Covert treatment and transcultural bioethics

Bioethics Centre Seminar
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Introduction

– Aim: to take some of the resources of transcultural ethics (Nie, 2000, 2011; Nie & Fitzgerald, 2016; Pickering & Nie, 2016) and apply them to an international debate over Covert Treatment in which claims about cultural differences have been deployed to deny universal ethical claims
Transcultural bioethics

The major features of this theoretical and methodological paradigm are:

1) overcoming stereotypes and stereotyping and appreciating the complexity of cultural differences;
2) taking seriously the internal plurality and diversity found within every culture;
3) focusing not only on cross-cultural differences but also on transcultural similarities or commonalities;
4) promoting a genuine and deeper dialogue between different cultures; and
5) upholding the necessity of moral judgements and the primacy of morality over culture.
Introduction (cont.)

– Three sections
  – The cultural objection presented
  – Solutions? Accommodations?
  – Cultural heterogeneity
The cultural objection
Ethical analysis of Covert Treatment (a proposal)

- CT will be ethical if and only if the following criteria are met:
  - The incompetence criterion – the individual must lack decision making capacity in order to be a candidate for covert treatment
  - The best option criterion – covert medication must be the best option in the context
  - The best practice criterion – covert medication must be given according to best practice for this mode of delivery of treatment

- Note: these are the same criteria as would apply to the ethical analysis of the use of coercive treatment
The cultural objection - briefly

– The first criterion represents a cultural bias towards individualism
Case
(Wong et al. 2005)

- Y is a 25 year-old unemployed man with a two year history of paranoid schizophrenia. He lives with his parents and a younger sister. During previous psychotic episodes, he had persecutory delusions that his mother wanted to harm him, with a history of violence against her. ... Despite his excellent response to antipsychotics, his insight into his illness was poor.

- One day, Y’s mother came to the clinic alone, and told Dr W that Y had refused to take the antipsychotics and to come for follow up. ... as a result had become actively psychotic again. He had accused his mother of persecuting him, and had become very hostile towards her. The mother asked Dr W for her son’s regular antipsychotics so that she could encourage him to take them up. Since the mother had always been the main carer actively involved in Y’s psychiatric care, and bearing in the mind the threat of violence to her, a prescription was given to her ... Dr W went on maternity leave.

- When Dr W returned to work, she saw the mother alone in the clinic again, at a time when Y was scheduled to come back for a follow up visit. The mother described [how] ... She had failed to persuade Y to take the antipsychotics, or to attend for psychiatric follow up. In desperation, she had started to mix Y’s medication covertly in his soup. This had a good effect. He had got better and was not longer psychotic and hostile to her. Relieving doctors had continued to supply prescriptions for the mother ... The mother was happy with the current arrangement. “Doctor, just give me the prescription and I can put the medicine in his soup.”
The cultural objection

– The point here is that, for all its ethical defects ..., the system, in its own way had managed a difficult situation against heavy odds till a smart aleck like me, had come along with fancy notions, to torpedo a stable, settled family. ...

– ... for decades to come the only community mental health teams that we are going to have are the families and as has been suggested here, we should look for ways to empower them and allot them a role in a due process of OPD medication (without consent).

– And we cannot take even the families for granted for ever. They may atomise and get lost in the rapidly rising dust of globalisation sooner than we think.

– (Kala 2012)
The cultural objection
Wong, Poon, Hui JME 2005

– ‘There should ... be a weighing of family rights against individual rights. In Chinese culture, the notion of respect for an individual’s right to self determination is a weak notion due to the Confucian concept of social personhood. Family input in treatment decision making in Chinese cultures is not only common and considered the norm, it is often decisive. While Western medical ethics tends to focus on the individual, this approach has been recognised as being limited, thus increasing attention has been put on social relationships and seeing each person within his or her social context. ...

– A justification for continuing treatment of the patient with covert medication can be found in society’s moral obligation to protect family interests and to preserve family autonomy. If the patient belongs to a family, then the interests of each member of the family are interconnected, and there should be mutual respect for each other’s autonomy. ...

– The act of discontinuing covert medication is intended to respect the patient’s autonomy, but if such an act carries the potential risk of precipitating a relapse whereby, not only may the patient lose his capacity for decision making, but also the autonomy of other family members may be violated, then the moral validity of the act should be questioned.’
Autonomy/paternalism

– It may be argued that in the case, in fact Mr Y was decision-making incompetent when refusing medication
  – Thus – in fact – the first criterion is met in both cases
  – These cases do not constitute a questioning of the proposed framework
– But as the analysis of both Kala and Wong, Poon and Hui show, they believe the argument supports strong paternalism/family autonomy
  – Mr Y is competent now, albeit because he is medicated – but continuing CT may be appropriate
  – Kala and Wong et al explicitly extend their analysis to cases where patients are competent
Solutions?
Accommodations?
Culture accommodated – a bit

– Cultural differences can be expressed in the current 2\textsuperscript{nd} criterion (i.e. ‘the best option in the context’ criterion) which allows for
  – Culturally influenced weightings of e.g. interests (so that the interests of families may be given more weight in communitarian settings than in individualistic settings)

– But the independence of the 1\textsuperscript{st} criterion doesn’t seem to have the same flexibility
  – It is not weighed in the balance
Possible solution

