Health and Human Rights

Asylum Evaluations—
The Physician’s Dilemma

HARVEY M. WEINSTEIN and ERIC STOVER

In the following paper, Annemiek Richters of the University of Leiden in the Netherlands addresses the dilemmas faced by health professionals who are asked to evaluate and provide supporting documentation for those refugees who seek political asylum in the countries of Europe. It is in the politically charged arena of asylum applications, government regulations, and public policy where bioethics, human rights, and health converge. Despite the 1951 Convention on Refugees, a treaty signed by nations around the world to safeguard the rights of those who are displaced, and other treaties that protect the rights of vulnerable populations, refugee and asylum policies have become increasingly strict in an effort to deter those who would seek safety. This tightening of borders in the countries of the West challenges physicians who find themselves caught between obligations to treat, to advocate, and to challenge policies that make treatment a potentially dangerous proposition. Unfortunately, the World Trade Center attacks have exacerbated the problem by labeling asylees and refugees as potential terrorists and subject to deportation.

Professor Richters explores the conflicts experienced by health professionals who must reconsider certain of their ethical obligations in light of international human rights law. Asylees whose rights have been violated in their own countries must prove a “credible fear of persecution” to an asylum officer whose language may be quite different and whose understanding of the politics of the asylee’s country is very limited. If deported, the asylee applicant may face death or engage in ongoing attempts to enter a safe country with all the risks that road entails. In clinical vignettes, Professor Richters describes how ethical practice can be challenged by these larger human rights considerations. Physicians may be confronted by a situation where their “duty to treat” confronts the harsh reality that treatment may contravene the tenet of “do no harm.” For example, harm may arise from good treatment when recovery leads to deportation. The original therapeutic considerations such as treatment of depression or anxiety may seem almost irrelevant when the asylee patient faces a return to repression, fear, and even death. Richters raises our awareness of the need to address these dilemmas and suggests that health professionals cannot confine themselves only to the doctor-patient relationship but also must become political advocates when human rights concerns threaten the well-being of those they serve. Finally, she revisits the question of how a postmodern ethical perspective can offer a framework for clarifying bioethical obligations.

At the beginning of 2001, the United Nations High Commission for Refugees estimated that there are more than 22 million refugees and internally displaced
persons in the world—one for every 275 persons on Earth. These figures do not take into account the thousands of others who each year escape from government repression, persecution, torture, disappearances, and extrajudicial executions to seek political asylum in countries of safety. Despite the events of September 11, Professor Richters’s observations remind us of the importance of maintaining borders open to refugees and of the critical role played by health professionals in protecting and promoting the human rights of those who seek sanctuary.

When Ethics, Healthcare, and Human Rights Conflict: Mental Healthcare for Asylum Seekers
Annemiek Richters

Introduction

Mental health professionals who care for asylum seekers in Western European countries increasingly encounter problems for which standard diagnostic and therapeutic protocols and institutional healthcare policies offer no ready answers. In the following case vignettes¹ some of these problems can be identified.

Mrs. N. is a 52-year-old woman who fled from Iraq with her husband and came via Turkey to the Netherlands. During the flight her husband who was active in the Kurdish resistance was murdered. She does not know the whereabouts of her seven children. Even though she adheres to the Islamic faith, she tells her therapist through an interpreter that she no longer wants to live. She states that she definitely will commit suicide if sent back to Iraq. Her conviction is that as soon as she returns, she will be killed. Her lawyer notifies the therapist that the Dutch government has decided that it is safe for Iraqi Kurdish refugees to return to Iraq. The therapist finds it difficult to decide what diagnosis to give to Mrs. N.’s psychological complaints. Should she think of a diagnosis that will offer Mrs. N. the greatest opportunity to remain in the Netherlands? Should she use her position as a therapist and her power to select a diagnosis that will exert political influence?

Mr. C. is a 37-year-old man, also from Iraqi Kurdistan, who is under treatment in a Dutch psychiatric day clinic for depression and posttraumatic stress disorder. He has fought for many years in a Kurdish rebel group against the regime of Saddam Hussein but also against other Kurdish groups. Mr. C. is a warm, open man and a welcomed member of a therapy group that consists mainly of victims of war crimes. He particularly wants medication for his complaints but also accepts other advice. His situation deteriorates when he suddenly receives information that he is considered a war criminal and therefore may have to be deported and returned to his country of origin. The therapist now must rethink the therapy options. Another problem faced by the therapist is that Mr. C’s lawyer sees many

This article is a revision of an earlier paper presented at the seventh International Research and Advisory Panel (IRAP) of the International Association for the Study of Forced Migration (IASFM), January 8–11, 2001, Johannesburg, South Africa. I thank psychiatrist Hans Rohlof and his psychotherapist colleagues at De Vonk, a trauma therapy center for refugees in the Netherlands, for sharing some of their work experiences with asylum seekers. I also thank Harvey Weinstein for his encouragement to rework the conference paper for this article and for his editorial advice.
possibilities to successfully proceed with the asylum procedure and asks the therapist for a statement that Mr. C. has a warm and nonaggressive personality.

