ETHICS CULTURE AND PSYCHIATRY

INTERNATIONAL PERSPECTIVES

EDITED BY

Ahmed Okasha
Julio Arboleda-Flórez
Norman Sartorius

ETHICS, CULTURE, AND PSYCHIATRY

International Perspectives

This page intentionally left blank

ETHICS, CULTURE, AND PSYCHIATRY

International Perspectives

Edited by

Prof. Ahmed Okasha

Prof. Julio Arboleda-Flórez

Prof. Norman Sartorius

American Psychiatric Press, Inc.

Washington, DC
London, England

Note: The authors have worked to ensure that all information in this book concerning drug dosages, schedules, and routes of administration is accurate as of the time of publication and consistent with standards set by the U.S. Food and Drug Administration and the general medical community. As medical research and practice advance, however, therapeutic standards may change. For this reason and because human and mechanical errors sometimes occur, we recommend that readers follow the advice of a physician who is directly involved in their care or the care of a member of their family.

Books published by the American Psychiatric Press, Inc., represent the views and opinions of the individual authors and do not necessarily represent the policies and opinions of the Press or the American Psychiatric Association.

Manufactured in the United States of America on acid-free paper
03 02 01 00 4 3 2 1
First Edition

American Psychiatric Press, Inc.
1400 K Street, N.W., Washington, DC 20005
www.appi.org

Library of Congress Cataloging-in-Publication Data
Ethics, culture, and psychiatry / edited by Ahmed Okasha, Julio Arboleda-Florez, Norman Sartorius. — 1st ed.
p. cm.
Includes bibliographical references and index.
ISBN 0-88048-999-5 (alk. paper)
1. Psychiatric ethics. 2. Cultural psychiatry. 3. Psychiatry, Transcultural. I. Ukashah, Ahmad. II. Arboleda-Florez, J. (Julio), 1939- . III. Sartorius, N.
[DNLM: 1. Ethics, Medical. 2. Psychiatry. 3. Cross-Cultural Comparison. WM 62 E833 2000]
RC455.2E8 E836 2000
616.89—dc21
99-040828

British Library Cataloguing in Publication Data
A CIP record is available from the British Library.

Contents

SECTION II

Overarching Issues

This page intentionally left blank

Contributors

Dr. Renato D. Alarcon
Professor and Vice Chairman, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine; and Chief, Mental Health Service Line, Veterans Administration Medical Center, Atlanta, Georgia

Prof. Julio Arboleda-Flórez
Member of the Ethics Committee of the World Psychiatric Association; and Professor and Head, Department of Psychiatry, Queen's University, Kingston, Ontario, Canada

Dr. M. Dolores Crespo
Associate Professor, Department of Psychiatry, Ramón y Cajal Hospital, University of Alcalá, Madrid, Spain

Prof. Dr. Hanfried Helmchen
Member of the Ethics Committee of the World Psychiatric Association; and Professor of Psychiatry, Department of Psychiatry, Free University of Berlin, Berlin, Germany

Dr. Marianne Kastrup
Medical Director, Rehabilitation and Research Centre for Torture Victims, Copenhagen, Denmark

Prof. Xiehe Liu
Professor and Director, Institute of Mental Health, West China University of Medical Sciences, Chengdu, China

Prof. Juan J. López-Ibor, Jr.
President of the World Psychiatric Association; and Head and Chairman, Department of Psychiatry, San Carlos Hospital, Complutense University, Madrid, Spain

Prof. R. Srinivasa Murthy
Professor of Psychiatry and Dean, National Institute of Mental Health and Neurosciences, Bangalore, India

Prof. Yoshibumi Nakane
Professor, Department of Neuropsychiatry, Nagasaki University School of Medicine, Nagasaki, Japan

Prof. Ahmed Okasha
Chairman of the Ethics Committee of the World Psychiatric Association (WPA) and President-Elect of the WPA; and Professor of Psychiatry and Director of the World Health Organization Collaborating Center for Training and Research in Mental Health, Institute of Psychiatry, Ain Shams University, Cairo, Egypt

Prof. Michael O. Olatawura
Professor of Psychiatry, University College Hospital, University of Ibadan, Ibadan, Nigeria

Prof. Mark Radford
Visiting Professor, Department of Neuropsychiatry, Nagasaki University School of Medicine, Nagasaki, Japan

Prof. Norman Sartorius
Past President of the World Psychiatric Association; and Professor of Psychiatry, Hospitaux Universitaires de Genève, Geneva, Switzerland