– Absorb the incompetence criterion into the best option criterion:
  – Concern for a person’s autonomy (as expressed in concerns about competence) would be put into the scales against concern for that person’s own interests and the autonomy/interests of e.g. family

– Three models of this:
  – The sliding scale model
  – The harm principle model
  – The pure balance model

– But note dropping the 1st criterion may be criticised from an individual rights perspective
  – This tends to add fuel to the claim that we have a cultural issue here
The material differences account

- Provision of health care, accessibility etc. (India)
  - 70 million-plus people living with mental disorders (WHO 2015)
  - Expenditure on health:
    - 5–6% of GDP
    - 1–2% of this is spent on mental health
  - number of psychiatric beds per 10 000 patients in psychiatric hospitals is 1.490, and in general hospitals 0.823 (Lancet 2014)
  - 0.301 psychiatrists, 0.166 nurses, and 0.047 psychologists for every 100 000 patients in India (Lancet 2014, WHO 2011)
  - 43 government-funded mental health hospitals (WHO 2015)
  - No community health infrastructure (Kala, 2012)
The material differences account

– Material differences account explains different behaviour, without (necessarily) justifying it
  – For example, the use of CT by families where no in-patient facilities are available to them, and coercive treatment is not a genuine alternative, and where family living conditions are very crowded (etc. etc.), may be the only practical solution
  – But this doesn’t remove the possibility of an ethical assessment from within the community that there is a systematic problem with the lack of mental health resources
Cultural heterogeneity
Individualism vs communalism?

- How far is dichotomisation of cultures into such broad ‘types’ reliable?
- Use of dimensions upon which to ‘measure’ human variability
- ‘Location’ of a culture on any of these may shift over time
  - Individualism
  - Cognitivism
  - Free will
  - Materialism
  - Communalism
  - Emotionalism
  - Determinism
  - Spiritualism (Laungani, p.509)
- Problem is that any point on a dimension may represent an abstraction from the range of situations in any society relating to the dimension
Individualism vs communalism?

- Suffice it to say that Indian society cannot be seen other than in familial and communal terms. It is and has been for centuries a family-oriented and community-based society. In an Indian family life, one’s individuality is subordinated to collective solidarity, and one’s ego is submerged into the collective ego of the family and one’s community. Consequently when a problem – financial, medical, psychiatric, or whatever – affects an individual, it affects the entire family. ...

- A community in India is not just a collection of individuals gathered together for a common purpose. A community in the sense in which it is understood in India has several common features. People within a group are united by a common caste-rank, religious grouping and linguistic and geographical boundaries ... (Laungani, p.521)
Individualism vs communalism?

- It is expected for an individual to stay part of the family and of the community, the individual will submit to communal norms, and will not deviate to an extent where it becomes necessary for the deviant to be ostracized. The pressure to conform to family norms and expectations, cause acute stress and anxiety in individual members in the family …

- [P]ersonal choice is … virtually non-existent in a Communal-oriented society. Occupations are largely caste-dependent, and caste of course is determined by birth. ... pressures from the elders and threats of ostracism ensure that one stays within the confines of one’s caste and community. ... The pressures which prevent a person from choosing his/her own future, often leads to severe stress and psychiatric disturbances. (pp.522-523)
Individualism vs communalism?

- **Note**
  - The individual is presented here as to at least some degree independent of his/her culture
  - Society is presented as having sources of pressure to command conformity
  - In theory (at least) this opens up the possibility of a conversation within the society about the individual and his/her context

- Note, too, that this analysis is not restricted to some cultures and not found in others
Individualism vs communalism

- It is expected for an individual to stay part of the family and of the community, the individual will submit to communal norms, and will not deviate to an extent where it becomes necessary for the deviant to be ostracized. The pressure to conform to family norms and expectations, cause acute stress and anxiety in individual members in the family ...

- [P]ersonal choice is ... central in an individualistic society. Occupations are largely personally chosen, and nothing is determined by birth. ... pressures from peers and family and threats of ostracism ensure that one is not confined by one’s class and community. ... The pressures which demand a person must choose his/her own future, often leads to severe stress and psychiatric disturbances. (adapted from pp.522-523)
Societies in transition

Observation that Indian culture is not fixed or uniform itself, but is subject to change

Shar and Basu 2010: argue that ‘with the rapidly changing socio-economic, cultural, and psychosocial profiles of the traditional rural-oriented and family-centered societies of India and the Asian countries in general, it is all the more important to be aware of the individual rights and preferences regarding the necessity, mode, and venue of psychiatric treatment, along with those of family members’

And with respect to the relational notion of autonomy (Wong, Poon, Hui)

Consider the strong currents supporting this approach amongst ‘western’ academics
Current stopping point

- The cultural objection is that the proposed framework of evaluation for CT rules out the ethical use of paternalism/family autonomy, but these are a feature of some (communalistic) cultures.
- Insofar as the objection is based on material realities, it may be accommodated to the framework, e.g. if an internal ethical dialogue has emerged about the material realities.
- The individualistic/communalistic dichotomy appears to be an abstraction from a much more complex interplay between cultural/societal pressures and individuals – which characterises societies of both ‘kinds’.