Specific Ethical Codes for Mental Health Care Professionals: Do We Need to Annotate?

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ABSTRACT: **Background:** In Israel a general code of ethics exists for physicians, drafted by the Israel Medical Association. The question arises whether psychiatrists require a separate set of ethical guidelines.

Objectives: To examine the positions of Israeli psychiatrists with regard to ethics in general and professional ethics in particular, and to explore opinions regarding a code of ethics or ethical guidelines for psychiatry.

Methods: A specially designed questionnaire was compiled and completed by psychiatrists recruited for the study.

Results: Most participants reported low levels of perceived knowledge regarding ethics, professional ethics, and the general code of ethics. Older and more experienced professionals reported a higher level of knowledge. Most psychiatrists agreed or strongly agreed with the need for a distinct code of ethics/ethical guidelines for psychiatrists. This support was significantly higher among both psychiatrists under 50 years and residents.

Conclusions: Our findings suggest that the existing code of ethics and position papers may not be sufficient, indicating a potential need to develop and implement a process to create the ethical code itself. In addition, the findings highlight the importance of ethics education, suggesting that the need for a code of ethics is more urgent in the early stages of professional training, as younger professionals may be more exposed to advanced media technology. While some may fear that a distinct code of ethics will distance psychiatry from modern medicine, others assert that the profession combines aspects from the humanities and social sciences that require a unique sort of management and thus this profession requires a distinct code of ethics.

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The field of mental health and the discipline of psychiatry in particular foster many clinical and ethical dilemmas. Should the a priori professional, practical and clinical approaches in medical practice be different for patients with mental illness? To what extent do personal and social biases in psychiatry impact the physician's decision making and behavior in the presence of the mentally ill patient, and to what extent do these biases ultimately affect the patient's behavior and their own outlook? How can an individual with severe mental illness and resulting impairment be protected from being exploited? Does the complexity of therapy and psychiatric treatment require unique tools that can be adapted to the circumstances to cope with ethical dilemmas, or can the profession "make do" with the tools that are generally available?

It may be argued that a professional community can act ethically without having an ethics code. Kasher [1] holds that an ethics code is not a cure for unethical practices, but a decision of a professional community to formulate its own code of ethics. Formally adopting it and encouraging implementation should be seen, according to Kasher, as an upgrade of the level of professional ethics practice [1].

In various countries [2] including the State of Israel [3], the field of psychiatric treatment has been granted separate legislation that refers specifically to the field of psychiatric treatment. Thus, for example, in Israel the Law for the Treatment of the Mentally Ill (1991) defines the authority and domain of psychiatric treatment at the civil and criminal level, and the legal procedures related to these authorizations. This legislation provides a glimpse of the ethical balance that the legislation found appropriate for a variety of issues that involve the patient, his/her family, his/her therapist, and the public.

In Israel, a comprehensive set of ethical guidelines for clinicians was published by the Israel Medical Association in 2009. The set of guidelines includes 20 major general physician's obligations, 95 specific rules regarding physician's behavior, and 58 position papers by the members of the Ethics Committee of

the Israel Medical Association. Notably, none of these position papers referred explicitly to the field of psychiatry [4]. Today, there is no general ethics code for psychiatrists in Israel, nor is there any ongoing process to develop such a code within the Israeli Psychiatry Association or elsewhere.

However, for comparison purposes, in Canada, the United States and Russia, the issue of professional ethics has been a focus of discussion in various psychiatric associations. The Canadian Psychiatric Association published a unique position paper following publication of the Code of Ethics of the Canadian Medical Association (CMA) that expanded and discussed ethical guidelines specific to the field of psychiatry. Thus, for example, in the section where the Physician's Code of Ethics relates to approaching the general public, the Code emphasizes the physician's responsibility when propagating a position that differs from the general consensus, and the responsibility to note the general consensus and indicate where his/her position differs. This clarification by the Canadian Psychiatric Association suggests the importance of professionals appearing in the media in order to educate the public. However, the psychiatrist who is a public figure with social opinions must distinguish between his or her various roles and maintain the boundaries between these roles and their contact with patients' families. It also deals with psychiatrists' character analyses of famous people and exposure of information after the death of patients, two activities that are not ethically acceptable according to the Code of Ethics of the CMA [5].

