

FORUM

THE DECLARATION OF MADRID AND CURRENT PSYCHIATRIC PRACTICE: USERS' AND ADVOCATES' VIEWS

Introduction

Norman Sartorius
President, World Psychiatric Association

Current Opinion In Psychiatry 1999, 12:1-2
1999 Lippincott Williams & Wilkins 0951-7367

The 10th World Congress of Psychiatry took place in Madrid in August 1996. Some 14000 psychiatrists from nearly 100 countries attended the Congress - the largest international Congress of psychiatry ever held. There were numerous scientific sessions, workshops, courses, lectures and debates. Meetings of various component bodies of the World Psychiatric Association (WPA) were also held, the most important of these the Triennial General Assembly of the Association.

The Assembly operating under the recently revised Statutes and By-laws of the WPA considered a large number of issues. No doubt the most important among them was the adoption of a code of professional behaviour for psychiatrists. The discussion of the text of this item did not take too much time: this was not surprising in view of the fact that the text of the declaration drafted by the Ethical Committee of the WPA had been circulated to all member societies, to the zonal representatives, to the heads of Spa's scientific sections and to a number of WPA advisors several times and that it was possible to accommodate the comments received into the text that was submitted to the Assembly. A few significant additions were made, however. One of these additions concerned the duty of psychiatrists to fight against the discrimination of the mentally ill in the eyes of insurance companies and governments that do not ensure parity between mental and physical disorders in reimbursement schemes, sickness benefits and in other respects.

The Assembly finally adopted the Declaration of Madrid by acclamation and it was agreed that every effort will be made to ensure that psychiatrists worldwide follow the guidelines presented. Psychiatric societies, for example, that will not ratify the Declaration will no longer be allowed to be members of the WPA and a basic condition for new applicant societies will be their endorsement of the Declaration and the acceptance of the principles that it contains.

This was not the first document concerning the ethical duties of psychiatrists that the WPA has produced, but it was the most recent and the most comprehensive so far. In addition to the general principles embedded in the Declaration, the WPA Standing Committee on Ethics also produced a series of guidelines about the behaviour of psychiatrists in special situations, for example when it is proposed that a psychiatrist participates in procedures of euthanasia.

A few days after the adoption of the Declaration the members of the Standing Committee met again, this time to plan the continuation of the work on ethical issues concerning the WPA. This, they proposed, should include the production of a series of additional guidelines, for example in relation to genetic investigations of mental illness, and further work on the formulations used in the Declaration of Madrid to maximize the clarity and explicitness of ethical concerns that should govern the behaviour of psychiatrists in their clinical practice, their teaching and their research. While engaged in these discussions, the members of the Standing Committee were conscious of the fact that this second phase of work on the WPA consensus about ethical issues will be more arduous than the first.

First, the Standing Committee suggested, the formulations should be left untouched until they have been translated, reviewed and tried out in practice. Second, they stressed that now that a fairly comprehensive text is available, suggestions for improvement should be sought from those outside of the profession. A much broader process of consultation was therefore proposed, involving other non-governmental organizations assembling professionals in related disciplines as well as all those others (i.e. patient organizations, governments, family organizations, industry) that are involved in the provision of care to people with mental illness. This should allow an improvement of the texts and contribute to the awareness of all concerned that the guidelines exist and that a deviation from the agreed upon principles stated should not be tolerated. Third, the Standing Committee felt that it would be important for the WPA to also explore possible collaboration with other professional groups in order to help them to formulate guidelines about the ethical behaviour of their members, because the need for such guidelines and explicit statements about a profession's behaviour is just as present in other health (and other social sector) disciplines as it is for psychiatry. Finally, the Standing Committee on Ethics recommended that symposia and workshops concerning ethical issues should be included on the agenda of all WPA regional and global meetings.

The Executive Committee of the WPA accepted these proposals and decided to keep their implementation under constant review. It initiated some of the necessary action itself for example, it included specific requests for information about ethical matters into a survey of all WPA components and requested psychiatric societies to explicitly accept the Declaration of Madrid as a set of principles for the behaviour of their members. The Executive Committee also set dates for the finalization of a second set of guidelines for special situations. This second set will be presented to the General Assembly of the WPA during its 11th Congress in Hamburg in August 1999.

The invitation to representatives of patient and family organizations and to human rights activists to give us their comment on the Declaration of Madrid is part of the same effort. The views of all those who are - in one way or another - partners in the effort to improve the quality of psychiatric care and the quality of life of people with mental illness are of vital importance if the WPA and the psychiatric profession is to continue progress towards effective, humane and scientifically based practices in psychiatry and relevant teaching and research.

These comments could have been requested and used in the work of the Standing Committee without publication at this stage, but the Executive Committee decided against this and requested Professor Mario Maj, the WPA Secretary for Publications, to make arrangements which will allow the publication of the comments received so as to stimulate debate and involve as many people as possible in this important project.

The work on the Declaration of Madrid and its possible successors will not finish in Hamburg. Guidelines concerning the practice of a medical discipline have to be constantly reviewed and improved to follow progress in knowledge about mental illness and mental health as well as overall socioeconomic development. It is my pleasant duty to thank the contributors to the debate published in this issue of Current Opinion in Psychiatry the WPA's official journal - and to express the hope that they, as well as the many others whom we have invited to help us, will continue to give us their views and allow us to benefit from their ideas and experience.

The comments that follow make a variety of suggestions: some of them are directed at the Declaration of Madrid, a document that should govern the behaviour of psychiatrists, others are comments concerning the implementation of mental health programmes in which psychiatrists play

a role, but which are managed by governmental and other agencies. In relation to these comments, psychiatrists can at best act as advocates of their patients' interests; in this they could and should become one of the groups that will fight for better care, more resources for families and carers, well-equipped facilities, the creation of job opportunities for those with mental illness, and so forth.

FORUM - THE DECLARATION OF MADRID AND CURRENT PSYCHIATRIC PRACTICE: USERS' AND ADVOCATES' VIEWS

Users' and advocates' views

Margaret Pedler, Margaret Leggatt, Bas van Raay, Peter Lehmann, Nirmala Srinivasan, Judi Chamberlin, Adrienne Szokoloczy-Grobet

Current Opinion in Psychiatry 1999. 12:3-1 1
© 1999 Lippincott Williams & Wilkins 0951-7367

Margaret Pedler, MIND

There is still a long way to go in England and Wales to achieve the 'fair and equal treatment of the mentally ill' advocated by the Declaration of Madrid.

The Mental Health Act 1983 allows compulsory detention in hospital and compulsory treatment not only on grounds of the patient's safety or protection of others, as advocated in the Declaration, but also where it is deemed necessary for the person's own health. Between 1990-1991 and 1995-1996 there was a 45% increase in compulsory admissions. This allows imposition of treatment such as drugs with damaging side-effects or electroconvulsive therapy (ECT) on those who do not accept the need for treatment regardless of capacity. Disagreement with treatment is often dismissed by professionals as lack of insight. This removes the power of free decision over for example whether the symptoms of the illness are preferable to the effects of the medication.

