Deconstructing and Reconstructing the "Goldwater Rule"

August 25, 2016 | Couch in Crisis [1], Career [2]
By Ronald W. Pies, MD [3]

The ethical core of the Goldwater Rule is sound, but the rule needs clearer and more nuanced language.

On the face of it, the statement by Dr Maria A. Oquendo, President of the American Psychiatric Association (APA), could not have been clearer: ". . . Simply put, breaking the Goldwater Rule is irresponsible, potentially stigmatizing, and definitely unethical."[1] I completely agree with Dr Oquendo, in so far as the general principle goes. Ah, but it is far from clear that the Goldwater Rule (GR) itself can be "simply put" or that its language is easily transferable to the complex ethical issues that arise when psychiatrists express opinions about figures who are "in the light of public attention."

Indeed, at least two recent reviews[2,3] suggest that the GR is in need of substantial revision—or, more radically, that the GR itself may sometimes be unethical![3] In this piece, I argue that—while fundamentally sound—the GR requires more precise and limited language. I propose a reformulation of the GR that allows for greater leeway in some circumstances, while retaining its core ethical principle.

The APA's Principles of Medical Ethics: Section 7

The Goldwater Rule is published as an annotation in Section 7.3 of the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*. It states:

On occasion psychiatrists are asked for an opinion about an individual who is in the light of public attention or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. However, 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 for such a statement."[4]

As is widely known, the GR was a reaction to the debacle that occurred during the US presidential election of 1964, when a large group of psychiatrists, responding to a magazine survey, declared Senator Barry Goldwater psychologically unfit to be president. As Dr Oquendo noted, ". . .some responding doctors even issued specific diagnoses without ever having examined [Goldwater] personally."[1]

I share Dr Oquendo's view that such "diagnoses" are fundamentally unethical, not to mention scientifically dubious. But wait—*the GR as written does not use the term "diagnosis."* It refers to offering "a professional opinion." (The rule also did not specifically distinguish living versus non-living subjects who are "in the light of public attention," though it seemed clearly intended to limit psychiatrists' comments about living persons).

I would argue that not all "professional opinions" proffered by psychiatrists constitute specific diagnoses, nor should all such opinions be deemed unethical, when properly limited in scope. I would distinguish four types of comments or claims regarding public figures, though these categories are not exhaustive.

First, there are *historical inferences as to likely diagnosis,* as applied to persons no longer living; for example, when historians (or psychiatrists) examine the psychology of figures like Abraham Lincoln or Winston Churchill.[5,6] Second, there are *non-diagnostic professional opinions* regarding living persons, as when a psychiatrist might comment broadly about the clinical significance of a *pattern of behavior*, without proffering a specific "clinical diagnosis" of the *person* in question.Not all "professional opinions" proffered by psychiatrists constitute specific diagnoses, nor should all such opinions be deemed unethical, when properly limited in scope.

Third, there are professional comments that offer a *differential diagnosis* of a symptomatic or behavioral pattern in a living person—again, without providing a clinical diagnosis of the particular person in question. Finally, there are comments that amount to a *clinical diagnosis of a living person*—and here is where the Goldwater Rule emerges as useful and necessary.

Indeed, as the **Table** indicates, I do not believe that the GR ought to apply to the first category of

comments, and is breached only in the case of the fourth category, when a clinical evaluation is not carried out.

I believe we need to unpack this concept of a "clinical diagnosis." Like so many medical terms, our word "clinical" is rooted in ancient Greek medicine. Specifically, it is derived from the Greek, *klinikē,* meaning, " [at the] bedside" ; and from the Latin, clinicus, meaning, "[a] physician that visits patients in their beds."[7] Thus, a clinical diagnosis, correctly understood, is one made on the basis of direct personal examination of the patient. A diagnosis that purports to be a clinical diagnosis but does not include a direct examination of the patient is a contradiction in terms—a bit like the claim, "Here is my physical diagnosis of Mr Jones, but I did not perform a physical examination."

