

Contrary to the experience at the Crichton Royal, our major difficulty is providing in-patient beds for the functionally ill, which again may be a local problem. Functional patients will always require in-patient services while one could argue that the long-term care of dementia need not, or should not, be in a hospital ward. We no longer have long-stay dementia beds and it seems highly likely that all areas will find their long-term care beds being dismantled. Our concern is that while we pursue a largely futile case for more long-term dementia beds, the problem of acute functional illness may be forgotten.

Functional illness remains more prevalent than dementia, active psychogeriatric services generate increased demand for in-patient treatment for functional illness (Joint Colleges' Report, 1989) and the 'graduate' population in the community continues to increase. This will inevitably drift into the psychogeriatric domain and may prove a considerable drain on resources. It will be a mistake to underestimate the future demands of functional illness in old age.

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How old are the elderly?

SIR: I read with interest the paper by Cook *et al* on depression and previous alcoholism in the elderly (*Journal*, January 1991, 158, 72–75). The majority of psychogeriatricians in the UK deal with clientele above the age of 65, and in some cases the age limit goes to 75. Interestingly, the authors consider subjects above the age of 55 as elderly and the mean ages for subjects with alcoholism and no alcoholism were 57.7 years and 62.5 years respectively. Probably this reflects the differing views of what age is considered as being elderly?

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The 'new cross-cultural psychiatry'

SIR: Professor Leff has the advantage of having his letter (*Journal*, December 1990, 157, 932–933) pub-

lished in the month following mine. My own letter (*Journal*, November 1990, 157, 775–776) languished somewhat after its submission in March and the original argument may no longer be so fresh to readers of the *Journal*. In his editorial preceding my review of the 'new cross-cultural psychiatry' (Leff, *Journal*, March 1990, 156, 305–307; Littlewood, *Journal*, March 1990, 156, 308–327) Leff made a number of errors of fact and interpretation, two of which he replies.

My point on the 'existence' and gender of smallpox deities was essentially factual. Professor Leff answers more generally on evaluative questions, inevitable for a pragmatically-orientated psychiatry as opposed to a more distanced if nuanced anthropological position. I am far from certain that "an anthropologist is neutral as to whether or not people die of smallpox"; I for one am not. As I described in my paper, clinically-applied anthropology, including understanding of local beliefs about sickness, is now a part of the provision of clinical services (Chrisman & Maretzki, 1982; Kleinman, *Journal*, August 1990, 157, 295–296), a development which both of us appear to value.

The fundamental difference between the two disciplines seems now to be one of the degree of 'objectivity' claimed. Neither, of course, are context-independent reflections of some transcendental reality existing independently of our procedures of observation, but it is interesting that social anthropology, once regarded by biomedical science as somehow dealing in 'soft' data, seems here to have acquired a harsher objectivity (cf. Clifford & Marcus, 1986) in a way psychiatry has not, conflating as it does fact and value whilst mistaking the latter for the former. There is an irony here in that disciplines which allow for observer bias suddenly seem to switch from extreme subjectivism to super objectivism.

I would, of course, hardly quarrel with Leff's restatement of the value of our examining local meanings before carrying out comparative studies. Indeed this may be taken as the central 'motif' of the 'new cross-cultural psychiatry' (Kleinman, 1977). Nor would one be surprised that this procedure might not prove to be feasible, either for economic, organisational or ideological reasons. But our failure to carry out a study of local contexts must be accompanied by an appreciation of the limits of the data we can collect without it. Inevitably, a purely epidemiological study employing diagnostic criteria derived from one society alone will lead to our 'conventional error'. Attempting to remove culture from the whole study initially to control for it as an independent variable later leads to a fictitious construction of the whole field, in which culture is simply

subtracted from psychopathology leaving our phenomena of interest simply as an ill-connected assortment of biological, psychological and social variables. Our failure to provide plausible explanations for the cross-national prognostic differences in the International Pilot Study of Schizophrenia is a striking instance.

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This correspondence is now closed. I.P.

Informed consent in India

SIR: The ethical issues raised by the concept of informed consent for medical procedures are complex. The controversies have mainly arisen secondary to the choice of the standard employed. The two criteria commonly used have been individual freedom (and the patient's right to refuse treatment), and society's right (and the related right to therapy), which are often mutually exclusive. The western world has tended to favour individual rights when the patient's 'competence' is intact, while it takes over decision-making when this faculty is considered impaired. The implementation of the ethical criterion is thus dependent on the clinical situation and represents a compromise. Electroconvulsive therapy (ECT) has been given a special status among treatments and hence requires specific consent. Although informed consent and true voluntarism are ideals, in reality they are rarely attained, as such decisions contain an element of coercion, ranging from subtle to overt (McGarry & Chodoff, 1981). Thus, in practice, the ethical choices are difficult.

In India, this decision is further compounded by the existing socioeconomic and political realities. The majority of patients, being illiterate and poor, are unaware of their individual rights or the issues involved and may not comprehend the significance of the explanations offered. In addition, the doctor-patient relationship commonly viewed within a 'guru-disciple' context leads to a situation where the physician decides for the patient. Informed consent against this background tends to become a formality.

Consent for ECT as generally practised is part of the general implied consent to treatment given at the time of seeking therapy, although a proportion of psychiatrists would, from the legal point of view, recommend specific consent as mandatory. This stand may be ideal for the educated classes who are aware of the issues involved, but it does not alter the position of the majority of the patient population, as it would only comply with the letter rather than the spirit behind consent. Blindly adopting western standards in regions where the ground realities are not comparable would be a pretence.

The ethical answer to this complex situation has to be found within the social context of the society. The prevalent culture in India, and hence the majority, is inclined to attach more importance to health than to individual autonomy. Thus, the physician would have to assess the patient's value system and priorities and if health is considered cardinal, the decision to use ECT, despite it being the physician's choice, may be ethically justified. Similar arguments have been employed in the West to support the use of the placebo in treatment where the fiduciary nature of the physician-patient relationship is violated in order to retain its therapeutic aspect (Kluge, 1990). Obtaining informed consent for the use of the placebo would imply that its therapeutic aspect is abandoned. In such contexts, the ethical decision would be dependent on the physician and this would be part of his burden of caring for patients. Although simple explanations about the procedure should be offered, in the prevalent circumstances this by itself would not necessarily satisfy the spirit of informed consent. Informed consent obtained on paper may provide legal protection to physicians but it certainly would not take away the moral responsibility and in fact adds to the ethical dilemma. Similar situations probably exist in many third world countries for which medical interventions and ethical solutions would have to be found within the socio-cultural context.

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