MIND wants to see

(1) A full debate about the possibility of linking powers of compulsory treatment with incapacity. This would enable there to be equity between treatment for physical and mental disorders. Is it right that a person with capacity should be less entitled to refuse treatment for, say, depression than for diabetes - a refusal which might be similarly life-threatening? If there are grounds for compulsory detention on the basis of risk to others, why should this apply only to those with mental health problems when greater risk may be posed by those who drink to excess on a Friday night? These are profound ethical issues which warrant further discussion.

(2) A ban on ECT without fully informed consent, except for those without capacity in cases of urgent necessity when they do not object. ECT poses a serious ethical dilemma in that some people find it helpful, others harmful, and there is no way of knowing which in advance. For suicidal people to lose power so utterly as to be given ECT against their will may potentially strengthen their resolve to determine their own destiny by taking their own life.

(3) The involvement of users in all stages of planning; running and evaluating services and development of the range of community based services that users say they want. This will include 24-hour crisis services, support for self help groups (such as those for people hearing voices) and a range of therapies. Users are far more likely to engage with services that they feel address

their needs. The availability of community support in a crisis also offers a less restrictive environment than a hospital, in accordance with the Declaration's principles.

(4) More information given to patients on drug treatments. Mind operates a scheme - the Yellow Card Scheme - for people taking psychiatric drugs to report the adverse effects they are experiencing. The scheme also asks what information was given about side-effects. 'No' was given as the answer to the question 'were you warned of possible adverse effects?' by 71% of respondents whose main drug was a selective serotonin reuptake inhibitor antidepressant and 77% of those whose main drug was an antipsychotic. How can there be partnership or free and informed decision making if there is not sharing of information?

(5) Measures for assessing mental health services that are based on their contribution to encouraging social inclusion and involving users in the wider community. People with mental health problems are one of the most excluded groups in society. There is clear evidence that inequalities such as poverty, poor housing and joblessness contribute to poor mental health; that those diagnosed with mental health problems suffer discrimination and stigma in their daily lives, which for some is worse than the original problem and inhibits recovery; and that the situation is particularly difficult for people from black and minority ethnic and other disadvantaged groups who suffer double discrimination.

(6) Rejection of the proposals in the Council of Europe Convention on Human Rights and Biomedicine (which the UK has not yet signed) that non-therapeutic research on a person not able to consent could be ethical if strict safeguards were provided. In our view such research can never be justified.

Margaret Pedler, MIND - the Mental Health Charity, 15-19 Broadway, London E 15 4BQ, UK

**Margaret Leggatt,
The World Schizophrenia Fellowship**

The World Schizophrenia Fellowship is an international organisation that provides information, education, advocacy and support to the world family self help movement. The voting members are national family organisations. Other members include regional family groups, individuals coping with disabling mental illness and mental health professionals. These comments on the Declaration of Madrid are written from a predominantly family perspective.

The discovery of antipsychotic medications and the increasing trend towards community treatment of the mentally ill have given the patient's family a primary care-giving role. Families face difficult problems in this role; problems which are often not fully appreciated by many psychiatrists. The result has been that the needs of families have been ignored. In developing countries such as India, Africa and South America where there are very few psychiatrists, families are often the only providers of care and protection. They carry a heavy burden without accurate information, education and support to assist them.

In western countries, some psychiatrists still consider the families as 'pathogenic'. Recent scientific developments indicate a neurobiological basis for the major psychotic disorders so families should no longer be blamed for causing these illnesses. When families experience problems which have existed before the onset of mental illness, and frequently as a result of the mental illness, there must be help available.

Unless families worldwide, and particularly in the developing world, are not given support, they will be unable to continue caring effectively. This is not 'in the best interest of the patient'.

In setting out ethical guidelines for the practice of psychiatry worldwide, the Declaration of Madrid does not adequately acknowledge or pay attention to the important care-giving role of the family of the patient.

Family members can assist psychiatrists to provide 'the best therapy available in consistence with accepted scientific knowledge and ethical principles'. They can give 'advice in areas of their work in which they (psychiatrists) do not have primary expertise' (point 1 Declaration of Madrid). Family members have intimate knowledge of their mentally ill relative, so they should be listened to very carefully, They have information as well as social, emotional and material resources (although this varies considerably) that psychiatrists should utilise in planning their patients' comprehensive treatment and care.

At the same time, psychiatrists can help family members overcome other problems that may be interfering with their capacity to care effectively. Families must be included as a valuable resource, not only in the day-today care for their mentally ill relative, but as advocates for the better and more 'equitable allocation of health resources', particularly the newer medications. In countries where family organisations are well developed, the role of advocacy by families has produced some amazing results.

'Since 1980, twenty-two controlled studies of long-term cognitive-behavioural interventions integrated with optimal drug treatment and case management' ('statement from an annotated bibliography prepared for the World Schizophrenia Fellowship by Ian Falloon, Professor of Psychiatry, University of Auckland, New Zealand) have shown many positive results for patients primarily with schizophrenia when their family members and friends have been included as partners in treatment and care, Major exacerbations of psychotic symptoms are significantly reduced. There are fewer hospital admissions, better compliance with medications, and reduced social disabilities. Family burden is lessened and an improvement is shown in the emotional and physical health of family members. Although there are some small additional costs in the beginning, these are more than compensated for by reduction in the need for acute hospital admissions and the expenses incurred by families through social disruptions (often involving the law) associated with treatment delays. The involvement of families, therefore, leads to high cost effectiveness.

Many psychiatrists seem unaware of these scientific studies and families are still left unsupported. If it is 'the duty of psychiatrists to keep abreast of scientific developments' (point 2) and to incorporate these developments into their treatment regimes, how is this to happen? Good research results are frequently not implemented in practice.

Family members who have a role as primary carers, should also be accepted as partners 'by right in the therapeutic process' (point 3), and co have relevant and appropriate information given to them so that they know how best to help their mentally ill relative. Often the information families can provide to psychiatrists helps towards knowing if the patient's decisions about his or her treatment are rational.

When a patient refuses to allow involvement with his or her family, the psychiatrist needs to find out if the patient's reasons are legitimate or whether the patient's desire to exclude the family is part of his or her symptoms. In the latter instance when families have been excluded, the end results for both the family and the patient often have been disastrous. The psychiatrist has not

been able to make an accurate assessment and the treatment plan has not been adequate. Families suffer anger, frustration and resentment, knowing that they have information that would help the doctor and lead to a better outcome for everyone. For them, this adds enormous stress to existing high levels of burden. This does not provide an emotional atmosphere in the home that is conducive to the patient's recovery.

From the comments already made, it follows that families should not be consulted only when the patient is incapacitated to the point where he or she is likely to endanger life (point 4). Collaboration between clinicians, family carer and patients should be seen as 'best practice' from the onset of the illness and for as long as is required

Assessment (point 5) should, therefore, involve seeking evidence from family members, friends, neighbours or people who are in close contact with the patient. Patients often welcome this, particularly when it helps their family and friends to understand their illness and its effects.