The Code of Ethics of the American Psychiatric Association (APA) emphasizes the uniqueness of the therapeutic relationship between the patient and the therapist, and the role of the psychiatrist in a behavioral model with whom the patient could identify. It specifies that the psychiatrist must not satisfy his/her own personal needs by taking advantage of his or her patients. Psychiatrists must always be alert and aware of how their behavior impacts the boundaries of the therapeutic relationship, since the relationship is private, personal and often emotionally intense. This clarification specifically relates to intense therapy that can potentially give rise to sexual fantasies of the patient and of the therapist which can weaken the degree of objectivity necessary to maintain distance, and therefore declares unequivocally that sexual relations with a patient or a former patient is unethical.

The APA clarifications emphasize the autonomous status of the psychiatrist. The psychiatrist must not be party to a political policy that discriminates, isolates, or degrades a patient based on his or her origin, race, gender, age, socioeconomic status, or sexual orientation. In addition, the psychiatrist should carefully address issues of remuneration unique to psychiatry, such as payment for a session that did not take place. Reference to these issues of payment apparently stem from the organization of the private health system in the USA and the physician's need, perhaps more than in other countries, to deal with collecting payment. It also emphasizes the sensitivity of psychiatric information and patient privacy and focuses on technological developments that include information systems, computerization and databases. The clarifications recognize that the profession interfaces with other professions and thus places ethical responsibility on the psychiatrist to ensure professional behavior of those to whom he or she refers. Following appropriate notification, a psychiatrist may terminate treatment of a patient who received a second opinion that is unacceptable to him/her. In addition, a psychiatrist may decline to treat an individual, who, in his or her opinion is not diagnosed with a mental illness that can be treated from the perspective of the psychiatry profession [6].

In Russia, the Psychiatric Code of Ethics especially emphasizes human dignity, freedom, privacy, the dangers of exploiting psychiatric authority beyond the boundaries of medicine, and the welfare of the patient. The psychiatrist is willing to help anyone who needs help, regardless of faith, age, gender, political affiliation, etc. The patient shall not be harmed or damaged, and the physician shall not be indifferent when harm is inflicted by others. He must not use his knowledge or skills against the medical interests of the patient and must not distort the truth. Personal and non-professional motives shall not influence medical decisions. The Russian Code of Ethics emphasizes that the psychiatrist is morally and ethically responsible beyond his personal responsibility for his actions and for the activities of the psychiatric community to which he belongs. He must do all that is in his power to instill in his community these ethical and moral principles. It may be suggested that these emphases stem from the problematic conduct of the psychiatry profession during the era of the Soviet Union [7].

It should be noted that while the Israeli Association for Child and Adolescent Psychiatry has formulated and adopted a specific code of ethics for child and adolescent psychiatrists, the Israeli Psychiatry Association has never formulated its own code of ethics for psychiatrists.

In order to explore the issue, it is important to examine the position of Israeli psychiatrists regarding the role of a Psychiatric Code of Ethics with elements unique to Israel. We thus performed an explorative study among Israeli psychiatrists to examine self-perceived knowledge of professional ethics, opinions regarding the need for an ethics code for psychiatry, and relevance of various topics to potentially be included in the Code of Ethics for Psychiatrists. In addition, we were interested in comparing responses of younger and older psychiatrists regarding their opinions on these issues.

SUBJECTS AND METHODS

A specially designed questionnaire was compiled by the research team for the unique purpose of this exploratory survey. The questionnaire was presented by two members of

the team (B.G., E.D.) at two major mental health centers in Israel that provide a broad range of psychiatric services including general adult psychiatry, child and adolescent psychiatry, forensic psychiatry, and outpatient ambulatory community services. All participants were psychiatrists who are Israeli citizens and currently employed in their profession. Participants were requested to complete the form anonymously and in a voluntary fashion and to return it in a sealed envelope to the primary investigator (T.B.L.) either directly or by regular mail. The questionnaire was kept as short and simple as possible to ensure confidentiality and a high response rate.

