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PRESIDENTIAL ADDRESS

ETHICS IN PSYCHIATRY

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"Pale conscience makes cowards of us all"

- William Shakespeare

Psychiatry is a rapidly developing specialty in India. There were only a handful of psychiatrists at the time of independence whereas now we have around 3000 psychiatrists in our country. The level of clinical practice and research has become appreciably high. However, the debate on ethical issues is conspicuous by its absence. The ethical guidelines of our society were approved by the general body in 1989 within minutes and without any discussion. This may mean two things: either the guidelines were so aptly framed that there was no scope for improvement or the members felt that it was not going to affect them either way. So they approved whatever was proposed without much ado. I fear that the latter explanation is more apt.

ETHICS IN PSYCHIATRY

Ethics has not been formally discussed in any of the postgraduate teaching programs nor has it been a focus of research. I could find only one Indian survey on ethical issues (Srinivasamurthy et al, 1986). The survey showed that only 23% of the mailed questionnaires were returned and that too by people mainly involved in research (80%). Of the 1151 respondents, all medical personnel, 84.5% did not have any training in medical ethics and 90% expressed the view that medical ethics training should be initiated at the undergraduate level and a further 5% felt that it should be done at the postgraduate level.

A workshop on ethics was organized at Lucknow in 1987 where a number of ethical issues were discussed. This workshop recommended certain guidelines in this regard which were duly adopted. There are only a few references on ethical issues in Indian Psychiatric literature (Agarwal, 1986; Agarwal & Gupta, 1992; Agarwal, 1989a & b). This again suggests that ethical issues have largely been ignored. Nowadays, doctors in general are a focus of criticism. The widespread opinion appears to be that the majority of them are not committed to their profession. *B.J.Karkaria, a columnist, in Nov.23,* 1993 issue of the Times of India states that in the lay perception, the committed doctor is now a rare exception and medical ethics a contradiction in terms. However, a recent survey done by MRAS-Burke (Nov.21, 1993) on behalf of the Pioneer in Delhi showed that out of a maximum of 11 points doctors scored 9.06 on their usefulness to the society. This clearly demonstrates that doctors are still considered useful by the lay public. We should therefore attempt to make the profession both honorable and needed. It is in this perspective that we have to evolve and practice certain ethical guidelines for our profession.

THE BASIS OF ETHICS

Ethics is primarily based on two philosophies namely, Utilitarianism and Personal Autonomy.

a) Utilitarian hypothesis

This implies that one's action should lead to the maximum good for maximum number. It does not need the consent or approval of others. However, the difficulties with this approach are:

(i) The definition of 'good' is difficult to conceptualize. What may be considered good by one may not appear the same to another; e.g. compulsory hospitalization of a psychotic patient may appear beneficial to the family but may not be in the best interest of the patient.

(ii) Secondly, the consequences of one's action may not be accurately foreseen. For instance, antidepressants prescribed for relieving depression may lead to attempted suicide during the recovery phase.

In spite of its limitations utilitarianism is still the basis of ethics. However, this approach leads to paternalism in medical practice. The physician takes on the role of the parent and does what he considers to be in the best interest of the patient. Medical ethics the world over and especially in our country has been adhering to paternal model although the renaissance with its emphasis on the individual and his free will forces the present thinkers to pause and reconsider their paternalism.

The deontologists maintain that the good consequences of an act should not be the only factor determining the rightness or wrongness of an act but other fundamental issues such as liberty, fairness and justice should also be considered (Chodoff, 1984). Absolute paternalism often leads to a situa-

tion where the doctors may feel that no one should question them for their decisions. This attitude of medical profession has been very accurately described by May (1975): "The medical profession imitates God not so much because it exercises the power of life and death over others, but because it does not really think itself beholden, even partially to anyone for those duties to patients which it lays upon itself".

Unbridled paternalism in medical practice has led to the emergence of patient's protection groups and to law suits against doctors. Extension of the applicability of the Consumer Protection Act to the doctors by our legislature is a step in the same direction. The lay public perceives that doctors are not behaving responsibly and need to be regulated.

