The Hippocratic oath which I have just administered to myself before you in all solemnity—an oath which was never administered to me at any stage of my career. None of you too, I guess, has ever been subjected to this or any such oath. Although the Hippocratic oath may look out of place in our midst, the noble sentiments and high ideals expressed therein, the guiding principles for doctors are perhaps timeless.

I have been chosen for this oration which I consider the greatest event of my life not because of the honour that I deserve but because on this occasion I have the unique opportunity to pay my humble tribute to that great man who lived and breathed among us—D.L.N. Murti Rao—a glorious example of a physician who lived up to the highest standards of medical morals and ethics from whatever scale you may choose to measure him. I knew him very intimately—perhaps more than most of you almost since the days of infancy of psychiatry in the country. The development of psychiatry in India as we see today is the result of his pioneering and dedicated work. When the history of psychiatry in India will be written, his name will adorn the place of pride on its foremost pages. He was a true embodiment of a versatile physician, with profound knowledge, an ideal teacher—a guru, and above all a great human. It is for this reason that I have chosen this occasion to talk on the subject of ‘Morals in Medicine’ which most people talk about but only a few honestly practice it. The task I have set forth for myself is undoubtedly rough. To speak on ethics, is to stir a hornet’s nest. I may be dubbed as a moralist or a hypocrite or at least an utopian idealist as Chavez (1964) calls it. It also involves application of moral rules to situations and relationships in changing moral and social values here a rather cumbrous exercise.

Oaths in Ayurved:

Much before Hippocrates laid down the rules of conduct contained in the oath that I have just taken, there already existed in Ayurvedic texts a much more comprehensive and well-documented description of the codes of behaviour for the ‘Vaidya’—the physician and the teacher, for students of medical sciences, for administration of drugs, for duties of attendants, and various other activities connected with health care. It is perhaps too comprehensive to describe in detail all that is written about medical ethics in Ayurved, but it is not possible not to mention today some of the ethical demands incumbent on the physician and the student of those days. The Vaidya i.e. the physician teacher and his student had to undertake certain sacred vows (Shastri and Chaturvedi, 1976; Shastri, 1974).

The ‘Guru’ as he was called after invoking and making fire as a witness administered the following oath to his prospective students:

“A bachelor that you shall be, you shall abstain from all sex activities, anger, greed, attachment, pride, grandiosity, jealousy, roughness, back biting, immorality, idleness and defamation; you shall keep your head shaved and nails cut every fifth day; shall remain properly dressed, ever-
ready to speak the truth and be respectful and obedient to the Guru”. He warned his disciple that if the later acted otherwise, “it would amount to immorality and he will loose all the powers gained through imparted knowledges”. The Guru, in turn, also took the following oath himself, again before the holy fire as a witness: “If you keep to all the requirements worthy of a disciple student and if I do not systematically and fully impart the proper knowledge due to you, I shall be condemned to be a sinner for all times and will be bereft of all my knowledge”.

The Ayurvedian’s seemed to attach great imporiance to the moral values and conduct of medical practilioncrs. They agreed to admit only such individuals as their student who undertook the specific vow to work strictly within the code and the then prevailing rules of conduct. This was the bond of Guru-chela relationship (Neki, 1974). The trainees were kept under close scrutiny and those who failed to prove worthy of the conduct rules were suspended and debarred from continuing their training or entering the medical profession subsequently. On completion of their course, the practitioners were called upon “to treat brahmins, gurus, poor, friends, saints and destitutes without distinction like ones own brethren”. The code of conduct of those times prohibited them “to shun from treating bird killers, bad characters and the sinners”.