Involvement of the family has caused psychiatrists to worry about breaching patient confidentiality, but this does not need to interfere with the relationship of trust between psychiatrists and patients (except in those cases 'when serious physical or mental harm to the patient or to a third person could ensue if confidentiality were maintained' - point 6). Families do not want to know confidential information that is shared between doctors and patients, but they do need to know about the symptoms and how to manage them, the medications and possible side-effects, what mental health services can offer, and expect that psychiatrists can help them with their own personal difficulties if and when these occur and interfere with their capacity to be effective care-givers.

In the preamble to the Declaration of Madrid, it is stated that 'medicine is both a healing art and a science'. We now have reputable scientific studies that show many positive results for patients when caring family members and friends have been included in their treatment and care. The aim of working with families ~ means that psychiatrists in the future will need appropriate education and training in how to include their patients' families. The Declaration of Madrid might consider how this could be reflected in its statement.

Margaret Leggatt, President, World Schizophrenia Fellowship, 238 Davenport Road, Box 118, Toronto, Ontario M5R 1J6, Canada

**Bas van Raay,
European Federation of Associations of Families of Mentally Ill People**

The European Federation of Associations of Families of Mentally Ill People (EUFAMI) is very pleased to be invited by the World Psychiatric Association (WPA) to make comments and remarks on the Declaration of Madrid. In our seminar 'best practice in psychosis and schizophrenia', held in September 1998 in Bilbao, the Declaration was presented to and discussed with our representatives.

First, EUFAMI is glad that such ethical codes exist because they give 'patients' and carers an idea of what one can expect and what not. Second, the document can be used both by Associations of Psychiatrists and by consumer organisations for quality assurance; that is a positive thing.

The fact alone that consensus has been reached in such a huge organisation as the WPA can be considered a major achievement. However, looking at the Declaration from the carer's point of

view, and specifically at the number of items that refer to carers (one! number 4), EUFAMI considers the Declaration an unsatisfactory document.

Item 4 of the Declaration states that 'when the patient is incapacitated and/or unable to exercise proper judgment because of a mental disorder, the psychiatrist should consult with the family . . .'. This item is in accordance with most mental health acts in Europe. It is in fact stating that psychiatrists cannot break the law. Therefore this is nothing new, it is a statement of fact. EUFAMI has the strong opinion that carers should not just be consulted in a crisis. There should be ongoing consultation.

It would have been much more interesting, for EUFAMI, to know what the ethical standards of psychiatrists should be towards carers, according to the WPA, when there are no legal rules involved. In fact, there is no word on this subject and we do not think this is good enough. This is not only because carers play a vital supporting role~ for people with a severe mental illness, but also because there are existing examples of documents in which there is a particular focus on the role and place of carers who deal with mental illness.

The Dutch Consensus Document on Schizophrenia is such an example. This document states the minimal requirements for the treatment of schizophrenia or, in other words, the minimal standards people with schizophrenia and their carers are entitled to when it comes to a treatment. The document was endorsed by the Dutch Psychiatrists' Association, the Dutch Association of People with Schizophrenia, and Ypsilon, The Dutch Schizophrenia Fellowship (families). Four of the 12 items in this document were mentioning family under the headings 'relapse prevention', 'guidance and psychoeducation' and 'mental health services'. Those items are reported here:

- Clear and written arrangements should be made together with the patient and the relatives on how to cope in case of a psychotic relapse or likely relapse, so that the treatment can be adapted immediately. Both the patient and the relatives should have the name and telephone number of the health-assistant who should be informed in this case.
- Patients should get individual and specialised guidance in which relatives and others close to the patient should be involved. There should be attention for the process of acceptance of the illness.
- The patient and the family should receive both verbal and written information about schizophrenia, the applied treatment, the expected results and possible adverse side-effects. Family members should be informed about organizations of family members of people with schizophrenia and other advocacy groups.
- Mental health services should have a treatment protocol for patients with schizophrenia. Such a protocol should meet at least the requirements of this consensus document.

EUFAMI is of the opinion that documents such as the Declaration of Madrid should not only confirm reality as it already is (or is supposed to be), but also challenge common practice to advance the ethical standards of psychiatry. Documents of this type should not be used as an echo of reality, but as an explorer of new frontiers.

EUFAMI is determined to act like an explorer. EUFAMI therefore invites the WPA to make an effort to take up the issue of family involvement and adapt the Declaration of Madrid in such a way that it reflects an awareness of the role of carers in severe mental illness.

Obviously, an ethical standard on how to approach families and their role in psychiatry needs to be drawn up. EUFAMI is, of course, very willing to assist in this process if it is considered to be appropriate.

Bas van Raay, President, EUFAMI, Groeneweg 151, B-3001 Heverlee, Belgium

**Peter Lehmann,
European Network of (ex-) Users and Survivors of Psychiatry**

We list here some remarks and points that should be added, in our opinion, to the Declaration of Madrid.

Psychiatrists have to reflect that their measures can only suppress 'symptoms' with medical methods because treated persons regularly suffer from emotional problems of social nature and not from bodily diseases. To call all subjects 'infirm' is libelous.

To base ethical behaviour on the psychiatrist's individual sense of responsibility allows him or her to act arbitrarily. Ethical psychiatric behaviour should be based primarily on the treated person's individual ethic, on the Universal Declaration of Human Rights and other United Nations documents, especially the right of freedom from bodily harm, and on the civil and criminal law.

At any given facility, there should be sufficient space for the number of inmates or patients admitted. There should be phone boxes for inmates or patients in every psychiatric ward. There should be easily visible coin operated telephones at the entrance hall of each psychiatric institution. In each psychiatric ward there should be an easily visible notice stating that inmates or patients can get writing paper, envelopes and stamps if wanted. There should be notice boards in every ward on which local, regional and national organisations of (ex-) users and survivors of psychiatry can put uncensored information. For each inmate or patient there should be the offer to have a daily walk in the open air for at least 1 h. On each ward there should be a kitchen where inmates or patients can prepare food and drinks around the clock. The nonsmokers' right to have good air to breathe should be guaranteed. The smokers' right to smoke as long as they want should also be guaranteed. Meals served to inmates or patients should meet recommended minimum nutritional requirements. The needs of people who want special diets should be met.

Psychiatrists should provide not only relevant information to empower individuals to make a rational decision; they should give all information about the risks of treatment which are possible and not to be excluded.

It should be acknowledged by psychiatric associations and/or by reforms of the law that advance directives (made during non-doubted states of normality) about wanted and unwanted treatments have to be respected.

Psychiatrists who treat without informed consent should lose their medical approbation. The national psychiatric associations should have a section particularly dedicated to human rights. No decision should be made without the consent of national organisations of (ex-) users and survivors of psychiatry.