The contractual model of medical practice has flourished in United States of America and has also made some inroads in Britain. However, other parts of the world are not as much affected so far. The day is not far when Western ethics will influence medical practice in this country also. To stem this tide of ethical invasion in this country we need to improve our ethical standards on the basis of our own philosophy.

b) Autonomy hypothesis

It implies that each adult individual is capable of deciding as to what is good for him or her and no other agency should abridge this free will without due process of law. Under this doctrine, the doctor - patient relationship is a contract between two competent individuals to mitigate a particular problem. All decisions in this regard should be taken with the approval of each other. It, therefore, presupposes the following in context to mental illness:

(i) Mental illness is a myth (Szasz, 1963), or if it does exist at all it does not impair the individual's capacity to decide for himself.

(ii) Patient knows as much about the illness and its treatment as the doctor and thus can decide equally well as to what is best for him.

Nevertheless, Moore (1975) states, "the problem is that mental illness is not a myth. It is not some palpable falsehood propagated amongst the populace by some power-mad psychiatrists, but a cruel and bitter reality that has been with the human race since antiquity". There is also abundant evidence to support the view that mental illness does affect the competence of the affected individuals and they may not be able to take proper decisions regarding themselves.

Even the most well-informed patient may not know enough about his illness, its outcome and the various options available to him for treatment. According to Moore (1978), "The purchasing patient is not an equal of the vendor physician in knowledge of what he or she is purchasing. Thus, caveat emptor can hardly apply". Hence, the principle of individual autonomy may appear excellent on paper but it needs to be subjugated to old fashioned clinical judgement.

MORAL ENVIRONMENT OF OUR TIMES

Professional ethics can only be evaluated in the context of the value system currently prevalent in society. Needless to say, a physician is also part of the society, and its prevailing moral and ethical standards have to influence him (Fink, 1989). Ancient Indian values of contentment, self deprivation and detachment have now been replaced by philosophy of achievement and acquisition. A person content with himself nowadays is considered to be lazy or a waster. Success is measured in terms of fame, power and money. Happily or sadly, the older principle that wrong means can never reach to a good end has been given up in today's achievement oriented society. Medical men also imbibe the same moral principles and cannot be expected to be radically different from the ethos of society.

It is well known that medicine is a highly sought after profession in this country and millions of bright, young students compete in the medical entrance examinations. What do these examinations test? Intelligence of the students? May be so. Or their competence to become good physicians? Definitely not. Compassion for fellow human beings, a necessary quality for becoming a good doctor is not assessed in these examinations. Many students use unfair means to gain admission to medical institutions. Can one expect them to become ethical doctors? The process of selecting and training medical graduates does not seem to be the right recipe for producing good doctors. It may produce brilliant doctors, but certainly not gentleman doctors.

Inspite of the scenario described above, all hope is not yet lost. The ancient Indian values still influence the majority of the population. Most of us, therefore, do feel disturbed whenever anything is done which does not measure up to the moral expectations. However, with the passage of time this sense of unease may give way to total acceptance of declining moral standards. In general, the assumption is that 10% of the population is highly moral and

10% highly immoral, and that the rest can be swayed to either side depending upon the moral standards of the dominant segment of the society. It is essential to stop this slide of moral standards and the effort has to be made to ensure that the leadership is retained by people with high moral standards - definitely not a very easy enterprise.

Ethical standards of medical men in general and psychiatrists in particular have to be considered against this background. We cannot stand aloof from the general moral standards of the society. There is a need for reconsideration of ethical practices which could be meaningful today. A dogmatic approach will have to give way to pragmatism.

RESOURCE ALLOCATION

Resources should be allocated in a manner so that it does the maximum good for the maximum number. Whether the allocation of funds for building a few high-tech institutions should get preference over strengthening of the primary health care is a moot question. Or, should a balance be maintained between these two? At the level of individual psychiatrist within the existing restraints of time and money one must consider whether one should spend long hours in psychotherapy for only a few patients or should one attempt to provide succor to as many as possible.