Ethics through ages:

Long before the birth of Christ medical codes and values derived from prayers and oaths were found in a number of writings (Moors, 1978). To mention a few: Code of Hammurabi (2000 B.C.), Hippocratic oath (4th century B.C.), Sun-ssu Kiao—the father of chinese medicine—in his book—“Thous­and Golden Remedies” (6th century, and other codes and values developed for man engaged in healing professions are some of the important sources where rules of medical ethics are laid down. Although laws of conduct and the moral rules were so well documented and were so rigorously practiced by Ayurvedic practitioners, it is very strange that it does not find a reference among any of the best of these chronicles. Ethical codes since the days of yore when Socrates and Plato preached in the market place have changed through ages but their basic character has remained the same.

The direct source of our modern ethical codes is the work of Thomas perceival—a physician, philosopher and writer. Following an altercation between physicians and trustees of the Manchester Infirmary, he published a book in 1903, “Medical Ethics or a Code of Institutes and percepts adapted to the professional conduct of Physicians and Surgeons” in which he described the conduct of physicians in relation to hospitals, private or general practice, pharmacists and druggists, and legal aspects. Since then the scope of medical ethics has transgressed into countless specialities rendering serious limitations to those codes in addressing to every day decisions.

During the last decade one has witnessed a striking upsurge of interest in professional ethics particularly in the field of medicine. The subject of ethics, it seems, has made sudden appearance in the latest edition of Comprehensive Text Book of Psychiatry which chapter was completely absent in its earlier publication of 1967. Growing scepticism about the sanctity of science, medicine and psychiatry means that these fields are no longer above rebuke or exempt from active moral review by their recipients, professional poors and others outside of their practice (Karasu, 1980). The concern for safeguarding human values and rights was never so widespread as now.

There could be countless ethical problems facing contemporary psychiatry today. It would be an effort in futility to list them all since they relate to specific situations and circumstances. Recent unparalleled scien-
scientific and medical advances have changed the orbit of the code of ethics which is difficult to put down in a short paper. There are however several often referred ethical considerations and their ambiguity and paradoxical character in specific situations, which can neither be settled nor an always correct answer found.

**Definition:**

"Random House" dictionary definition of Ethics is: "a system of moral principles, the rules of conduct recognized in respect to a particular class of human actions or a particular group, culture etc." Chamber dictionary defines Ethics as: "that branch of philosophy which is concerned with human character and conduct". It deals with rightness and wrongness of certain actions and to the goodness and badness of the motives and ends of such actions. It relies on 'judgement' and addresses itself to 'what ought to be'. If only the therapist and the patient were the only two parties involved, the question of ethical behaviour may never come to the surface. Ethics in psychiatry or medicine largely comes to the fore on account of the exposure of patient and the therapist to the judgement of social reality i.e. when the third party is also involved. Codes of behaviour and ethics have been laid down in the International Code of Medical Ethics in the Geneva declaration of the World Medical Association in 1948. Subsequently many other declarations such as declaration of Helsinki (1964), declaration of Sydney (1968), declaration of Oslo (1970) have added more view points within the orbit of medical ethics.

**Patient Physician Relationship:**

When a patient comes to you, he chooses you out of so many other doctors, is an event of great significance. He has already made positive rapport with you much before he has seen you. It is your bounden duty to make use of this transference situation to the best advantage for the welfare of patient and not to believe the trust he has already reposed in you. It is strengthening of this faith that often helps to improve your patient much more than all other drugs and remedies in the world. In this situation, often a patient may not be easily treatable, or may need observation, or may be negativistic but the first interview is the most vital and it should make sure that even if not much help is rendered at first interview, he comes back to you again for help, otherwise he will go from pillar to post and may not receive any care at all.

