EDITORIAL

Beyond the 'Goldwater rule'†

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Summary Mitchell discusses the moral responsibilities of psychiatrists who, when outside professional settings, suspect that a person might benefit from psychiatric help. Is making an unsolicited psychiatric diagnosis ever the right thing to do? The American Psychiatric Association's guidance is that it is not, unless the psychiatrist has been granted authorisation. Although sensitive to harms from 'unsolicited diagnoses', Mitchell argues that this guidance is too blunt: the benefits may outweigh the harms. We foresee, however, the possibility that psychiatrists may become pressured to make unsolicited diagnoses to protect or improve society rather than serve the best interests of the individual.

Declaration of interest None.

In 1964 Senator Barry Goldwater was the Republican candidate for US president. The *Fact* magazine carried out a survey of psychiatrists in which over 1000 respondents stated that the Senator was not fit to be president. Was it right for psychiatrists to give such an opinion? The American Psychiatric Association thought it was not. They issued the following professional guidance, known as the 'Goldwater rule': 'it is unethical for a psychiatrist to offer a professional opinion unless he or she has conducted an examination and has been granted proper authorization'.[1] In the current issue of *The Psychiatrist*, Mitchell shows that psychiatrists, and indeed health professionals more generally, face the question of whether to make unsolicited diagnoses outside professional settings in a rather broader range of situations than that of public figures running for high office.[2] He argues that a blanket ban is too simple an ethical response.

Every inch a doctor

Medical students realise early in their education that being a doctor is not a role that they can cast off, like their stethoscopes, whenever they leave the hospital, clinic or surgery. Universities have disciplinary mechanisms for dealing with the unacceptable behaviour of students, but some leeway is granted in recognition that 'students will be students'. However, the behaviour of medical students might come under scrutiny not only from the university disciplinary mechanisms relevant to all but also from a fitness to practise committee. If a medical student behaves in a way not deemed appropriate for a neophyte doctor, the fitness to practise committee may take action and even prevent the student from progressing with their medical studies. And it is not only the behaviour of students in clinical settings that might come under scrutiny: what the student does on a night out might catch the attention of the fitness to practise committee.

Most medical students will at some stage be approached by friends for advice. Whether they like it or not, the mantle of the doctor is thrust upon them. The advice wanted may be about a physical complaint: abdominal pain or a skin rash, for example. But sometimes it is more personal, more psychological.

Clinician's (moral) responsibilities *v.* acceptability of an unsolicited intervention

A few months after one of us (T.H.) began training as a psychiatrist he went on a week's painting course. He was on holiday and off duty. On the first evening all those on the course met in the lounge of a country house. Everyone exchanged brief biographical information and T.H. told the others that he was a psychiatrist. Over the next week every person on that course took him aside at some stage and told him about their psychological problems or those of a close relative.

What were his responsibilities? How should he have responded? Although the answers to these questions are unclear even in the country house, Mitchell goes one step further in discussing the issue of the moral responsibilities of psychiatrists and other health professionals outside their clinical settings. He focuses on what are even more problematic situations: those in which no one is asking for help. Perhaps the health professional is relaxing on the beach, or at home, or in the coffee room at the office, when she suspects that a person she sees experiences a mental disorder that might be undiagnosed. Does she march over, diagnostic manual in hand, or sip her drink and turn quietly away? Mitchell gives three examples of the kinds of diagnoses he has in mind: possible depression in a colleague, psychosis of a son's housemate and borderline personality disorder of a friend's partner. We can add three further

†See special article, pp. 297–301, this issue.

disorders from our own experience: Alzheimer's disease based on the subtle reduction in the ability to chair a conference session; eating disorder in the teenage daughter of a neighbour; and all too frequently the suspicion of alcohol problems when the glass of wine has been drunk before anyone else has taken their second sip. Once the professional has noticed something, she cannot choose to 'un-notice' it. She either acts on that information or does not act. If she says something, is she an interfering busybody sticking in her medical oar where it is neither wanted nor appropriate? If she says nothing, is she reneging on her duties as a doctor? Should she feel responsible if something indeed goes terribly wrong?

