

Medical ethics in India: ancient and modern (I)

C.M. Francis

Introduction

Ancient Indian thoughts, philosophy and ethics, developed with a rational synthesis and went on gathering into itself new concepts. Spiritual experience was the foundation of India's cultural history. Next to spirituality, *dharm* (ethical conduct according to one's state) was the most important concept of Indian thought. Both are, unfortunately, on the decline.

With the coming of the Europeans, and especially during the colonial rule, imitation of what the rulers did and practised became more and more popular. But, there was also resistance to this wholesale copying of the foreigners' practices. 'Reverence for the past is a national trait. There is a certain doggedness of temperament, a stubborn loyalty to lose nothing in the long march of the ages. When confronted with new culture or sudden extensions of knowledge, the Indian does not yield to the temptations of the hour, but holds fast to his traditional faith, importing as much as possible of the new into the old. Conservative liberalism is the secret of the success of India's culture and civilization.'¹

The value systems in India have been influenced by all the religions, but mostly by Hinduism, the major religion (82.64% of the population), contributing to the philosophy and ethics of the people of the country. The fundamental basis of ethics arises from the Hindu belief that we are all part of the divine *Paramatman*; we have in each of us *Atman*, part of that *Paramatman*.

The ultimate aim is for our *Atman* to coalesce with *Paramatman* or *Brahman* to become one. According to the Vedas (4000 BC to 1000 BC), the call to love your neighbour as yourself is 'because thy neighbour is in truth thy very self and what separates you from him is mere illusion (*maya*).'² Closely allied to Hinduism are Jainism and Buddhism. These religions proclaim *Ahimsa Paramo Dharma*. Most important of all our actions is *ahimsa*, non-violence. Patanjali defined *ahimsa* as *Sarvatha sarvada sarvabutananz anabhidroha*³, a complete absence of ill-will to all beings.

Ayurveda is the ancient science of life. It lays down the principles of management in health and disease and the code of conduct for the physician. Charaka has

described the objective of medicine as two fold: preservation of good health and combating disease.² Ayurveda emphasised the need for healthy life-style; cleanliness and purity, good diet, proper behaviour, and mental and physical discipline. Purity and cleanliness were to be observed in everything: *jalasuddi* (pure water), *aharasuddi* (clean food), *dehasuddi* (clean body), *nznasuddi* (pure mind) and *desasuddi* (clean environment).

Ayurveda calls upon the physician to treat the patient as a whole: '*Dividho jayate vyadhih, Sariro manasasthatha, Parasparam tayorjanma, Nirdvadvam nopalabhyate*. (Diseases occur both physically and mentally and even though each part might be dominant, they cannot be compartmentalised). Ayurveda treats man as a whole - body, mind and what is beyond mind. The earliest protagonists of Indian Medicine, such as Atreya, Kashyapa, Bhela, Charaka and Susruta have based their writings on the foundations of spiritual philosophy and ethics. But the one teacher of Ayurveda who established the science on the foundation of spirituality and ethics was Vagbhata, the author of *Astanga Hridaya*³. Vagbhata says: *Sukarthah sarvabutanam, Matah sarvah pravarthayah, Sukhamcana vina dharmat, thasmad dharmzaparao bhavet*. (All activities of man are directed to the end of attaining happiness, whereas happiness is never achieved without righteousness. It is the bounden duty of man to be righteous in his action).

Charaka Samhita prescribes an elaborate code of conduct. The medical profession has to be motivated by compassion for living beings (*bhuta-daya*)⁴. Charaka's humanistic ideal becomes evident in his advice to the physicians'. He who practices not for money nor for caprice but out of compassion for living beings (*bhuta-daya*), is the best among all physicians. Hard is it to find a conferrer of religious blessings comparable to the physician who snaps the snares of death for his patients. The physician who regards compassion for living beings as the highest religion fulfils his mission (*sidhartah*) and obtains the highest happiness.

Ethical problems

The problems are mainly: (1) those related to the professional activities of the doctors, (2) those connected with social justice and equity, including the use of sophisticated technology, experiments on human beings and right to health, and (3) those related mainly

to the beginning and end of life.

Informed consent

There is a general belief among the doctors in India that it is not possible to get informed consent because of rampant illiteracy. They believe that the patients are unable to make a reasoned choice because they cannot appreciate the intricacies of alternative medical treatment, procedures or drug trials. Often a paternalistic view is taken: 'The doctor knows best.'

Dr. Srinivasamurthy and colleague⁸ at the National Institute of Mental Health and Neurosciences, Bangalore, conducted a study into the relevance of obtaining informed consent. Almost all (99%) of the subjects invited to participate in a drug trial gave a clear choice whether to participate or not. Patient's level of understanding and decision-making related to the amount and quality of information provided. They did not correlate with social, economic, educational or other background characteristics.

