

# Centre of Biomedical Ethics and Culture

## Bioethics Links

In the lead article, Dr. Riffat Zaman discusses how the categorization of medical illnesses in the 20th and 21st centuries reflects changing understandings of psychiatric disorders and has resulted in the medicalization of some conditions. Dr. Amar Jesani's article investigates the role of physicians as instruments of torture. Also included are a short write up by Ms. Anika Khan on a writing workshop for PGD and MBE students and brief reports on CBEC events in the first half of 2016.

Editor

### Emotional Suffering and Psychiatric Diagnosis

*Riffat Moazam Zaman\**

*In the animal kingdom the rule is, eat or be eaten, in the human kingdom, define or be defined.*

*Thomas Szasz*

Definition and classification of mental illness can be traced back to the 5<sup>th</sup> Century (BCE) physician Hippocrates. The concepts of mania and hysteria, which are attributed to Hippocrates, have evolved into 20<sup>th</sup> century diagnostic terms such as conversion disorder and bipolar disorder. Nosology (classification of diseases) is indispensable to any field of science as it provides a common language of communication among clinicians and researchers. Nosology is also essential for an understanding of etiology, diagnosis and treatment. The history of psychiatric nosology has been fraught with controversies. The major categories of mental disorders to which modern psychiatrists subscribe are based on a *priori* assumptions about the nature of psychiatric illness, assumptions conceived through the clinical experience of European psychiatrists.

To appreciate the reasons for the debate around the credibility of psychiatric nosology, it is important to view the history of the Diagnostic and Statistical Manual (DSM) by

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the American Psychiatric Association (APA). The DSM which is considered the Bible of psychiatric diagnosis was first published in 1952 (DSM-I) and has gone through several subsequent revisions of which the latest, DSM-5, was published in 2013. DSM-I and DSM-II were conceived on a psychosocial model influenced by the psychiatric experience of soldiers in World War II and Freud's theory of personality development based on intrapsychic conflicts. This psychosocial model assumed a fluidity of the boundary between the normal and mentally disturbed and raised questions about the legitimacy of psychiatry as a medical

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Dr. Paul Lombardo, CBEC visiting faculty, and Dr. Natasha Anwar, CBEC alumnus, take a rickshaw ride to the walled city of Lahore. Dr. Lombardo was in CBEC in January to teach MBE and PGD students.

## Doctors and Police Interrogation of Detainees

*Amar Jesani\**

Often in our part of the world there is a denial of any problem in the interrogation of detainees by the police or security agencies. This denial is followed by another denial, that although many doctors routinely examine and/or treat patients who are detainees, there is nothing problematic in this.

The denials do not mean that there is no knowledge about what happens during interrogation of detainees in our countries. There is hardly any police station where suspects and sometimes even complainants do not get beaten. The detainees are often subjected to what is universally called “the third degree” treatment. Our societies have coined many other terms for “the third degree”, but they scrupulously avoid the term “torture” for this phenomenon. In our debates and even in our laws, the term torture is conspicuous by its absence (1). Denial of the problem in police interrogation is also intimately connected to our acceptance of torture as a normal and legitimate method of interrogation.

However, torture is neither a morally correct nor practically efficient method. Internationally it is denounced as morally and legally wrong because it violates due process of law and makes the collection of testimonial evidence involuntary and thus not reliable. The United Nations adopted the Convention Against Torture (CAT) and other cruel, inhuman or degrading treatment or punishment in 1984 and brought it in force in 1987 (2). India signed the CAT in 1997 but has so far failed to bring its laws in line with its provisions.

The efficacy of torture is questioned because generally a tortured detainee confesses anything that the torturer wants. Courts normally do not accept confessions or statements made by detainees to the police, and criminal cases built on the forced

confession of detainees are more likely to get lost in court. This is evidenced by the low conviction rates for criminal cases in our countries.