Prof. Dr. Dr. Jochen Vollmann
History of Medicine Institute, Free University of Berlin, Berlin, Germany

Prof. David N. Weisstub
Philippe Pinel Professor of Legal Psychiatry and Biomedical Ethics, Faculty of Medicine, University of Montreal, Montreal, Quebec, Canada

Preface

The idea of this book was born during a meeting with the leaders of the American Psychiatric Association, the American Psychiatric Press, Inc., and the Ethics Committee of the World Psychiatric Association (WPA). The group discussed how best to promote the use of the Declaration of Madrid (see the Appendix to this book), a consensus document adopted in 1996 by the General Assembly of the WPA.

The Declaration of Madrid was developed by the Ethics Committee of the WPA through a long process of consultation involving WPA member societies and individual experts, ethicists, psychiatrists, philosophers, and lawyers. The document contains a set of principles in the form of guidelines concerning ethical behavior in the practice of psychiatry.

It soon became obvious that the way in which the use of the declaration—and the application of the guidelines it contains—will be promoted will depend on the strength of the conviction of the Ethics Committee and of the General Assembly of the WPA that it is possible to formulate a set of principles that will be valid for all psychiatrists, regardless of the cultures to which they belong or in which they live and practice. Alternatively, perhaps there are as many sets of ethical principles as there are cultures, an approach that would mean a different way of proceeding in the years ahead.

Helman (1994) viewed culture as a set of guidelines, both explicit and implicit, that individuals inherit as members of a particular society and that indicate to them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. These guidelines are transmitted to the next generation through the symbols, language, art, and ritual of culture. Ethics—through which what is good and what is bad are explored and which provide indications regarding behavior that enhances the good and minimizes the evil—could be expected to be culture specific, unless we were to postulate that in addition to belonging to individual cultures, humans also share a common culture.

To facilitate the exploration of this territory, we invited experts belonging to different cultures and familiar with the practice of psychiatry to write essays on ethical issues and psychiatry in the settings they knew well. We de-

cided not to provide guidelines for the essays, because we thought the contributions would be richer and more emphatic about topics preoccupying psychiatrists in different lands if the writers were not constrained by guidelines.

Religious beliefs have a strong influence on ethics, morals, and deontological mistakes. Readers of this book shall discover, however, that although there are diverse cultures, only one human conscience, one human sense of responsibility, and one human moral obligation exist. There may be some agreement across all cultures on what is good, what is bad, and what should be denounced or praised.

We were impressed by the similarities among Indian, Chinese, Japanese, Latin American, and Arab cultures and by the denial of self for the sake of others and the devotion of the individual to the promotion of the group in these cultures. Individual autonomy is valued in Scandinavian, European, and American cultures but is not empowering for the traditional, family-centered societies in Arab, sub-Saharan African, Indian, and Japanese cultures. This difference may affect the use of involuntary admission, informed consent, and religious psychotherapy, among other practices, in traditional versus Western societies. In some cultures, traditional and religious healing have been combined with the most up-to-date psychopharmacological interventions.

We decided not to include a final chapter with conclusions about the ethical issues arising in the practice of psychiatry in the groups of countries covered in this book. One reason is that it is uncertain how closely the cultures are related in the groups of countries dealt with by the contributors and how representative the authors' views are of all psychiatrists working in the groups of countries described. Perhaps a more important reason for omitting a concluding chapter is that by bringing these materials together, we hope to stimulate and support, rather than close, the debate on ethical aspects of professional behavior in our own setting and in others—a debate animated by the wish to learn about the position of others and marked by respect for others' views and by a continuous search for a consensus on how to live together and make contributions to the well-being of people with mental illness, their families, and the family of humans on our planet.

Prof. Ahmed Okasha
Chairman of the Ethics Committee of the World Psychiatric Association (WPA)
President-Elect of the WPA
Professor of Psychiatry

Director of the World Health Organization Collaborating Center for Training and Research in Mental Health
Institute of Psychiatry, Ain Shams University
Cairo, Egypt

Prof. Julio Arboleda-Flórez
Member of the Ethics Committee of the WPA
Professor and Head, Department of Psychiatry
Queen's University
Kingston, Ontario, Canada

Prof. Norman Sartorius
Past President of the WPA
Professor of Psychiatry
Hospitaux Universitaires de Genève
Geneva, Switzerland

Reference

Helman C: Culture, Health, and Illness: An Introduction for Health Professionals, 3rd Edition. Oxford, England, Butterworth-Heinemann, 1994, pp 6–9

This page intentionally left blank

SECTION I

Ethics and Psychiatry Around the World

This page intentionally left blank

CHAPTER 1

Ethics and the Societies of the World

Prof. Norman Sartorius

Two questions have led to the writing of this book. Both are easy to pose and difficult to answer. Both are important, because the responses to them will determine the organization of mental health care in many countries as well as international collaboration in the field of psychiatry.

