Editorial

Ethical Perspectives in Psychiatric Care and Research

By

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Ethical implications become more difficult to discern, as medical interventions become more complex and as social changes impact more directly on the interaction between the physician and the patient, including the specific therapist-patient relationship in psychiatry. Social changes, political conflicts, and technological advancements create new ethical dilemmas, which demand an ethical answer from the physician. Psychiatry, as a medical specialty cannot escape responding. Ethical guidelines could help the psychiatrist by providing a general outline of what is permissible, or forbidden.

Mental illnesses have a destructive effect on affected individuals, causing them to suffer physically, mentally and socially. The families also suffer and experience economic losses; both employers and employees can be affected directly by mental illness and the repercussions usually affect society as a whole, with a consequent loss to the national economy (Moscarelli, 1995). Mental health problems constituted 12% of the global distribution of health burden in 1999 as measured by the percentage of Disability Adjusted Life Years (DALYs) and is expected to reach 15% in the year 2020. Depression is ranked the second in developed and the fourth in developing countries (WHO, 2000) among the ten most frequent diseases in the world causing disability. Depressive disorders represent the highest percentage of disability among mental disorders (17.3%), while psychosis 6.8%, drug dependence 4.8%, Alzheimer's 12.7% and epilepsy 9.3%. In the year 2020 unipolar depression will be the second cause of the ten leading causes of DALYs and among females it will be the first cause of disability. Five mental disorders are among the 10 leading causes of DALYs. The global call for controls of health care expenditure suggests a need for a consideration of repercussions of mental illness across society, the costs related to health care provision and the healthy and economic return due to care and assistance. From all of the above we can conclude that the ethics of caring for the mental patient and research in Psychiatry will be a challenging issue.

What is the role of the WPA?

The WPA plays a dual role as regards the ethics of psychiatric practice and research. On the one hand it draws the ethical guidelines that should be the terms of reference for the practice of its member associations and their members through the Ethics Committee. On the other hand it has an internal mechanism that investigates alleged complaints regarding violation of those ethics through the Review Committee.

I. WPA as a reference for ethical guidelines

The Hawaii Declaration (WPA, 1977)

The Declaration of Hawaii was the first positional statement of the psychiatric profession concerning ethical questions. It was adopted by the General Assembly of the World Psychiatric Association in Hawaii in 1977. Its primary aim was to encourage psychiatrists in conflicts of loyalty in contemporary societies and to help them in conflicts of psychiatric decision-making. A major trigger was the political misuse of psychiatric concepts, knowledge and techniques in countries such as the former Soviet Union, Romania, and South Africa that came to public awareness during the early 1970s.

The very first paragraph of the Declaration is concerned with the ethical problem of the political misuse of psychiatric concepts, knowledge and techniques.

The Declaration of Hawaii explicates the ethical principles of respect for autonomy and of beneficence: By formulating the components of *informed consent*, by calling to mind the obligation of *confidentiality*, by stating rules for *forensic evaluation* and *compulsory interventions*, by demanding the possibility of independent proof of compulsory measures and by obliging psychiatrists not to misuse their professional possibilities and particularly to abstain from any compulsory intervention in the absence of a mental disorder.

A growing recognition of the fundamental rights of the mentally ill led to the UN Resolution 46/119 for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (Principles for Policy on Mental Health) in 1991. In this resolution, human rights of the mentally ill and their right to treatment were codified for the first time in a UN document. Psychiatrists were meant to use these regulations as a reference viz. a viz. the authorities and governments of their countries. The national

governments, for their parts, were to promote the principles of this resolution by means of appropriate legislative, juridical, administrative, educative and other provisions.

The Madrid Declaration (WPA, 1996)

Against this background and at the 1993 World Congress in Rio, the WPA gave its Ethics Committee the mandate to update the Hawaii Declaration and to develop guidelines for specific situations.