Mrs. K. is a 40-year-old Iranian woman who fled from Iran after imprisonment for her involvement in political activities. In the Netherlands, where she has applied for asylum, she received various psychiatric treatments for obsessive compulsions without improvement. Since the age of 14 she has suffered from contamination phobia and compulsive behavior. These problems worsened after traumatic experiences. The compulsive behavior distracts Mrs. K. from dismal feelings and thoughts. Her present therapist does not know whether to try another treatment approach as long as there is no clarity about the residence status of Mrs. K. She can be expelled from the country at any moment. However, if there is a medical indication that Mrs. K. needs treatment, she may be allowed to stay. Such an indication means that she should keep her complaints, not improve, and stay under psychological or psychiatric treatment. But what has psychiatry to offer a patient who seriously wants to be relieved of her suffering but is not motivated to get better because cure would mean expulsion?

In the Netherlands, regulations indicate that healthcare providers, such as psychiatrists and other mental health professionals, should not be involved in asylum procedures. This is done to avoid any strain in the trust relationship between therapist and patient. In reality, however, psychiatrists cannot avoid the contentious aspects of human rights issues related to the legal status of their patients, either in their diagnostic or in their therapeutic endeavors. For instance, patients, friends, family members, and lawyers may ask them to write statements about the personality of the asylum applicant or the origin of the symptoms that are more definitive than the professional is prepared to say, to give a posttraumatic stress disorder diagnosis when not all features of this disorder are present, or to state that long-term treatment of the disorder at issue is needed. The problems that patients experience with their asylum procedures become part of their suffering and their geopolitical stories. Psychiatrists in their turn become part of the geopolitical stories of their patients and face difficult moral dilemmas. These dilemmas can only be understood in the context of the geopolitical, sociocultural, and legal framework in which asylum seekers seek psychological assistance.

Refugee Protection in Europe

During the last 15 years, refugee protection in Western Europe has become increasingly compromised by apparent public hostility and growing government restrictions. Those critical of this development refer to Europe in this respect as an impregnable fortress in which the balance between the right to asylum and the right to restrict migration tends to tip in favor of the latter. In all Western European countries, the 1951 United Nations Refugee Convention provides the basis for refugee protection. However, in the course of its 50 years, its position in relation to wider human rights tools and its use in practice has generated a wide range of questions and issues and continues to do so. According to the Convention a refugee is a person who...

...owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to
such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his habitual residence as a result of such event, is unable or owing to such fear, is unwilling to return to it.  

On arrival in the country where the refugee seeks safety, she is expected to submit a request for asylum. Until this request is granted and the status of “recognized refugee” is obtained, she is viewed as an “asylum seeker.” The distinction between asylum seeker and refugee is primarily a judicial one. In this sense, “refugees” may refer to both asylum seekers and other forced migrants who do not apply for the formal status determination procedure. Voluntary migrants are considered “immigrants.”

The majority of asylum seekers do not strictly fulfill the individual refugee criteria as described in the Refugee Convention, but they cannot be returned to their country of origin on the basis of the nonrefoulement criterion, which is formulated as follows:

No Contracting State shall expel or return (“refoul”) a refugee in any manner whatsoever to the frontiers of territories where his life or freedom would be threatened on account of his race, religion, nationality, membership of a particular social group or political opinion.

Thus, no one can be returned to a situation where she is at risk of serious human rights abuses. However, article 33.2 stipulates that

the benefit of the present provision may not . . . be claimed by a refugee whom there are reasonable grounds for regarding as a danger to the security of the country in which he is, or who, having been convicted by a final judgment of a particularly serious crime, constitutes a danger to the community of that country.

However, the latter article raises a serious concern where, in cases like the one of Mr. C., he may be called a freedom fighter and hero in one context but designated a war criminal in another.

With regard to the first section of article 33, the issue is: what are the criteria used to determine a safe country? Countries of origin that are officially declared safe by officialdom may not be considered safe by people who have more in-depth knowledge, like the asylees themselves or various human rights organizations.

An asylum seeker can be granted refugee status also on pressing humanitarian grounds other than the ones mentioned in the Convention. Some examples include serious suffering from traumatic events in the country of origin (as in the case of Mrs. N.) and the need for medical treatment (as in the case of Mrs. K.). If good reasons remain present, temporary status can be changed in due course of time into permanent status.

To stem “the flow” of asylum seekers, to prevent “asylum shopping” between European countries (i.e., seeking asylum in multiple countries), to have a more proportionate distribution of asylees and refugees throughout the European countries, and to harmonize asylum policies, Western European countries have fostered the development of a Europe-wide asylum policy. There is concern among refugee-policy scholars and activists that this development will strengthen the tendency toward a “Fortress Europe” that is hostile to outsiders and that may diminish the human rights protections of asylum seekers and refugees. Refugee policy appears to have shifted from a humanitarian perspective to one of internal and international security. It is too early to say if and to what extent the increasing threat of terrorism after the September
attack on the World Trade Center will reinforce this development and lead to increasingly tougher restrictions on refugees. However, we are already seeing proposals to tighten the tracking of visa holders in the United States and to restrict the admission policy for migrants to Great Britain.

