrity as mentally competent individuals. One price of this respect for their autonomy may be a loss of their physical liberty, if their decisions to refuse medication have the result of making them appear dangerous to themselves or others. Concerns are acute, however, when adolescents suffer from anorexia and refuse to eat or to be fed. Parental decision-makers may approve forms of treatment, such as by nutritional interventions, adolescents previously refused. It is a grey area of ethical choice whether involuntary feeding is justifiable when lack of nutrition endangers adolescents' health and lives.

Capacity to consent raises the ethical and often legal concern of whether the same test of capacity applies to decisions to accept recommended care and to refuse it, or whether capacity

is asymmetrical in that there is a lower threshold of capacity to accept advised treatment than to refuse it. If adult patients agree to medically advised care, it seems dysfunctional to assess them incompetent to decide and then seek the decision of guardians or substitute decision-makers whose duty to act in dependent persons' best interests requires them to consent to medically advised care. If adult patients refuse such care, it seems self-serving and manipulative of caregivers to assess them as incompetent to decide and seek the decisions of guardians whose duty is to consent to advised care. However, if capacity is specific to function, the decision to refuse advised care is more serious than the decision to accept advised care and capacity to refuse may have to be assessed by more critical criteria.

A further grey area of ethical choice concerns research. It is a black and white issue that individuals with mental impairment should not be recruited as subjects of research when unimpaired people would serve the scientific purpose. However, research into mental impairment, such as by application of unproven drugs, may be possible only by recruitment of those affected by the impairment under study. Whether affected individuals can provide adequately informed and free consent to participate can be ethically challenging. Clearly no pressure or coercion can be applied to condition their consent, but they may be induced to participate by the promise of relief of symptoms, or the need to appear agreeable to their care providers. A benefit-to-risk ratio has to be struck. Their uncritical recruitment into studies may expose them to risks, such as, consuming unproven products or forgoing their regular medications, but their exclusion may result in improvement in their treatment being forfeited. The ethical principles of promoting good, by improving treatment, and of avoiding harm, by not exposing dependent persons to risks, are in conflict. Promotion of one principle subordinates the other and striking a balance may not be a clear-cut, black or white issue.

## Conclusion

The ethics of acting ethically are less complex when an issue presents a "right" or "wrong", black or white solution. In the many grey areas, however, prioritization of one ethical value over another requires reflection and discussion. Reasonable people may differ without finding that preferences that differ from their own ethical conclusions are unethical. That is, in the grey areas where part-white, part-black decisions have to be made, there can be different ways of acting ethically. More important than the individual conclusion is the process of ethical evaluation of competing principles and values that shape it.

International experience, including judicial assessments, poses the contrast. In 2001 in Erwadi, in the Indian state of Tamil Nadu, 28 women patients who were shackled in a hut were burned to death when a kerosene lamp overturned. The Supreme Court of India found the conditions in which they were maintained to be a human rights abuse and condemned the state government for its apathy regarding care of patients with mental health needs. Patients suffering other conditions are not usually shackled in their places of accommodation. This discriminatory management seems ethically indefensible.

In contrast in 2003, the U.S. Eighth Circuit Court of Appeal, in the Arkansas case of *Singleton v. Morris*, upheld legality of mandatory medication over the objection of a schizophrenic prisoner whose execution for brutal murder could not proceed while he remained mentally disordered. His condition manifested itself while he was awaiting execution. The court considered that medically indicated care would be required to be administered to any other prisoner and that a mentally disordered patient was no different even if he would be liable to execution when fit. Other prisoners, not being free to control conditions of their detention, cannot voluntarily remain ill. Whether a psychiatrist would act ethically to provide such treatment is a matter on which there can be legitimate disagreement, even accepting that American Medical Association professional ethics forbid participation in capital punishment. The ethical grey area is whether restoring a prisoner to his usual health is “participation” in his sentence, or showing respect for his human right to health care.

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