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UTILITARIANISM AS THE BASIS FOR PSYCHIATRIC ETHICS : A CRITICAL REFLECTION

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ABSTRACT:

Utilitarianism is one of the “grand Enlightenment” moral philosophies. It provides a means of evaluating the ethical implications of common and unusual situations faced by psychiatrists, and offers a logical and ostensibly scientific method of moral justification and action. Here, in this paper first we trace the evolution of utilitarianism into a contemporary moral theory and review the main theoretical critiques. Then, we contextualize utilitarianism in psychiatry and consider its function within the realm of the professional

ethics of psychiatrist as physician, before applying it to two dilemmas faced by psychiatrists as individuals and as members of a profession. We conclude that psychiatry must search beyond utilitarianism in grappling with everyday clinical scenarios.

KEYWORDS: *Psychiatric Ethics, Utilitarianism, Critique, Professional Ethics.*

INTRODUCTION Original Conceptions of Utilitarianism

The notion of maximizing pleasure, or avoiding pain, seems an intuitive *raison d'être*, and indeed forms the basis of a body of moral philosophies dating from antiquity. Ethical hedonism, first described by Epicurus (341 BC – 270 BC) (Epicurus, 1926), posits that the good life is one spent in pursuit of pleasure, defined simply as the avoidance of pain. A consequentialist philosophy holds that the rightness or wrongness of an action is determined solely by reference to the ‘goodness’ or ‘badness’ of

the consequences of that action. Integrated, these two ideas give us the broad foundation of utilitarianism. Indeed in medicine, the injunction premium non-nocere (“first, do no harm”) is one of the earliest utilitarian constructs.

These notions were formulated as a moral philosophy to provide an ethical framework for the political liberalism emerging in the post-Enlightenment West. Utilitarian ethics were to be the blueprints for social justice, and utilitarianism is habitually considered the starting point of contemporary moral philosophy (Kymlicka, 2002).

The original utilitarian ideas come from Jeremy Bentham (1748-1832), who constructed a hedonistic view of utilitarianism (Bentham, 1970/1823). To

Bentham, man was at the mercy of ‘the pleasures’ and it was therefore preferable to be ‘a contented pig’ than ‘unhappy human’. Bentham did not valorize the ‘higher pleasures’, arguing that happiness arising from the mindless game of “pushpin” was as good as that from reading poetry. John Stuart Mill (1806-1873), by contrast, argued that cultural, intellectual, and spiritual pleasures are of greater value than the physical pleasures in the eyes of a competent judge (Mill, 1968). Mill viewed the maximization of some form of eudemonic happiness as the source of the good. In an assertion slightly undermining the secular humanism of his project, Mill sought to endorse his utilitarianism by proclaiming, “In

the golden rule of Jesus of Nazareth, we read the complete spirit of the ethics of utility" (Mill, 1968 p. 16). Mill's utilitarianism does not necessarily avoid the same difficulties as Bentham's version, particularly the so-called 'quantification problem', i.e. how to measure overall pleasure. GE Moore (1873-1958) averred that no true conception of the good could be formulated, and that an intuitive view of maximizing "ideals", like aestheticism, may be the ultimate goal of maximizing good (Moore, 1903/1988). Later, economist-driven formulations of the ultimate good of utilitarianism involved the satisfaction of preferences, allowing people to choose for themselves what has intrinsic value (Arrow, 1984).

RECENT CONCEPTUALISATIONS OF UTILITARIANISM

Utilitarians writing since Mill have elaborated the original ideas and modified utilitarianism to make it more workable. RM Hare (1919-2002) distinguished between two levels of utilitarian thinking (Hare, 1981; Hare, 1997). Hare asserted the existence of more lofty 'critical' level of thinking, applying the so-called 'Golden-Rule Argument', as against an 'intuitive' level, utilising simple consequentialist principles and integrating emotional responses. The intuitive level applies at the ethical coalface, and its deliberations must be acceptable at the critical level, whereas critical levels of moral reasoning are the domain of the 'archangels'. This latter kind of elitist moral philosophy, assuming that the common man is incapable of any form of reflective moral agency, was first described by Henry Sidgwick (1838-1900) (Sidgwick, 1907) and has been termed "government house utilitarianism" (Williams, 1973).