The first section of the Madrid Declaration outlines the ethical commitments of the profession and the theoretical assumptions upon which these are based. It acknowledges that medical professionals are facing new ethical dilemmas resulting from increasingly complex medical interventions, new tensions between the physician and the patients, new social expectations from the physician, development of new research modalities and rapid advancement of research technology with prospects for possible technological interventions especially in the field of genetic research and counselling. It also stresses that, despite cultural, social and national differences, the need for ethical conduct and continual review of ethical standards remains universal. It states that as a practitioner of medicine, the psychiatrist must be aware of the ethical implications of being a physician, and of the specific ethical demands of the specialty of psychiatry.

The second section contains seven general guidelines that focus on the aim of psychiatry. It states that:

1. Psychiatry is a medical discipline concerned with:
   a) The provision of the best treatment for mental disorders;
   b) The rehabilitation of individuals suffering from mental illness and
   c) The promotion of mental health.

Psychiatrists serve patients by providing the best therapy available consistent with accepted scientific knowledge and ethical principles. They should devise therapeutic interventions that are the least restrictive to the freedom of the patient.

2. It is the duty of psychiatrists to keep abreast scientific developments of the specialty and to convey updated knowledge to others.

3. The patient should be accepted as a partner by right in the therapeutic process. The therapist-patient relationship must be based on mutual trust and respect to allow the patient to make free and informed decisions.

4. When the patient is incapacitated and unable to exercise proper judgment because of a mental disorder, the psychiatrist should consult with family and, if appropriate, seek legal counsel, to safeguard the human dignity and the legal rights of the patient. Treatment must always be in the best interest of the patient.

5. When psychiatrists are requested to assess a person, it is their duty to inform the person being assessed about the purpose of the intervention, about the use of the findings, and about the possible repercussions of the assessment.

6. Information obtained in the therapeutic relationship should be kept in confidence and used, only and exclusively, for the purpose of improving the mental health of the patient or safeguarding the safety of a third party as might be the case in intended murder or child abuse.

7. Research that is not conducted in accordance with the canons of science is unethical.

The ethics of research in psychiatry target the objective of using research in raising new horizons of knowledge without violation of patient's rights to safety and right to best available treatment. Several challenges remain to be addressed in that regard: We have to finalize the rationale and ethics of medication-free research in schizophrenia; research on double blind placebo trials in major depression; the ethics and scientific perspectives of placebo controlled studies in schizophrenia etc. Research in schizophrenia and the discontinuation of antipsychotic medication should be addressed. Several questions remain unanswered regarding the morality and value of experiments conducted mainly in psychotic patients and subjects whose mental capacity and judgment are often impaired making them incapable of giving informed consent.

Furthermore there is the issue of the ethics of treating subsyndromal or subthreshold psychotic states and the ethical dilemmas that have followed the discovery of the genome and cloning, which has created a lot of controversy among scientists, ethicists and politicians.

The third section of the Madrid Declaration deals with guidelines on specific issues, which the World Psychiatric Association Ethics Committee's recognized as important to develop. Five of those specific guidelines, addressing euthanasia, torture, death penalty, sex selection and organ transplantation were endorsed by the WPA General Assembly in Madrid in 1996.

On the issue of mercy killing or *Euthanasia*, the psychiatrist should be aware that the views of a patient might be distorted by mental illness such as depression. In such situations, the psychiatrist's role is to treat the illness. On the issue of *Torture* the Madrid Declaration states that a psychiatrist should not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts. Psychiatrists should not under any circumstances participate in legally authorized executions nor participate in assessments of competency to be executed for convicts receiving the *Death Penalty*. Also, under no circumstances should a psychiatrist participate in decisions to terminate pregnancy for the purpose of *sex selection*. On the issue of Organ Transplantation, psychiatrists should not act as a proxy decision maker for patients or use psychotherapeutic skills to influence the decision of a patient in these matters.