It is apparent that there are no clear answers for the above, but these issues should at least be seriously considered while making such decisions. There has been a debate on whether costly drugs such as Clozapine should be used or not. The protagonists feel that even if a costly drug produces benefit to a few patients it will be unethical to withhold it whereas others feel that scarce resources should not be squandered for such expensive treatments (Healy, 1993; Bosanquet & Zajdler, 1993).

The VIP syndrome has also to be evaluated on the basis of ethics of resource allocation. A large amount of time is often devoted to VIP patients which is neither clinically warranted nor gives any benefit to the patient. It often leads to paucity of time and resources for the general patient. Ethically every patient should be considered a VIP and treated similarly (Wilkins, 1993). Actually, VIP patients are created by the doctors themselves on account of their inner needs.

BOUNDARIES OF MENTAL ILLNESS

What constitutes a mental illness and what can be competently managed by psychiatrists is the basic issue which needs to be precisely delineated. The concept of mental illness is difficult to define but the newer classification systems (ICD-10 & DSM-IIIR) have reduced this ambiguity to a large extent. Many psychiatrists view that all human misery and unhappiness is a manifestation of mental disorder which is as absurd as the view that mental illness does not exist at all. Kendell (1975) puts it succinctly, "It is worth reflecting whether the many attempts we have recently witnessed to discredit the concept of mental illness might not be a reaction to the equally absurd claim we have made that all unhappiness and all undesirable behavior are manifestations of mental illness".

Szasz (1993) calls mental illness as metaphoric illness or non-disease. His basic contention is that any symptom which has no pathological basis cannot be considered to be due to a disease. However, these views have been strongly criticized and there is a general consensus that mental illnesses are real illnesses (Mindham et al, 1992; Torrey, 1992). We, therefore, must try to be more precise in defining the boundaries of mental disorders.

Psychiatrists are trained to identify and treat mental disorders and they should restrict themselves to it. Violence, aggression and misery facing the world today do not come under their purview and psychiatrists could only be one of the many experts in the think-tank, working towards improvement of the lot of mankind. For instance, the psychological aspects of criminal behavior, developmental problems of children, crisis in adolescence and marital problems may be best managed by a team of experts including psychologists, social workers, educationists and men from the field of religion. Psychiatrists could, at best, be a part of the team mentioned above.

HOW TO CHOOSE A THERAPEUTIC MODALITY

Perhaps you may be wondering as to what ethics has to do with choosing a treatment plan which is based solely on scientific considerations. Stone, in his presidential address to the American Psychiatric Association (1980), raised the question of ethical impasse based on theoretical pluralism in psychiatry: whether a patient could be best treated with pharmacotherapy, psychotherapy, family therapy, occupational therapy, or by a judicious mix of all these? What is the evidence in favor of any one of these choices needs careful consideration.

Fortunately, the last few years have witnessed a silent revolution in psychiatric treatment. All treat-

ments are now scientifically evaluated for efficacy. The earlier presumptive treatment methods have given way to treatment models with reasonably proven effectiveness. Treatment decisions should include not only symptomatic recovery but should also increase the patient's ability to relate socially for gainful employment and ultimately, personal happiness. Every patient is a complex organization of subsystems that are interrelated with each other. A change in any one of these induces change in the other (Sider, 1984). For instance, a schizophrenic patient may show better symptomatic recovery with higher doses of phenothiazines but it may impair his social competence. In such a situation, it should be worthwhile to allow some symptoms to persist for sake of better social functioning.

Unfortunately, psychiatry has been divided into schools, e.g. Biological, Psychodynamic, Behavioral, etc. Often the proponents of one do not consider other options. However, recent research in psychiatric treatment is gradually reducing most of these rigidities. The recent controversy regarding the effectiveness of pharmacotherapy versus exposure treatment for panic disorder with agoraphobia is an example in this content (Marks et al, 1993a & b; Spiegel et al, 1993). Strong views in favor of either approach are being replaced by scientifically proven treatment methods.