Media portrayals of refugees in a negative light, racial prejudice, and public fears of being overwhelmed by “strangers,” “terrorists,” “criminals,” “bogus applicants,” “spongers,” “economic migrants,” and “vulnerable, destitute people” have all contributed to a climate in which there is much skepticism about the bona fides of asylum applicants. In most Western European countries, the burden of proof that the fear of persecution is well founded is now shifting more and more from the authorities to the applicant. An additional, aggravating factor is that the enormous increase in the number of asylum seekers in recent years has resulted in strong political pressure to handle the application cases more quickly. Combined with greater reluctance to receive more “strangers,” these factors have endangered the quality of the admission interview (usually called the first interview) during which the asylum application is assessed. If turned down, the subsequent appeal process may take a long time, causing much uncertainty and stress that can affect adversely the asylee’s psychological state. If mental healthcare was not indicated from the start, it might become indicated during the appeal process.

Truth Finding, Justice, and Care of Refugees in the Netherlands

Like other Western European countries, the government of the Netherlands wants to restrict admission of refugees into the country while remaining hospitable to the “real refugees”—the so-called firm but fair policy. To this day the Refugee Convention remains the basis for the reception of asylum seekers in the Netherlands. At the same time, conventions concluded at a European level regarding the protection of human rights are adhered to. The Aliens Act regulates how the Netherlands interprets these international agreements. This Act can be amended when necessary by government order. During the last decade a series of restrictive asylum amendments have been made.

The numbers of asylum seekers taken in by European Union countries vary widely, with the Netherlands taking in relatively large numbers (something more than ten percent of the asylum seekers in Europe). In recent years the inflow has fluctuated between 20,000 and 45,000. In recent years, at least 44 percent of all asylum seekers in the Netherlands have received a residence permit. Asylum application on medical grounds has become more and more frequent and currently represents ten percent of the total requests for asylum. A large percentage of these problems (60–70 percent) are of a psychological nature.

As noted, refugees must go through an asylum procedure to secure a legal residence permit. In the Netherlands, it is generally accepted that it is not the task of healthcare providers to gather evidence with regard to this procedure. The search for evidence to support the asylum application and care for asylum seekers’ health are seen as strictly separated activities. It is the task of the judicial system to assess the reliability of the refugee story, whereas the healthcare provider treats the medical and psychological problems of the asylum seeker. Healthcare providers must not assimilate the norms and values of the authorities, where there is a culture of disbelief about the reality of torture and persecution.
The Immigration and Naturalization Department (IND) of the Ministry of Justice decides on the asylum application request. For medical judgment and advice, the Department calls in the Bureau of Medical Advice (BMA), which was established in 1999 under the IND. The medical assessment by the consulting physician of the BMA generally is based on written information about medical problems of the asylum seeker and the necessary treatment. The IND holds that medical examinations cannot contribute to truth finding with respect to asylum pleas, therefore no medical-forensic questions are asked. With the written consent of the asylee concerned, information is always requested from the treating healthcare provider. Only factual medical data such as concrete information about complaints, treatment, and prognosis is expected. The healthcare provider may be asked as well whether the asylee, from a medical point of view, is able to travel to the country of origin or a third, safe country and whether the appropriate medical treatment is available there. Additionally, the healthcare provider may add a statement about the need for residence in the Netherlands. The consulting physician, however, will only weigh the factual medical information to come to a judgment. It is also possible that someone representing the interest of the asylee, such as a lawyer, may request medical information from the treating healthcare provider for submission to the BMA physician. Also, the latter can take the initiative to invite the asylee for a direct examination. The BMA physician, as well as the person providing legal assistance to an asylum seeker, also can ask a third, independent party for medical information, such as the Medical Research Group of Amnesty International, although this happens mainly during the appeal stages of the asylum procedure. The medical advice eventually given to the IND can have a substantial influence on the final judgment.

In his work as a psychiatrist in De Vonk, a Dutch treatment center for traumatized refugees and asylum seekers, Hovens observed that psychiatrists treating asylum seekers often have a tendency to become either over- or underinvolved with their asylum-seeking patients. Overinvolvement can lead to lengthy reports designed to help their patients in acquiring refugee status. However, this involvement can exceed professional expertise and may, in the long run, diminish confidence in the objectivity of the health provider’s reports. The temptation to exaggerate, speculate, or take the patient’s side may undermine rather than bolster the credibility of the asylee’s case. Underinvolvement on the other hand can lead to making no reports at all, which can be harmful to patients as well.