The distinction between intuitive and critical levels has evolved into 'Act' and 'Rule' utilitarianism (Hare, 1963). Hare argued that his utilitarianism may have been more what Kant had in mind in his moral philosophy, and saw 'The Kingdom of Ends' of Kant's Categorical Imperative (Kant, 1964) as being utilitarian in nature (Hare, 2000).

Hare advanced his version of utilitarianism as a workable basis for psychiatric ethics (Hare, 1993), arguing that utilitarian accounts of psychiatric ethics are often abandoned because of the perceived duties of psychiatrists to their patients. Hare suggested that psychiatrists:

"need not think like utilitarians; they can cleave to principles expressed in terms of rights and duties and may, if they do this, achieve better the aims that an omniscient utilitarian would than if they themselves did any utilitarian calculation" (Hare 1993, p.30).

Rather than act automatically based on a simple calculation of maximized utility, the psychiatrist, as moral agent, acts on a utilitarian basis at the intuitive level, and reflects upon how rights and duties may be best served at a critical level.

Another formulation of utilitarianism is that of "negative utilitarianism", originally outlined by Karl Popper (1902-1994) in the aftermath of the political excesses of the 1930s and 40s (Popper, 1945). Negative utilitarianism argues that, as moral agents, we seek to prevent the greatest amount of harm or evil, as against maximizing preferences. An argument, *reductio ad absurdum*, against negative utilitarianism is the so-called 'pin-prick argument', which states it would be better to destroy humanity painlessly than allow one person to experience a pin-prick ("DP", 2006). Other, less straw-man arguments have also been made against negative utilitarianism (R. Smart, 1958).

The elaboration of utilitarianism by Peter Singer (1946-) follows on from Hare (Singer, 1993). Singer's principle of equality encompasses all beings with interests, and it requires equal consideration of those interests, whatever the species. This kind of universalization, Singer admits, is Kantian in spirit. Singer contends that suppressing individual need for that of the collective has a survival advantage, an argument for the naturalism of utilitarian ideas (Singer, 1981). All species may have an interest in avoiding pain but few have an interest in cultivating their unique individual abilities and Singer considers this as justifying different treatments for different interests. This is manifest in his concept of 'diminishing marginal utility', a form of hyper-consequentialism whereby the distinction between interests is as much about the need as the desire for the preference. For example, a starving person's preference for food has greater utility in its allocation than someone who is only slightly hungry. In expanding this idea, Singer takes a 'journey' model of life, which measures the wrongness of taking a life by the degree this thwarts a life journey's goals. To Singer, only a personal interest in continuing to live

brings the journey model into play. Singer's utilitarianism has led to heated debate, in particular over the manner in which his philosophy appears to validate euthanasia and abortion (Singer & Kuhse, 1985). The core of his argument here relates to the perceived value of life being linked to sentience and the capacity to reach a life's journey goals, two issues highly relevant to severe mental illness.

ADVANTAGES OF UTILITARIANISM:

The advantages of utilitarianism as an ethical theory lie in its intuitive appeal, particularly in the case of act utilitarianism, and its apparent scientific approach to ethical reasoning. Beauchamp and Childress (2001) have devised a set of criteria by which a moral theory can be assessed (Beauchamp & Childress, 2001). These include clarity, coherence, comprehensiveness, simplicity, explanatory power, justificatory power, output power and practicality. On criteria such as output power, practicality and clarity, utilitarianism fares well. However, on issues such as justificatory power and comprehensiveness, there are problems. The ethical decision making process in utilitarianism may be quite straightforward. However, the justification and practicality of many utilitarian based decisions are limited, and its comprehensiveness as a moral philosophy is also a source of criticism.

Beauchamp and Childress (2001) believe that the principle of utility approximates their principle of "beneficence" and that it has tremendous output power. They also regard one of utilitarianism's strengths is its fitting well with approaches to public policy.

CRITIQUES OF UTILITARIANISM:

Over time, there have been a number of cogent criticisms of utilitarianism as a moral philosophy. The more practical critiques have focussed upon the simple issue of the measurement of outcome of a utilitarian choice. Whilst this problem is more difficult with the Benthamite version of utilitarianism, the matter of how robustly one can measure gratification of preferences is problematic. The issue of adaptive preferences, whereby people accept less because of low expectations (such as the 'contented slave'), is one such area (Elster, 1982). The issues of unexperienced preferences (i.e., ones we will never know existed) and granting harmful preferences are also challenges to preference utilitarianism (Kymlicka, 2002). Some have argued that this potential limitation can be overcome by only applying preference utilitarianism to goods which are universally desired or provide basic necessity (Goodin, 1995), or for some form of utilitarian elite, like that described by Sidgwick (1907), to oversee and exclude irrational preferences (Rawls, 1980). Ronald Dworkin (1931) has distinguished between 'personal preferences', referring to self, and 'external preferences', referring to a person's choices about others (Dworkin, 1977). We have seen recent examples of this in the vexed area of gay couples being restricted in access to assisted fertility treatments or entitlements to social welfare on the basis of their relationship. The capacity of utilitarian calculations to manifest latent prejudices prompted Dworkin and other writers to call for external preferences to be proscribed (Harsanyi, 1976; Kymlicka, 2002).

There have been a number of other logically based challenges to utilitarianism. Among these are the so-called 'replaceability problem' (Foot, 1967), based upon a thought experiment involving the utilitarian justification of one healthy person being killed to provide transplant organs for a half a dozen others in need – a utilitarian calculation. This is as confronting as the metaphor offered by Le Guin (2000) in her short story, *The Ones Who Walk Away from Omelas* (Le Guin, 2000), in which a thriving population's prosperity is contingent upon the torture and imprisonment of an individual.

The above consideration relates to the so-called 'doctrine of double effect', first outlined by Thomas Aquinas (c.1225-1274), which seeks to explain the permissibility of an action that causes a serious harm as a side effect of promoting some good end (Cavanagh, 1997). The distinction here is between the direct or wilful creation of harm as a means, rather than a regrettable consequence of seeking a good. In medical ethics, this issue has been discussed primarily in terms of the intentions of the moral agent, and the proportionality of the harm in relation to the good (Boyle, 1991). Those who see this as the morally vacuous side of utilitarianism have called for a degree of 'deontic constraint', to this principle, rather than tolerating completely impersonal considerations of the positive and negative

effects of actions (Nagel, 1986). In other words, rather than be purely beholden to utility in a vacuum, the moral agent should also reflect upon duties to other persons.

Bernard Williams (1929-2003), one of utilitarianism's most comprehensive critics, challenged us with his thought experiment 'Pedro and Jim', as to whether we would execute one man to save ten (Williams, 1973). The utilitarian decides to shoot one man; however according to Williams, being compelled to act on the basis of utility alienates us from our moral agency. In answer to these, somewhat 'straw-man' arguments, some have asserted that utilitarian arguments only evolved to fit common or mundane situations, and therefore cannot credibly apply to the kind of extraordinary situations cited by critics of utilitarianism (Sprigge, 1965). Derek Parfit's "repugnant conclusion" argument (Parfit, 1984) also takes a logical knife to utilitarianism in that it is, according to the utilitarian calculation, better for the world to have 100 billion all living in marginal poverty than the current situation of wealth being concentrated in a comparatively small part of humanity. Bernard Williams argues that the utilitarian moral agent is both responsible for the consequences of the consequences of their actions, as well as failing to prevent the negative consequences of these. Williams charges that utilitarianism places the moral agent under the burden of unreasonable expectations (Williams, 1973), although others have taken the view that the responsibility for ongoing consequences of actions actually diminishes over time (J. Smart, 1973).

Williams has further charged that utilitarianism, like deontic ethics, alienates the moral agent from their moral agency (Williams, 1973). The idea of a 'U-Agent' (Brink, 1986), totally devoid of any personal morality and wedded to the utilitarian abacus, is clearly unrealistic, prompting some to soften the utilitarian stance to incorporate 'agent relative values' as against 'agent neutral values'. In the former, an act is considered morally wrong if its consequences have less overall value from the perspective of the agent; the latter where this is not a consideration (Sen, 1982). Indeed, any conceptualization of utilitarianism committed to our reneging on important personal commitments in order to promote the welfare of others, is unrealistic (Railton, 1984).

Kymlicka's criticism of utilitarianism (Kymlicka, 2000) is more historical than based on logic or thought experiments. Kymlicka argues that in Bentham's time utilitarianism was a progressive theory, but in modern liberal democracies it is a conservative one:

"In short, when the question is whether to defend an oppressed majority against a small privileged elite, utilitarianism gives us a clear, progressive answer. But when the question is whether to defend an oppressed minority against a large, privileged majority, utilitarianism gives us vague and confusing answers (p. 48)"

Before applying these considerations to three scenarios commonly faced by psychiatrists, we will summarize the strengths and criticisms of utilitarianism as a basis of ethics. In terms of the strength of utilitarianism it has the veneer of scientific and rational method; it fits well with decision making at a macro-policy level; and appears to parallel decision procedures in daily life.