The questionnaire consisted of a statement explaining the study, the voluntary nature of the study, as well as the commitment to confidentiality. In addition to demographics – including age, gender, marital status, occupation, years of experience (calculated from first year of residency), level of religiosity, medical education (Israeli vs. foreign) – participants were also asked about the nature of their psychiatric practice. The study protocol and instruments were approved by the Beer Yaakov Mental Health Center Institutional Review Board.

STUDY QUESTIONNAIRE [APPENDIX A]

The questionnaire included two sections. The first section consisted of seven general statements regarding the psychiatrists' perceived knowledge of the field of ethics, professional ethics and ethical codes, and attitudes towards an ethical code adapted specifically for psychiatry. Psychiatrists were asked to rate their degree of response using a 5-point Likert scale ranging from definite disapproval to definite approval. In order to create the variable "self-perceived knowledge," a mean of questions (Q) 1–3 was calculated. (Cronbach's alpha coefficient for internal reliability = 0.75). At the end of this section participants were asked (Q6 and Q7) to rate their support for the creation of a separate ethical code for psychiatrists, or formation of annotations specific to psychiatry to add to the existing general code.

In order to create the variable "support for adopting an ethics code or annotations for psychiatry," a mean of questions 6 and 7 was calculated (Cronbach's α coefficient for internal reliability 0.78). Eighty-nine psychiatrists (83.1%) rated their approval as high or very high in at least one of these questions and were asked to continue to the second section of the questionnaire. Only the participants who recommended ethical code/guidelines (Q6 and Q7) were asked to answer further questions.

The second section of the questionnaire included eight additional statements regarding the optional issues to be addressed in a potential ethical code or annotations for psychiatry, including issues regarding relations between physicians and the pharma industry, boundaries of the therapeutic/supervision relationship, and research in mental health. A 5-point Likert scale was used, similar to the one in the first section. In order to create the variable "suggested relevant issues," a mean of questions 8–16 was calculated. (Cronbach's α coefficient for internal reliability 0.78). At the end of the questionnaire responders were asked if they would agree to participate actively in the process of creating ethical code/principles and were also given the option to provide suggestions for potential content.

DATA ANALYSIS

Standard descriptive statistics measures were applied to analyze the sample's characteristics. Associations between variables were tested using the Pearson and 2 x 2 chi-square tests. Experience in the field effects were analyzed using *t*-tests. Various associations were analyzed using the Pearson correlation. Internal reliability tests (Cronbach α coefficient) were analyzed. For the purpose of analysis of self-perceived knowledge, the answers were classified as low level (not at all – to a mild degree) or high level (to a large degree – to a very large degree).

RESULTS

The sample comprised 107 psychiatrists (adult, child and adolescence psychiatry, or combined sub-specialties). The gender division was 41 males (40.2%) and 61 females (59.8%) (5 cases had missing data). The average age was 45.5 years (SD 10.7, range 30–66 years) and the average number of years in practice was 14.6 (SD 11.2, range 0.4–40 years). Most of the subjects were married (n=78, 75.9%), 18 were single (17.5%), 6 were divorced (5.8%), and one was defined as "other" (4 had missing data). With regard to level of religious affiliation, 86.7% defined themselves as secular (n=78) to atheist (n=11), while 12 (13.3%) defined themselves as traditional (n=6) to religious (n=6) (17 had missing data). The group comprised 32 psychiatry residents (30.8%) and 72 as board-certified in psychiatry (69.2%) (3 had missing data). Forty-nine respondents had studied medicine in Israel (49.5%) and 50 (50.5%) had studied in other countries (8 had missing data).