Some psychiatrists, however, may cherish personal freedom and autonomy to such an extent that they may hesitate to enforce treatment on reluctant patients which at times may be detrimental to them. It is important that the therapist learns to understand when his own biases are affecting the therapeutic choices. If a therapist fears that the patient is not getting better, a peer review may help in making therapeutic decisions.

INVOLUNTARY TREATMENT

Psychiatry is the only medical specialty where a large number of patients may not voluntarily agree for their treatment largely because they do not consider themselves to be ill due to the distorted view of themselves and or others. Szasz (1963) calls the voluntary admission of mental patients an unacknowledged example of medical fraud. However, acquiescence to their right of refusal to treatment might lead to perpetuation of the illness. Peele et al (1974) states "It is perversion and travesty to deprive the needy and suffering people of treatment in order to preserve liberty which is in actuality so destructive as to constitute another form of imprisonment."

The obvious solution of this dilemma is to use involuntary hospitalization for as short a duration as possible. As soon as the patient recovers he should be motivated to take treatment. But, if clinical experience is any guide, most schizophrenics and even a large number of bipolar patients are unwilling to take prophylactic / maintenance treatment, although clinical research has unequivocally established its importance. Some amount of persuasion may be required for most of them.

The Mental Health Act (1987) has not paid any attention to the treatment aspects of the mentally ill (Agarwal, 1987; Agarwal & Trivedi, 1989). The Act is only concerned with the hospitalization of a mentally ill patient but it does not take into cognisance of the existing inadequate facilities for hospitalization in this country. There are hardly 25,000 hospital beds for a population of approximately 10 million seriously ill mental patients. Most of these beds are presently clogged with chronic patients, leaving hardly any vacancy for new patients. Thus, a large number of patients have to be treated on an outpatient basis and often against their wishes. In such a situation, the consent of family members and their active involvement in treatment is the only viable alternative. The law has to take cognisance of such treatment practices.

CONSENT

This requires the following:

a) Corpus mentis which means adequate understanding. It implies the competence to understand the information provided and to take proper decisions. Many methods are available to assess the competence of an individual (Roth et al, 1977) yet none are foolproof.

b) Available information should include:

i) The treatment options available.

ii) Major risks associated with the procedures.

iii) The harm expected by not accepting the treatment advised.

iv) The option of withdrawing the consent at any time.

However, this concept only appears ideal on paper. Most patients neither have any knowledge of mental illness nor of treatment options. Many consider that mental illness is caused by supernatural powers and hence, may opt for faith-healing. Asking for consent before providing treatment may, in effect, confuse the patient or their attendants into

thinking that the doctor himself is not quite certain of the treatment. The dilemma produced by excessive information is beautifully described by late Dr.Franz Inglefinger, editor of New England Medical Journal.

He was diagnosed to have a terminal illness and he received multiple and contradictory advice from his physician friends. He describes his agony in the following words: "I received from physician friends throughout the country a barrage of well intentioned and contradictory advice... as a result not only I, but my wife, my son and daughter-in-law (all doctors), and other family members became increasingly confused and emotionally distraught. Finally, when the pangs of indecision had become nearly intolerable, one wise physician friend said, "What you need is a doctor". He was telling me to forget information I already had..... and to seek instead a person who would tell me what to do, who would in a paternalistic manner assume responsibility for my care. When this excellent advice was followed, my family and I sensed immediate and immense relief".

The aforementioned words clearly show that when patients are faced with a state of helplessness and ambiguity they require someone to provide them clear-cut advice. This does not imply that the doctor has the right to decide the patient's destiny. It is important to discuss with the patient the goal of treatment, its side effects and difficulties, but the information should also be tempered with compassion. Clinical skill should guide us as to who should be informed and how much.

