

Ethics in Psychiatry



Five Skills Psychiatrists Should Have in Order to Provide Patients with Optimal Ethical Care

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ABSTRACT

Analyses of empirical research and ethical problems require different skills and approaches. This article presents five core skills psychiatrists need to be able to address ethical problems optimally. These include their being able to recognize ethical conflicts and distinguish them from empirical questions, apply all morally relevant values, and know good from bad ethical arguments. Clinical examples of each are provided.

KEY WORDS

Ethics, cancer, suicide, memory, minimal cognitive impairment, dementia, mental status exam, cholinesterase inhibitors, research, confidentiality, genetics, advance directives, caregivers, autonomy

INTRODUCTION

Psychiatrists face new, ever-emerging ethical questions that have few, if any, precedents. These include how to handle “do not resuscitate” (DNR) orders and attempted suicide,

how to assist suicide where this is legally permitted, and how to respond when transgendered people want to adopt children.^{1–3} All clinical decisions involve underlying ethical conflicts. When these conflicts impact patients significantly, psychiatrists should address these issues separately, but concomitantly. The analysis of an ethical conflict differs greatly, however, from the analysis of an empirical question (e.g., which drug to give).^{4,5} Thus, to be able to give their patients the best care possible, psychiatrists, like all providers, must recognize when an ethical conflict exists and also recognize how to optimally resolve it.⁶

There are five skills psychiatrists should have in order to identify and resolve ethical conflicts optimally. These skills include recognizing ethical conflicts, questioning empirical assumptions, weighing all values potentially relevant to the decision, assessing whether these arguments are sound, and anticipating possible, negative effects on the patient/psychiatrist relationship. Each of these skills will be described and discussed.

RECOGNIZE ETHICAL CONFLICTS (AND DISTINGUISH THEM FROM EMPIRICAL QUESTIONS)

The first task of a psychiatrist is to discern whether ethical conflicts are present. Counterintuitively, perhaps, this may be a psychiatrist’s most difficult task, because often these conflicts are not readily apparent. An ideal example of this is taken from a clinical question that has arisen in internal medicine involving patients with lung cancer for whom two kinds of treatment may be effective: surgery and radiation. Surgery offers an increased survival time, while the radiation offers less morbidity.^{7,8} Some patients prefer radiation to surgery. Yet, suppose a doctor favors surgery due to its statistically longer survival time. Suppose also that since the

doctor holds this view, he or she does not mention the other option of radiation to his or her patients.

Obviously, it would be ethically wrong not to mention the option of radiation to a patient, because, in this case, it is the patient who will undergo the treatment and experience the outcome. Therefore, the patient, not the doctor, should decide which procedure he or she will have. Clearly, if a surgeon sees this only as a clinical question and misses that there is the embedded ethical question of who should decide, the outcome could be entirely different than if the surgeon recognized the ethical conflict.

The same analysis applies to psychiatry. The paradigmatic example I present that best illustrates such an application in psychiatry is one that will no doubt be controversial; indeed, it challenges and contradicts what most, if not all, psychiatrists do at this time—what should a psychiatrist do when he or she first sees a patient who complains of a memory problem. The psychiatrist may, for example, ask the patient such questions as “What did you have for breakfast?” and/or ask the patient more formal questions from the Mini-Mental Status Exam, such as to remember paired objects, like “the flower/a rose,” and to repeat this at once and again after several minutes. The psychiatrist may also ask the patient whether he or she remembers past Presidents, prefacing this perhaps with, “These questions may seem silly,” to try to reduce the possibility that in response to these questions, the patient feels infantilized.

Psychiatrists have sound reasons for doing this testing. Patients who present with memory problems may have treatable conditions, such as a benign brain tumor or normal pressure hydrocephalus. There is, however, a possible harm in asking these questions. A patient who presents with memory problems may have minimal cognitive impairment (MCI), which

may become Alzheimer’s disease (AD).⁹ If this is the case, the patient may prefer not to know he or she has MCI at the time of the initial evaluation.¹⁰

To explain a bit more, some patients also may have memory loss that is consistent with normal aging, and some patients may, if given a choice, prefer believing that their memory loss is nothing more than that due to normal aging unless or until their memory gets worse. Furthermore, a patient who believes his or her memory loss is normal may, for a time, have an increased quality of life, due to this choice, because he or she is not worrying as much about the possibility of developing AD to the same extent.