This does not mean that a direct evaluation of a patient constitutes the totality of clinical diagnosis. As Kroll and Pouncey observe in an excellent analysis of the GR:

. . .personal [psychiatric] examinations are notoriously flawed . . . Patient interviews are not fully reliable because of conscious (intentional) and unconscious distortions, which is why thorough diagnosis considers the accounts of other persons and written records. Patients under direct interview or in psychotherapy do not tell the whole story, or the accurate story, or they tell a rationalized and distorted story . . . [However, the fact] that patients may not respond truthfully to an interview does not entail abandoning first-person interviews as a key component of the diagnosis. First-person testimony is critically important to clinical examination, but it is subject to the unavoidable limitations of all human interactions."[3]

What Kroll and Pouncy call "thorough diagnosis" is what I call clinical diagnosis, and it includes more than just a personal "interview" of the patient (either face-to-face, or via an adequate video hook-up when direct examination is not feasible). A valid clinical diagnosis also includes data from the patient's significant others (when possible); careful observation of signs, such as psychomotor activity, as distinct from the patient's subjective complaints (symptoms)[8]; and, ideally, the use of validated screening instruments, such as the Beck Depression Inventory, to supplement one's diagnostic impression.A diagnosis that purports to be a clinical diagnosis but does not include a direct examination of the patient is a contradiction in terms—a bit like the claim, "Here is my physical diagnosis of Mr Jones, but I did not perform a physical examination."

In many cases, laboratory and/or neuroimaging studies are also a part of the psychiatrist's clinical diagnosis. In my view, no clinical diagnosis occurs without *klinikē*—the bedside or office examination of the patient. Furthermore, when a psychiatrist purports to "diagnose" a public figure without such an examination, he or she has breached the ethical core of the Goldwater Rule. In view of the foregoing, I offer the following suggested reconstruction and revision of the GR:

On occasion, psychiatrists are asked for an opinion about a living individual who is in the light of public attention, or who has disclosed information about himself/herself through public media. In such circumstances, a psychiatrist may share with the public his or her expertise about psychiatric issues in general. In some cases, a psychiatrist can also offer a professional opinion regarding the possible significance of well-documented and publically reported behaviors on the part of the person receiving public attention, such as documented instances of intoxicated or assaultive behavior. The psychiatrist's generalized differential diagnosis of such behaviors is also within ethical bounds. However, it is unethical for a psychiatrist to offer publically a putative clinical diagnosis of any living person, unless the psychiatrist has conducted a thorough clinical examination of the person; evaluated appropriate ancillary data (such as the person's family history or psychometric testing); and been granted proper authorization for stating the person's diagnosis publically.

So restructured, the GR would in no sense limit psychiatrists or other health care professionals from expressing purely political views about, say, a presidential candidate. After all, psychiatrists, as citizens, are no less concerned about their country than are butchers, bakers, or candlestick makers. Psychiatrists have every right—indeed, an obligation—to make their political views known, when the nation's course and destiny are at stake. As Dr H. Steven Moffic has said in these pages, "All of us have the right to comment on behaviors we observe and to voice our political opinions—but, from the mental health perspective, such rights should be exercised with respect and dignity."[9]

That said, the APA's ethical guidelines caution that *". . . psychiatrists should avoid cloaking their public statements with the authority of the profession ". . . as a whole; and ". . . should always be mindful of their separate roles as dedicated citizens and as experts in psychological medicine."* (Sec. 7, clauses 1 and 2)[4] Finally, as psychiatrist Richard A. Friedman wrote in 2008, in reference to the Goldwater Rule:

For a mental health professional—or any physician—to publically offer a diagnosis at a distance of a non-patient not only invites public distrust of these professionals, but also is intellectually dishonest

and is damaging to the profession."[10]

Acknowledgment: I wish to thank Dr Nassir Ghaemi and Dr Steve Moffic for their stimulating thoughts on this topic.

For further reading:

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Table. Refining the Goldwater Rule

Disclosures:

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