(Ex-) users and survivors of psychiatry should be involved in the education (including the boards of examiners) of psychiatrists meaningfully and on a well paid level. Organisations of (ex-) users and survivors of psychiatry should be acknowledged as organisations of individuals with a high level of

expertise. There should be ombudsmen and ombudswomen who are (ex-) users and survivors of psychiatry at national levels.

There should be bodies including (ex-) users and survivors of psychiatry specifically charged, at national levels, with monitoring the respect of human rights of people with mental disorders or who are said to have mental disorders. The task of these bodies should include the registration of new treatment measures and decisions of ethics" commissions in research fields. Help and support should be made available by staff to family members, friends and persons of trust.

Treatment, if ethical, should be primarily based on nonpharmacological measures such as psychotherapy. Psychosurgery and other intrusive treatments which may possibly cause irreversible damage, such as psychiatric drugs, electro- and insulin shock treatments, should never be carried out on an involuntary inmate or patient without informed consent. Sterilisation, abortion or any treatment that can be harmful for the inmate's or patient's (future) children should never be carried out on people with mental disorders or who are said to have mental disorders.

Clinical trials and experimental treatments should never be carried out on an involuntary inmate or patient without informed consent. The institutions and persons carrying out these trials should be obliged to prove that resultant damage is not a result of these measures.

Information obtained in the treatment relationship should principally be kept in confidence. Written records should be appropriately maintained for all inmates and patients, who should be entitled to access their own records at any time and without justification. Copies of records should be available. Inmates and patients should have the right to revise records or to add commentaries.

Peter Lehmann, Chairman, European Network of (ex-) Users and Survivors of Psychiatry, Zabel-Krüger-Dam 183, D-13469 Berlin, Germany

**Nirmala Srinivasan,
AMEND**

In developing countries such as India, professionals must have a sense of social responsibility to bring about interventions that are beneficial to the community. Hence, all professionals are agents of change and psychiatrists are no exception to this.

India has a rich independence movement history that marks our struggle against the British but, unfortunately, it did not spawn a civil rights movement or even human rights movement, for the simple reason that the masses were under the effect of Gandhi and had full faith in the national government. These historical and political legacies are greatly responsible for the lack of civil discourse in our daily lives. The mental health system in India is part of this wider environment. The deficiency of mental health professionals, especially psychiatrists, in relation to demand is a major handicap for the country as a whole. Within these limitations, whatever psychiatrists can achieve is highly appreciated.

At the same time, however, care can be taken to see how far the services of psychiatrists fulfill the mandate given by the society in terms of various aspects of psychiatric practices mentioned in the Declaration of Madrid. Our suggestions are listed below.

- (1) Psychiatrists must impart information to the patient and/or the family in the first few sessions. This information must include the nature of the illness, drugs required, side

effects of drugs, and support required. This is not done in all cases at present. In fact, my group has been asking for small booklets to be published by psychiatrists with pictorial illustrations on the above. Because there have been no results so far we, as a self help group, are planning to do this very soon. Sharing information fully and repeatedly is a must: the regional psychiatric societies can undertake to do this on a nationwide basis. Information is empowerment. By providing information, the partnership between professionals, families and users is established.

- (2) Medication alone is not enough, we are told. Whenever therapy for the patient and/or family is required, the psychiatrist must make an effort to network with experts who are not psychiatrists but are in related fields so that the treatment progresses. This is unfortunately not done in India, particularly by some private practitioners.
- (3) Some certifying body internationally recognised by the profession must inspect the quality of services in the profession. This internal assessment must act as a self-monitoring system: wherever required external agencies must be involved. Are psychiatrists open to this? In countries such as India, where citizens are not oriented to civil or human rights, the profession must take the lead in quality and service assurance as an ethical initiative.
- (4) State of the art drugs are not available in all countries simultaneously because of trade agreements between the countries. For example, clozapine reached India nearly 2 years later than elsewhere in the world. In fact, once again my group `AMEND' took the lead to obtain it, but we were just swept over by the bureaucratic rules. Also, from my experience, if families ask for information on the latest drugs, psychiatrists do not like it. They dismiss the issue by saying that all drugs are similar, one slightly better or worse than the other. Their clinical knowledge will no doubt be correct, but psychiatrists must realise that users and consumers have the right to the latest drugs all over the world, without which psychiatric practice is incomplete. Hence, once again, because the vast majority of consumers in India are illiterate, professionals must ensure general availability of drugs.
- (5) There is a loc of secrecy shrouding drug trials in India. Of late, thanks once again to the advocacy of my group, knowledge is being made public. Of course, we are not demanding the efficacy factor co be made public, but at least we must know that trials are being conducted and on what basis the selection of candidates for research is made. Probably, and this is only my hunch, not all patients are informed because the entire social milieu of the psychiatrist-patient relationship is very different here to in the west. If I recall, when clozapine was introduced in India, some patients were subjected to lumbar puncture. In my case, the concerned doctor explained to my family why it was optional and the reason why it is done. I know in one other case, however, I had to tell the family that it was not relevant to their relative's treatment but was being done for some research purposes. Because I do not have data on this, I am unable to comment further. That ethical standards should be observed in sampling research individuals is very important. The Declaration of Madrid focuses on the patient alone, whereas in a country such as India the family cannot be left out of any information pertaining to their ward.
- (6) To ensure best practice is the responsibility of the professionals. There can be no two opinions about it. At the same time, in times of emergencies we have no help to get the patient to the hospital. In India, most users stay with families. If there is a crisis and the patient becomes violent, psychiatrists do not (or cannot) visit the patient, nor facilitate a visit by other nursing staff. Neither are ambulance facilities available. According to Indian law, the magistrate's signature is required and the police have to come to move the patient.

First, our police force is not enlightened about disturbed mentally ill persons. Second, how can families run around for a magistrate's signature with an ongoing crisis at home? On occasions, no magistrate will be available. Given such situations, we must broaden the definition of treatment beyond writing prescriptions.

Nirmala Srinivasan, Association of Families of the Mentally Disabled, AMEND, C-358, Jalvayu Viha 2, Kammanahalel Manka, St Thomas Town, Bangalore 560084, India

Judi Chamberlin
National Empowerment Center

The Declaration of Madrid is a statement of the ethical standards of the World Psychiatric Association. Although it speaks in its preamble of the obligation of psychiatrists to 'advocate fair and equal treatment of the mentally ill, and social justice and equity for all', this principle is immediately contradicted in the very first numbered paragraph, which refers to 'interventions that are the least restrictive to the freedom of the patient'. Such a statement simply would not appear in the ethical principles of any other field of medicine and therein lies the key difference between psychiatry and other medical specialties.