To guarantee quality treatment, the professional staff at De Vonk chose not to function as an assessment center to produce reports for political purposes. The consensus was that Amnesty International and independent psychiatrists should provide such reports. Psychiatrists at De Vonk are only available for consultation to provide the relevant psychiatric findings and treatment of patients to lawyers, independent psychiatrists, and the BMA. Although the staff at a treatment center like De Vonk thus hold the opinion that treatment and fact finding should be strictly separated (a rule of conduct supported by the Dutch Medical Association), there seems to be an understanding among health and human rights activists that forensic medical examination can and should contribute to the evidentiary basis for asylum pleas. However, this view is not uncontested. Opinions differ about the relationship of fact finding, justice,
and care in both the Netherlands and across the countries of Western Europe. We are far from agreement on a harmonized approach regarding medical conduct in these matters.

The dramatic increase of deeply war-traumatized people from relatively unknown cultures in Western Europe has confronted psychiatric practice with various problems previously unknown. The Dutch Aliens Act is continuously revised under the influence of actual developments in politics and society. Additionally, the BMA has improved, adjusted, and further developed its procedures and mandate. Psychiatry, in its turn, is attempting to determine the correct responses to these developments based on a consideration of the best interest of their patients and potential patients. This raises the question of what role psychiatry could or should play in the prevention of war- and repression-related suffering. This concern coupled with the changing nature of human rights protection makes it all the more imperative to reflect on what constitutes appropriate mental health interventions for refugees.

The Changing Nature of War-Related Suffering and Care

In the nineteenth and twentieth centuries, humankind experienced officially declared wars between nations, the modern “killing fields,” and the unintended damage to people and material infrastructures outside the battlegrounds. Some of this so-called collateral damage to human beings was definitive—people died. Other damage was of a psychological nature and often long-lasting. Experience showed it to be easier to repair material damage than to repair damage to the mind and soul. In most cases, however, victims remained in or returned to their traditional lives, their familiar homes and houses. In their misery, that often gave some help and comfort.

In World War Two, the nature of war began to change. In that war, humanity came face to face with intended collateral damage outside battlegrounds—for instance, damage was done to people and material infrastructure through the bombing of cities and engineered killing and starvation in the Nazi concentration camps. It still remained easier to repair material damage than to repair damage to the mind and soul. Different from before, however, was that now many victims could not or would not return to their prewar worlds, to the security of what once was so familiar. In their misery, they were forced to turn to new places and people for help and comfort. As their suffering was unquestionable, most victims, sooner or later, obtained the needed help and comfort from relatives and friends and, with much delay, from governments. However, the horrible memories of war experiences remained as vivid as if they had happened the day before.

The war theater has changed even more drastically since World War Two. Most wars now are fought within, not between, states. They are undeclared and do not follow the rules of war as stated in The Hague Peace Conferences (1899, 1907) and the Geneva Conventions (1949). The period of the cold war also showed that war inside states does not mean that outside states are not involved in some fashion. Even now that the cold war has ended, many civil wars are still directly or indirectly related to outside interests. For the victims of such wars, the consequences, however, are fundamentally different. Often, the victims of war, engineered killing, torture, and starvation are unable to remain in or return to their pre-war lives and must turn to other countries for help and comfort. Rather than being welcomed with open arms,
most of them must prove their suffering beyond any doubt to obtain assistance in strange and unfamiliar environments. Governments and strangers now provide this help as relatives and friends are either dead or likewise displaced. Europe, with its long history of political and religious conflicts, has for centuries been a melting pot of people migrating from one country to another—people with different religions and languages, cultural values, norms, rules, and traditions. These people may have gone to their own churches such as The English Church or L’Eglise Wal-lone (French); they may have preferred different food or music and had different mentalities; but as they all had the same Judeo-Christian background, there were more commonalities than differences. Most importantly, these forced migrants accepted the secular state and the basics of democracy.

Since the 1960s, labor migrants arrived in Western Europe often with very different backgrounds from the “regular” population. They had different religions, did not speak the local language, took no part in cultural and political life, and were not interested in the history of their “new worlds.” They had different mentalities and abstained as much as possible from social responsibilities. Their principal goal was to save as much money as possible and return home someday. Although their numbers initially were regulated by state and economic necessity, this changed once they decided to stay and were afforded the right to family reunion. These reunions were followed often by birth rates among the first generation of immigrants that were very much higher than those of the indigenous Dutch population. A truly multicultural society was born, with new boundaries and differences.

Because of these processes, society changed even more from Gemeinschaft to Gesellschaft than it already had due to industrialization and urbanization. In the new global village, there is no township, no civitas. Parallel to this development a worldwide process of globalization has occurred. For many, the Old World with its well-known problems and solutions has been taken away. Instead of sharing the securities of community and well-known traditions, many people gradually have felt disaffected and alienated as they perceive themselves being treated like goods in a global marketplace. Ethics and morality have become more and more “situational” and functionally related to the interests of particular (sub)groups. The postmodern world, with its extreme individualism and egocentrism, with its growing historical and sociocultural analphabetism, has brought new problems. It asks governments for new solutions, and healthcare systems for new kinds of services.

