Medical ethics in India: ancient and modern (II)

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Control of fertility

The Government of India and its people are concerned with the increase in population. One method proposed to control it is that of incentives and disincentives - incentives to those who subject themselves to sterilisation and disincentives to those who are not willing to undergo sterilisation. Such discrimination raises an ethical issue. Why should a third or fourth child suffer from handicaps in education, nutrition, etc., in comparison to other children? The educational and other facilities in the country are limited, especially in the villages. Discrimination in favour of one spells discrimination against another.

Right to life

Article 3 of the *Universal Declaration of Human Rights* states: 'Everyone has the right to life, liberty and security of person.' Article 6 states: 'Everyone has the right to recognition as a person before law.' *The International covenant on Civil and Political Rights* (1966), article ***6*** states: 'Every human being has the inherent right to life.' These and other declarations and affirmations raise the question: Who is this 'person', 'human being'?

According to ancient Samkhya philosophy, there are two ultimate principles in the universe: *Purusha* (soul) and *Prkriti* (the body). The soul is immutable *(Kutastha)* and imperishable *(nitya)*[1]. The soul or *atman* descends into the zygote, produced from the union of the sperm and ovum. It is accompanied by the mind, which carries with it the influences of major actions done in previous states of existence. 'Life starts with the union of the sperm and the ovum. Individuality is reckoned from that moment. It is at the moment of the sperm-ovum union that the transmigrating *atman, purusha* (the individual) gets his material encrustation, as dictated by his previous *karma'*, (Dr. A. Ramaswamy Iyengar, personal communication).

Interventions on the new human being should be such as to maintain and improve the quality of life. Therapeutic procedures on the human embryo are licit, if there is respect for life and integrity of the person (embryo/foetus) and they do not involve disproportionate risk. The procedures must be directed towards healing, improvement in health and survival. The growing child in the womb cannot be considered as an object, to be disposed off as thought fit by the mother or any other person.

What happens if an injury is caused to a foetus while in the uterus? Can damages be claimed? If the answer is yes, then the child is a person. Can the life of this person be ended by procedures approved by others? It is sad that most doctors in India do not wish to concern themselves with this subject.

Abortion

Indian law allows abortion, 'if the continuance of pregnancy would involve a risk to the life of the pregnant woman or grave injury to her physical or mental health.'

Abortion was being practised earlier by many. Because it was illegal, it was practised in a clandestine manner. The passing of the Act made medical termination of pregnancy legal, with certain conditions for safeguarding the health of the mother.

From April 1972, Indian doctors have zealously performed abortions at the mother's request. Doctors advertise and invite women to have abortions done at their clinics. The Government saw it as one more method of population control. Though abortion is legal, many find it immoral. Most physicians in India do not see anything unethical or immoral in carrying out medical termination of pregnancy within the first trimester, for the 'greater good' of the country in the light of the expanding population.

Abortion is severely condemned in Vedic, Upanishadic, the later *puranic* (old) and *smriti* literature.

Paragraph 3 of the Code *of Ethics* of the Medical Council of India says: 'I will maintain the utmost respect for human life from the time of conception.'

There is a conflict of the rights of two persons: the mother and the growing foetus. Has the mother the right to destroy the life of the child she is carrying in her womb? Is the right something akin to the possession of some material good, which can be disposed of as the mother wants, without consideration of the right of the unborn child?

Sex ***pre-selection, sex determination and female foeticide***

There are a number of methods available for sex determination and sex selection. Like traditional practices and mores, they are pro-male and anti-female.

Some doctors in India have been carrying out procedures for sex determination. It is perhaps peculiar to India that pre-natal determination of sex is employed for abortion of a female foetus. Such abortion clinics thrive in the country inspite of public opinion against it.'

Whilst many condemn abortion of a foetus merely because it is of the female sex, there are quite a few who justify female foeticide in the Indian setting with-its social custom of dowry. And there are quite a few physicians who would like to take advantage of this to make quick financial gains.

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The Government, though proclaiming against female foeticide, does not seem to be keen to effectively enforce that policy. India has a sex ratio adverse to women (929 women to 1000 men, according to the 1991 census). The availability of sex pre-selection, sex determination and female foeticide worsens the situation.

There is a growing tendency in many parts of the world to do away with life if the foetus is found to have deformities compatible with life but likely to put a great burden on the family (e.g. myelocoele and paraplegia). The diagnosis of such a condition can be made whilst the child is still in its mother's womb. This tendency is less evident in India. Parents accept such offspring as part of their fate or *karma.* There is a growing number of persons who advocate that the choice regarding whether such foetuses should be aborted be left to the parents.

Infanticide

There are also instances where infanticide of the female child is resorted to. The practice of doing away 'with the newborn female child if the mother died during childbirth was condemned by Guru Amar Dass, the third Guru of the Sikhs and fell into disuse because of his efforts.

In Vedic times there was no reference to infanticide of children born in wedlock but there is a reference to the exposure to the elements of the child born to unmarried women.