This difference is reflected throughout the document. Principle 3 speaks of 'mutual trust and respect' between patient and doctor and the necessity for the patient to make 'free and informed decisions' concerning treatment. But what principle 3 grants is immediately negated in principle 4, which provides for decisions to be made by the patient's family members or legal counsel if 'the patient is incapacitated and/or unable to exercise proper judgment because of a mental disorder'. While incapacity is recognized in all fields of medicine (for example, it is ethical to administer emergency treatment to an unconscious person without obtaining consent), the 'inability to exercise proper judgement' is quite another matter. When the psychiatrist is both the person who determines that the judgement is 'improper' and the one implementing the treatment, an inevitable conflict of interest is created. Disagreement with one's psychiatrist becomes, in practical terms, impossible. Psychiatric patients, unlike the patients of other doctors, no longer have the right to be wrong.

Nor do psychiatric patients have another basic right all other medical patients have: the right to choose whether to be patients at all. It is somewhat surprising that the words 'involuntary commitment' appear nowhere in the document, despite the fact that large numbers of psychiatric patients (the percentage varying from country to country) did not choose their status and often quite accurately perceive the psychiatrist not as their doctor but as their jailer. The document does not even attempt to justify the role of the psychiatrist in the involuntary commitment process, despite the fact that psychiatric testimony is an essential element in the legal process of depriving an individual of his or her liberty for the purpose of 'treatment'. In a document that makes repeated references to 'the therapeutic relationship', patient 'autonomy' and 'mutual trust and respect', the absence of the recognition of the real relationship between psychiatrists and many of their patients is all the more perplexing.

If the stirring phrase 'social justice and equity for all' is to have real meaning, surely the only meaning it should have is the elimination of all legal and social barriers to full citizenship for those diagnosed with mental illness. Similar to people who may or may not have other illnesses, such individuals should be free to seek out, or to reject, any services that may assist or ameliorate the condition, and such judgement should be placed in the individual. The paternalistic stance that holds that mental illness, and mental illness alone, should abrogate basic citizenship rights is in

essential conflict with the plain meaning of the document's ringing endorsement of social justice and equity.

It would be far more honest, although hardly to be expected, that a psychiatric declaration of ethical standards would baldly state: 'we, as psychiatrists, believe that those whom we determine to be mentally ill lack the ability to make decisions concerning their treatment, or even to recognize that they are ill at all, and we therefore propose to treat them for their own good, even if over their express objections and against their will'. If such a belief was clearly stated, perhaps we could then embark on a more honest discussion of ethical principles in psychiatry. Because the Declaration of Madrid prefers to gloss over such realities, it becomes difficult to discuss these ethical questions in any meaningful way.

It would also be helpful if the document recognized the existence of international legal principles such as the United Nations Universal Declaration of Human Rights, which may impose limitations on psychiatric practice beyond those which psychiatrists may choose to impose on themselves.

Judi Chamberlin, Center for Psychiatric Rehabilitation, National Empowerment Center, 599 Canal Street, Unit SE, Lawrence, MA 01840, USA

**Adrienne Szokoloczy-Grobet,
Les Sans Voix Association**

I have been asked to comment on whether the principles outlined in the Declaration of Madrid are actually fulfilled in the practice of mental health services, according to my experience, and whether there are other points that should be added to the Declaration. With regard to my legal training, I could only do this if I first determined what the principles are and what they actually mean. I could have to answer such questions as why the World Psychiatric Association felt the need to update the Hawaii Vienna declarations? Why have all the paragraphs been rewritten? Why have certain words been changed, certain things omitted, certain others added? What is the true purpose of the different guidelines? What is the exact meaning of the significant terms? I would then have to analyse mental health services and practices, no two of which are totally alike. In short, to be anywhere near specific, I would need to write a book not a short article. It seems to me I would be more useful by making a few general comments.

Having become, thanks to 16 years of advocacy, a connoisseur, so to speak, of the dialectics of psychiatry and of what actually goes on in psychiatric institutions, a number of terms in the Declaration of Madrid stand out to me as though written in red ink: 'care and protection of those who are ill', 'fair and equal treatment of the mentally ill', 'equitable allocation of health resources', 'the scientific frontiers of psychiatry'. Read with psychiatrists' complaints in mind - that their profession is looked down upon and has a questionable reputation even among doctors, that mental health is not given sufficient weight or money in public health policies, that psychiatrists earn less than their colleagues in other specializations - it seems obvious that the Madrid 'review of ethical standards' aims primarily at refurbishing the profession in the eyes of the public and the allocators of funds and not at improving the lot of the 'mentally ill'. Furthermore, the expressly stated or implied appositions suggest, among other things, that they who (supposedly) know - because of the scientific knowledge they (allegedly) possess - are face to face with those who (supposedly) are ill and do not even know that they are. The reality behind these phrases is that of a legalized power structure where one category of persons can unquestionably - and often unquestioned - exert power of life and death over another category.

It is my feeling that psychiatry will not improve its image or succeed in getting more public money until it improves its methods. In the long term, you cannot successfully sell a bad product even if the packaging is beautiful. When I read the Declaration, it immediately occurred to me that an effort had been made to improve the packaging, but I wondered whether much thought had been given to the product. I noticed that all references to compulsory treatment had disappeared, but so had the 'possible alternatives' and the need to give patients 'the opportunity to choose between appropriate and available procedures'. I could only conclude that the new emphasis on ethics probably did not mean there ought to be, or there was going to be, any change in habits. Habits of speech, of thinking and of doing.

The phraseology of psychiatry and its power politics are in fact so entrenched in everyone's minds, including those of patients and of their advocates, that it takes a moment of reflection to realize there is something the matter with the contents of the following sequence:

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. It is the duty of psychiatrists to provide the patients with relevant information so as to empower the patient to come to a rational decision according to his or her personal values and preferences.

Try inverting the words patient and psychiatrist (or therapist) in these sentences and you immediately get the feel of the relationship deemed to be ideal (the psychiatrist remains indisputably the boss)!

What else? Psychiatric patients do not necessarily want to be partners with their psychiatrist, especially if they do not appreciate the 'therapeutic process'. However, they do want to be looked at, first and foremost, as human beings, as persons. Some, but not all, accept the identity of being sick persons, but even for them that is not their whole identity.

Psychiatric patients want respect. Unconditional respect on the part of the therapist and not respect provided they make the 'right' decisions. Mutual 'trust and respect' are required not to 'allow the patient to make free and informed decisions' but to ensure that the patient has the right to be what he is at a given moment and that his qualities and potential are recognized. As to the 'mutual' quality of such trust and respect, how can a patient trust and respect a person who doesn't recognize him for what he really is and wants for himself, who claims he is mentally ill, does not know what is good for his own health, is dangerous for himself or others, and who locks him up, ties him up, gives him forced injections etc?

And what of 'providing the patient with relevant information so as to empower the patient to come to a rational decision'? Why is it that psychiatrists do not understand that they also need to be provided with relevant information, that their patients know much more about themselves than the psychiatrist does and may well know much more about their 'illness' and the ways to 'treat' it?

How is it that information about risks is apparently not considered relevant because it is not given and only 'unpleasant side-effects' are sometimes recognized? I have actually heard psychiatrists state publicly that patients cannot be told of the risks because then they wouldn't take their medication.