Three further guidelines on psychiatrists addressing the media, psychiatrists and discrimination on ethnic or cultural grounds and psychiatrists and genetic research were endorsed by the WPA General Assembly in Hamburg in 1999: Psychiatrists should oppose discriminatory practices against mental patients that limit their benefits and entitlements, deny parity with other groups of patients, curb the scope of treatment, or limit their access to proper medications. The Madrid Declaration states that discrimination by psychiatrists on the basis of ethnicity or culture, whether directly or by aiding others, is unethical. On the issue of genetic research and counselling, the Madrid Declaration states that People and families who participate in genetic research should do so with a fully informed consent; that any genetic information in their possession is adequately protected against unauthorized access, misinterpretation or misuse and that care should be taken in communication with patients and families to make clear that current genetic knowledge is incomplete and may be altered by future findings. Also psychiatrists should not refer patients to genetic testing unless there are satisfactory levels of quality assurance and adequate genetic counselling. i.e. that facility should: demonstrate satisfactory quality assurance procedures for such testing and have adequate and easily accessible resources for genetic counselling.

The Madrid Declaration has been endorsed almost by all member societies from allover the world. No admission of new member societies to the WPA is permitted without endorsement of the Madrid Declaration.

Four ethical issues related to psychiatric practice are currently under discussion, namely: the ethics of psychotherapy, psychiatrists' relationship with the pharmaceutical industry and third party payers and a position statement regarding sexual involvement between psychiatrists and patients.

Psychotherapy

The draft being currently discussed states that like any other treatment in medicine, the prescription of psychotherapy should follow accepted rules for obtaining informed consent prior to the initiation of treatment as well as reconfirming it in the course of treatment if changes in the patient's condition necessitate this. If clinical wisdom, long standing and well-established practice patterns (this takes into consideration cultural and religious issues) and scientific evidence suggest potential clinical benefits to combining medication treatment with psychotherapy this should be brought to the patient's attention and fully discussed. It also states that under no circumstances shall the psychotherapist use this relationship to personal advantage or transgress the boundaries established by the professional relationship. Finally, at the initiation of psychotherapy, the patient shall be advised that the contents and any materials produced will be kept in confidence, except where the patient gives specific permission (after being well informed of the reasons) or in exceptional other circumstances when there is serious risk of harm to self or others, or in case of child abuse.

Relationship with industry

The proposed statement obliges the practitioner that he/she must diligently guard against accepting gifts that could have an undue influence on professional work; that psychiatrists conducting clinical trials are under an obligation to disclose to the Ethics Review Board and their research subjects their financial and contractual obligations and benefits related to the sponsor of the study and that they have to ensure that their patients have understood all aspects of the informed consent.

Conflicts arising with third party payers

The obligations of organizations toward shareholders regarding maximization of profits and minimization of costs can be in conflict with the principles of good practice. Psychiatrists should oppose discriminatory practices against mental patients that limit their benefits and entitlements, deny parity with other groups of patients, curb the scope of treatment, or limit their access to proper medications. Professional independence to apply best practice guidelines and clinical wisdom in upholding the welfare of the patient should be the primary considerations for the psychiatrist.

Sexual involvement between psychiatrists and patients

Since the psychiatrist-patient relationship may be the only relationship that permits an exploration of the deeply personal and emotional space, as granted by the patient, within this relationship, the psychiatrist's respect for the humanity and dignity of the patient should be build the foundation of trust that is essential for a comprehensive treatment plan. The relationship encourages the patient to explore deeply held strengths, weaknesses, fears, and desires, and many of these might be related to sexuality. Knowledge of these

characteristics of the patient places the psychiatrist in a position of advantage that the patient allows on the expectation of trust and respect. Taking advantage of that knowledge by manipulating the patient's sexual fears and desires in order to obtain sexual access is a breach of the trust, regardless of consent. In the therapeutic relationship, consent on the part of the patient is considered vitiated by the knowledge the psychiatrists possesses about the patient and by the power differential that vests the psychiatrist with special authority over the patient. Consent under these circumstances will be tantamount to exploitation of the patient. Ordinarily, sexualized therapeutic relationships cause anguish to the patient and may worsen the symptoms and distress that brought the patient to therapy. As such, sexualization of the therapeutic relationship constitutes a breach of the fiduciary duty to protect the patient from harm. Sexualized psychiatrist-patient relationships including seductive statements and non-verbal behavior interfere with the quality of the therapeutic encounter and with the aims of treatment. Breach of trust, utilization of private information for personal gain, harming the patient, and breach of the fiduciary duty are unethical practices that could also be construed as an assault and hence, being actionable in law. Under no circumstances, therefore, should a psychiatrist get involved with a patient in any form of sexual behavior.

