CORRESPONDENCE

Psychiatrists' fitness certificates

I write to share my empathy with Mr A V Srinivas (1)who wrote of what happened after his mother donated a part of her liver to his father. I am particularly pained by Mrs Prameela's present condition and wish her speedy recovery. Mr Veer Prasad's (2) detailed, but defensive and overly aggressive response raised a lot of questions, among which I want to mention only one.

Mr Srinivas states that no counselling was received, and that his mother was "hesitant" at first, but later agreed and was declared "fit". Mr Veer Prasad, while contesting that she was hesitant, reveals that a psychiatrist had examined her to certify fitness. Apparently, the certificate clearly mentioned that she was strong in her decision to donate a part of her liver to the husband.

It is news to me that psychiatrists are involved in these life and death decisions in India. This demands a higher level of ethical awareness, moral responsibility and technical development in the profession, which, in my opinion, is not at present at the moment. I would be interested in knowing the process by which the psychiatrist arrived at this "fitness" certificate. I am doubly concerned because Mrs Prameela, being a woman, was at high risk for having to take the consequences of gender bias, which is quite prevalent within the mental health services (3). The quality of counselling done is also an issue to talk about in Indian psychiatric settings, particularly the goal of counselling and whether it was established in partnership with the person who was counselled. The question of undue influence cannot be ruled out in the issue of the certificate.

The decision to continue or not continue with the treatment depended on the psychiatrist's fitness certificate. If there had been a finding of "unfitness" for the procedure, she may have been spared her present condition. More importantly, it takes away the whole justification for doing the procedure in the first place. Perhaps other alternatives may have been brought on board for discussion. The doctor's process of deciding fitness or otherwise is therefore of vital importance.

In India, "fitness" certificates are regularly issued by psychiatrists for the following: to stand trial, to work, for marriage, to take custody of a child, to enter into contract, etc. A "fitness to discharge" certificate is also given for discharging somebody from mental institutions. Psychiatrists are the only professionals, among the medical community, called upon to produce legally binding documents that are often presented before the courts, and that can determine the course of one's life and liberty, and life choices. How such legal determinations are often made against women's interests is described by Dhanda (4).

Professional bodies such as the Indian Psychiatric Society have never come up with protocols for preparing or presenting medico-legal opinions and the certification process. There is little appreciation of the fact that this legal process can take away somebody's civil, political, social or economic rights, as well as care and treatment rights, and that the highest level of medico-legal ethics must be brought into the decision making.

There is no instrumentation developed in this area in India, unlike in other countries where legal incapacity decisions are done under very high statutory prescription, ethical dialogue and technical development of tools of assessments. Thus, attribution of "fitness" is often a personal judgement. A recent expose described how a psychiatrist from the Agra Mental Hospital gave false certificates of mental illness, in return for money, to husbands desiring to divorce their wives. The famous Supreme Court case of Anamika Chawla also showed lapses in medical opinion and the psychiatric certification process. Two doctors issued verbatim certificates of mental illness, recommending institutionalisation, without ever seeing Ms Chawla, as required by the law.

There should be greater ethical responsibility from psychiatrists in the medico-legal opinion and the certification process. But more important is the issue of the development of application tools: if someone is judged to be a "dangerous" person and involuntarily committed, what is the tool used to make an assessment of "dangerousness"? A finding of mental illness alone does not render a person dangerous. Further, can dangerousness alone be a criterion for involuntarily committing someone and taking away their right to liberty? Such issues come up in every assessment of fitness of capacity or the determination of incapacity.

Bodies such as *IJME* should explore this topic in depth, as this is an extremely important medico-legal and ethical problem plaguing the mental health sector. We need to look more closely at the fitness certification process. Gaps in this process throw a cloud of doubt on the justification of the procedure. Sometimes procedures such as this at the point of expected "medical breakthroughs" are seen as technical and economic opportunities to be harvested and the end user of the procedure is the sufferer.

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References

1. Srinivas AV. Living donor liver transplantation. *Indian J Med Ethics* 2005; 2: 89-90.
2. Veera Prasad M. Response: living donor liver transplantation. *Indian J Med Ethics* 2005; 2: 91-93.
3. Davar BV. Diagnosis of 'gender bias' in mental health. *Psychological Foundations: The Journal.* 1998, 1: 64-68.
4. Dhanda A. The plight of the doubly damned: mentally ill women in India. In; Leelakrishnan, editor. *New Horizons of Law.* New Delhi: 1987. p.187-198.

Birth by stars

Birth is a natural phenomenon which may sometimes need assistance in the form of application of forceps or surgery or induction of labour. These interventions are decided on the

merits of a case, keeping the interests of the woman and/or unborn baby, and are done by the obstetrician.

These days some families consult astrologers to learn the most auspicious time for birth and then insist that the baby be delivered precisely at that auspicious moment. This practice must be opposed vehemently. The auspicious time pronounced may be prior to the expected time of the birth, thus depriving the newborn of physiological benefits which accrue during the intrauterine life, which may be shortened by active intervention. Alternatively, if the natural birth process starts earlier than the suggested time for birth, parents may insist that delivery be delayed, thus putting the woman and the baby to risk. Important family functions or travel schedules of the pregnant woman may also be reasons for such requests. Moreover, if such practices are encouraged, in future, astrologers might start forecasting the auspicious time for the conception of a male child.

Some obstetricians may agree to such interventions to oblige the family, or out of fear of losing the patient and for financial considerations. Obstetricians must keep the interests and safety of the mother and baby uppermost and not be a party to iatrogenic risks caused by the interventions because of considerations other than medical or surgical indications.

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Correction

The last three references from the article by Barry Schwartz and Anant Bhan on professionalism and challenges in dental education in India (*Indian J Med Ethics: 2005*; 2: 119-121) were inadvertently deleted during the production process. The error is regretted. The references are:

19. Ibid Barer page 75.

20. Ontario Ministry of Health and Long Term Care. Ontario Nurse Practitioner Initiative. [cited 2005 May 8] Available at: http://www.health.gov.on.ca/english/providers/project/nursepract/practitioners_mn.html

21. National Aboriginal Health Organization. The Profession of Dental Therapy Discussion Paper. April 15, 2003. [cited 2005 May 8] Available at: http://www.naho.ca/english/pdf/research_dental.pdf