The first of these questions is the following: Is there one set of rules that should govern the practice of psychiatry as a discipline, or are there as many sets of rules as there are societies? The second question is, If there is such a set of rules, what should we do to ensure that psychiatry as a discipline makes a significant contribution to societal good without helping the evil?

In seeking an answer to these two questions, I shall use the word *ethics* to describe the study of good and bad and of the general nature of morals in different societies; *deontology* to describe the study of standards governing the conduct of members of professions; *morals* to describe the standards of rectitude prevailing in a particular society at a given point in time; *ethical* to describe the accordance of an action with general or ideal standards of right and wrong, related to its contribution to the balance of good and bad in society; and *moral* to describe the accordance with standards prevailing in a given society at a given point in time.

The Context of Ethical Practice of Psychiatry

The answer to the first of the questions just stated will depend on, first, whether ethicists will be able to define the good and the bad in ways that can somehow be proven and, second, the likelihood that what is good and what is bad remain equal across time.

Over the years, various external criteria of validation of the definition of good and bad have been proposed. They include the following:

- The intervention of a divine being who has from time immemorial defined the good and the bad and ordered humankind to maintain the original distinction or be punished
- A reference to the evolutionary advantage that the acceptance of certain rules has for the species (the same justification has also been formulated somewhat differently regarding the survival and advancement of society as a whole)
- Historical analyses showing the immutability and repeated appearance of the same rules in different cultures and in different religious systems
- The consensus of the just and the wise, so wise that they could, despite their own anchors in time, see or sense the eternal truth

Through the ages, attempts have also been made to convince everyone that people of a particular country had discovered the way of distinguishing good and bad and that the moral behavior of professionals or citizens of belonging to that (usually economically or militarily strong) culture or country was in fact ethical behavior and that it was therefore justifiable and in the best interest of all to impose rules of moral behavior of professionals in that country on people in general or on professionals in all other countries in the world. Often the argument sounds plausible, drawing strength from the fact that the country putting forward a particular set of rules at a point of its maximum strength has, after all, achieved a position on the summit that might have been the consequence of observing the very rules proposed.

The immutability of the ideal definition of good and bad over time is also dependent on the orientation of the persons who argue about it. Those who hold the platonic view that somewhere there is a set of ideal models will be more easily convinced of the immunity of the definitions against the influences of time; those who hold the Aristotelian view and are not convinced that ideal models exist and who therefore search for the truth by examining

all matters within their reach will probably argue that it is likely that the definition of good and bad changes over time, because, for example, of the changes in the capacity of humans to study historical development using modern methods of information exchange. The truth is probably in the middle: rules will change with time, but their changes are infrequent and reflect changes in ethical paradigms of society—in the same way that rules in science change with changes in the paradigms of science (Kuhn 1970).

Even if it were possible to produce an eternal and cross-culturally valid definition of good and bad, it would still be necessary to develop criteria for guidance in deciding which paths for achieving good and avoiding bad are acceptable. In Indian ethics, for example, happiness, health, survival, progeny, pleasure, calmness, friendship, knowledge, and truth are placed on the side of good—the highest good is the total harmony of the cosmic order—and misery and other opposites of the good things are considered bad (Bilimoria 1997). All people are expected to behave in a way that promotes the good and that does not lead to the production of bad things, because otherwise the order of the universe might be disturbed. However, there is no precise guidance about matters such as the quantity of bad things that one would be allowed to do to arrive at the good things. The answer that the pursuit of good must be limited to actions that do not produce bad things is too facile, given that human actions will usually produce some good and some bad. It is left to the individual to determine, or to a social group or a set of rituals (often of obscure origin) to indicate, what behavior is best under the circumstances.