Why are patients not given genuine choices, that often no real alternatives (for instance alternatives to neuroleptic medication) are available? Why is it that most of their problems are 'medicalized' and remain unresolved and unprevented and that even their medical problems are

not properly diagnosed and handled? Who is to judge whether a decision is 'rational' or not and why should patients have to come to a rational decision?

Years of working with psychiatric patients who have been committed and treated against their will in psychiatric institutions have convinced me that there is no justification for present day psychiatric services which are largely based on routine methods and especially, all too often, on violence towards patients, with seclusion, restraints, forced medication, threats, punishment, and other forms of inhuman and degrading treatment, including neglect. I am convinced that all patients should be equal before the law and that the special discriminatory legislation applicable to psychiatric patients serves only the purpose of perpetuating a system which, instead of helping patients, is in fact detrimental to their physical and mental health.

Hopefully a day will come when medical practitioners all over the world will adopt an individualistic holistic approach to help their patients. Hopefully a day will come when people will not be labeled 'mentally ill', will not receive dubious or erroneous psychiatric diagnoses, will not be interned in special institutions, will not be treated against their will, will not be administered dangerous treatments, and will not be 'protected' by special laws which in reality restrict their rights and protect the health practitioners. Hopefully a day will come when the necessary social, economic and health policy measures will be taken to promote mental health, prevent mental distress, guarantee proper care and respect for all patients and ensure non-discrimination and social integration for all handicapped people, including the psychologically and socially handicapped, which is a term I sometimes find useful, although many 'survivors of psychiatry' do not view themselves as having ever been handicapped or mentally ill, or users or consumers of services because psychiatry was forced upon them.

Last summer, during the congress of the World Federation for Mental Health, we visited a new psychiatric hospital with its spick-and-span seclusion room (blue sheets on the bed and a tube of Vaseline to apply before fastening the leather shackles), its empty park, empty music room and empty swimming pool, its diminutive inner courtyards with male smokers rocking back and forth, its women's bedrooms with waiting inmates restlessly moving from one foot to the other, its dining room where nobody was talking to anyone else but some patients were endlessly muttering to themselves. The director rashly asked for our impressions. I told him I felt like a woman from the International Red Cross visiting a concentration camp.

I hope to retain the faculty of getting angry and even verbally abusive when I am confronted with such realities. And I hope that a new generation of psychiatrists will find them unethical!

Adrienne Szokoloczy-Grobet, Co-Chair, Les Sans Voix Association APRES, Case Postale 235, 1211 Geneva, Switzerland

FORUM

THE DECLARATION OF MADRID AND CURRENT PSYCHIATRIC PRACTICE: USERS' AND ADVOCATES' VIEWS

Comments

Otto W. Steinfeldt-Foss, Dieter Birnbacher, Ahmed Okasha

Current Opinion in Psychiatry 1999 12:12-16
1999 Lippincott Williams & Wilkins 0951-7367

Otto W. Steinfeldt-Foss

Like the rest of medicine, psychiatry is undergoing rapid development to improve diagnostic, therapeutic and prophylactic procedures for the understanding of the etiology and pathogenesis of mental disease. In current medical practice most procedures involve hazards. With its roots in biology, social and psychological sciences as well as general humanistic traditions, ethical norms and standards are especially challenged. Psychiatry also having to deal with social control in society, in addition to traditional curative and caring functions, implies an additional ethical obligation compared with the more somatic disciplines. The problem of objective definition of normality is varying with shifting norms and values in different cultures. Regardless of these differences, the need for universal guidelines and declarations on medical-ethical standards is essential.

Conflicting loyalties for physicians in contemporary society, the delicate nature of the therapist-patient relationship, the possibility of abuse of psychiatric concepts, knowledge and technology in actions contrary to the laws of humanity are illustrative of this need. The general human rights declarations and conventions have developed from the Declaration of Geneva of 1948 and the Declaration of Tokyo of 1975 into the special Declarations of Hawaii of 1977 and were further updated through the Declaration of Madrid of 1996.

It should be underlined that the above standards as drafted are only a guide to physicians throughout the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries. The national mental health laws in the United Nations' member countries are again built on the ten Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care adopted by UN General Assembly Resolution 46/119 of 17 December 1991, as follows: (1) Promotion of mental health and prevention of mental disorders; (2) Access to basic mental health care; (3) Mental health assessments in accordance with internationally accepted principles; (4) Provision of the least restrictive type of mental health care; (5) Self-determination; (6) Right to be assisted in the exercise of self-determination; (7) Availability of review procedure; (8) Automatic periodical review mechanism; (9) Qualified decision maker; and (10) Respect of the rule of law.

The Hawaii Declaration, as well as the further elaboration through The Madrid Declaration, is thus resting on these general UN principles and must not be regarded as covering the whole mental health arena in detail. Health services all over the world are in rapid transformation, being influenced by new economic steering mechanisms, especially market forces, that are changing priorities in a way that are not always professionally and scientifically based. This situation requires a continuous updating and revitalization of the international codes and declarations on medical ethics.

Consumers' comments on the Declaration of Madrid can be summarized using the following key words; autonomy, integrity and dignity. We will now examine them, making reference to the Declaration's items.

Item 1 is concerned with the promotion of mental health and prevention of mental disorders according to accepted scientific standards. Giving psychiatry the responsibility of securing a just allocation of health services is lifting priority setting in health care to an ethical dimension. Hitherto, mental disorders have not been sufficiently included in normative analysis of quality assessments and nationally and internationally approved lists of priority. The commentaries are reflecting and highlighting the importance of a broad-spectred service apparatus.

The strongest reaction is however related to the term 'therapeutic interventions that are least restrictive to the freedom of the patient'. This formulation is built on principle 4 of the UN General Assembly Resolution 46/ 119 of 1991 related to the definition of a mental case. The principle includes the following components to be considered in the selection of the least restrictive alternatives: the disorder involved; the available treatment; the person's level of autonomy; the person's acceptance and cooperation; the potential that harm be caused to self or others.

There is a fundamental difference between somatic and psychiatric disease. Mental disorders represent to a much higher extent an unstable situation with exacerbations and remissions. The social breakdown condition with functional disability is to some extent identical to the disease picture itself. In the more severe psychiatric conditions as manifest psychoses, according to the ICD-10, one of the main symptoms is loss of insight into reality and inability to make proper evaluation and judgment of own situation.

But according to UN principle 5 on self-determination, consent is required before any type of interference can occur. Interference includes bodily and mental integrity (e.g. diagnostic procedure, medical treatment such as use of drugs, electroconvulsive therapy and irreversible surgery) and liberty (e.g. mandatory commitment to hospital).

In case the person is unable to consent, which happens occasionally but not systematically, there should be a surrogate decision maker to decide on the patient's behalf. Special precautions should be taken to make sure that mental health care providers do not systematically consider mental patients unable to make their own decisions and exercise self-determination with regard to all components of integrity and liberty because the patient was found to be unable with regard to one.

