

S11 *Informed consent in psychiatry*Informed Consent in Psychiatry

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The old challenge of informed consent in medicine has been developed as a legal doctrine very intensively during the last three decades.

Mainly driven by the tremendous progress of medicine and particularly of medical research it has become an essential component of ethical guidelines and legal regulations due to its relevance for basic human rights as autonomy and respect of dignity. However, some aspects of this concept need more clarification.

This seems to be valid particularly in psychiatry because a lot of psychiatric conditions may impair or at least may raise the question of impairment of the capacity to give informed consent.

Although primarily developed in the Anglo-American societies the concept has spread more or less all over the world. But its acceptance, efficacy - and possible risks in different cultures with fairly different value systems as individual autonomy-related versus family-related ones remain to be explored. More knowledge about this may have implications for both the concept and its application in practice. Concepts and methods of the assessment of the capacity to consent need further development and empirical evaluation with regard to its practicability, validity - and possible risks.

Finally, very little information exists on how, where, when, and by whom knowledge about the concept, experience with its application in practice, and consideration of its dependence and impact on the value systems of different cultures each will be taught and trained.

S11 *Informed consent in psychiatry*Assessment of capacity to give informed consent in psychiatry

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During the last three decades the doctrine of informed consent has become a legal standard in medicine. However, ethical problems arise if patients or subjects have lost the capacity to give an informed consent due to their medical condition. In particular in the field of psychiatry the assessment of competence to give informed consent to medical treatment and to participation in clinical trials is a controversial issue. New empirical data suggest different standards for assessing patients capacities to make treatment decisions. The choice of standards for determining competence affect the identity and proportion of patients classified as impaired. Therefore the selection of these standards has to be discussed critically under medical and ethical issues and formal policies relating to the characterisation of persons as incompetent must be fashioned with caution.

S11 *Informed consent in psychiatry*The legal doctrine of informed consent and its significance in psychiatry

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Informed consent is today a well-established legal doctrine in Europe and North America. It has been based on the assumption that everyone has the fundamental right to decide what shall be done with his own body. In order to reach a true decision as to a treatment, one must be informed of all its relevant aspects (diagnosis, prognosis, risks, cost, etc.). The physician who does not inform adequately his patient makes himself legally liable for any unwanted outcome of the treatment.

One of the basic premises of the informed consent doctrine is the patient's ability to understand a situation and to make a decision on the basis of his own appreciation of it. This is why the implementation of the doctrine has met with so many difficulties in psychiatry.

This contribution will explore these difficulties, especially the assessment of the capacity to consent and the legal mechanisms to make decisions on behalf of an incompetent patient.

S11 *Informed consent in psychiatry*The reality of informed consent in different cultures Mediterranean versus Anglo american culturesA. Okasha, Egypt

Whether we like it or not, the encounter of psychiatry and law keeps bringing us back to the duality that exists between our conflicting conceptions of the value of health on the one hand and our conception of liberty, integrity and autonomy on the other. Informed consent requires certain criteria to be valid, however we should know when a patient's consent is not required. Cultural, ethnic and sometimes sociodemographic data like education suggest different attitude regarding patient's autonomy and informed consent. The decision making style might be described in some cultures as family centered. In some Mediterranean countries the issue of telling the diagnosis, prognosis and lines of treatment is not viewed as empowering. Traditional societies value the family centered model. The higher value may be placed on the harmonious functioning and the family rather than the autonomy of the individual members. In Mediterranean countries many people especially Islamic societies have an external locus of control and all events are attributed to God's will. Islam is centered on the idea of man's obligation or duties rather than rights that he may have. What is the perceived harm when the medical community violates cultural conventions and insists on telling the truth to the patient? What disruptions occur in the coping mechanism in the individual and family? In what ways does acculturation change the beliefs of patients of various ethnicity's. I suggest that psychiatrists ask patients if they wish to be informed about their illness and be involved in making decisions about their care or if they prefer, that their family handles such matters. Allowing patients to chose a family centered making style means broadening our view of autonomy so that respect for persons includes respect of the cultural values they bring with them to the decision making process.

This paper will discuss the reality and the concept of informed concept in different cultures, studying the Mediterranean and traditional cultures versus the Anglo American model.