Manu, the lawgiver, recommended that the king award the death sentence to him who kills a woman, a child or a brahman. 'Neither in this world nor in the next can any action leading to the injury of living beings be productive of good results. The conduct of persons who do not perform *vratas* (religious ceremonies) but whose minds are not given to killing can lead to heaven*.'

The great majority of physicians in India are totally against infanticide, even when the newborn has many defects at birth.

Euthanasia

'Hasn't a person the right to quit a life which, according to him or her, is not worth living? Is the right to die not implicit in the right to live?'[3]

India does not allow suicide or aiding and abetting suicide. This is being questioned. The Law Commission in its forty-second report stated: 'It is a monstrous procedure to inflict further suffering on an individual who has already found life so miserable, his chances of happiness so slender, that he has been willing to face pain and death to cease living.'

The controversy regarding punishment for attempted suicide has exacerbated with the recent judgements of the High Court and Supreme Court. While the High Court decision was to cut down the provision of punishment, the Supreme Court has overruled it. The present position is that attempted suicide (and aiding suicide) is punishable.

None of our ancient documents allow euthanasia but there were advocates among our ancient physicians for abandoning treatment when the disease reached a stage from which recovery was considered unlikely.

Most people reject positive euthanasia - actively bringing about death. The exceptions are among a few intellectuals. People, by and large, accept suffering as part of their fate, resulting from *karma*. Many favour the omission of treatment with the intention of not prolonging the process of dying. They also favour measures to relieve agony, even if these hasten death.

Artificial insemination/Assisted pregnancy/Surrogate mother

The universal desire to have children is strong. What is to be done when there are impediments to having a child in the natural way and there is no way of overcoming sterility in one or the other partner? One way out is adoption. But many desire children with their own genes.

What do the ancients say? According to *Caraka Samhita,* 'the man without progeny is like a tree that yields no shade, which has no branches, which bears no fruit and is devoid of any pleasing odour'. India's social structure requires a son. He is expected to provide support to his parents in old age. He is also required to perform religious rites on their death. A married woman is under social pressure to conceive soon after marriage. A sterile woman is considered inauspicious.

Artificial insemination by husband or anonymous donor is practised fairly widely, especially among the upper and middle classes. In vitro fertilisation and other forms of assisted pregnancy are gradually gaining ground. In each case, the cost is high as is the rate of failure. The practice of surrogate motherhood is, as yet, rare in India.

Medical education

The process of training often determines the ethical values held by the physician and the profession. The emphasis given to the teaching of medical ethics can affect the professional behaviour of the future physician. In general, today, there is little emphasis on training in ethics and related subjects. There are a few exceptions but they do not constitute even ten percent of the institutions in the country.

Dealing with instructions to medical students, Charaka[4] says:

- Your action must be free from ego, vanity, worry, agitation of mind or envy; your actions must be carefully planned, with concern for the patient and in keeping with the instructor's advice.
- Your unceasing efforts must, at all costs *(sarvatmana) be* directed towards giving health to the suffering patients *(aturanam arogya).*
- *You* must never harbour feelings of ill-will towards your w pr even if it entails risk

to your life.

- Never should you entertain thoughts *(manasapi)* of sexual misconduct or thoughts of appropriating property that does not belong to you.
- Take no liquor, commit no sin, nor keep company with the wicked.
- Your speech must be soft, pleasant, virtuous; truthful, useful and moderate.
- What you do must be appropriate to the place where you practice and the time, and you must be mindful in whatever you do.
- Your efforts must be unremitting.
- Do not reveal to others what goes on in the patient's house hold.
- Even when you are learned and proficient, do not show off.
- Difficult it is to master the entirety of medical science; therefore, one must be diligent in maintaining constant contact with this branch of learning.

According to the ancients, medical wisdom is acquired by three methods:

1) study *(adhyayana)*, earnest and continuous;
2) teaching *(adhyapani)*, after examining the student and ascertaining his character, ability, health and interest and imparting lessons concerning life in general, medical profession, medical ethics and science of medicine; and
3) academic discussions *(tatvidya-sambasha)* with colleagues and fellow students, in order to enrich one's own knowledge, to obtain clarity of knowledge, to get rid of doubts, to deepen one's understanding, to learn new methods and ideas and to become skilled in expressing one's thoughts. Active learning is placed before teaching. Medical ethics are among the broad subdivisions to be taught.

At the time of commencement, the student had to take an oath. What was more interesting was that the teacher also had to take an oath: 'When you on your part keep your vows and if I do not respond fully and impart all my knowledge, I shall become a sinner and my knowledge shall go fruitless.'"

One major problem in the country today is the development of 'Capitation Fee Medical Colleges', where admission of students is based upon the payment of a large sum (mostly in the form of unaccounted money) by the student or parent. The fee now varies from Rs. 20,00,000 to Rs. 30,00,000. Other students, even though they may be far more meritorious - academically and otherwise - are not admitted because they cannot afford to pay the large amount. Because the basis of admission is the capacity to pay the large amount to the management, many unhealthy practices arise. The whole environment has become commercialised and vitiated. Teaching and patient care are also tainted by commercial considerations in these institutions.