The negative features of utilitarianism based moral choices are that they: involve assessments of preferences which may be biased or flawed; expect too much of the moral agent in responsibility for consequences of consequences and negative responsibility; may require abandonment of emotional or filial bonds; potentially involve alienation from moral agency; may involve the active disadvantage or harm of individuals; and, are based on a political and moral philosophy that is arguably anachronistic.

Utilitarianism and Psychiatry:

Whilst many factors influence its craft, psychiatry is ultimately considered a profession. Any medical practitioner abides by a social contract as both a healer and professional (ABIM Foundation, ACP-ASIM Foundation, & EFIM, 2002). Physicians have reaffirmed the concept of medicine as a profession, in the face of commercialization of healthcare, globalization and advances in biotechnology. Cruess et al (2002) have argued:

"In developed countries it (medicine) has changed in one or two generations from a cottage industry to one consuming a significant portion of each country's gross domestic product (Cruess, Johnston, & Cruess, 2002)"

Professional ethics, arguably, have three core components: specialized training and the acquisition of specific skills; the provision of expert assistance to those in need and vulnerable; and the virtues of trustworthiness, efficacy and knowledge which ultimately enhance the common good and aggregate well being (Fullinwider, 1996). As a distinct professional entity, Radden (2002) has advocated that psychiatry has a unique status and requires a specific ethical basis, predicated on the special virtues of compassion, humility, fidelity, trustworthiness, respect for confidentiality, veracity, prudence, warmth, sensitivity, humility and perseverance (Radden, 2002). This has been refuted, with one author positing that the ethical basis of the profession is best served by it possessing the core trait of “phronesis” (‘practical wisdom’ or ‘prudence’) - the ability to both decide how to act and reflect upon the desired end. (Crowden, 2002). Phronesis was championed by Aristotle and indeed the ethics of Aristotelian virtue have been preferred as the basis of psychiatric ethics (Fraser, 2000). Against such views is the contention that psychiatric ethics are meaningless, or even detrimental, if they lack a socio-cultural context and fail to acknowledge the embedded nature of the psychiatrist as moral agent (Dyer, 1988). Despite this, many physicians’ associations argue that there can be universal principles of ethics, despite socio-cultural differences (ABIM Foundation et al., 2002).

It is possible that the socio-cultural forces impacting upon medicine in the latter part of the twentieth century led to the dominance of utilitarianism and principlism as the ethical bases of medical practice (Pellegrino, 1993), perhaps because of their intuitive appeal in complex, evolving professional environments.

In recent times, two factors, extraneous to psychiatry, may have promoted utilitarianism’s position in psychiatric ethics. First, legislated responsibilities of psychiatrists, particularly in relation to issues of risk management, have effectively trumped any ethical code of conduct intrinsic to the psychiatric profession (Bloch & Pargiter, 2002). Such legal imperatives are invariably utilitarian in nature and have usually emerged in the context of social and political responses to issues such as public safety (Adshead, 2000; Welsh & Deahl, 2002). This has led to utilitarian justifications of the otherwise vexed ‘double agent role’ in regards to forensic patients (Halleck, 1984)

The other factor promoting utilitarian thinking in psychiatric ethics has been the profound changes to healthcare systems in the face of globalisation and financial pressures, particularly in the US and Australia. Indeed, as Dyer has stated, medicine has become a three way relationship between doctor, patient and third-party provider (Dyer, 1988). This issue was given close consideration by Green and Bloch (2001), who identified that when applied to mental health care decisions in a managed care setting in the US, there emerged the problem that “maximizing the common good encompasses a central limitation—the indifference to the uniqueness of the person” (Green & Bloch, 2001). Green and Bloch go as far as to suggest that the psychiatrist may be ethically compromised submitting to a market driven approach in the management of mental illness.

Utilitarianism as a Method of Ethical Reasoning in Psychiatry:

Whilst it is reasonable to provide a theoretical critique of utilitarianism as applied to psychiatry, we suggest that the most useful method of evaluation is to apply Hare’s utilitarian basis of psychiatric ethics to two typical situations faced by psychiatrists.