Legally, as well as ethically, it may be that psychiatrists should give such patients this option of not knowing. Patients have the legal right to choose to *not* know information, and ethically, if patients are adequately informed of the possible benefits and risks of not knowing, they may choose not to know whether their memory seems normal or impaired on the basis of the initial testing. Psychiatrists who accepting this as a choice for their patients respect patient autonomy.

Practically, if a psychiatrist discusses the option of *not knowing* initially with his or her patients, the psychiatrist could ask them certain questions to help them decide. The psychiatrist might ask the patient, for example, whether, based on the patient’s past history, he or she believes it likely that he or she would be capable of maintaining *this* degree of denial, or of continuing to enjoy his or her present quality of life, knowing that the memory problems he or she has now might be a harbinger of greater problems to come. If the psychiatrist did this, he or she should perhaps inform the patient of the possible, serious losses that the patient would risk as a result of making this

decision of not knowing. If, for example, the patient declines testing initially, the patient would probably not have the possible benefits of early use of cholinesterase inhibitors. Pursuing ethical analysis to its logical extreme, the psychiatrist could give the patient a choice of whether he or she would want information on what he or she is potentially giving up or losing by not knowing about his or her memory loss.^{11,12}

My point is not that all psychiatrists should do this now. This may be going much *too* far to respect a patient’s autonomy. In fact, a psychiatrist going this far could actually frighten a patient unduly. My point is that ethical analysis carried out sufficiently and independently might suggest the possibility that psychiatrists *might* go this different way. Many patients, if presented with the risks and benefits of not knowing their diagnosis, may very well decline this option and choose instead to know what is “going on.” Still, practically, even if a patient wants to undergo the initial testing for memory loss, he or she likely will appreciate the psychiatrist for giving him or her the choice.

QUESTION EMPIRICAL ASSUMPTIONS

Psychiatrists may act on the basis of assumptions that are false, which is true of all healthcare providers. This may be a particular risk in some areas of psychiatry, however, because some psychiatric assumptions are unlike many assumptions in some other areas of medicine, such as those based on microscopic findings or cultures grown in a lab that can be objectively verified. For example, unlike tuberculosis (TB) or cancer, which can be verified by laboratory tests, there are no laboratory tests that can establish and verify the cause of some sources of memory loss.

One psychological belief that has been proven false is the belief that

patients, when told they had cancer, would be at undue risk of taking their own lives. Based on this belief, not all that long ago, many healthcare providers now would often choose not to tell their patients that they had cancer.¹³ Now, we know that most patients, upon learning they have cancer, will not commit suicide. Thus, almost all healthcare providers believe that they should inform their patients of a diagnosis of cancer.¹⁴⁻¹⁶

Another example of a psychological belief that has been proven false is that bad parenting caused children to have schizophrenia. Some psychiatrists, “armed” with the concept of simultaneous, multilevel, contradictory messages, “went stalking for double-binding parents and especially for schizophrenogenic mothers who they believed were parasitically feeding on their child.”¹⁷

Likewise, psychiatrists have unknowingly suggested to children that their parents sexually abused them before they remembered this abuse taking place.¹⁸⁻²⁰ We have also since learned that we should think carefully and think twice before we debrief our patients because the process of raising memories of past trauma may retraumatize the patient due to these repeated images.^{21,22} We also used to believe that when infants were born with genitals that in terms of gender were ambiguous, if we surgically made their genitals “male” or “female” while they were still infants, their psychological gender identity would most likely follow suit. Now, what we should do, when we should do it, and why are much more open to question.²³

Kohut taught us that we should not always confront narcissistic patients, but sometimes we should allow them to idealize us, and Miller and Rollnick taught us that motivational interviewing is another approach to treating patients with substance abuse problems, as opposed to allowing them

to hit bottom.²⁴⁻²⁶ These days, many psychiatrists believe they can treat patients over the internet and even respond to them at a different point in time.^{27,28}

A paradigmatic example that illustrates the importance of carefully reviewing empirical data before making inferences is genetic testing for the APOE gene, a marker for late-onset AD. Psychiatrists and other healthcare providers widely believed, at least until recently, that they should advise patients not to seek genetic screening for the APOE gene. They feared that these patients would be unduly harmed by the knowledge that they carried the APOE gene. The assumption may be somewhat analogous to providers assuming in the past that patients would unduly harm themselves if they learned they had cancer.

