lish mental health policies for victims and perpetrators in future reparation.
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e-Poster viewing: ethics and psychiatry

EV0539

Is a psychiatrist-patient confidentiality relationship subservient to a greater good?

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Before embarking in a fruitless exchange the title question must be unpacked:
– is the 'psychiatrist-patient confidentiality relationship' a subset of the general doctor-patient confidentiality relationship?
– if different, what causes the difference? Is it the nature of mental disorder, for example the fact that some mental disorders may impair 'mental capacity' in ways different from general medicine?
– given that in addition to psychiatrists, psychologists, nurses, and social workers also enter into 'confidentiality relationship' with patients, should all be considered as tokens of the same type or as different types? If the latter, should such differences be considered as intrinsic or extrinsic? Intrinsic differences refer to structural dissimilarities; extrinsic differences to dissimilarities created by the respective legal frames imposed by each profession to its practitioners.
– is 'subservience to a greater good' an acceptable good way to describe the metier upon which the ethical scrutiny will be applied? Given that it does describe a 'consequence' of the process then it would seem that it prematurely opts for utilitarianism, an ethical theory that many may feel is not adequate to the case.
The general question and the pre-formulated debating positions are setting up a pseudo-debate. A more useful question should be: "Given the strong political and economic pressures being currently brought to bear upon all confidentiality relationships (held by priests, medics, lawyers, bank workers, etc.), what ethical system may be more convenient to:
– justify blatant breaches in confidentiality relationships;
– placate our moral conscience?"
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EV0540

500 years of reformation: The history of Martin Luther's pathography and its ethical implications

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Introduction In the context of the 500th anniversary of the Reformation, it is time to take a survey of the history of Martin Luther's (1483–1546) pathography.
Method Relevant writings were evaluated.
Results While in a 1035 page work written in German between 1937 and 1941, the Dane Paul Reiter retrospectively diagnosed Luther as manic-depressive, Kretschmer (1888–1964) in 1955 saw in Luther "a great polemic and organizer". In 1956, Grossmann was unable to prove persistent synchronicity of depressive mood and reduced motivation in Luther in the key years 1527 and 1528, which led him to conclude that Luther had a cyclothymic personality with a pyknic constitution. In Roper's view in 2016, Luther suffered from "a condition [...], that we would call depression today".
Discussion In 1948, Werner concluded that Reiter's pathography was based on an incorrect assumption: Luther's solution of the cloister conflict as a dilemma situation between paternal and clerical authority was not a flight into "the mysticism of despair". Hamm adopted this interpretation in 2015 in viewing the escalation of the emotional conflict potential as a logical consequence of an interiorized and individualized intensified piety. In 2015, Scott saw a cyclothymic temperament in Luther starting in about 1519, but emphasized the elasticity of Luther's emotional reserves: "For the rest of his life, Luther oscillated between euphoria and dejection but not to the point of dysfunction".
Conclusion Luther can be used as an example of the importance of religiousness as a curative resource for the psyche.
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Emotional decision for accepting patients in the ICU in Greece – where are the guidelines?

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Introduction It is not a rare phenomenon to ask a bed in the ICU in a basis of emergency. Then, the answer coming from the intensivists may be more than surprising. Objective of our study is to highlight the fact that emotional reasons and not medical criteria are the dominant ones for accepting a patient in the ICU.
Methods We present 4 cases of interest.
Results A poor Russian 75-year-old man with gastric cancer, anemia and haemodynamic instability was not accepted in the ICU with the oral and not written rejecting answer that he suffers from advanced cancer. A 35-year-old transplanted patient with bone marrow, fever, severe lactic acidosis, was not accepted in the ICU for hours because the intensivist would give her consent only if the patient would undergo a cholecystectomy first! The intensivist was a pneumonologist! In the end multiple liver abscesses were discovered, so an operation would not help. An 80-year-old man operated for colon cancer with haemodynamic instability was accepted in the ICU without delay. A 72-year-old with colon cancer, cachexia, thrombopenia and severe dementia, coming from the Psychiatric Hospital where he remained for months, was accepted in the ICU without delay.
Conclusions If there is not an Ethics Commitee to examine these unexpectability matters concerning patients needing a place in ICU, then a psychiatric evaluation of Intensive Unit physicians might help, for the good of patients. Would a member of the Parliament or a celebrity receive a "No" from the ICU?
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