This growing alienation from the traditional community appears to predispose to “right wing” resentments, often too easily labeled as “racism.” Asylum seekers suffer from this development. Many people privately think or express such sentiments as, “We already have troublemakers enough; we can hardly stop illegal immigrants; why officially accept more strangers?” These people may then begin to show racist tendencies. To complicate these changes even further, individuals who would have become national heroes for resistance work in the context of World War Two are, in the context of the present civil wars, considered to be war criminals. In this current complex situation, an age-long process of humanism and experimentation with formulations of universal human rights is in danger of being halted.

The Road to Human Rights
It was one of the illusions of the Enlightenment that by replacing reli-
gious speculative metaphysics with rationality, and man as a shadow of God on Earth by man as a responsible, semiautonomous subject, that reason, ethics, and morality would go together. The Enlightenment was the start of modern times, the period of metanarratives about civilization and humanism, and a belief in social engineering and the fashioning of the world. Although Western Europe was still a melting pot of states and nations, slowly a process leading to one mentality, humanism, took place.

In due course, however, reasoned ethics as a foundation of morality and mentality was found to entail something mechanistic, something calculable. Enlightened philosophers even started to speak about the “dictatorship of reason.” It gradually became clear that wisdom is not a product of rationality. A centuries-long process of social experiments full of conflicts and violence culminated in the twentieth century in two World Wars and one cold war, with millions of deaths, invalids, and traumatized people.

This bloody history raised doubts about man’s nature, for instance, in the minds of scholars of philosophical anthropology. It seemed as if a gradual “reasoned” enhancement of man’s inborn moral identity—a process that the humanists of the Enlightenment believed could take place—was very questionable. Further, it appeared that man is so egocentric by nature that notions of ethics and morality under the control of man himself had to be replaced by notions of ethics and morality as products of stringent government control, discipline, and punishment— notions that were applied in all sorts of fascist ideologies.

We still are unable to offer a scientifically based answer to queries raised about the nature of man in matters of social civility. What we do know, however, is that rationality as the proper basis of critical (self-)reflection and (self-)monitoring is questionable. Goal-oriented rational behavior is not by definition a successful instrument for emancipation and civilization. As no two eyes see the same world, rationality is too instrumental and functional for universal uses. History and scholarship show that although most people have notions about justice that make ethics and morality possible, their subjective inclinations often bring them somewhere else.

In the nineteenth and twentieth centuries, some of the discussions about ethics, progress, and civilization gradually centered around the problem of whether the Western idea of civilization is by rational and logical necessity a product of state-organized indoctrination, or whether state-organized indoctrination is by rational, logical necessity a product of Western civilization. In both perspectives, violence seemed an integral part of this indoctrination. The history of civilization suggests that no “transhistorical” human subject exists, no essence is apparent beyond the relativities of time, place, and language, and that getting history wrong is part of being human or being a nation.

Notwithstanding the negative and pessimistic arguments and experiences mentioned, an old and persistent belief in man’s inclination toward justice survived. This belief is based on the presupposition that even when violence is part of man’s innate evolutionary programming, that programming is ontogenetic and could, consequently, be changed by information.

In the nineteenth century, with the rise of “utopian socialism,” notions of justice and human rights became stronger than before related to the social, political, and economic reality of the “masses.” With modern socialism, when “scientific socialism” turned into a “historical materialism,” utopian thinking changed into an international...
ideology.29 As a protest movement against that other international ideology, capitalism, and the constant conflicts generated by that ideology, the slogan “no peace without justice” gained ground.

Riding piggyback on this development, humanism turned into an international force. The *Communist Manifesto* as a “human declaration of rights” had its influence far beyond the borders of Europe. It provoked not only traditional power elites defending nationalism but also international forces like liberalism, capitalism, colonialism-imperialism, and Christianity. When historical materialism turned into “communism” and succeeded in changing Russia into the Soviet People’s Republic, these counter-forces remained active until the fall of the Berlin Wall. Historical materialism in its various forms was finally defeated by capitalist globalization.