I recently came across an elderly patient who was blind for many years and I sent him to an ophthalmologist who advised him that there was some hope of vision in one eye by operation. When I informed the patient he said, "Sir, I have now turned to God. I can see hazily which is enough for my daily needs. I do not want to take the risk of operation." His decision was respected.

CONFIDENTIALITY

The physician is expected to maintain confidentiality. However, the doctrine of confidentiality is not absolute. In certain situations confidentiality has to be violated such as a) when asked by a court of law; and b) when the information provided by the patient may harm others if no preventive action is taken, e.g. when a patient plans to kill someone. Confidentiality is desirable but if it comes in conflict with public good then the confidentiality clause may be violated.

RELATIONSHIP WITH PHARMACEUTICAL FIRMS

A large number of pharmaceutical firms are marketing the same drugs or drug combinations. To counter competition, their marketing strategy is to obtain prescriptions by influencing the prescriber by various means: donations and sponsorship for research, providing free travel and giving gifts of various kinds. Should an ethical psychiatrist fall prey to such inducements? Acceptance of these inducements can often lead to undesirable and even dangerous consequences including excessive prescription of a particular drug or an unethical endorsement of a particular firm and its products. Under the existing scenario, it is not possible to give a clear answer to this all pervading problem, but some kind of limit setting is obviously the need of the day.

AYURVEDIC FORMULATIONS

A large number of manufacturers are marketing Ayurvedic medicines and these are being prescribed by most of the allopathic practitioners. I am not against the Ayurvedic system but a practitioner of modern medicine chooses his treatment on the basis of scientific evidence of its effectiveness. Unfortunately the law does not require the manufacturers to conduct any clinical trial before the manufacture and sale of Ayurvedic medicines. The manufacturer only needs to show that the substance has been mentioned in one of the Ayurvedic texts as a treatment and he can get a license to manufacture the drug. For ethical practice, we must insist that manufacturers should undertake large scale trials to prove the effectiveness of these drugs before prescribing them.

RELATIONSHIP WITH OTHER MEDICAL SPECIALISTS

There is a trend towards offering inducements under various guises by investigative agencies and consultants which often leads to unnecessary investigation or consultation. It is time to consider these issues in an objective manner which is both practical as well as ethical.

ADVERTISING PROFESSIONAL EXPERTISE

Doctors are restrained by the existing ethical codes from advertising their competence or their facilities. This practice could have been appropriate, say a few decades ago when one could communicate his competence in fora like the medical association

meetings etc. But, in the present day with limited professional contacts and everybody being busy it is impossible for a beginner to start his medical practice without a certain amount of publicity. Hence, it is timely to reconsider the issue of non-advertisement by medical men in the current perspective.

CONCLUSION

What is the remedy for the ethical impasse of our times? There are no straight forward answers but some of the following could be considered:

Medical entrance examinations should evaluate essential human qualities for becoming good doctors. Medical education should emphasize the scientific and humane basis of medicine. Treatment offered should not only be scientifically proven but also be economically and culturally appropriate. Ethical principles should be discussed formally during medical education.

Ethics is mainly learned by the imitation of one's teachers. Unethical behavior of a teacher is likely to influence the youngsters' mind to such an extent that it may further deteriorate medical practice. Medical men should also not brush aside unethical acts of their colleagues. Quite often such practices are encouraged under the assumption that it will save their institution or profession from disrepute. Protecting such persons does more harm than good to the profession as well as to the institution.

A profit motive cannot be denied or decried but it should not supersede compassion as we deal with sick individuals. One could be confronted with hundreds of situations which are not discussed in any texts on medical ethics, but in all these situations the basic principles of beneficence and fairness to the patient should be paramount.

The aim of this address was to sensitize our members regarding ethical aspects of psychiatric practice. However, I have just touched the surface of the various issues involved. I have tried to raise some of the controversies for which I have no answers, but I am sure that the combined wisdom of my colleagues may show a ray of hope in this area of darkness. If I am successful in initiating a debate on ethics I will feel more than content.

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