II. Procedural Role of WPA

Two WPA standing committees are involved in issues of ethics in psychiatry.

1. WPA Standing Committee on Ethics.

The primary objectives of this Committee are to explore areas of ethical concern for psychiatry and consider developing ethical guidelines, position statements and consensus statements for use in psychiatric research, training and clinical practice. The ethics committee (EC) can provide support and advice to Member societies, at their request and depending on availability of financial resources. It will not consider individual cases or complaints, which are attended to by the Review committee. The Ethics Committee will collaborate with Member Societies towards the adoption of an ethical code of psychiatric practice consistent with the WPA's code (currently the Madrid Declaration) and towards the formation of an Ethics committee within each Society.

2. The Standing Committee on Review

The objective of this committee is to review individuals' complaints and allegations and to initiate investigations concerning abuse of psychiatry and to make recommendations to the EC and the General Assembly as to possible action. In this context, abuse of psychiatry is delineated as a violation of the principles outlines in the WPA's ethical code. Complaints on alleged abuse of psychiatry may reach the Review Committee through its members directly or through the Executive Committee. The Review Committee will promptly acknowledge the receipt of a complaint and inform the person complaining about the steps that will be taken and the foreseeable timetable. Also the Committee may initiate investigations on the violations of ethical guidelines for the practice of psychiatry contained in the Madrid Declaration and complementary guidelines. A log of complaints and a record of the procedures should be kept in the Secretariat.

The Review Committee will investigate cases carefully and diligently. Member Societies, in their respective countries are expected top cooperate with the Review committee in the investigations of cases and their eventual resolutions. The Review committee shall work for the review of cases in close collaboration with the pertinent Member Societies and Zone Representatives as well as available legal experts and local advocates. It is expected that the Ethics committee and the Review Committee will maintain close communication and possibly hold joint meetings.

Upon the issuance of the Hawaii Declaration the Russian Society of Psychiatry refused to cooperate with a fact finding mission because of authority orders and the Society withdrew from the WPA, to be reinstated as a member only after the Perestroika. Today History repeats itself as the WPA Ethical Committee is being informed of an alleged abuse of Psychiatry among the members of the Falun Gong in China. The WPA has during the last year received a large amount of information regarding the Falun Gong and its followers in China. The complaint states that persecution of the Falun Gong by the People' Republic of China allegedly began in July 1999 and has been relentless and brutal. The institutions of psychiatry in China have been allegedly employed to torture the practitioners of Falun Gong since the very beginning of this persecution*. The scale of this abuse grows rapidly. In April 2000 over one hundred Falun Gong practitioners were allegedly reported to have been detained in mental health facilities. Today the number detained, according to the Hong Kong Center for Human Rights, has grown to over one thousand. The government has recently issued a decree calling for the eradication of Falun gong, and in the wake of this decree more and more hospitals and doctors are enlisted in an attempt to destroy the will of the Falun Gong practitioners sentenced into their care. A report on "Human rights Abuse Against Falun Gong in People's Republic of China, Special Report on Psychiatric Abuse" lists six hundred cases of such abuse. These cases of alleged abuse of psychiatry violated all patient rights as stated in the United Nation's Declaration of Human Rights, issued by the General Assembly in 1948, which was signed by China, in addition to the Madrid Declaration, the ethical code of the WPA of which

* Washington Post, Agence France Press, Feb 11, 2000. The Associated Press, Feb 11, Jun 28, 2000. The New York times, Jan 21, 2000, the Voice of America, Reuters, Lancet March 8, 2000. A report on Extensive and Severe Human Rights violations, 1999-2000. Deutsche Presse-agentur Jan 20, 2000 Edited by Falun Gong Practitioners. New York Times, Reuters, the Voice of America 01-20, 2001.