We as psychiatrists are quite aware of the pitfalls in the practice of our specialty. A psychiatrist not only has an access to the personal life history data with intimate details but has much confidential and very personal information, not normally available to most doctors in other fields. This, of course, would depend on the transference, counter transference, resistance, negative therapeutic response and reaction formation situations between the psychiatrist and the patient. Should this get much intense, there is a danger that the psychiatrist may get too much emotionally involved from which he may not be able to extricate himself. Essentially the relationship is one of mutual trust and confidence in which the patient may disclose his sexual inclinations and practices, his distraught and unhappy family circumstances, his delusions, his failures and frustrations and many other such foolings and ideas which may have been lying dormant in his preconscious or in unconscious mind. The patient may regard his therapist as a father figure or may see him in the role of a lover or an object of hate or revenge. For the last, the psychiatrist may himself become unconsciously revengeful and retaliate. Cases in literature are abound where medical men have often had sexual liaison with their patients. Instances of psychiatrists transgressing moral codes are not unknown.
Let us examine another aspect of the nature of relationship between the doctor and his patient—should it be friendly, business like, authoritarian, agalitarian, caretaker, parental, helper or what? Further what should be the emotional and intellectual depth in these relationships? It is extremely difficult to provide an ideal answer to these questions. The nature, depth and extent of the type of relationship are largely a function of the specific situations the therapist is faced with. The elements for determining these specific situations must primarily relate to the patients and his problems which I am sure does not always happen. However, there are certain types of relationships which are not only unethical but illegal. The cardinal consideration of respect for the patient and for basic moral obligations should be binding on all our professional decisions.

I recall Sir William Osler's (1943) three personal ideals: to do the day's work well, to act towards professional brethren and patients committed to care; and to cultivate such a measure of equanimity as would enable one to bear success with humility; the affection of friends without pride and readiness to meet the day of sorrow and grief with courage; and in a fight for principle and justice even when failure seems certain, cling to ideal.

Coming back to the question of Sex, recently there have been a number of articles in professional journals dealing with subject of sexual promiscuity between the physicians and patients. I feel that the problem is even more serious than publicised. In this sub-continent reports regarding sexual malpractices in medical specialities are scanty but similar reports emanating from other countries should be a warnings to all of us. In comparison with other medical specialities, psychiatrists by the very nature of their work are more likely to get involved in sexual intimacies, since psychiatric interviews are held closed in a room without the presence of any other individual except the patient. Under the circumstances these sessions may become emotionally surcharged and the interviewing psychiatrist—who basically is a human being—may be unable to resist his activated passions. The initiative for sex advances may be taken by the patient but the psychiatrist too could make the first advances—and what is worse—some times under the cloak of therapeutic procedures. I draw the attention of my colleagues that sexuality between the psychiatrists and their patients is highly unethical, and immoral in the practice of psychiatry.

Confidentiality, Privacy and Privileged Communication:

There are ethical problems with wide personal, political, social and legal implications which may impale any one on the horns of a dilemma. More questions can be raised than can be settled on this issue. Should the psychiatrist follow the dictates of professional conscience or act to the requirements of social conscience? Does the law support the psychiatrist's commitment to confidentiality? Can the psychiatrist waive his responsibility towards the community and society at large? In what special situations can the psychiatrist choose to betray the trust and confidence reposed by the patient? In an entirely different situation should the psychiatrist render to the public the medical records of the patient with his consent or can the psychiatrist plead for not keeping full records about the patient and also make excuses on grounds of memory lapses? Should the psychiatrist inform the legal or administrative machinery if his patient harbours strong homicidal, anti-social, anti-authority or anti-governmental ideas or can he disclose to the concerned authorities such significant revelations made to him in confidence by the patient which may help to solve a legal or a social riddle? How far it is ethical to
ask and expect the patients to make significant revelations about their inner world in special groups such as a 'T' group, a confrontation group, a transactional analysis group, or the like? A resolution of these and many other related problems concerning the matters of privacy and confidentiality does not seem close at hand.

Informed Consent:

There is an old doctrine which requires the willingness of the patient to undergo a treatment. This implies a complete understanding of the treatment procedures he is agreeing to. How can and how will the essence of complex medical and technical aspects of the treatment be conveyed to a lay person, specially when he is mentally unwell? Thus for instance before agreeing to electro convulsive treatment, the patient or his relative would have to be told of the rare cases of accidental broken back bone, possible permanent brain damage or death. Anything less would not be a "fully informed" consent. On the question of a using a placebo in a double blind trial or administering an experimental drug, the very nature of the question of the informed consent to my mind is a scientific absurdity. Would any patient in the right spirit of informed consent give the ridiculous permission to ingest chalk or distilled water in the guise of a medicine, or take an experimental drug? Again exposing patient to drugs with dependence producing qualities could result in refusal to take drugs or he may be exposed to the risk of becoming an addict.