Can the doctor withhold treatment, if there is no informed consent? Can a man refrain from benefiting from medical treatment and forfeit saving his life? Will the doctor be assisting suicide? On the contrary, does not the patient have the right to control what shall be done to his/her body?

What is the status of informed consent when a patient is admitted to the hospital in a critical condition but in full possession of his/her senses? Can the surgeon who diagnosed the condition requiring immediate surgery refrain from operating on the sole ground that the patient had not given his/her consent for the operation? If the patient later dies, what is the liability of the doctor?

An interesting case came up in the State of Kerala. A patient with acute abdominal pain was admitted to a district hospital. He was examined by the surgeon, who diagnosed perforated appendix with general peritonitis, which required an immediate operation. But the operation was not performed by the surgeon and the patient died the next day. The relations filed a petition in the court against the doctor personally and against the Kerala Government vicariously. The doctor's defence was that the operation was not performed as the patient did not consent to it. The court rejected this plea and granted a decree against the doctor. The decision was confirmed by the Kerala High court in the appeal preferred by the doctor. Two specialist surgeons who were called as expert witnesses stated that they would have operated on the patient without the explicit consent.

In contrast is the view that every human being has a right to determine what shall be done with his or her own body. A surgeon who performs an operation

without the patient's consent commits an assault for which he is liable? Indian physicians who are trained abroad or have imbibed this principle find themselves in a conflicting situation.

What is the ancient teaching in such circumstances? Charaka advises the physician to take into confidence the close relatives, the elders in the community and even the State officials, before undertaking procedures which might end in death of the patient. The physician is then to proceed with the treatment.

In India, great trust is reposed in the doctor, but more and more people are questioning the practice. Trust based on 'goodness' of the doctor is slowly giving way to the concept that making the decision is the right of the patient.

Advertisement

There are instances of unethical advertising by doctors. Such doctors are frowned upon by their colleagues but little action follows. The Medical Council of India and the state medical councils are to look into such matters but because of technical flaws, the doctor often escapes. Of late, advertisements by hospitals and diagnostic centres are coming up in a big way proclaiming their superiority over others.

Diagnostic aids

There is a growing supermarket in diagnostic equipment. Sophisticated equipment is bought at great expense of scarce foreign exchange. Most of the imaging equipment currently in use in the various hospitals and diagnostic laboratories is in excess of the needs. Yet another problem with the purchase of equipment from abroad has been the difficulty of servicing and maintenance.

Doctors trained abroad in the specialties ask for such equipment, but should these requests not be tempered by the realities of the situation? Is it ethical for the doctor to order costly, sophisticated equipment, which is not likely to function, utilising scarce foreign exchange? Is it ethical for firms to supply these items without back-up service? This is a problem in most third world countries. Thairu⁶ suggests that an ethical code should be agreed on by both (manufacturers and users) regarding the sale of equipment.

Drugs and pharmaceuticals

There is a huge proliferation of drugs in the Indian market, with more than 60,000 formulations. They are manufactured by large, medium, small and tiny factories - multinational and national. There are many drugs in the Indian market which are banned in other countries. There are drugs which were banned in India itself but continue to be marketed, after getting stay orders from the courts. Legal proceedings take years. During this period, doctors continue to prescribe these hazardous

drugs, patients continue to take them and the firms continue to make huge profits.

Many of the drugs in the market are spurious or of substandard quality. It has been reported that as a rule 20-30 percent of the samples tested are substandard. Government agencies take a long time to test the samples and to announce the details of the substandard drugs. Manufacturers are expected to give the indications, contra-indications, side effects and adverse effects. They often do so but in such a way that it will not attract attention; the greater the hazard, the smaller the print.

One of the most distressing aspects of the present health situation in India is the habit of doctors to over-prescribe or to prescribe glamorous and costly drugs with limited medical potential. It is also unfortunate that the drug producers try to push doctors into using their products by all means - fair or foul. These basic facts are more responsible for distortions in drug production and consumption than anything else. If the medical profession could be made to be more discriminating in its prescribing habits, there would be no market for irrational and unnecessary drugs.⁷

The drug firms do not generally follow the WHO ethical criteria for drug promotion. Gift giving, almost universal⁸, raises many ethical issues as in other countries; the effects are much more pronounced in a poor country.

In the past, medicines were prepared under the personal supervision of the physician or by the families of the patients. There were strict guidelines for the collection of herbs and other raw materials and for the processes. Medicines thus prepared were reliable for quality and purity.

Right to health

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services - Article 25 of the Universal Declaration of Human Rights. If health is a fundamental human right, it becomes the responsibility of the State to protect and promote the health of all the people. There has to be an irreducible minimum of health care services to all. There is need to close the gap between the 'haves' and 'have nots', achieve more equitable distribution of health care resources and attain a level of health for all. The Alma-Ata Conference declared: 'Governments have a responsibility for the health of the people, which can be fulfilled only by adequate and equitably distributed health and social measures.'