The *New England Journal of Medicine* recently published an article that questioned this assumption.²⁹ Based on this new data, some leading experts on AD now suggest that healthcare providers present to appropriate patients the option to have the testing done, but leave the decision entirely up to the patient. Should psychiatrists, in the absence of data supporting the notion that patients would be harmed by this knowledge, have done this all along?

Psychiatrist S. Nassir Ghaemi suggests that the biopsychosocial model, sacrosanct to many psychiatrists, should be replaced. He sees it as, to an undue extent, privileging objective data over more subjective approaches. He cites the compelling work of psychiatrists Leston Havens and Alfred Marguelis, who emphasized the importance of *connecting* with patients however this might best be accomplished. Ghaemi describes a case where Havens and Marguelis interviewed a man who had previously not benefited from treatment. The psychiatrists focused

on better establishing what was going on in this patient's life, why he felt as he did, how he felt about his peers, his father, his mother, his enemies, and his world.³⁰ Havens went so far to suggest, as Ghaemi reports, that to convey empathy, psychiatrists should try to mirror the patient's actions, sometimes even by looking at the floor if the patient does. Havens stated that by doing this, ideally psychiatrists may be able to think such patients' thoughts a split second before they do, and thus this can enhance empathy felt by the psychiatrist.

Should we revise our bio-psycho-social model, as suggested by Ghaemi, to privilege more subjective approaches? There may be many patients with whom only a more subjective approach will connect. I recall, for example, a patient who rejected multiple psychiatrists before coming to see me. In response to a medical question he asked me, I told him he was “doing himself in,” which I followed immediately with a smile and said, “If I were you, I'd want to tell me where to go!” I believe it was at that moment that he decided he would continue to see me for treatment.

APPLY ALL VALUES AND, PARTICULARLY, ALL “DEONTOLOGICAL” VALUES

Ethical analyses must put all significant values “on the table.” Four values commonly cited, and reasonably taken to be sufficiently inclusive, are the values of respecting patients by fully informing them, treating them as equals, doing good for the patient, and avoiding harming the patient.¹

The latter two values, “doing good” and “avoiding harm” are consequential. These values involve outcomes (e.g., how patients with AD may do with or without anti-AD medications).^{31,32} The first two values, “fully informing them” and “treating them as equals” are “deontological” values. These values do not involve consequences, but do

involve how we should treat people. Deontological values warrant priority in the view of some ethicists. Yet, in practice, healthcare providers may undervalue deontological values because they are not based on consequences, which are visible and thus easier to defend. Therefore, I will focus on the more neglected of the four values, the deontological values.

Respect patient autonomy. To enable patients to decide what they want, psychiatrists must give them the information they need. The information psychiatrists give patients is, however, theoretically without limit. Thus, this raises the question of where the psychiatrist should draw the line. A paradigmatic example of this is a case of a patient I see whose husband has AD. The patient asked me whether her husband should switch or add different cholinesterase inhibitors, take twice the dose of the anticholinesterase he was taking, and/or try intranasal insulin, which she had read had shown some success.³³⁻³⁵ The FDA, in fact, had approved doubling the dose of the cholinesterase inhibitor her husband was on. One question this case example raises is when should psychiatrists alert patients of possible treatments that *might* be effective. A second question is should the psychiatrist take the initiative to share this information even when the patient or his or her caregiver does not ask.

Ethically, if psychiatrists do not take initiatives to share information with *all* patients, this will in one sense violate equity. Not taking this initiative will favor those who are more assertive and/or savvy enough to ask over those who are not, and thus discriminate between these two groups.³⁶ Empirically, patients who participate in a study in which the outcomes do not show statistical significance may individually benefit from a new or experimental treatment. Thus, the desire of the patient or the patient's caregiver to try such a treatment may

be not unreasonable even though the treatment has not been shown to be effective by scientific standards. This may be the case in particular when a patient's condition continues to deteriorate despite treatment. A rule of thumb psychiatrists might find useful as a guide to answering the question of how much initiative they should take is to ask themselves how much information the patient would have if he or she were an expert in the field. Patients who are not experts in the field may want and need the same amount of information.