Vignette # 1

A 45-year-old, unemployed single man suffers recurrent episodes of alcoholic hallucinosis, manifesting as florid paranoid psychosis. When abstinent from alcohol, his mental state is free of any psychotic symptoms and he regains full insight without antipsychotic treatment. He displays some level of impaired judgement and mental inflexibility, but is able to manage his finances and maintain a reasonable level of self-care. He can also comprehend the consequences of choosing to drink.

During one episode of alcoholic hallucinosis, he developed the belief that his neighbour was spying on him whilst he was in the shower. As a result, he attempted to stab his neighbour. He was arrested and convicted of attempted murder. He was found to be mentally ill by the court, and was released into the care of a psychiatrist. One condition of his release was that he was to abstain from

drinking alcohol and attend 'counselling'. The court had presented this to the psychiatrist as a fait accompli. In the light of his history of violent offending, the psychiatrist opted to treat the patient with regular depot antipsychotic medication.

The patient attended an appointment with the psychiatrist whilst intoxicated with alcohol and admitted he had not attending alcohol counselling sessions. He demonstrated evidence of recent physical trauma and admitted that he had been involved in a number of altercations. Although he was not floridly psychotic, probably due to the regular administration of depot antipsychotic medication, the patient was clearly in breach of his conditional release. The psychiatrist does not have a statutory duty to inform in this particular jurisdiction. How should s/he proceed?

DISCUSSION

Involuntary or coercive psychiatric treatment is justifiable in a variety of ethical theories, including utilitarianism and communitarianism (Munetz, Galon, & Frese, 2003). Applying a utilitarian approach to the present clinical dilemma, incarceration of the patient would seem to satisfy the greatest number of preferences – his alcohol use and its consequences are becoming a public menace and it is probable that the patient, and members of the community, may be harmed by his choice not to abide by the requirements of his conditional release. Few of these types of ethical decisions are based on therapeutic grounds, but rather grounds of risk (Szmukler & Holloway, 1998)

This kind of dilemma has certainly become a critical area of psychiatric ethics in the 'post-Tarasoff' era (Anfang & Appelbaum, 1996; Miller, 1990; Stone, 1984; Wexler, 1979). If the psychiatrist decided to breach confidentiality the patient will, in all probability, be incarcerated. The therapeutic relationship will be harmed and the likelihood of developing rapport in the future would be significantly compromised. The psychiatrist will find him or herself in the 'double agent role', in which their actions are more akin to law enforcement, rather than clinical care. Adhering to a duty to inform delivers the psychiatrist into the role of social agent, rather than healer (Guerwitz, 1977). Involuntary or coercive treatment of the mentally ill, particularly in the UK, is often asserted on the basis of utilitarian justice channelled through 'knee-jerk' populist reactions of governments in light of public safety (Welsh & Deahl, 2002); a process any physician schooled in the Hippocratic tradition would find anathema.

The patient may be harmed in goal, or his mental state may deteriorate, which, despite the Thomasian 'doctrine of double effect', still violates the ancient injunction *primum non nocere*. The negative responsibility arising from harm to the therapeutic relationship is likely to mean the patient (assuming he is only briefly incarcerated) is unlikely to divulge further information. This may become an issue for the profession generally, as others may become less likely to see psychiatrists for fear of breaches of confidence, arguably increasing public peril (Stone, 1984). In the light of the Soviet era experience of psychiatry as a tool of repression by the state, the utilitarian grounds of involuntary treatment require a 'self-critical and chastened paternalism' (Chodoff, 1984).

Vignette #2

A psychiatrist is the clinical director of a regional psychiatric service and has found her budget has been significantly reduced as the result of a widespread government austerity programme. She is required to maintain the current levels of acute treatment services, in order to meet performance indices of 'patient flow' from the emergency department and mental health admission centres of the region.

In order to meet these expectations the clinical director has to choose to cut either a vocational psychiatric rehabilitation service for people suffering chronic schizophrenia, or an early psychosis intervention programme, targeting young people with 'high risk mental states' or psychotic illnesses of duration less than six months. What should she decide?

DISCUSSION

This issue of distributive justice highlights even more clearly the value of utilitarian approaches to psychiatric ethics. This decision can be seen in terms of a triage approach to the allocation of limited resources. This kind of dilemma is not unique to psychiatry and normative analogies could be made between this type of decision and those related to the critical care of very premature infants or elderly patients.