Item 2 states that psychiatrists have a responsibility to keep updated about scientific developments so as to secure the patients the most proper and modern treatment. In many parts of the world, this can be experienced as pure phraseology, since the development of social and health services in general is poor and psychiatry especially has a tendency to be given a low priority. Nevertheless, the responsibility put on the individual psychiatrist to keep updated, and giving this responsibility an ethical dimension as related to allocation of resources, is of value.

The importance of the therapist patient relationship is highlighted in item 3. One of the main complaints of the users of mental health services is a growing retreat from talking with patients. Shorter working time combined with increasing case loads, increasing patient circulation, increasing emphasis on technologic procedures, reduces the available time for talking with patients at length and over time. The organization of the services has put psychiatrists more and more in the role as diagnosticians and medication prescribers to patients treated psychosocially by other professional groups. Uneritical use of neuroleptic drugs and minor tranquilizers instead of proper psychosocial and psychotherapeutic procedures are an increasing danger in services lacking human professional resources, thus threatening the patient doctor relationship. Securing this relationship is also critical for obtaining relevant information to help the patient coming to a rational decision about their own choices as to different treatment options. Compliance is a necessity for providing the alliance giving the patient a feeling of being a real partner.

The individual patient's dignity and legal rights are underlined in item 4. According to international mental health acts and the ten basic principles drawn from the UN General Assembly Resolution, the criteria for compulsory treatment are stated. Regretfully, psychiatric diseases sometimes imply the need for compulsory admission and treatment provided in the best interest of the patient. ~ The inequity between treatment for somatic and psychiatric disorders is thus a fact and cannot be rationalized.

The importance of mental health assessments being provided in accordance with internationally accepted medical principles is covered in item 5. Refraining from reference to nonclinical criteria such as political, economic, social, racial and religious criteria is a central issue.

The importance of confidentiality in the patient-doctor relationship is discussed in item 6. In a time when electronic data processing and communication is increasing, securing confidentiality is more urgent than ever.

Item 7 underlines the importance of psychiatric research being conducted according to the ethical canons of science. The fundamental distinction must be recognised between medical research in which the aim is essentially diagnostic and/or therapeutic, and research where the essential object is purely scientific and without direct value to the persons objected to the research, according to the World Medical Association's Declaration of Helsinki 1964, revised 1975. In any research on human beings, each potential participant should be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. When obtaining informed consent, the doctor should be particularly cautious if the individual is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a doctor who is not engaged in the investigation and who is independent of this official relationship. This is of special importance related to psychiatric patients.

Finally, the comments are related to the importance of user involvement in all stages of planning, running and evaluating services. This concern is implicitly covered in item 1 in the Declaration of Madrid. The planned parallel development of alternatives to hospital into a comprehensive treatment chain with continuity of care, has hitherto not occurred at the same speed as the reduction of hospital beds. More systematic studies are needed to evaluate the effect of different elements, as well as development of more reliable methods in evaluation. Main themes are need assessment, quality of life, family/caregiver burden and satisfaction with services as stated by the European Network for Mental Health Service Evaluation (ENMESH) in 1994. The active involvement of users, including their families, is of central importance to secure services that are meeting real needs of the population to serve. In this connection also, the proposal regarding the establishment of an Ombudsman institution is relevant.

In conclusion, the Declaration of Madrid, as stated initially, is not supposed to be complete, but is only highlighting some of the main issues confronting psychiatry and mental health patients today. The standards drafted in the Declaration are guidelines, not relieving doctors from legal responsibilities to their own countries, or loyalty to the United Nations Resolutions on The Principles for Protection of Patients with Mental Illness and the Improvement of Mental Health Care, which again are based on the general principles for human rights.

Otto W. Steinfeldt-Foss, University Health Services of Oslo, PO Box 0314, Blindern, Norway

Dieter Bimbacher

The World Psychiatric Association is to be applauded for giving groups of consumers and patients of psychiatry the opportunity to comment on its latest international declaration on ethics in psychiatry. This is an important step in the right direction; in the direction of an ideal ethical code which could give a voice not only to the providers, but also to the consumers of psychiatric services. In fact, a bilateral (or multilateral) rather than unilateral declaration would not only be more in line with a cooperative understanding of the doctor-patient relationship (and, apart from

that, with general democratic principles) but would also seem to correspond to an extensive reading of the Declaration's own statement that 'the patient should be accepted as partner' (Item 3). In Germany, the Federal Board of Physicians has started to invite public discussion on its latest proposal of guidelines on the termination of treatment and euthanasia, so that all parties concerned have a chance to contribute to the final version. This, too, should be welcomed. By the same token, the former practice of issuing such guidelines on the part of the medical profession without giving a vote to existing and potential patients whom these guidelines most intimately concern, becomes more and more doubtful in retrospect. In fact, these guidelines reflect the traditional ethic of physicians (or rather, physicians' representatives) much more than the ethical beliefs and expectations of the general public.

This is perhaps one factor which helps to explain the critical stance taken by some of the consumers. The opportunity to protest after the event is only a poor substitute for the chance to participate from the start. As a consequence, many of the innovative and fertile ethical ideas contained in the declaration go unnoticed, such as the remarkable postulate in Item 3 to 'empower the patient to come to a rational decision according to his or her personal values and preferences'. The fact that these ideas are idealisations far away from actual practice does not at all diminish their importance. On the contrary, appeal to the Declaration will greatly help local efforts to change practices and to introduce reforms, wherever necessary.

Part of the explanation of why some reactions to the Declaration are so critical is the understandable dissatisfaction with the common birth defects of international declarations. As usual, the most urgent and controversial issues are left out, or are dealt with in a more or less noncommittal manner, in order to reach a consensus. Thus, orientation is lacking where it is most needed. The pressure of compromise leads to the ironic result that exactly those questions which prove to be the most irritating and disturbing in actual practice are left unasked and unanswered: the limits of involuntary detention and treatment, physicians' attitude to patient suicide, nontherapeutic research on psychiatric patients unable to consent, and the problems of therapy under compulsion in forensic psychiatry. All these issues, which have been under continuous discussion in recent years, are given only casual treatment in the Declaration if they are at all mentioned. Some are clouded by contradictions originating in an effort to have the best of both possible worlds, as in Item 4, where it is said that no treatment should be provided against the patient's will (unless the life of the patient or others is threatened) and that treatment must always be in the best interest of the patient - as if these conditions were always, or commonly, compatible. Ethical problems arise exactly in those cases in which the security interests of others are not compatible with the will and the best interests of the patient, or where the will of the patient is opposed to treatment which would be their best interest. Asserting the ethical requirement of against their will is fine but uninformative. The ethical problems begin as soon as these self evident principles come into conflict, as they often do in psychiatry, and more often than in other fields of medicine. On these conflicts, however, the Declaration is silent. Furthermore, the preamble exemplifies what philosophers call a pragmatic contradiction in leaving the decision about the ethical quality and appropriateness of physicians' conduct to the 'individual sense of responsibility' while at the same time making proposals as to the content of this responsibility. What then is to have priority? The norms of the declaration or the conscience of the individual psychiatrist?