An additional ethical question this inquiry then raises is when, if ever, should psychiatrists offer to take initiative on a patient's behalf to enable the patient to get a new or experimental treatment the patient wants to try. The psychiatrist can, for example, contact another psychiatrist who specializes in a particular area or a researcher who knows much more than the psychiatrist about a new, different treatment and may be able to provide the treatment the patient or caregiver is requesting. A psychiatrist contacting another healthcare provider on a patient's behalf may, of course, make the difference in whether or not this other provider is willing to give the patient this new or experimental treatment.

Consider equity (and how patients' relationships with others may be affected). When there is more than one person that will be significantly affected by a psychiatrist's decisions, ethical questions may arise involving equity or justice. A paradigmatic question here is when, if ever, should a psychiatrist try to influence his or her patients to share information that is confidential.³⁷⁻⁴³ One example of this is when a patient has genes for Huntington's disease or for early onset AD that are autosomal dominant. When a patient has these genes, this information may profoundly affect other family members' lives and

choices. Family members may, for example, choose also to get tested for the genes, and the presence of the genes may affect their decision whether or not to have children.

Legally, healthcare providers must respect patient confidentiality, but all the same, healthcare providers may try to persuade these patients to inform their family members if these genes are present. The healthcare providers can also raise the question of whether they, themselves, should inform the family members when the patients do not. In this situation, a value that may compete with confidentiality is equity. Something else to consider is how this information may affect a patient's relationships with his or her family members and his or her psychiatrist.

Philosopher Mary Urban Walker addressed both these values in a case she discussed years ago. In the case of "Carlos and Consuela," Carlos would not tell Consuela, his sister and his caregiver, that he had human immunodeficiency virus (HIV) because he did not want her to learn of his homosexual orientation. Walker asked whether the clinician treating Carlos should have violated Carlos's confidentiality and told Consuela that Carlos had HIV. Walker asked the extent, if any, to which clinicians should also take into account the interest of other parties, such as a sibling like Consuela, and whether Carlos should have taken more responsibility so as to not exploit Consuela's good will under conditions of ignorance.^{44,45}

What should a psychiatrist do in such instances? This question is made more complex because if a psychiatrist takes the initiative to raise this issue of informing others upon him- or herself, this may adversely affect the therapeutic relationship he or she has with the patient, whereas some patients may feel a *greater* trust of the psychiatrist, knowing that the

psychiatrist had sufficient moral concern and the willingness, despite this risk, to do this.

ASSESS GOOD VERSUS BAD ETHICAL ARGUMENTS

In ethics, different arguments are able to accomplish different outcomes. Ethical arguments may be able to show definitively what is *not* right, such as the notorious research done at Tuskegee, which, as readers recall, involved researchers who withheld treatment for syphilis in several African-American men, despite having treatment available, in order to study the untreated course of the disease. Ethical arguments may *not*, however, be able to show what *is* right. An example, here, might be whether or not to allow assisted suicide. In instances in which ethical arguments cannot determine *what* the outcome should be, the soundest approach may then be to change the question from what the decision should be to *who* should decide. Reasonable people may reasonably disagree on *what* the decision should be, but may wholly agree on who should decide. When the patient is an infant or child, for instance, most would agree that so long as certain conditions exist, parents should be the ones who make decisions for their children.

Psychiatrists should know good ethical arguments from bad ones. One example of an argument likely to be flawed is an argument based only on a most remote possibility. Suppose, for example, a patient has incurable cancer and is trying to decide whether or not to try chemotherapy. While there may be many good reasons for this patient to try chemotherapy, doing it because a new drug may be discovered in the near future that will cure the cancer is probably not among these good reasons because this is not at all likely to occur.