Nor is it clear whose health and happiness, survival, knowledge, calmness, or knowledge should have priority. When it is impossible to satisfy everyone's ambitions, should the level of goodness be measured by the numbers of people who are receiving benefits—subtracting, for example, the number of people who will not receive benefits or whose benefits may have to be curtailed so that benefits can be provided to some? And how should the decision be reached when more than one good outcome could be pursued? Because many of the aims considered to be good (e.g., health) can only be reached if significant changes affecting everyone in a society are undertaken, it is also necessary to state how decisions about the course of action for other desirable goals will be made and enforced. How much coercion is acceptable for the common good? And acceptable to whom? How do we resolve the conflict between families', communities', and broader society's needs?

Faced with the variety of cultural and other differences across the world, and in the absence of external criteria and evidence that would help in the answering of questions like those just listed and allow the formulation of rules of behavior based on ethical principles confirmed by evidence, profes-

sionals of many disciplines decided to compose guidelines for ethical behavior by consensus. This decision is based on the belief that by incorporating the experience and opinions of many in a consensus about a course of action, we can make such a consensus closer to timeless and culture-free ethical paradigms. However, it is clear, though sometimes forgotten, that consensus and democratic decisions regarding matters about which we have no external (e.g., scientific) evidence are not necessarily the same as the truth. Each instance of nonconformism with consensus-based statements should therefore be considered carefully, because the nonconformist position might be more creative and more contributory to the good and thus require a reexamination of the consensus.

Once it is accepted that the rules of behavior agreed on by a worldwide consensus are the best possible substitute for the rules of ethical behavior of professionals based on timeless and cross-culturally valid paradigms of ideal behavior in a profession, it is necessary to examine whether the moral rules of behavior for the profession are, on the whole, close to these ethical rules. This exploration must cover rules for the performance of clinical duties, research, and teaching activities, but it cannot stop there. The behavior of psychiatrists in the public arena must also be explored, perhaps even more than the behavior of other professionals. The stigma and special position of psychiatry in society, for example, make it likely that unbecoming conduct will not only tarnish the particular psychiatrist's reputation but also affect the image of the profession as a whole, which in turn might slow the development of programs that could help patients, thus diminishing the usefulness of the profession as a whole.

The consensus among members of a profession, including psychiatry, is often based on consensus of representatives of political groups, national governments, and groups of international and national, nongovernmental and governmental organizations. For example, in 1948 the World Medical Association (WMA) produced the Declaration of Geneva, which states the duties of the person "being admitted as a member of the medical profession" (Bojadjiev 1996, p. 9). The text of the declaration is very similar to the Hippocratic Oath, although there are differences, mainly results of attempts to make the text acceptable to the majority of the delegates. Other differences are due to changes in society and culture over the many years since antiquity, when the ethical principles of professional conduct were produced. However, these changes are minor—an indication that what was proposed has a certain timelessness, which should be a mark of the truth.

The WMA produced a number of other consensus statements, including the International Code of Medical Ethics (1949; amended in 1968 and 1983)

and the Declaration of Helsinki (1964), which concerns biomedical research involving human subjects. Many of the consensus statements of the WMA have been amended several times, exemplifying the need to examine whether the rules defined at a point in time remain applicable. These general statements have also been complemented by a series of others regarding the behavior of physicians in different situations—when functioning in a national health care system (1963), at times of armed conflict (1956), or in rural areas (1964) or when faced with the coercion to participate in torture (1975). Furthermore, the WMA also addressed the behavior of doctors in relation to therapeutic abortion (1970), family planning (1967), and the new challenges to confidentiality presented by the rapid spread of use of computers in medicine (1973). Over the years, the WMA has produced no fewer than 74 statements on the behavior of medical doctors in different situations and in the performance of tasks of the profession (Bojadjiev 1996). There is no doubt that the WMA will continue this tradition of amending statements or producing new ones.

In addition to the WMA, other agencies have also produced important statements by international consensus. Among these, two statement by the United Nations stand out: the Principles of Medical Ethics (UN Resolution 37/194) (Bankowski and Howard-Jones 1982) and the statement concerning the protection of persons with mental illness and the improvement of mental health care. The latter statement is of particular interest to psychiatrists because it indicates not only that mentally ill patients have the right not to be abused but also that they have "the right to the best available mental health care." The importance of this resolution (46/119, adopted by the General Assembly of the United Nations in 1991) is both theoretical and practical; in adopting this resolution, the United Nations, the world's supreme political body, has stated ethical principles that should govern the provision of care and has created the legal basis for the provision of mental health care, because receiving such care is a human right.