All the humanitarian movements mentioned, and so many others, in one way or another promoted a kind of democratic pluralism. The pluralistic character of Europe led to a kind of “trans-historical identity” of European man and society, a secular and democratic identity. All European states developed structures and institutions to teach, maintain, and control their “culture,” their values, norms, and rules. This was done by translating “culture” to social structures and institutions that contained frameworks of instructions, directions, prescriptions, and regulations. These frameworks were adapted to a multiplicity of subcultures—governmental, political, industrial, scientific, healthcare, gender, and age related. These subcultures are only relatively independent from each other and are not free from top-down interventions. And as most interventions protect interests, not people, that is where the origin of many sociocultural problems and troubles can be found. For instance, in matters of asylum seekers and their state of mind, more often than not, mental healthcare institutions are faced with the problem that there is “no healing without justice.”30

**Suffering, Care, and Human Rights: Moral Dilemmas for the Psychiatrist**

Healthcare may be the one societal institution where, more than anywhere else, we are confronted with the fact that clear directions cannot always be found on maps or in documents. Although constrained by economic realities, I contend that health services and access should be grounded in compassion. However, the healthcare system in modern states is embedded in the total governmental and bureaucratic structure. One strength of the Dutch social structure is that no group, no citizen, is to be excluded from healthcare. Universal access to healthcare is a basic right for all Dutch citizens with some restrictions in regard to illegal migrants. Healthcare in a qualitative and quantitative sense should also be the same for all; however, one may question whether this is either possible or appropriate. Can the same kind of care effectively be given to people with different cultural and ideological backgrounds and often different types of minds, bodies, and diseases?

Mental disorders, the subject matter of psychiatry, are considered manifestations of a behavioral, psychological, or biological dysfunction in the person. However, I argue that, particularly for asylum seekers and refugees, mental disorders characterized by standardized psychiatric diagnoses may often better be described as normal reactions to abnormal political, social, and cultural situations. As physical integrity cannot withstand the dissolution of the social personality, it is at the level of the political, social, and
cultural that healing should occur. And, for a psychiatrist, that would mean a transgression of the boundaries of the profession as defined by mainstream psychiatry. In working with asylum seekers, this perspective can raise a number of specific moral dilemmas for the psychiatrist.

These moral dilemmas can transform asylum evaluations into “moral cases.” An evaluation becomes a moral case when it is characterized by the presence of divergent and often irrec-

concilable rights, duties, interests, goals, and normative basic assumptions of the people or institutions involved. A moral issue becomes a problem when there is uncertainty concerning the acceptability of a particular decision or action. This then raises the question of what constitutes a morally justifi-

able response.31

Examples of such moral dilemmas that arise in the care of asylum seek-

er include the following: what should the physician do when it is expected that the application for asylum of a patient will be rejected? Should the treatment be continued or stopped and the patient prepared for a return to the country of origin? If a patient is under treatment for generalized anxiety disorder or panic disorder, with the threat of expulsion, the anxiety becomes real. If he has to return, the fear of persecution may be very real-

istic. Does the psychiatrist then work to fight the return, change treatment strategies to try to assist the patient to anticipate the consequences of return, or continue to assist the patient with medications and psychotherapy as before and accept the bureaucratic decision?

Another dilemma occurs when conti-

nuing a treatment that may be unnec-

essary from a narrow psychiatric perspective gives the asylum seeker the right to stay in the country of asylum, whereas completing the treat-

ment means that the patient will have to return to the country of origin, where, according to the psychiatrist, she will have to fear for her life.

What does the psychiatrist do when a female asylum seeker does not want to talk about the sexual abuse she experienced in detention because of culturally produced and constructed shame, and the psychiatrist’s judgment is that, at least in the current phase of treatment, her wish should be respected? However, the dilemma is that her testimony of the abuse will contribute to the evidence needed for a residence permit.

Finally, psychiatrists working with refugees and asylees must turn suffering into medical diagnoses. Many men-
tal health professionals are concerned that, under current policy and inter-

vention guidelines, people traumatized by political violence must be transformed into victims and into patients with psychological and med-

ical pathologies (like posttraumatic stress disorder). Under this perspec-

tive, a social and political problem is made into a medical one, which sub-

sequently is “treated” at an individual level. At the same time, the psychia-

trist knows that for “the patient” to secure justice, it is necessary to medi-

calize the problem and present it as posttraumatic stress disorder to the authorities that have decisional power with regard to a refugee status. Should the psychiatrist against her better judgment limit herself to therapy because that is what her institution expects her to do, or should she take social action by mobilizing people with the goal to secure a residence permit for the patient and/or stimulate a societal debate about the moral problems raised by the care of asylum seekers?

All of these dilemmas, in one way or another, touch on such problems as the nature, scope, and boundaries of professional psychiatric care. Should
care be limited to a narrowly defined institutional framework, to a limited professional standard focused on the individual patient, or does the psychiatrist also have more general, universal humanistic or civic responsibilities? If so, what exactly do these responsibilities entail with regard to patients, herself, and society? Which justice, whose rationality, should she apply? What role should she play: Should it be that of the psychiatrist as professional, as a critical, morally engaged citizen, or as a representative of the state?