Another flawed argument involves the law.⁴⁶ Psychiatrists should know

that doing what they think is best for their patient is probably better than doing what they think is best for themselves (i.e., doing what will best protect them legally).^{47–49} An example here is a patient whose suicidal ideation has waxed and waned for years, but who is adamantly opposed to hospitalization. The patient's psychiatrist may believe that his or her own best protection from a possible lawsuit is to hospitalize the patient, even though this goes against the will of the patient. However, the patient may benefit more over the long term from continuing to see the psychiatrist as an outpatient. The psychiatrist's preferable ethical choice may then be to pursue seeing the patient more frequently, but as an outpatient, *even though as a result, this patient's short-term risk of committing suicide might be increased.*

Consider this: The number of suicidal patients actually killing themselves could be reduced greatly by keeping all suicidal patients in restraints. Obviously, this would not be in the best long-term interest of any patient. Psychiatrists should always consider the law first, but be willing to depart from the law somewhat in order to do what is best for their patients. If a psychiatrist is sued, the fact that his or her actions were driven by doing what he or she thought was best for the patient will be his or her best defense.

ANTICIPATING HOW THE ETHICAL APPROACH MIGHT NEGATIVELY AFFECT THE PATIENT/PSYCHIATRIST RELATIONSHIP

All or almost all value considerations by psychiatrists take place in the context of the relationships they have with their patients. Thus, psychiatrists should anticipate how decisions will affect these relationships. Psychiatrists

know well that maintaining positive relationships with their patients is of utmost importance—studies confirm this repeatedly.⁵⁰

Even if an ethical decision seems right from all abstract perspectives, the psychiatrist still should consider how the decision might affect the patient/psychiatrist relationship prior to proceeding. Here I shall use as an example a patient I saw in which I *did not* do this. A patient came to see me with his wife. He was having some difficulty with his memory. I asked him what medications he was taking and how often he was taking them. He could not tell me exactly how often he was taking his medications. I, without thinking, looked at his wife and asked her if she could keep track of this for him so that she could tell me the next time we all met. As I said this to her, I saw him flinch, and I immediately regretted I had said this—I had infantilized him in front of his wife.

This is an example, I fear to say, of what healthcare providers do all too frequently to patients with AD. We talk with the patient's caregiver as if the patient is not there. Ethically, it makes sense that this patient's wife should keep track of his medications. Handling it the way I did, however, was insulting and could have undermined our relationship. Consequently, I now routinely ask all patients I see with AD whether it is okay with them for me to speak with their partners about them. I tend to do this no matter what stage of AD they are in. This makes sense, in part, because patients with AD may retain full emotional sensitivity even after they have lost their capacity for cognition.⁵¹ It also makes sense to me to continue to meet with patients with AD and their partners as long as I can, even after these patients have lost their capacity to respond in a "meaningful" way. I have wondered, on occasion, why I do this. Their partners give me the answer. The caregivers of these patients tell me that the patients

cherish our meetings like little else. I believe psychiatrists should also try to keep in contact with these patients' caregivers even after the patients have lost the capacity to recognize the caregivers or have died. In this instance, unlike perhaps Kohut's theory, every psychiatrist is *not* replaceable. Only one psychiatrist has "lived" with the patient and partner through both thick and thin.

CONCLUSION

All psychiatric decisions at some level involve underlying ethical conflicts. When these conflicts are significant, psychiatrists should concomitantly and separately assess them. This requires different assessment skills. Psychiatrists must first be able to recognize that these conflicts indeed exist, and then they must question their empirical assumptions, try to include all relevant values, check that the arguments they are making are sound, and consider how their decisions could affect their patient/psychiatrist relationships. More specifically, psychiatrists might particularly consider what information their patients *might* find useful and then consider sharing this information, *even when patients do not ask*. Above all else, psychiatrists should try to ensure that the ethical response they have chosen is not likely to impair their patient/psychiatrist relationship.