Nevertheless, torture is routinely employed in our countries and has massive social support, including that of the state while the judiciary turns a blind eye to it. As a consequence, the role of our police forces has been restricted to the maintenance of order and protection of the state - a role developed by our colonial rulers to subjugate people rather than to protect them.

### ***Ethical obligations of doctors***

Interestingly, this social support for torture includes support from doctors who often believe that some amount of torture may be necessary in order to obtain information from or confession from the detainee.

There are different ways in which the doctor gets “involved” in torture during police interrogation. The commonest is the situation when tortured detainees needing medical attention are brought to doctors in the hospital. My experience shows that normally when doctor-patient interaction takes place, the patient is in fetters and a police person is guarding the detainee. The doctor does not make any attempt to remove the police from the scene and as consequence, the detainee is not able to give cause of injuries as torture. Even if the detainee does not say anything about torture, the type and pattern/distribution of injuries should make the doctor suspicious about the torture, but that question is not asked. The minimum that a medical person should do is to put down detailed documentation of the torture related injuries using the Istanbul Protocol (3) and if possible, not allow the detainee to go back to the torture. The medical professional has ***Continued on page 3***

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an obligation to speak out but that hardly every happens. Not preparing a good medical record of torture and not making any effort to inform and/or protect the detainee may make the doctor complicit in the torture. The Tokyo Declaration (4) of the World Medical Association (first adopted in 1975, the last revision in 2006), prohibits doctors from sharing medical information of the detainees with the police, prescribes complete independence of the doctor from the police while treating a detainee-patient and stipulates that doctors not remain present or participate during torture.

Medical ethics teaches us that the doctor should maintain neutrality in respect to the background and alleged crime committed by the detainee while providing medical care. But in reality this neutrality is often violated or is absent. We come across many doctors unwilling to provide medical care to a “terrorist” or rather to persons detained under terrorism laws, violating the principle of non-discrimination and passing judgment on somebody not yet judged by the court of law. Some may be ready to provide direct assistance to the police or even advise the best way to carry out torture.

***Why doctors get involved in torture***

Doctors who get involved in torture are not unusually evil personalities but average, ordinary people. They may even be very compassionate in other areas of clinical practice but their acceptance of torture by the police as a normal way of interrogation means that they are ignoring their ethical obligations. Many get involved because their conception of professionalism is mechanical and technical, devoid of ethical commitment.

However, a more important reason is that social institutions not only tolerate torture but encourage it. Their ideology is used to overpower the ethical strictures against participation, and conforming to the system is

rewarded in various ways. With the overwhelming social support to this phenomenon, the situation becomes very intimidating for those who try to uphold ethics and to not conform to the demands of the system.

***Dilemma: Abandon the patient or be complicit in torture***

Chiara Lepora and Joseph Millum in an article titled “Tortured Patient: A medical dilemma” in the Hastings Center Report, 2011 (5) describe a dilemma faced by doctors in certain circumstances where the tortured patient needs a doctor's assistance and the provision of it could be construed as complicity in torture. For instance, when a detainee is being flogged or a convict is being amputated, should the doctor remain present to medically assist the patient? They argue that it is not the presence of the doctor but her/his presence without regard to the detainee's condition, or assistance in enhancing the effect of torture that should be considered unethical. They suggest that three factors should be considered in judging the appropriateness of the doctor's presence and assistance to the detainee: (a) the expected consequences of the doctor's action, (b) wishes of the detainee-patient, and (c) the extent of the doctor's complicity with the wrongdoings.

However, the essential point is that for reasons of political ideology, religion or disapproval of the detainee's acts, etc., the doctor must not willingly get involved in assisting police interrogation using torture. For the same reasons, in the provision of medical care doctors must maintain strict neutrality and provide medical care irrespective of the alleged crimes against the detainee.

*(References for this article are available in the online version of Bioethics Links, Volume 12, Issue 1)*



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science. Criticism was also leveled from those within the profession by biologically oriented psychiatrists who defended a medical model of classification. This was also a period in which psychopharmacology had advanced; medications like Lithium Carbonate, anti-depressants, and antipsychotics had proved to be beneficial in certain kinds of psychiatric disorders.