the Chinese Society of Psychiatry is a member. The WPA Executive Committee and the Review Committee have received information from the Chinese Society of Psychiatry on their commitment to investigate cases of alleged abuse and to provide full information to the Review Committee, especially for the cases reported in the media. In a recent meeting in New Orleans during the APA meeting in May 2001, the EC of the WPA and representatives of the Chinese Society met and discussed the possibility of international experts from the WPA to investigate the matter both in Security and Mental Hospitals. As the Chinese Society of Psychiatry is waiting for the authorization of the Ministry of Health to start its investigation, the WPA President has written to the Minister of Health, the Minister of Public Security, the Minister of State Security and other authorities responsible for institutions where alleged cases of abuse may be in, in order to express the concern of the WPA and its willingness to collaborate in any investigation to solve the abuse if confirmed. Meanwhile the Review Committee is gathering and processing information from many sources including WPA member societies, other NGO and colleagues from different parts of the World. The Executive Committee is monitoring this process in order to make it as efficient and fast as possible.

Psychiatric Ethics and the Challenge of Culture

Whether we like it or not, the encounter of psychiatry and law keeps bringing us back to the duality that exists between our conflicting conceptions of the value of health on the one hand and our conception of liberty, integrity and autonomy on the other. Cultural, ethnic and sometimes socio-demographic data like education, age and gender, suggest different attitudes regarding patient's autonomy and informed consent. To understand this pattern one has to be familiar with the main characteristics that differentiate the position of the individual within his/her community in a traditional society as compared to a western society. Although societies should not to be taken as stereotypes, yet general common attitudes could be assumed (Leff, 1988). Table (1) outlines a very crude contrast to highlight the main differences between traditional and western societies. However, it should be noted that those differences are the mainstream norm and not an absolute description of a stereotyped behavior.

Traditional cultures have general features. They have traditional beliefs in devils, evil eye etc. (delusional cultural beliefs). The family structure is characterized by affiliated behavior at the expense of differentiating behavior. Also rearing is oriented towards accommodation, conformity, cooperation, affection and interdependence as opposed to individuation, intellectualization, independence and compartmentalization. The extended family helps in managing intergenerational conflicts. Young individuals vacillate between two worlds of values: one world is felt to be dying; the other is not yet born. For those who hold the family centered model, a higher value may be placed on the harmonious functioning of the family than the autonomy of its individual members. Although the patient autonomy model is founded on the idea of respect for persons, people live, get sick, and die while embedded in the context of family and culture and inevitably exist not simply as individuals but in a web of relationships (Blackhall et al., 1995).

Mainstream differneces between traditional and western societies

	Traditional society	Western society
A – Family vs. Individual		
• Orientation	Family and group	Individual
• Family	Extended family (not so geographical as before, but conceptual)	Nuclear
• Individual	can be replaced. The family should continue	Irreplaceable, self pride
• Status	and the pride is in the family tie Determined by age and position in the family, care of elderly	Achieved by own efforts
• Relationship between kin	Obligatory	Determined by individual choice
• Relatives	Extensive knowledge for distant	Restricted only close relatives
• Marriages	Arranged, with an element of choice dependent on interfamilial relationship	Choice of marital partner, determined by interpersonal relationship
B- Decision making	Dependent on the family	Autonomy of individual
C- Health and disease concepts		
• Locus of control	External	Internal
• Attribution of illness and recovery	Dependence on god's will	Self determined
• Family care for the mental patient	Pride in family	Community
D-Doctor – Patient relationship		
• Physician's decision	Is still healthy	Mistrust
• Malpractice suing	Respect and holiness	doubt
	Rarely	Common

We would like to stress that we are not forwarding those patterns of interaction to bypass the implementation of ethical codes in different cultures. It is still our primary mandate to secure an ethical foundation for our practice and not to leave our patients at the mercy of the good intent of the practitioner. We just wish to highlight that the guarantee of ethical practice is not merely by drafting statements of conduct. Implementation of the ethical codes needs tact and understanding of the local constraints in order not to further jeopardize the ill-defined image of the psychiatrist and the specialty of psychiatry. In any case, the patient's wishes should be respected allowing patients to choose a family centered decision-making style, which does not mean abandoning our commitment to individual autonomy or its legal expression in the doctrine of informed consent. Rather it means broadening our view of autonomy so that respect to persons includes respect for cultural values which they bring with them to the decision making process.

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