**Mental Healthcare in the Middle**

The story of Mrs. N. moves any compassionate person and leads to the conclusion that it obviously would be inhumane to send her back to Iran. However, asylum evaluations are complex and motivations are multifold and multifaceted. Should a psychiatrist refrain from disbelieving (parts of) a story and take the history at face value? What conscious and unconscious negotiations and by whom, are at stake in the psychiatric care of asylum seekers—care that may include writing reports to authorities who have the power to decide the fate of the patients? These conflicts and negotiations may reside within the asylum seeker, as she negotiates between what is the real truth and what is self-interest; between the asylum seeker and the psychiatrist, who also negotiates internally between professional standards and her own feelings and prejudices; and finally, between the psychiatrist and the government, which in its rules and regulations negotiates between universal human rights and the interests of the state, interests that should not always be equalized with justice? All of these negotiations clearly apply with regard to the situation of Mr. C.

In different ways, psychiatrists and governments are faced with a moral double bind—how to protect the interests of the state and its citizens while, at the same time, taking seriously the concept of justice, as laid down in international human rights treaties. Not being certain what to expect, the asylum seeker has every reason to suspect the psychiatrist of being a double agent, feeding the bureaucracy with information necessary for the “decisionistic reasoning” applied in these matters. Decisionistic reasoning does not start with the cause of a phenomenon and then look for its effects. In asylum evaluation, it is based on the presumption that too many asylum seekers will take away resources needed for the domestic population, that the rules for expulsion should be strictly applied and, if necessary, be made even more strict. The decision is logically implied by the presumptions and has the sensible and democratic form: “in every case of A, always B.” Einstein warned of the dangers of this type of reasoning when he said, “Everything should be made as simple as possible, but not simpler.”

Psychiatrists insofar as they are directly or indirectly involved in the decisionmaking procedures of the state—procedures that make it more and more difficult to grant refugee status—are obliged to comply with this type of simple reasoning. Consequently mental health professionals are faced with these moral questions: whose justice should be practiced, and which rationality should be used? This is particularly difficult when they are aware of the background of some of the contentious aspects of the human rights issues at stake. The psychiatric profession, due to its subject matter, should ask for something different—logical reasoning that considers contextual complexity as a factor in reaching conclusions.

It is easy to say that psychiatrists should not become overinvolved with
their patients while reporting to the authorities, and not underinvolved either. In practice, however, this prescription can make psychiatrists feel like Ulysses sailing between Scylla and Charybdis.32

**Ethical Issues**

It should be clear by now that the dilemmas that arise in psychiatric care for asylum seekers cannot easily be solved by the application of axiomatic medical ethical principles: beneficence, nonmaleficence, respect for the autonomy of the patient, and serving justice. Too often, relying on those principles places hope over experience. Acting according to these principles will very often bring moral dilemmas to the fore rather than solve them. The most one often can do is to try to determine—a difficult task—what is “the least harmful” and act accordingly. Whereas “autonomy” of the patient is a contested concept in Western culture, in many other cultures the application of the principle of autonomy is even more problematic.33 Which rationality to use may be a tricky issue, but whose justice and how to apply it are the most difficult issues to confront.

Based on her own morality, a psychiatrist may want to make a positive contribution to justice—if only because, without justice, the therapy will never be effective. However, as noted, the decision of whether an asylum seeker is granted a refugee status or not is left to government-appointed people who apply decisionistic reasoning. How independent these decisionmakers are from the political system may differ among nations, and how independent they position themselves within their own country is an individual choice. What also differs is the history and situation of each asylum seeker. Overriding all is the principle of “protecting interests,” given that asylum policy currently is based on the reductionistic reasoning that too many asylum seekers will take away space and resources needed for domestic populations. As a consequence, the rules are strictly applied and, if necessary, made even stricter. I would suggest that expelling asylum seekers thus may be only a demagogic ritual sacrifice designed to accommodate the uninformed negative feelings of the domestic population.

What options then are left for integrative moral deliberations about the cases in question? Can the bureaucratic process incorporate considerations that honor the sanctity of human life? In the last decades, the axiomatic, general four-principles approach became the dominant one in modernist medical ethics. Alternative postmodernist approaches—for example, phenomenological ethics, narrative ethics, hermeneutic ethics, discourse ethics, care ethics, and feminist ethics—have taken issue with the presuppositions of the principle approach.34,35 These presuppositions include individuality, rationality, and a foundation in abstract principles. From a postmodernist perspective, it has been argued that the modernist search for codification, universality, and foundations in the area of ethics has been destructive to the moral impulse.36 The postmodernist emphasizes the contextuality of human existence and, furthermore, that human and social life is filled with problems, twisted trajectories, ambivalences, doubts, and moral agonies with which people must learn to live.

Postmodern ethics enjoins us to face the world without easy recourse to guiding codes or principles. It recognizes that the wholeness of a person as presupposed in modernist thinking is an illusion and that people avail themselves of multiple, inconsistent self-representations that are context dependent and may shift rapidly. What
is morally at stake in a particular case should be approached from a variety of perspectives. Every facet of a particular case has to be understood. Ethics is not a matter of theoretical knowledge about justice and of rational arguments but of practical insight, feelings, and emotions.