PERCEIVED KNOWLEDGE OF ETHICS

Most participants perceived their knowledge as low regarding ethics (Q1, 61%), professional ethics (Q2, 55.1%), and the Israel Medical Association general code of ethics for physicians (Q3, 79.4%). No significant difference was found with regard to gender. The rate of men reporting a high level of knowledge on professional ethics (56.11%) was higher compared to women (39.3%). There was a trend of men reporting higher levels of self-perceived professional ethics knowledge than women (chi-square analysis, $P = 0.072$). Professional experience and age (in years) of the psychiatrist was found to be significantly correlated ($r = 0.31, 0.34, 0.27$, $P = 0.002, 0.001, 0.007$; $r = 0.34, 0.4, 0.3$, $P = 0.001, 0.001, 0.001$ respectively) with high levels of perceived knowledge/agreement in all three questions (Q1–Q3). No significant associations were found with marital status or level of religiosity, location of medical studies, or between child and adolescent psychiatrists and adult psychiatrists.

A significant difference was found between psychiatry residents and attendings in self-perceived knowledge ($t = 4.07$, $P < 0.01$). Residents reported lower self-perceived knowledge (mean 2.75, SD 0.53) than experts (mean 3.26, SD 0.61).

SUPPORT FOR A UNIQUE ETHICAL CODE FOR PSYCHIATRY:

Overall, 84% of respondents agreed or strongly agreed that there is a need to create a unique code of ethics for psychiatry or ethical guidelines for psychiatry. This included 81.3% of respondents stating (agree to strongly agree) that they would support the creation of a distinct code of ethics for psychiatry, while 75% would support the creation of ethical principles/guidelines with special annotations for psychiatry.

Comparing residents and attendings, 90.9% of residents and 77.5% of attendings supported the adoption of an ethics code for psychiatry. In an independent *t*-test no significance was found. Moreover, when comparing residents and experts, 90.3% of residents and 70% of attendings supported the adoption of ethics annotations for psychiatry. In an independent *t*-test a significance was found where residents agreed more than the attendings ($t = 2.76$, $P < 0.01$). Psychiatrists who studied medicine in Israel were more supportive of a unique psychiatry ethics code (or annotations) than those who attended medical school in other countries (92% vs. 77.6%, $P = 0.045$). This support was significantly higher in psychiatrists under age 50 compared with those over 50 years for both a code of ethics (88% vs. 71%, $P < 0.035$) and ethical guidelines (93% vs. 55%, $P < 0.001$). No association was found between perceived level of knowledge (Q1–Q3) and the amount of support in favor of ethical code/principles unique to psychiatry (Q6 & Q7). No significant associations were found with gender, level of religiosity, marital status, type of psychiatric practice, and where they studied medicine. Among those who rated their support for adopting a unique psychiatry ethics code (or annotations), a significant difference was found with 11 psychiatrists over age 50 not completing the second section of the questionnaire (28.9%) compared to only one psychiatrist from the < 50 year subgroup (1.8%) ($P < 0.001$).

Overall, 78.1% of respondents agreed to actively participate in the creation of an ethical code for psychiatry. A tendency toward statistical significance for active participation was found for age when comparing psychiatrists < age 50 to those > 50 years old, with psychiatrists under 50 years of age tending to agree more to participate in the creation of a code of ethics (84.4% vs. 65.4%, $P = 0.064$). The internal reliability tests (Cronbach α coefficient) were found to be sufficient at 0.78 and to support the formulation of a document with distinct content of professional psychiatric ethics.

OPINION REGARDING CONTENT OF PSYCHIATRIC ETHICS CODE

Eighty-nine psychiatrists (83.1%) proceeded to answer questions Q8–Q16. From the items that were presented to the participants, the rates of agreement (agree to strongly agree on the Likert scale) ranged from high to low [Figure 1].