Will medical ethics survive under such conditions?

Organ transplants

There is a big demand for organ transplants, especially of kidneys. These demands and the means of meeting them often raise ethical nightmares because of unscrupulous activities.

There is a small number of transplants where close relatives donate their kidney. This is possible because of the strong family ties. The large majority of transplants are carried out on a commercial basis.

Some doctors in India saw a potential gold mine in kidney transplants. There was a large number of patients with end-stage renal disease in the rich Middle East, in addition to the rich Indian patients. They were prepared to pay. Kidney transplant became a commercial proposition. A new class of agents or organ procurers came into being. The doctors involved were not bothered about the ethical issues of robbing a kidney from an unsuspecting person.

It is often the illiterate people of the slums of Bombay, Madras and other places that 'donate' the kidney. At times, even knowledgable persons are prepared to give away one kidney because they are in desperate need for money. Almost all our kidney transplants have been from live 'donors'. There have been very few cadaveric transplants.

The new Act passed by Parliament is expected to favour cadaveric transplantation. It has defined 'brain death'.

Whether live or cadaveric, organ transplantation raises many ethical issues.

Terminally ill

Physicians have been brought up to preserve life and to prevent death. The ancient teaching has been that knowledge of incurability of the disease should not make the physician withdraw care or treatment. As long as the patient breathes, it is the duty of the physician to provide treatment (tatvat pratikriya karya yavae chvasiti manavah).[6] But there is also another view: one should know when to stop treatment. Among the qualities that brought credit to the physician is the withdrawal of treatment of one whose condition is definitely moribund *(upekshanam prakristheshu).* [3]

The two apparently contradictory statements may probably mean that heroic specific treatment was to be withdrawn once the patient was deemed to be terminally ill and that care was to be given to such patients to reduce suffering. The present thinking is in harmony with this view. Prolonging life with the help of machines when there is no chance of recovery or in patients suffering with great pain and distress because of incurable illness has been questioned in recent times.[7] If restoration of health is no

longer possible and death is imminent, the physician need not do anything extraordinary or heroic to prolong living (dying) but it is proper and necessary to relieve pain and suffering. These measures have to be taken, even if they may incidently shorten life. The physician is expected to assist the patient in achieving a peaceful death.

To tell or not to tell

According to Charaka and Susruta, the physician must be careful in disclosing to the patient the incurable nature of his illness. It should not be told bluntly? It may shock the patient. It is preferably made known to the patient's relatives. State officials are also informed to avoid punishment should the patient die under the doctor's care,! Treatment of a heroic nature is to be undertaken only with the consent of the patient's relatives and elders.

Present-day doctors differ in their approach about when to tell the truth, and how much to disclose, to the dying patient. There are many conflicting considerations: the patient's right to know; the benefit to the patient and possible harm. A study conducted in the Postgraduate Institute of Medical Education and Research, Chandigarh, showed that 69.2% of the doctors favoured telling the truth, while 30.8% did not believe in telling the truth to the terminally ill patients." Most of the doctors favoured involvement of the family members and close relatives.

Conclusion

We have moved a long way from the precepts and practices of the ancients. This is true of ethics in general. The medical profession is also affected by the changes. Part of the change has been because of an erosion of the values cherished in olden times. Part is due to different thinking, influenced to some extent by contact with other cultures. Yet another part has resulted from advances in science and technology. We have been creating situations to which our ethical responses have been slow or even undeveloped.

What is the way out? A judicious blend of the ancient with the modern, integrated with each other to make our responses progressively relevant to the times and needs and based on the cherished ideals of human relationships may be the answer.

References

1. Wadhwani YK: Subtle bodies postulated in the classical Samkhya system, *Journal of the L. D. Institute of Indology, 1976;* 5 : *29-40*
2. Sarkar Benoy Kumar: *Indian Culture,* Patna: I.B. Corporation, 1936; 2: 804
3. Das Gupta SM: Mercy killilng, an analysis based on human rights, *Proceedings of the International Conference on Health Policy: ethics and human values, New* Delhi: 1986, E-29.
4. Jayadeva Vidyalankara (Ed.): *Charuka Samhitu,* Delhi: Motilal Benarsidass, 1986.
5. Chren Mary Margaret, Landfeld C Seth, Murray Thomas H: Doctors, drug companies and gifts. *J.A.M.A.* - India, 1990; 6; 641-44.
6. Ramachandra Rao (Ed.): *Encyclopedia of Indian Medicine,* Bombay: Popular Book Prakashan, 1987.
7. McCarthy Donald G, Moraczewski Alberts: *Moral responsibility in prolonging life decisions,* St. Louis: Pope John Centre, 198 1.
8. Bhattacharya NL (Ed.): *Susruta Samhita,* Mysore: University of My sore, 1973.
9. Jindal SK, Jindal UN: To tell or not to tell: professional practices in the case of the dying. *Proceedings of the International Conference on Health Policy: ethics and humun values, New* Delhi: 1986, E-20.