The right to health brings on the issue of distributive justice to make available an acceptable and affordable

care to all. One important aspect of such service is the provision of qualified persons for providing health services where such services are not available at present. Can the physician be compelled to provide service in villages where there are no doctors? The State and the institutions generally subsidise medical education. Even if there is no subsidy, the doctor has been provided an opportunity, not available to many. But opposing questions arise. The doctor is not owned by the people or the institution. Can the doctor be deprived of the right to earn legitimately as much as he or she can and where he or she can? Can a person be compelled to act against his or her wish as long as no harm is done to the Society? The consensus is that the doctor owes a duty to serve the people in the areas where they are needed but the medical profession, in general, is not in favour of mandatory service. Health is included in the Directive Principles of State policy, which is considered as the 'conscience' of the Indian Constitution. Article 39 of the constitution directs the State to ensure health; article '47 requires the improvement of public health to be among the primary duties of the State. In pursuance of these articles the Government had issued a number of policy statements and programmes. The latest in the series is the National Health Policy (1982).

Health policy

The stated health policy of the Government of India has been frustrated by poor implementation. The allocation of resources to the health sector has been very small. Often, the priorities are assigned not on the needs of the people but on what is fashionable and on who has the maximum political leverage. Very little allocation is made for control and treatment of infectious diseases such as tuberculosis, malaria and kala-azar (especially prevalent in the villages of Bihar, Orissa and West Bengal).

Questions arise: Who shall receive what health care? What resources can be allocated, how and to whom? How do we set our priorities? What is an acceptable form of health care? Who should decide on health policy?

Many issues are being debated currently. There is a demand for more equitable distribution of the benefits of medical knowledge. Against it is the much more powerful force for the use of sophisticated, spectacular and costly technology for the benefit of the few. Newer technology is pushing skyhigh the expenses for diagnostic and therapeutic procedures. Patients are made to feel that, unless they go through a whole array of expensive diagnostic procedures, a correct diagnosis is not possible. There are wide networks of costly diagnostic laboratories, aided and abetted by doctors who often get kickbacks.

Patients are completely mystified by the advice they get from their physicians. They shell out huge sums of money (relative to their earnings) which they can ill afford. The onus for this unethical practice rests squarely on the medical profession.

Does an individual have the right to buy expensive technology to the exclusion of others who share the same resources? Is it right that the scarce resources of qualified and experienced personnel, money (including foreign exchange) and materials be used for the benefit of a few while the large majority of people are not able to get even simple primary health care services?

All religions advocate the care of the poor and needy. Christ declared: 'When you have done this to the least of my brothers, you have done it to me.' Gandhiji said: 'I will give you a talisman. Whenever you are in doubt or when the self becomes too much with you, apply the following test: recall the face of the poorest and weakest man you have seen and ask yourself if the step you contemplated is going to be of any use to him. Will he gain anything by it?' Kabir said: 'The valiant fighter is only he who fights for justice to the poor.'

The debate on distributive justice goes on. Shall the State purchase ten renal dialysis machines (which will maintain the life of a few sick people) or employ fifty community health workers (to help 50,000 people achieve better health)? Shall the district hospital have two more specialist doctors or shall each of the many

primary health centres have trained laboratory technicians who can spot the malaria parasite? Shall the hospital buy one lithotripter or expand its programme for oral rehydration for children affected with diarrhoea? The cake is small. How shall it be cut?

Has the medical profession any ethical responsibility in influencing the health policy? The doctors in India are often passive spectators in the fight for social justice and against discrimination in health care.

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Educating the public on genetic engineering

We must not imply to the public that we are going to chase with the genome project, with somatic DNA therapy, all the ills of man. It is surely ethically more acceptable, in both the developed and the developing world, to tell the public that in the foreseeable future genetic engineering will not provide practical and affordable solutions to these problems. Scientific responsibility demands recognising this and not misleading the public with false promises and unattainable hopes, as has happened in several biomedical projects of immense dimension during the past half-century. There have been a number in my own field.

One has just been discussed at length in a recent book by Desowitz called *The Malarial Capers*, which describes...the malaria 'felons'. The story starts a century ago, with the catastrophic prima donna-like contention for the Nobel Prize between Grassi in Italy and Ross in England. All the chicanery that went on then in research reminds one of what the newspapers tell us today. The story continues to 1991, with the molecular biologists promising much too much to the public and Third World governments - that a practical subunit vaccine was just around the corner. One billion dollars went into the project and we are still nowhere near. And none of the scientists has loudly and clearly proclaimed that it ain't going to happen soon and, if it ever does, it will be for generals and armies and not for the general population in the Third World. No one has dared to say this because it would interfere with the project and our careers.

D. Carleton Gadjusek

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