The acceptability of unsolicited psychiatric diagnoses, Mitchell begins, is 'founded upon the trade-off between potential benefits and harm to the recipient of the diagnosis' (p. 297). He points out that the risk of harm in making the unsolicited diagnosis increases with its severity, reflecting the magnitude of the negative consequences of the diagnosis being wrong. Perhaps the most promising strategy, therefore, is to offer not a specific diagnosis, such as schizophrenia or depression, but the 'circumlocutory language of a formulation . . . pointing out the possibility of a problem potentially amenable to treatment and encouraging contact with healthcare professionals in general terms' (p. 298). Such a strategy may minimise the possibility of the harm from making an incorrect diagnosis but it would still carry risks of its own, such as engendering generalised anxiety that 'something might be wrong with me'. This could result in undue worry and hypermonitoring even if the bill of health is cleared on a formal visit to a health professional. A general increased concern about one's mental health, however, might be valuable if it encourages a pattern of health-enhancing behaviour, similar to the value in having a routine physical exam.

Issues inherent to a psychiatric diagnosis

Although such concerns will be present in any diagnosis, Mitchell rightly suggests that there are risks particular to a diagnosis of mental illness – those concerning stigma and thus confidentiality – and that these particular risks heighten the consequences of any action perceived to overstep the psychiatrist's limits of practice. The use of circumlocutory language might assuage some of these concerns: the advice may seem like that simply of a caring friend. But a doctor, legally and professionally, always speaks and acts as a doctor, and the risks of stigma as well as concerns about the limits of practice to a large extent remain.

In examining the question of unsolicited psychiatric diagnosis, Mitchell makes important headway in a difficult and underexamined area. We might glean the principle that the specificity (and severity) of the diagnoses should directly parallel the depth of knowledge of the individual's case and be guided foremost by the potential benefits and harms to that individual. Mitchell's arguments have ground the beginnings of a fine lens that will be valuable in examining related issues. Does it make a difference, for example, if the wife of the individual in question approaches the psychiatrist directly asking for an opinion about her husband's symptoms, rather than the psychiatrist acting without any such request? Or is it preferable if the psychiatrist who notices something in a husband approaches the wife, not the husband, with their concerns?

The dangers from making unsolicited diagnoses loom especially large when the professional is motivated not (only) by the interests of the person to whom the diagnosis would apply but by the interests of others. If in recommending action the psychiatrist is thinking more about the potential benefits and harms to his son not his son's housemate, or to his friend not his friend's partner, he should take extra precautions against taking a step down the slippery slope to the Goldwater case.

The Goldwater case may seem rare and remote. But in a more recent paper, entitled 'The mental wealth of nations',[3] Beddington *et al* argued that societal concern in early diagnosis and treatment of mental illness is necessary for maximising both the social good and the competitiveness of the society on the global scale. If this reasoning is pursued, then perhaps professionals will feel pressured to make unsolicited diagnoses as a kind of screening for socially hampering mental disorders ranging from Alzheimer's disease to depression. As Mitchell points out, we may already have begun down this path: the UK recently instituted a programme concerned first and foremost with the safety of society in which a 'diagnosis' of dangerous and severe personality disorder (DSPD), defined by a 50% risk of committing future violence, sanctions involuntary civil commitment.[4] Mitchell's appeal for a cautious and thoughtful approach to psychiatric diagnosis outside the clinic, therefore, is both important and timely.

About the authors

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3 Beddington J, Cooper CL, Field J, Goswami U, Huppert A, Jenkins R, et al. The mental wealth of nations. *Nature* 2008; **455**: 1057–60.

4 Dangerous People with Severe Personality Disorder Programme. *DSPD Programme – Useful Information*. Ministry of Justice National Offender Management Service, Department of Health (http://www.dspdprogramme.gov.uk/useful_information.html).

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