Figure 1. Rates of agreement regarding items relating to professional psychiatric ethics

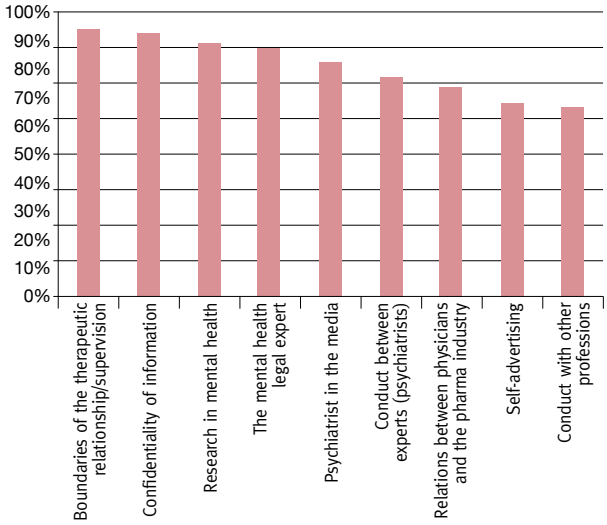

Table 1. Descriptive statistics of items relating to content of professional psychiatric ethics

	N	Mean	SD
Q14 = Confidentiality of information	89	4.44	0.706
Q10 = Boundaries of therapeutic/supervision relations	89	4.30	0.697
Q16 = Research in mental health	87	4.29	0.730
Q13 = The mental health legal expert	89	4.25	0.773
Q15 = Psychiatrists in the media	89	4.24	0.892
Q8 = Conduct between experts (psychiatrists)	89	4.00	0.879
Q9 = Relations with pharma companies	89	3.97	0.790
Q11 = Self-advertising	89	3.81	0.824
Q12 = Conduct with other professionals	89	3.80	0.979
Valid N	87		

A significant correlation was found between the rates of being in favor of writing an ethical code (Q6) ($r = 0.74$, $P < 0.001$) and ethical guidelines (Q7) ($r = 0.65$, $P < 0.62$) and the rates of overall agreement with items Q8–Q16. This suggests that the same population of participants who supported the writing of a code of ethics or guidelines demonstrated high rates of support for the proposed content of suggested items for a code of ethics [Figure 1, Table 1].

At the end of the research questionnaire, participants were also given the opportunity to specify other subjects relating to psychiatric professional ethics that were not included in the questionnaire. The issues documented included the boundaries of relations with the patient's family and caregivers, ethical

dilemmas that concern payment, and ethical perspectives of parenting of the mentally ill.

DISCUSSION

Most psychiatrists reported low levels of self-perceived knowledge regarding ethics in general, professional ethics, and the Israel Medical Association general code of medical ethics. Older and more experienced professionals reported higher levels of knowledge. Arguably, the most important finding of this study was that most psychiatrists agreed or strongly agreed with the need for a unique code of ethics/ethical guidelines specific to psychiatry. This support was significantly higher among younger psychiatrists and psychiatry residents. The same population of participants with high rates of support for writing a code of ethics/ethical guidelines demonstrated high rates of support for the proposed content suggested in the questionnaire. Our exploratory pilot survey consisted of 107 psychiatrists, a sample reflecting more than 10% of psychiatrists in Israel and which should be seen as representative.

Focus on medical ethics and the development of ethics committees in hospitals accelerated in the early 1980s against the background of ethical dilemmas stemming from developments in life-prolonging medical technology and subsequent effects on patients' quality of life [8]. Similarly, the notable technological developments that have occurred in the world of media and information over the past 20 years have also posed ethical dilemmas for the younger generation of medical professionals who are more exposed to such media. This may explain various observations of our study, where those under age 50 demonstrated greater support for the creation of a code of ethics or principles of ethics tailored to psychiatry. The development of digital media increases the need for renewed discussion and sheds an additional and possibly more complex light on the daily dilemmas in the mental health field. The realm of medical confidentiality, as related directly to information, was one of the widely supported areas in our study.

Our research findings clearly indicate that the existence of a code of ethics and position papers is not sufficient in and of itself, as attested to by the high rate of psychiatrists who report a medium to low level of knowledge of the ethical code published by the Israel Medical Association. The authors believe that this phenomenon is in all likelihood not limited to the field of psychiatry and that it reflects a situation that warrants research regarding other medical professions. Looking forward, there is a real need for continuous assessment of the level of doctors' familiarity with the general code of ethics, while taking action to promote its assimilation.