The anti-psychiatry movement of the 1970s included psychiatrists who questioned the validity and arbitrariness of psychiatric diagnosis based on family and social environment rather than on a pathophysiologic basis. Thomas Szasz, a notable and renowned critic, claimed that under the guise of psychiatric labels, people were stigmatized and controlled by the powerful establishment of psychiatrists. The legitimacy of psychiatry was further questioned when homosexuality, once listed as sexual deviation, was removed from DSM II following protests by vocal gay rights organizations. This made it embarrassingly evident that a supposedly classified disorder was contingent upon the political and sociocultural stance of the time rather than on scientific reasoning. It was also in 1972 that David Rosenhan, a psychologist, conducted an innovative study to determine the validity of psychiatric diagnosis. He had pseudo patients feign auditory hallucinations to get admitted in different psychiatric hospitals. Even though the patients acted normal during their hospital stay, they were still discharged with the diagnosis of “Schizophrenia in remission.”

DSM III, published in 1980, was an attempt to provide a solution to these justified criticisms. Its publication was a turning point and marked a paradigm shift in psychiatry. Its approach was descriptive and based on observable symptoms which could be supported by research. A nosology with specific symptoms for diagnostic criteria was

the beginning of reconciliation between psychiatry and medicine. At the same time, this nosology minimized the role of social and emotional factors in the etiology of mental disorders.

An approach that did not privilege social and emotional factors benefitted the pharmaceutical industry in promoting psychiatric drugs as a “quick fix” to emotional distress, thereby reinforcing and propagating the medicalization of mental illness. The popular and indiscriminate use, plus the miraculous qualities attributed to Prozac in treating depression is a well-known phenomenon of the 1980s. The much heralded DSM III however, had its own set of criticisms, some of which were directed at the inclusion of new diagnostic categories. Paula Caplan, a clinical and research psychologist, and a human rights advocate, put forth a trenchant argument against the inclusion of diagnostic labels such as Self-Defeating Personality Disorder (SDPD) and Premenstrual Dysphoric Disorder (PMDD). Both these disorders were applicable to a majority of women.

SDPD, facetiously

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“Islam in the Anthropocene: Geological Transformation of Nature and Islam”: Dr. Nauman Naqvi, Director of the Liberal Core, Habib University, Karachi, led a CBEC Forum on April 23, 2016. In his interactive session, Dr. Naqvi compared the geological transformations taking place in the contemporary era with changing Islamic perspectives in recent times.

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referred to as “good wife syndrome,” included characteristics such as putting needs of others ahead of one's own, feeling unappreciated etc. Interestingly, this “portrait” of SDPD is most germane to the accepted and desirable gender role for Pakistani women as well. The scientific basis of including PMDD was also questioned as some of its diagnostic features incorporated “bloating,” breast tenderness, irritability, fatigue etc, which are common symptoms of PMS experienced by many women. In lieu of the scathing criticism from feminists, the two diagnoses were not included in the main text of DSM-III-R and DSM-IV-TM (2004) but were instead placed in an appendix titled “Diagnostic Categories Needing Further Study.” Nevertheless, by defining diagnostic categories operationally, DSM III provided a common language for different mental health professionals. Its descriptive approach also made epidemiological research possible.

After a period of 13 years the DSM-5, a 947 page volume with over 300 diagnostic categories, was published in 2013. Well before its publication disputes arose over the intended introduction of new categories and the lowering of the threshold for certain existing ones. Allen Frances, who chaired the task force of DSM-IV, was the most forceful and potent critic of DSM-5. He criticized the arbitrariness of the changes and the scientifically untenable method of diagnosis based on check lists of symptoms more beneficial to drug companies than to the patients. The plausibility of Frances' concern regarding the enormous potential for misdiagnosis can be illustrated through two examples.