REFERENCES

1. Cook R, Pan P, Silverman R, Soltys S. Do-not-resuscitate orders in suicidal patients: clinical, ethical, and legal dilemmas. *Psychosomatics*. 2010;51:277–282.
2. Oduncu FS, Sahm S. Doctor-cared dying instead of physician-assisted suicide: a perspective from Germany. *Med Health Care Philos*. 2010;13:371–381.
3. Murphy TF. The ethics of helping transgender men and women have children. *Perspect Biol Med*. 2010;53:46–60.
4. Demarco JP, Ford PJ. Balancing in ethical deliberation: superior to specification and casuistry. *J Med Phil*. 2006;31:483–497.
5. Sreenivasan S, Frances A, Weinberger LE. Normative versus consequential ethics in sexually violent predator laws: an ethics conundrum for psychiatry. *J Am Acad Psychiatry Law*. 2010;38:386–391.
6. Strous RD. Ethical considerations in clinical training, care and research in psychopharmacology. *Int J Neuropsychopharmacol*. 2010;22:1–12.
7. McNeil BJ, Pauker SG, Sox HC Jr, Tversky A. On the elicitation of preferences for alternative therapies. *N Engl J Med*. 1982;306:1259–1262.
8. McNeil C. Early-stage lung cancer findings end a debate, put focus on next steps. *J Natl Cancer Inst*. 2004;96:1054–1055.
9. Howe E. Initial screening of patients for Alzheimer's disease and minimal cognitive impairment. *Psychiatry* (Edgemont). 2007;4(7):24–27.
10. Asscher E, Koops BJ. The right not to know and preimplantation genetic diagnosis for Huntington's disease. *J Med Ethics*. 2010;36:30–33.
11. Keating DT, Nayeem K, Gilmartin JJ, O'Keefe ST. Advance directives for truth disclosure. *Chest*. 2005;128:1037–1039.
12. McCullough LB. The physician's virtues and legitimate self-interest in the patient-physician contract. *Mt Sinai J Med*. 1993;60:11–14.
13. Novak DH, Plumer R, Smith RL, et al. Changes in physicians' attitudes toward telling the cancer patient. *JAMA*. 1979;241:897–900.
14. Surbone A. Telling the truth to patients with cancer: what is the truth? *Lancet Oncol*. 2006;7:944–50.
15. McCabe MS, Wood WA, Goldberg RM. When family requests withholding the diagnosis: who owns the truth? *J Oncol Pract*. 2010;6:94–96.
16. Marzanski M. On telling the truth to patients with dementia. *West J Med*. 2000;173:318–323.
17. Bateson G, Jackson DD, Haley J, Weakland J. Toward a theory of schizophrenia. In: Berger M (ed). *Beyond the Double Bind*. New York: Brunner/Mazel Publishers; 1978:3–27.
18. Whitehouse WG, Orne EC, Dinges DF. Extreme cognitive interviewing: a blueprint for false memories through imagination inflation. *Int J Clin Exp Hypn*. 2010;58:269–287.
19. Krähenbühl S, Blades M. The effect of interviewing techniques on young children's responses to questions. *Child Care Health Dev*. 2006;32:321–331.
20. Melinder A, Alexander K, Cho YI, et al. Children's eyewitness memory: a comparison of two interviewing strategies as realized by health professionals. *J Exp Child Psychol*. 2010;105:156–177.
21. Fauerbach JA, Lawrence JW, Fogel J, et al. Approach-avoidance coping conflict in a sample of burn patients at risk for posttraumatic stress disorder. *Depress Anxiety*. 2009;26:838–50.
22. Jezek K, Lee BB, Kelemen E, et al. Stress-induced out-of-context activation of memory. *PLoS Biol*. 2010 Dec 21;8. Accessed 7 Jan 2011.
23. Ahmed SF, Rodie M. Investigation and initial management of ambiguous genitalia. *Best Pract Res Clin Endocrinol Metab*. 2010;24:197–218.
24. Kohut H. *The Analysis of the Self: A Systematic Approach to the Psychoanalytic Treatment of Narcissistic Personality Disorders*. New York: International Universities Press; 1971.
25. Miller WR, Rollnick S. *Motivational Interviewing, Second Edition*. New York: Guilford Press; 2002.
26. Forsberg L, Forsberg LG, Lindqvist H, Helgason AR. Clinician acquisition