The World Psychiatric Association produced several statements about ethical behavior and the duties of psychiatrists. The first of these were the Declaration of Hawaii (amended in Vienna in 1983) and the World Psychiatric Association Statement and Viewpoints on the Rights and Legal Safeguards of the Mentally Ill (1989; cited in Bojadjiev 1996). In 1996, the World Psychiatric Association produced the Declaration of Madrid (see the Appendix to this book), an updated consensus statement on ethical issues and related to psychiatry, accompanied by a series of guidelines about the behavior of psychiatrists in specific situations (e.g., in relation to euthanasia).

These documents and resolutions deal with the practice of psychiatry and

the behavior of psychiatrists in specific situations. The rules of ethical conduct of medical doctors in general (and of psychiatrists in particular) in relation to research have been discussed in a range of documents. A number of countries have passed legislation requiring that institutions financing or hosting research establish ethical committees and other mechanisms to ensure that research is conducted according to specific guidelines regarding experimentation and medical ethics. International organizations (e.g., the Council for International Organizations of Medical Sciences [Bankowski and Howard-Jones 1982]) have convened meetings of ethicists, health care decision-makers, and researchers to define minimal ethical standards for scientific investigations and have made recommendations (e.g., Council for International Organizations of Medical Sciences 1993; Howard-Jones and Bankowski 1979). Rules about research in general have been complemented by rules about epidemiological research (Bankowski et al. 1991) and other types of studies. Unfortunately, there are still many countries in which investigations can be undertaken without the explicit approval of an independent ethical committee. In some countries, ethical committees have been established (often because of pressure exerted by investigators whose proposals were not eligible for international support without the approval of such bodies) but are not independent and do no more than rubber-stamp proposals made by influential members of the academic community. Also, in some instances researchers from industrialized countries with significant research funding find ways to carry out research in a developing country in which ethical control is less strict. Funding agencies and editors of widely read and respected scientific journals are gradually requiring approval of an independent ethical committee before proceeding to fund a particular project or publish its results. Rules for ethical behavior, in relation to collaborators in international research, have been proposed because of the frequency of asymmetrical and often exploitative relations in a variety of countries and situations over the years (Sartorius 1988).

Although ethical aspects of research have become a standard part of the agenda of research funding agencies and relevant governmental and non-governmental organizations, examination of ethical aspects of proposals for the purpose of reform of medical education or of restructuring medical or nursing curriculum is still rare, even though changes in medical education have a profound impact on the ethical behavior of whole generations of students and doctors. There is generally little or no pressure to present evidence to the government and to society that a particular reform will not only produce some gains in terms of knowledge and skills but also contribute to the development of the propensity to act in accordance with ethical principles.

Ethics and National Mental Health Programs

In the 1960s and 1970s, it was sufficient to reach a consensus on a text such as the Declaration of Madrid, translate the text into many languages, recommend application of the principles to psychiatric societies, and insist that these principles be reflected in research training and practice of psychiatry. Today, not only are translation, distribution, and promotion required (many of the earlier important documents and guidelines were not handled this way), but other steps must be undertaken as well. These steps stem from the currently more and more widely used strategy of mental health program development.

This strategy was first introduced some 20 years ago (Sartorius 1978). It generally takes two decades (one working generation), if not more, for a strategy to become a self-evident way of proceeding (Sartorius 1982). The new mental health program development strategy has three main features. First, mental health programs must encompass more than the treatment of mental disorders and the rehabilitation of the mentally ill. Promotion of mental health—that is, a systematic effort to enhance the value assigned to mental health by individuals, communities, and societies—must become part of mental health programs. Without that element, it is unlikely that mental health programs will become part and parcel of overall health and social development programs and that the population will be willing to invest in the improvement of mental health, the care of the mentally ill, and other components of the program (Sartorius 1998). Prevention of mental diseases—possible at primary, secondary, and tertiary levels, as is the case with any other group of diseases—is an additional necessary component, one that is often lacking (Sartorius and Henderson 1992). Another often neglected task of mental health programs is to contribute to the reduction of psychosocial problems, such as violence and drug abuse, and to ensure that psychosocial aspects of medical practice in general receive the attention they deserve.

The second characteristic of the overall strategy for mental health programs is a logical consequence of the first. The multitude of tasks that need to be undertaken to make progress in the areas of work just described cannot be accomplished by psychiatrists alone. Other professions, governmental health sector and sectors not related to health, patient and family organizations, industry, and the community must all be actively involved in the development, implementation, and evaluation of mental health programs. The establishment of a permanent collaboration and communication among these