By eliminating the bereavement exclusion from Major Depressive Disorder (MDD), if normal grievors checked 5 out of 9 general distress symptoms they would be falsely diagnosed to have MDD. If grieving for a loved one can be given a psychiatric diagnosis then it is not too far-fetched to expect specific

antidepressants for mourners. Interestingly, Eli Lilly has supported a clinical trial of its antidepressant Cymbalta for treating “bereavement-associated” depression. The second example is the introduction of Disruptive Mood Dysregulation Disorder (DMDD) for ages 6 to 18. With its main criteria being frequent temper tantrums inconsistent with developmental level and disproportionate to the provocation, this runs the risk of diagnosing difficult children with a mood disorder which could exacerbate the already excessive use of medications in children.

Unfortunately, the proliferation of diagnosis and the trend to “pathologize” normal behavior has jeopardized the credibility of the profession of psychiatry. Grave concerns have also been expressed over pharmaceutical companies' influence on the structuring of DSM. A study from the University of Massachusetts-Boston notes that 69 percent of DSM-5 task force members had ties to pharmaceutical companies. While APA has denied such claims, the possibility of conflict of interest is not an issue that should be minimized.

A visible, symptom based, descriptive model of psychopathology (DSM III onwards) has been useful in the treatment of some major psychiatric illnesses. However in its quest to be considered a “science,” psychiatry has lost sight of human suffering and healing. What is being forgotten is that psychic reality, the subject matter of psychiatry, can neither be categorized nor quantified.

*Some of the material in this article previously appeared as an editorial: Zaman, Riffat Moazam. “Psychiatric diagnosis and human emotions.” Pakistan Journal of Neurological Sciences. 10, no. 1 (2015).*

*(References for this article are available in the online version of Bioethics Links, Volume 12, Issue 1)*

## Collaborative Workshop: “Ethical Challenges in Biobanking for the Developing World” March 9-10, 2016



CBEC faculty with speakers from University of Copenhagen, Denmark and Pakistani institutions

In collaboration with the University of Copenhagen, CBEC organised a two day workshop at SIUT, Karachi. This workshop was the first of its kind in Pakistan addressing emerging ethical issues in biobanking in the country in particular and the developing world in general. The workshop also served as a first “mapping” exercise as it enabled the identification of stakeholders from across the country. These included scientists, research institutions and policy makers who found the workshop useful while also making the event relevant through their participation. The workshop also resulted in the identification of biobanks currently operating in the country.

Participants in the workshop included 3 speakers from the University of Copenhagen. Speakers and participants from Pakistan included scientists who are associated with biobanking, bioethicists, national bioethics committee members and researchers who wanted to learn about this emerging field and its accompanying ethical challenges. The speakers and participants were able to raise a number of relevant ethical issues about which

there was little or no general awareness even in the scientific community. The discussions were engaging with the 40 or so participants actively attending sessions on both days.

The discussions during the two days were wide ranging, often reflecting the lack of specific understanding of what biobanking entails. The format encouraged extensive debate, with each of the 8 talks over the two days coupled with 90 minutes of discussion time, a period that often seemed too short. The final session of the workshop was devoted to discussing the Guidelines for Collection, Usage, Storage, and Export of Human Biological Materials (HBM) which are under development by the National Bioethics Committee of Pakistan.

### Seminars for MBE Students



The four MBE (Class of 2017) students are engaged in a discussion with course faculty Amar Jesani and Mala Ramanathan during the seminar on Public Health and Ethics in Module 2, April, 2016.

In each academic module of the MBE program at CBEC, students have seminars connected to their courses in which they get the opportunity to interact with course faculty. These seminars, exclusively for MBE students, require specific additional readings for discussion. The students find the seminars helpful in giving them deeper insight into course topics and allowing them to clarify confusing issues.