The ethical dimension of the problem of "informed consent" is perhaps not so fully realised on the Indian scene. Most doctors in our country do not bother to seek the consent. On the other hand the fear of litigation in western countries has jeopardised drug trials and experimental use of newer drugs. A case in point is the stoppage of drug trials of newer drugs in first trimester in pregnant women following thalidomide tragedy. ECT and other similar treatment procedures even when most indicated are being used vary sparingly. To my mind the issue of "informed consent" should be waived off if it is in the best interest of the patient, where ever necessary. The discretion should be used with utter caution. How one goes to do this is another matter.

Right to treat and to be treated:

When a patient suffering from a serious cardiac condition needing intensive and urgent care refuses to go to a hospital or refuses any kind of treatment, no one can force him to do otherwise. In contrast when a seriously disturbed mentally ill does so, he is usually certified or forced to undergo treatment much against his will. What is the difference? Is it because one is said to possess a sound and a reasoning mind and the other not? What makes the man possessing sound mental faculties refuse the only sound and reasonable course i.e. to undergo the treatment for cardiac ailment? If he has not done so, would you consider him to have lost his reasoning and sound judgement. Right to treat and to be treated there foreraises ethical issues involving complex legal implications. Psychiatric patients very often may not want treatment. Inspite of it psychiatrists do treat them without their expressed consent. What the ethical position would be in such situations? In matters of treatment, West (1969) mentions several knottier problems: for instance blanket use of ECT for many other conditions where its use is not normally called for or is it ethical to recommend psycho-analysis for senility, painful aversive conditioning for autistic behaviour in children, nude group marathon sessions for marital discord, personal manipulations by physicians or coached inter-course for frigidity or impotency? Is Masters and Johnsons therapy proper and valid in our culture? With the present day emphasis on community psy-
chiatry and control of schizophrenia by drug maintenance, West (1969) argues that the carriers of the putative genetic defect would be more in the community who with relatively good symptom control by medication would manifest poor adjustment, make bad marriages, produce children for wrong reasons and thereby would cause increase in the number of off-springs genetically predisposed to the disease. No one seems to bother about the possibility of development of lenticular opacity or glaucoma with long term administration of phenothiazines or anti-depressants. In view of these problems keeping patients in the community on long term maintenance dose may not sound ethical and yet without them the patient may follow a deteriorating course. The same argument would be true if one keeps a patient within the forewalls of the hospital when a reasonable symptom control and even a substandard assimilation of the patient in the main stream of society is possible. The real answer to these questions infact would be extremely difficult indeed.

Selfish Motives:

Another crucial question on the ethical front requires some self searching. How many of us are truly and genuinely interested in treating a patient selflessly i.e. without regard to enhancement of our own interests, self prestige, monetary advantage, research publications etc. Would there at all be any psychiatrist if there were no psychiatric patients? None, and if so, I am sure very few would keep the patients’ interest supreme before their own.

Fraud and Abuse in psychiatric practice:

The definitional problems of what is fraudulent or abusive makes it difficult to delineate and precisely determine what is inappropriate and illegal in the practice of psychiatry. Towary and Sharfstein (1978) have listed a number of fraudulent and abusive practices:

i) 'Upgrading' i.e. billing for services more extensive than those actually provided.

ii) Billing for services not rendered;

iii) 'Ganging' i.e. billing for multiple services to the members of the same family on the same day;

iv) 'ping-ponging' i.e. multiple referrals between psychiatrists or other professional brothers when there is no real necessity for these services;

v) Charging for physicians services actually provided by non physicians—professionals not eligible for reimbursement;

vi) Offering or receiving kick backs;

vii) Billing more than one party for the same services;

viii) Distributing sample drugs indiscriminately to any one who can pay;

ix) Making excessive profits from a legitimate treatment; and

x) 'Steering' i.e. directing patients to a particular pharmacy.