A utilitarian approach to the dilemma would seem as follows. Mental health resources are finite and this strengthens the view that psychiatrists have a duty only to use effective treatments. In fact, "need" may be defined in terms of capacity to benefit from a treatment and it is therefore wrong to allocate resources to those who will not benefit through treatments that are not shown to work (Williams, 2004). In this situation, the choice appears to be between secondary and tertiary prevention, i.e., reducing the intensity and duration of an establishing illness, or reducing the disability of a well established illness. This is based on accepting the view that long duration of untreated psychosis imparts a poorer prognosis for the illness (Marshall et al., 2005). Secondary prevention is better than tertiary prevention in terms of measures of health economics such as Quality Adjusted Life Years (QALYs) (Harris, 1987; Williams, 1988), or Disability Adjusted Life Years (DALYs) (Murray & Lopez, 1996), particularly in regards to the concept of declining marginal utility applied to the chronically ill and disabled (Singer, McKie, Kuhse, & Richardson, 1995). The available evidence does not support vocational rehabilitation programs resulting in actual return to work, but rather limited improvement in measures of psychosocial functioning (Bond, 1992; Lehman, 1995). Allocating resources to the early psychosis program is arguably going to gratify the greatest number of preferences in the community, particularly given the reduction of consumption of future resources and the higher likelihood that the younger patients are more likely to enter the workforce. The humanitarian views, such as Singer's 'journey' view of life (Singer, 1993), also support the allocation of resources to the early intervention in psychosis program on the grounds of utility.

The counter position to this utilitarian approach does not dispute the logic of the target argument, but rather approaches the issue in a broader context. In general, utilitarian arguments have instrumental value in economic calculations, but are insensitive to clinical need (Morriem, 1988). One can directly argue against some of the facts used in the justification of the utilitarian position. For example, despite the hypothetical and intuitive appeal of the arguments of the 'early psychosis movement', there is still no firm evidence to support the efficacy and cost effectiveness of dedicated programs (Marshall & Rathbone, 2006). Moreover, the existing health economic methodologies are poorly studied in psychiatric disorder (Clark et al., 1994; Evers, Van Wijk, & Ament, 1997) and have been found to be insensitive in mental health (Chisholm, Healy, & Knapp, 1997).

These alone do not make for a particularly compelling critique of the utilitarian position, in that they merely 'argue the toss' on a few premises. In a broader context of psychiatrist as ethical agent, the counterargument against the utilitarian position considers the issue of the professional ethics of being a physician, particularly in regards to the duties of advocacy for justice and the patient's best interests. Indeed, the chronically ill group may have no advocacy at all, whereas the younger population may have families who also impart the deleterious effects of external preferences, which have no place in such a decision. This kind of dilemma was considered broadly by Green and Bloch, who averred, inter alia, that participation in utilitarian calculations affecting a "flawed health system" diminished the psychiatrist as ethical agent, particularly in the way the fidelity of the therapeutic relationship is eroded (Green & Bloch, 2001). In partaking in utilitarian (and indeed deontic) approaches to clinical dilemmas, the physician is alienated from his or her moral agency (Morriem, 1988). Moreover, population based choices about healthcare resources always convey harm to someone (Harris, 1987), so the process does violate the injunctions of the Hippocratic tradition, even allowing for the comfortable moratoria offered by the 'double-effect' doctrine. Applying some of Bernard Williams's (1973) critiques of negative responsibility, the 'U-psychiatrist' is arguably responsible for the adverse consequences of those patients disadvantaged by the decision to fund the early psychosis group.

CONCLUSION

In this paper, we have described the evolution of utilitarianism as an ethical theory and considered advantages and disadvantages. There have been a variety of critiques of utilitarianism varying from practical concerns to well constructed, logically based arguments. The critique of utilitarianism as the moral basis of psychiatry may be recast as a question of whether a functional, intuitive and practical moral philosophy is compatible with the profession of psychiatry. As we have argued, utilitarianism in its more evolved forms has become the starting point of all moral philosophy and therefore the default position in most ethical dilemmas faced in the practice of medicine generally. Our consideration of the genealogical and practical critiques of utilitarianism, in both their theoretical form and applied to common dilemmas facing psychiatrists, highlight that there are significant problems in psychiatrists basing their moral deliberations on utilitarianism. It seems that any moral philosophy which marginalizes the virtues required of a physician, particularly in situations where the tenets of professional ethics and the Hippocratic tradition are compromised, cannot be reasonably endorsed by the psychiatric profession.

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