Various questions arise, from accessibility to the degree to which it is feasible to assimilate a voluminous code of ethics. It may well be preferable to adopt general guidelines. Our findings clearly indicate a need to develop and implement the means of assimilation concurrently with the process of creating the ethical code itself. This may include, for example, a special educational course aimed at psychiatry residents [9]. The assimilation of an ethical code and education promoting ethics and sensitivity to ethics are no less important than the discussion and creation of the code of ethics itself. Involving health care professionals in the formulation process of an ethical code that considers the day-to-day dilemmas is a way to educate them about professional ethics. Involving the less experienced members of the profession, who according to our research findings support ethical guidelines, would most likely lead to further education in ethics as well as enhance ethical sensitivity. An advisory ethical committee that reviews relevant cases, i.e., gathers the cases and reports to organization members on a regular basis, may serve as a subsequent mechanism for education and assimilation of the code.

The effect of age on the degree of support for the creation of an ethical code or ethical guidelines indicates the significance of the timing of education and professional ethics instruction. Older specialists may believe that they do not need ethical guidance in light of their accrued professional experience. The need for a code of ethics that provides ethical tools may be more necessary in the early stages of professional training and work; thus, an emphasis on professional ethics education should be provided in the early stages of professional training. The inclusion of ethics in certification exams should be considered as well as the integration of ethics into continuous medical education.

Is there a need for a separate code of ethics in psychiatry? Some will say that a separate code of ethics or ethical guidelines would separate psychiatry from the rest of medicine and reinforce the stigma that already exists surrounding those who practice the profession, rather than strengthening the position of advanced modern medicine advocating the connection between neuroscience and behavior. Nevertheless, others would argue that there are additional aspects to psychiatry which include the humanities, social sciences and psychotherapy that require different or additional handling. The field of psychology, for example, is replete with various ethical codes governing the conduct of its practitioners. This would include the "Ethical principles of psychologist and code of conduct" of the American Psychological Association [10] and "the Meta-code of ethics" of the European Federation of Psychologists associations [11]. In addition, managing weaker members of society who lack the political power to rally public support and are extremely stigmatized may also necessitate a different manner of conduct. Thus for example, according to the general code of medical ethics [4], sexual relations with a patient are forbidden unless the doctor-patient relationship has ended and at least one year has passed since the conclusion of that relationship. With regard to psychiatric patients, the code is in fact more stringent and the period in which the relationship is not permitted is 3 years. Nonetheless, others believe that in all likelihood the processes

of transference and counter-transference that are considered by many in the field of psychiatry to be the cornerstones of treatment do not simply dissipate after a predetermined period of time and it remains unknown when they cease to exist. Thus, it is possible that these processes would place patients in a state of perpetual subjugation within the "new" relationship with the partner – the "former" therapist. Another example that demonstrates this difference is the Israel Medical Association's strict approach to self-advertising by doctors, as published by the Ethics Bureau in a 2009 position paper [4] which advised that "advertising and radio and television advertisements are not appropriate and harm the dignity of the profession." Is this true for the field of psychiatry? Some would suggest that television appearances by experts are warranted in order to fight the profound stigma suffered by the mentally ill, bring them closer to the public and integrate them into the community. Appearance by a professional may entail a necessary element of exposure to further the cause of patients.

As seen in Figure 1, all suggested items for a unique addendum focusing on psychiatry to the Physicians Code of Ethics received high percentages of support, and the differences may appear to be minor. However, there is a discernible gradation in the significance of the issues, with those related to safeguarding patients clearly being the most important to psychiatrists, followed by issues among psychiatrists themselves or in relation to other professionals. This gradation may indicate psychiatrists' sensitivity to the population of patients with mental illness.