Some of the above listed practices are common everywhere but practices which are usually indulged in this country and some of which I consider grossly unethical are:

i) devoting much less than required time and effort in attending to ‘out patients’ and ‘in patients in hospitals;

ii) whiling away time in hospital gossiping or roaming about and not doing full duty during working hours;

iii) 'touting' i.e. employing obtrusive ways such as appointing agents, soliciting professional support etc. for enhancing private practice;

iv) 'self advertising' and 'self aggrandisement' using audio visual aids and mass media communication methods. It is not unusual to see large and colourful eye cat-
ching name plates, street pointers directing way to reach the clinic, publishing advertisement/news items in local dailies about the opening of the clinics, information about shifting or the unavailability of the treating physician because of his absence (usually abroad) for participation in big conferences, calling pressmen to publish reports of the research work done (it does not matter whether the work was methodological and scientific or not) or for other minor non-significant achievements etc.;

v) not keeping one up to date with recent developments and advances in the field of treatment and care of patients;

vii) To practice quackery under the garb of modern medicine;

viii) selling of samples;

ix) making addicts;

x) false medical certification;

xi) duping the patients by administration of such procedures like injections of distilled water, I.V. glucose and tonics etc. when not warranted.

I have touched only the tip of the iceberg and do not have the power and capacity to look at what lies underneath. An iceberg may change due to melting or deposition of new snow or change in its position in the sea or salinity. The ethics, being a concept like an iceberg that also changes with time and place of practice will always be on controversial grounds when applied to scientific endeavours. Barnal Y Del Rio (1975) says that these principles are not laws, but standards by which a physician may determine the property of his conduct, his relationship with patients, with colleagues, with members of allied professions and with the public. In 1948 the Geneva convention adopted the modern version of Hippocratic oath which says, “The health of my patient will be my primary preoccupation” which can be summarized as “protect and prolong the life of human beings”. This, we will recall, was also the primary aim of Ayurveda—100 years of healthy life.

REFERENCES

BERNAL, Y. DEL RIO, V. (1975). Psychiatric Ethics, in Comprehensive Text Book of psychiatry, (2nd ed.) vol. 2, (Ed.) Freedman, A.M., Kaplan, H. I., Sadock, B. J., Baltimore ; Williams and Wilkins Co., 2546.

CHAVEZ, I. (1964). Professional Ethics in Our Time. J. A. M. A., 190, 226.

KARASU, T. B. (1980). The Ethics of psychotherapy. Am. J. Psychiatry, 137, 12, 1502.

MOORE, R. A. (1978). Ethics in the practice of Medicine, Origins, Functions, Models and Enforcement, Am. J. Psychiat., 135, 157.

NEKI, J. S. (1974). A Reappraisal of the Guru-Chela Relationship as a Therapeutic Paradigm. International Mental Health Research News Letter, Vol. XVI, No. 2.

OSLER, W. (1943). Acquaintment, (3rd ed.) Philadelphia, Blackiston.

SHASTRI, A. D. (1974). Susrut Samhita Part I, Chaukhamba Sanskrit Sansthan, Varanasi, 9.

SHASTRI, K. N. AND CHATURVEDI, G. N. (1976). Charak Samhita, Part I, Varanasi, Chaukhamba Sanskrit Sansthan, 191.

SINGH, MADHAN (1965). Psychiatry, Ethics and Religion, Ind. J. Psychiat., VII, 4, 278.

TOWERS, O. B. AND SHAPIRO, S. S. (1978). Fraud and Abuse in psychiatric Practice. Am. J. Psychiat., 135, 1, 92.

WEST, L. J. (1969). Ethical Psychiatry and Biological Humanism. Am. J. Psychiat., 126, 2, 226.