A key term in ethical discussion is “responsibility.” In the modernism/postmodernism debate a “responsibility to act” in the world in ways that are justifiable is contrasted with a “responsibility to otherness.” Responsibility in the rational, logical, modernist sense means inevitably closing off sources of specific, personal insight and treating people alike so as to procure uniform, rational, consistent, and defensible decisions about alternative courses of action. The modern cognitive machinery promises harmony, unity, and clarity and denies thereby the ineradicability of dissonance. But simple answers to complicated questions take the pain out of thinking. The postmodernist vision accepts that ambivalence and disorder are aspects of life that we should embrace, not just temporary difficulties that need to be overcome by further analysis, or the application of ever more structured ethical systems.

If we return to the three case studies presented in the introduction and the moral dilemmas I listed subsequently, it is apparent that the psychiatrist cannot keep the judicial system and its modernist reasoning and his professional ethics out of the interaction with the patient. This inability leads to a juridification of the doctor-patient relationship. The psychiatrist who does not believe in the appropriateness of a modernist psychiatric approach toward the patient will recognize that there are no good solutions for the problems that she is confronted with. In discussions with colleagues and ethicists, the psychiatrist may find some norms and values for her actions. However, each case will lead to a different weighting of those norms and values. Every “solution” leading to action will be relative and will always leave the care provider with feelings of frustration because she has not been able to fully reach her professional or humanist goals. She must live with the fact that she is obligated to some kind of pragmatic justice.

The Asylum Crisis: A Human Rights Challenge for the Medical Profession

Asylum seekers in various ways bring human rights abuses and politics into the consultation room. Highly restrictive immigration policies mean that asylum seekers increasingly depend on support from health professionals for justice. If, how, and to what extent these professionals can and should play a role in the gathering of evidence and the execution of justice are issues that are contested. There are good reasons to hold the position that fact finding to support the asylum application should be a separate activity from treatment. To understand the psychological problems of asylum seekers and provide appropriate treatment, finding the truth may be an essential element of psychiatric care. The search for truth is also essential if the psychiatrist wants to play an advocacy role regarding the protection of the human rights of asylum seekers in general. The British Medical Association considers that health professionals should use their influence to try to ensure that those human rights are not eroded in the interests of political expediency or popular prejudice.

There are a number of examples of how health workers have contributed to the political debate about asylum policies and how they have been involved in advocacy work for more
humane policies and the prevention of war. While I was working in besieged Sarajevo during the Bosnian war in 1994, a psychiatrist working with me in the development of a mental healthcare project said:

What we psychiatrists should do is claim one page in the daily newspaper and use it to report on all the suffering due to the war we encounter in our work. That might help to make our own politicians—who themselves operate from relatively safe living environments and who have sent their families to safety abroad—aware of what their contributions to the unnecessary lengthening of the war cause in terms of suffering to their own people. They just don’t know.

What the Sarajevo psychiatrist expressed in her desperation was that mental health problems in particular are the hidden wounds of war. Mental health professionals can make these visible to politicians and policymakers to prevent further suffering.

Healthcare providers have a tendency to medicalize problems in a way that obscures their fundamental moral and political nature. There also is however, as Ingleby argues, a virtue in the discourse of medicalization. It is the language employed by health workers in an attempt to objectify suffering. As such, it has a potency that may be even greater than that of moral and political discourses. This allows the moral and political perspective to be identified as such in the mental healthcare of asylum seekers. These larger questions may then be expressed publicly to support the obligation of nations to protect refugees and to care for those who are entitled to this protection. Until physicians can bring together their practice, their ethics, and advocacy for the protections of the human rights of asylum applicants, asylum policy will continue to be determined by political expedience and scaremongering tactics that ultimately undermine the ethical stance of the health professions.

Notes

1. The full cases were presented to the author by the Dutch therapists Ria Borra, Hans Rohlof, and Caroline Hof.
2. Where I write “psychiatrist” in this article one can also read “clinical psychologist, health psychologist, or psychotherapist.”
10. See note 4, British Medical Association 2000.
16. Whereas in the sixteenth and seventeenth centuries the Netherlands took in some 150,000 Flemings and Walloons and 75,000 Huguenots, which resulted in the fact that one inhabitant of the Netherlands in 40 was a refugee, nowadays it is one in 500. See note 15, Agency for the Reception of Asylumseekers 2000.
22. During a meeting organized by various health and human rights organizations in the Netherlands on October 6, 2001, there was unanimous agreement to this opinion voiced by a member of the Medical Research Group of Amnesty International in his presentation on the work of this Group. A report on this meeting is available from: http://www.johannes-wier.nl.
27. Abbé Charles Castel de Saint Pierre, for instance, wrote his Project for World Peace (1721) and called for the foundation of an European League of States, based on pacifism and internationalism (Burgmans H. Crisis en Roeping van het Westen: Twee en Een Halve Eeuw Europese Culturgeschiedenis. Haarlem, the Netherlands: Tjeenk Willink, 1952:10).
32. See note 10.
38. See note 4, British Medical Association 2000.