## The “I hate writing Workshop”

*Anika Khan\**

Each academic module at CBEC incorporates a humanities session to introduce students to diverse ways of approaching ethics. One reason for this emphasis on humanities is the large number of healthcare related professionals enrolled in CBEC's academic programs: the two year Master in Bioethics (MBE) and the year long Postgraduate Diploma in Biomedical Ethics (PGD). The scientific and medical focus of their education often means a very limited exposure to the humanities. In fact, students beginning the programs sometimes express discomfort in dealing with the abstractions, contradictions and fluidity of ideas present in the arts, literature and particularly, philosophy. Despite their initial ambivalence, by the end of the year, many of them profess a long-lasting interest in the humanities and sense a blossoming of their own capacities for reflection and introspection.

This year, CBEC introduced a creative writing workshop in its Research Ethics Module, the second module in the academic year. The session began with the premise that everyone in the room hated writing. However, by the end of the three hours, the mixed group of MBE, PGD and Certificate Course students had created metaphors and used them to write poetry and narratives. The highlight of the session was a painting by Pakistani artist, Jimmy Engineer, depicting a large group of weary travelers resting in the shade of a great tree (Jimmy Engineer, *The Last Burning Train* 1947, 2009). Students chose a figure from the array of people depicted in the painting and wove a narrative around it, displaying creativity and imagination. As students read out their narratives and critiqued each other's writings, some of them expressed

surprise at their own hitherto unsuspected ability to create narratives and write poetry.

The workshop ended with a case writing session in which groups of students brainstormed collectively and each group came up with a case that centered round an ethical dilemma. They brought in their recently learnt narrative writing skills by creating characters, and placing them within the dilemma. Finally, the groups came together to read out their cases and listen to the general critique of their work.

### Research Ethics: Using Role Play



Students watch the live relay of the role play for recruiting a sex worker for a research project

An interesting role play in CBEC's Research Ethics Module (April 18-29, 2016) involved two students taking informed consent from a female sex worker for a research project. The interview was filmed and relayed to the rest of the class in a separate location. It was followed by a general discussion in which CBEC faculty, Ms. Sualeha Sheikhani, who played the female sex worker and PGD alumnus, Dr. Asma Nasim, who played her 'aunty,' shared their impressions about the process. The role play highlighted the discrimination faced by people living on the fringes of society and made the audience aware of their own biases.

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An engrossed audience watches a screening of the documentary 'The girl in the river' during CBEC's Ethics and Culture Hour on April 27, 2016

A large audience attended CBEC's Ethics and Culture Hour on April 27, 2016. The event featured the screening of the Oscar winning documentary "The girl in the river," followed by a question and answer session.

Produced by SOC (Sharmeen Obaid-Chinoy) Films, the documentary deals with honour killing in Pakistan. It narrates the case of Saba, a young Pakistani girl who was thrown into a river by her father and uncle for flouting convention and marrying a man against her family's wishes. Left for dead, Saba miraculously escaped and her father and uncle were arrested. Using the real-life protagonists of the case, the documentary highlights the perspectives of different people involved through their recorded interviews and conversations.

In the interactive question and answer session, two members of SOC Films' production team discussed honor killing in Pakistan, the making of the film and Saba's ongoing quest for justice.

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## Armed Forces Postgraduate Medical Institute, Rawalpindi holds Symposium on "Values and Ethics in the Medical Profession" April 6, 2016

The Armed Forces Post Graduate Medical Institute (AFPGMI), the oldest such institute in the country, was established in Rawalpindi in 1953. Its degree awarding programs include a two year MSc in Advanced Medical Administration. Following a visit to CBEC-SIUT last year, the currently enrolled MSc students decided to organize a seminar on the theme "Values and Ethics in the Medical Profession" as their class project. A large audience packed the auditorium and consisted of physicians from the Army Medical Corps, Army nurses, students, and hospital administrators. The daylong seminar began with invited talks in which Dr. Moazam gave a lecture on "Medicine and Ethics: Then and Now." In the afternoon she participated in a lively, interactive panel discussion which explored the complex ethical challenges arising within clinical practice in Pakistan.



Teachers and educators attend CBEC's two day ethics workshop for schools, "Thinking critically about old and new dilemmas," June 3-4, 2016