But part of the explanation of why some consumers' views are critical of the Declaration is simply that they have a point. One of these points is the half-heartedness with which the Declaration deals with patient autonomy, the most vulnerable ethical value in psychiatry. Autonomy in the sense of the patient's right to self-determination is formally asserted as an important value but implicitly given a more or less secondary status. This is apparent from the quoted passage in Item

3 stating the aim of 'empowering the patient to come to a rational decision according to his or her personal values and preferences', which immediately invites the question how to deal with patients' non-rational or irrational decisions if these happen to conform to their personal preferences. Again, it is impossible to have the best of both worlds and to try (in a quasi Kantian fashion) to maximise autonomy and rationality at the same time. Giving primacy to the principle of autonomy would imply respecting even irrational and bizarre patient preference provided that their fulfillment did not severely endanger the health of the patient or of others, whereas giving the primacy to rationality would open a Pandora's box of justified paternalism not only in psychiatry, but also in the whole area of medicine. Giving primacy to autonomy would also mean more rigorous restrictions on non-therapeutic research with psychiatric patients unable to validly give consent, even if one does not want to go as far as some of the commentators and to demand that all such research be legally banned.

Dieter Birnbacher, Philosophisches Institut, Heinrich Heine Universität Düsseldorf, Universitätsstrasse 1, D-140225 Düsseldorf, Germany

Ahmed Okasha

On behalf of the Ethics Committee of the World Psychiatric Association (WPA), I thank those who contributed to this debate. We shall take all their comments into consideration, either in specific guidelines or in another step of updating the Declaration of Madrid.

The World Schizophrenia Fellowship raises an important point which the Declaration of Madrid should emphasise especially in developing countries in which the burden of care for mental patients mainly falls on the family. We should acknowledge the importance of the care giving role of the family of the patient; they should be partners in treatment and accepted by right in the therapeutic process. It should be highlighted that research shows a better outcome when the family is educated, consulted and involved in the management and that this partnership is cost-effective. The comment that collaboration between clinicians, family care-givers and patients should be the 'best practice' from the onset of the illness and for as long as it is required reflects the present consensus on management of mental patients.

Although EUFAMI's reaction to the Declaration of Madrid looks critical, it is contingent with it. EUFAMI invited the WPA to make an effort to take up the issue of family involvement, and adapt the declaration in such a way that it reflects awareness of the role of caregivers in severe mental illness. This is an important issue that should be addressed in future updating of the Declaration.

To comment on the contributions by patients' advocates and consumers, I would like to emphasise that we always ask for equity of treatment for mental and physical disorders; however, the power of judgement and insight differ in the severely psychotic from general medical conditions. When a diabetic patient refuses treatment out of stubbornness, nothing can be done for him, he has free choice; but if this refusal of treatment is secondary to an implicit suicide, or secondary to a psychotic depression, it is our duty to intervene by our treatment for the patient's safety. Similarly, to drink alcohol excessively may be a free choice of the individual but, if the excessive alcohol intake is secondary to a psychiatric condition that affects judgement and insight, our intervention may be necessary for the safety of the patient. The advocates comment that, for a suicidal person to lose power so utterly as to be given electroconvulsive therapy (ECT) against his will may potentially strengthen his resolve to determine his own destiny by taking his own life. However, psychiatrists never interfere with any suicide based on anomic state or altruistic purpose; it is only

when the suicide is secondary to a severe psychotic depression, for which ECT is universally known to be the best treatment, that they intervene.

Unfortunately ECT is still perceived by the mass media as a shock treatment and in films, patients' advocates it is called mental rape. However, it is currently given under anesthesia and there is no convulsion, no shock and only blinking of the eyes. The side effects of the ECT are much less than those of psychotropic drugs, and it is a life saving measure. MIND mention that, in their survey, 71% of the respondents whose main drug was a selective serotonin reuptake inhibitor and 77% of those whose main drug was an antipsychotic reported that they were not warned of possible adverse effects. That is why it was specified in the Declaration that, for any patient given any sort of treatment, information should be provided on the mode of action, the side-effects and the adverse effects and on whether there is any alternative intervention. If the patient is incapacitated, a member of the family or the next of kin should be aware of all the consequences. There have been some objections that ethical behavior depends on the psychiatrist's individual sense of responsibility, but sometimes an explicit ethical behavior may be hiding a very implicit unethical one. So, in front of everybody, the psychiatrist is behaving ethically, but actually he is harming the patient by neglecting his sense of individual responsibility. The only censor is not law, or ethical codes, but actually is dependent on individual conscience and responsibility of the psychiatrist. Unfortunately, some of the advocates' comments are based on a very superficial knowledge about the revolution in neurosciences and how it is related to psychiatric disorders. It is mentioned in the comments that treatment, if ethical, should be primarily based on non-pharmacological measures such as psychotherapy. However, this line of therapy is that which is supported by the least significant scientific evidence. Psychiatrists should never practice any line of treatment which produces irreversible damage; however, the statement that psychiatric drugs, electric shock and insulin shock may produce irreversible damages has never been scientifically proven.

A brief comment on the response by Nirmala Srinivasan, who mentions that psychiatrists must make an effort to network with experts who are not psychiatrists but are in related fields. Unfortunately, the WPA can only address psychiatrists; however, the Declaration of Madrid can be used as a guideline for other mental health professionals. Srinivasan also emphasises the problem of drug trials and selection of candidates, a topic which will be addressed in the new specific guidelines that the Ethics Committee is preparing. These will be submitted to all member societies of the WPA to be ratified in the next General Assembly at the World Congress in Hamburg.

Judi Chamberlin argues that the psychiatrist should be deprived of the authority to determine whether the patient is mentally ill, lacks the ability to make decisions or has impaired judgement. The contradiction in this argument is that we ask for equity between patients with physical and mental disorders. We do not discuss the diagnoses made by a surgeon, cardiologist, ophthalmologist or endocrinologist, but we feel free to interfere with the diagnoses of a psychiatrist. Psychiatry is a branch of medicine, and psychiatrists are physicians dealing with psychiatric disorders according to international and consensus criteria. The confusion comes when psychiatrists deal with problems of living and not with psychiatric disorders, something we do not encourage and we leave to other mental health professionals. I can assure Judi Chamberlin that the Declaration of Madrid was approved and distributed to all societies with an attachment of United Nations resolutions on the human rights of mental patients.

We totally agree with Adrienne Szokoloczy-Grobet's view that all patients should be equal before the law, and that 'special discriminatory legislation applicable to psychiatric patients serves only the purpose of perpetrating a system which, instead of helping patients, is in fact detrimental to their physical and mental health' (p 10). It is always left to the judiciary system to decide the

responsibility of the accused in spite of any psychiatric reports. We have to address the judicial system, not the psychiatrists, concerning this issue.

Ahmed Okasha, Ain Shams University, 3 Shawarby Street, Kasr El Nil, Cairo, Egypt