The fundamental position underlying this study considers a professional code of ethics to be a document that represents an organized and accepted view defining appropriate behavior in psychiatry. Naturally, the fact that a view is "accepted" does not mean that it necessarily represents the unanimous agreement of every person in that field, rather a "consensus" that may be attained in various ways. One of the potential ways to obtain broad agreement regarding a code of ethics is by utilizing the Delphi method – a group communication process that enables a group of individuals to deal with a complex problem as a single unit, as experts answer a number of rounds of questionnaires. At the end of the process, participants review an anonymous final summary of the results and are given the opportunity to change their minds if they so desire. In this manner the variance among the answers is minimized. The process ends based on predetermined criteria (variance, number of rounds) [12]. This system was utilized, for example, to determine various diagnostic criteria such as neuroleptic malignant syndrome [13]. This questionnaire, the first of its kind related to an ethical code for psychiatrists in Israel, can serve as the first stage of this process. The initial findings indicate great interest among psychiatrists in formulating a code of ethics unique to the profession.

Limitations of the study include the fact that the sample, while substantial in size, would be even more significant with a larger number of participants. Furthermore, the study participants were recruited from two state mental health centers. Thus, the sample population is not a true representative sample of the entire subpopulation of psychiatrists working in the country, but rather a convenience sample. Future studies should consider widening the participant representation to encompass other psychiatrists, including ambulatory and private psychiatrists. Finally, only those who recommended an ethical code/guidelines specific for psychiatrists were included in the group that answered questions regarding content of a future potential ethics code specific for psychiatry. It would be interesting in future studies to address all members of the profession, exploring opinions on potential content including those not entirely supportive of such an ethical code.

Future research is indicated to study the potential of each of the sub-topics to constitute a clause in the code of ethics for psychiatrists, within the realm of content for professional ethics. This manner of working with a consensus among participating psychiatrists could serve to identify the ethical threshold needed to develop a "toolbox" of ethics in this field. It is advisable that such ethical tools grow from within the professional population through a process of discussion, agreement and consensus. Furthermore, the findings may warrant the need for more intensive courses in ethics in Israeli medical schools. While the scope of this paper does not allow detail regarding ethics training and implementation of such values and mores, there has been increasing sensitivity to the need to focus on these issues in psychiatry training at both the undergraduate and postgraduate/clinical level [14-17]. The rationale underlying this study could be expanded to address other aspects of the profession as well as comparing issues of professional ethics with those of other medical professionals.

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Appendix A. Questionnaire

1. To what extent do you think you are familiar with the field of "Ethics"?
2. To what extent do you think you have knowledge regarding "Professional Ethics"?
3. To what extent are you acquainted with the ethics code of the Israel Medical Association?
4. To what extent do you think there is a need for an ethics code for psychiatry or ethical principles specifically directed at psychiatry?
5. To what extent do you believe the ethics code of the Israel Medical Association can represent the psychiatry profession?
6. To what extent would you support the creation of a complete ethics code adapted for psychiatrists?
7. To what extent would you support the creation of ethical principles (principal ethical guidelines rather than a complete ethics code)?
8. If you responded "Much" or "Very much" to either of the last two questions, kindly proceed to complete the questionnaire. Otherwise, end the questionnaire at this point.
9. To what extent do you think that an ethical code (or annotations) should relate to conduct between experts (psychiatrists)?
10. To what extent do you think an ethical code (or annotations) should relate to pharmaceutical companies' relationships with psychiatrists?
11. To what extent do you think an ethical code (or annotations) should relate to boundaries of therapeutic/supervision relationships?
12. To what extent do you think an ethical code (or annotations) should relate to self-advertising?
13. To what extent do you think an ethical code (or annotations) should relate to conduct towards other professionals?
14. To what extent do you think an ethical code (or annotations) should relate to the mental health legal expert?
15. To what extent do you think an ethical code (or annotations) should relate to confidentiality of information?
16. To what extent do you think an ethical code (or annotations) should relate to psychiatrists in the media?
17. To what extent do you think an ethical code (or annotations) should relate to research in mental health?

"Courage without conscience is a wild beast"

Robert Green Ingersoll (1833-1899), American lawyer, Civil War veteran, political leader, and orator during the Golden Age of Free Thought, noted for his broad range of culture and his defense of agnosticism