- and retention of motivational interviewing skills: a two-and-a-half year exploratory study. *Subs Abuse Treat Prev Policy*. 2010;13:1–14.
27. Kessler D, Lewis G, Kaur S, et al. Therapist-delivered internet psychotherapy for depression in primary care: a randomized controlled trial. *Lancet*. 2009;374:628–634.
 28. Yellowless PM, Oder A, Parish MB, et al. A feasibility study of the use of asynchronous telepsychiatry for psychiatric consultations. *Psychiatr Serv*. 2010;8:838–40.
 29. Green RC, Roberts JS, Cupples LA, et al. Disclosure of APOE genotype for risk of Alzheimer's disease. *N Engl J Med*. 2009;361:245–254.
 30. Ghaemi SN. *The Rise and Fall of the Biopsychosocial Model*. Baltimore, MD: The Johns Hopkins University Press; 2010:195.
 31. Parsons C, Hughes C, Passmore A, Lapane K. Withholding, discontinuing and withdrawing medications in dementia patients at the end of life. *Drugs Aging*. 2010;27:435–449.
 32. Miller FG. End-of-life care for patients with dementia. *N Eng J Med*. 2004;350:733–734.
 33. Sadowsky CH, Dengiz A, Olin JT, et al. Switching from donepezil tablets to rivastigmine transdermal patch in Alzheimer's disease. *Am J Alzheimers Dis Other Demen*. 2009;24:267–275.
 34. Farlow MR, Salloway S, Tariot PN, et al. Effectiveness and tolerability of high-dose (23mg/d) versus standard-dose (10mg/d) donepezil in moderate to severe Alzheimer's disease: a 24-week, randomized, double-blind study. *Clin Ther*. 2010;32:1234–1251.
 35. Stockhorst U, de Fries D, Steingruber HJ, Scherbaum WA. Insulin and the CNS: effects on food intake, memory, and endocrine parameters and the role of intranasal insulin administration in humans. *Physiol Behav*. 2004;83:47–54.
 36. Cooper C, Blanchard M, Selwood A, Livingston G. Antidementia drugs: prescription by level of cognitive impairment or by socio-economic group? *Aging Ment Health*. 2010;14:85–89.
 37. Raymond VM, Everett JN. Genetic counseling and genetic testing in hereditary gastrointestinal cancer syndromes. *Best Pract Res Clin Gastroenterol*. 2009;23:275–283.
 38. Berliner JL, Fay AM. Practice Issues Subcommittee of the National Society of Genetic Counselors' Familial Cancer Risk Counseling Special Interest Group. Risk assessment and genetic counseling for hereditary breast and ovarian cancer; recommendations of the National Society of Genetic Counselors. *J Genet Couns*. 2007;16:241–260.
 39. Nycum G, Avard D, Knoppers BM. Factors influencing intrafamilial communication of hereditary breast and ovarian cancer genetic information. *Eur J Hum Genet*. 2009;17:872–880.
 40. Godard B, Hurlimann T, Letendre M, et al. Guidelines for disclosing genetic information to family members: from development to use. *Fam Cancer*. 2006;5:103–116.
 41. Liao SM. Is there a duty to share genetic information? *J Med Ethics*. 2009;35:306–309.
 42. Elger B, Michaud K, Mangin P. When information can save lives: the duty to warn relatives about sudden cardiac death and environmental risks. *Hastings Cent Rep*. 2010;40:39–45.
 43. McSherry B. Health professional-patient confidentiality: does the law really matter? *J Law Med*. 2008;15:489–493.
 44. Walker MU. Keeping moral space open. New images of ethics consulting. *Hastings Cent Rep*. 1993;23:33–40.
 45. Huprick SK, Fuller KM, Schneider RB. Divergent ethical perspectives on the duty-to-warn principle with HIV patients. *Ethics Behav*. 2003;13:263–278.
 46. Katz DA, Williams GC, Brown RL, et al. Emergency physicians' fear of malpractice in evaluating patients with possible acute cardiac ischemia. *Ann Emerg Med*. 2005;46:525–533.
 47. Martell DA. Neuroscience and the law: philosophical differences and practical constraints. *Behav Sci Law*. 2009;27:123–136.
 48. Candilis PJ. The revolution in forensic ethics: narrative, compassion, and a robust professionalism. *Psychiatr Clin North Am*. 2009;32:423–435.
 49. Calcedo-Barba C. Objectivity and ethics in forensic psychiatry. *Curr Opin Psychiatry*. 2010;23:447–452.
 50. Cox JL, Gray AJ. Psychiatry for the person. *Curr Opin Psychiatry*. 2009;22:587–593.
 51. Feinstein JS, Duff MC, Tranel D. Sustained experience of emotion after loss of memory in patients with amnesia. *Proc Natl Acad Sci U S A*. 2010;107:7674–7679.

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