

Introduction

*“Life is short, and Art long; the crisis fleeting;
experience perilous, and decision difficult.
The physician must not only be prepared to do
what is right himself, but also to make the patient,
the attendants, and externals cooperate.”*

– Hippocrates



Preface

This story begins with a failure. Thirteen years ago a group of doctors fought the Maharashtra state medical council elections on the platform of ‘ethical medical practice’. They lost, and they lost badly. But instead of conceding defeat they turned that loss into a gain. They started a newsletter where people with a commitment to ethics could express their views, and thus promote better medical practice. That newsletter eventually became *Indian Journal of Medical Ethics*.

This selection of articles from the first 10 years of the journal provides a glimpse into concerns and debates in medical ethics in a decade that saw the beginning of turbulent times for health care in India.

The 1990s witnessed a marked expansion in private health care services in the country. This trend dates back to earlier decades but has been accentuated in recent years. Advances in medical technology have been exploited by the private sector. Health care costs have spiralled. As private medical colleges mushroom, the doctors of today will also have invested lakhs of rupees on their education – all of which must be recovered soon after graduation. None of this brings us closer to the ideal of accessible and affordable health care for all.

Simultaneously, the pharmaceutical industry has intensified its efforts to influence the medical profession. Thousands of similar but non-essential and even irrational and dangerous drugs compete for shelf space in pharmacies. Doctors are updated on new developments by medical representatives, not medical journals. Pharmaceutical sponsorship of medical conferences has now been institutionalised. The doctor-drug company relationship threatens the doctor-patient relationship.

Health care in India today is dominated by allopathic medicine despite the existence of centuries-old systems such as ayurveda and unani, or the more recent homoeopathy, all of which seem to treat the patient in a more holistic manner. Indeed, as the introductory articles to this selection show, the dilemmas of contemporary medicine are addressed in the works of Charaka and

Hippocrates. However, today the interaction between these systems and the dominant allopathy creates its own set of problems.

High-tech hazards

Western medical technology has steered doctors away from simpler approaches to more complex ones. In many areas, such as end-of-life care, it has created new dilemmas. And in fields such as organ transplant and prenatal diagnosis, the profession has used the technology for personal profit rather than social good.

We also face situations that have little or nothing to do with technology: epidemics, earthquakes and tidal waves highlight the inadequate role played by health professionals in humanitarian emergencies; state-sponsored violence and communal riots force the profession to confront its responsibilities – and culpability – in these situations. The provider-patient relationship is particularly complicated in other, ongoing, crises such as the HIV epidemic and its fallout.

While most of our attention has been focussed on clinical practice, research ethics is a growing concern. India is becoming fertile testing ground for researchers from abroad. With a billion-strong population and poor regulation, it is an ideal place to experiment with new medical products. And if biomedical research can put participants at physical risk, the expansion in social science research in health poses questions of a different kind of harm.

The medical profession and its discontents

Over the last decade patients and their relatives have become increasingly dissatisfied with their experiences of health services, and increasingly distrustful of the medical profession. Medical councils have done a poor job of ensuring ethical behaviour by doctors. Indeed, corruption controversies seem to be their only claim to fame. The medical associations have protected neither doctors nor patients. As patients turned to the law, including the Consumer Protection Act, it has resulted in the practice of ‘defensive medicine’. The profession is apparently insecure in what it sees as a fight for its own survival. Not surprisingly, most cases registered under the CPA were instigated by doctors against other doctors. It is rare to find patients suing doctors on their own.

Doctors in India as a community have traditionally stayed away from social issues. They have rarely taken a stand on larger issues like self-regulation within the profession, the need for relevant research, the impact of infrastructure inadequacies and drug shortages, and so on.

There are, however, some who have consistently spoken out against the wrongs in the profession. Most of them are medical professionals, but researchers, activists, and even the common man have expressed the need for introspection within the medical profession.

Selected views

Indian Journal of Medical Ethics – formerly *Issues in Medical Ethics* – has been instrumental in keeping this voice alive through the past decade. Most of the contributors to this anthology are practising physicians and represent a small but vocal minority within the profession. They speak of the dilemmas faced by health care providers on a daily basis in India. Some also look at efforts at resolving these dilemmas. Some of these articles discuss questions of personal ethical integrity. Others refer to the interactions amongst health professionals, and between them and patients. And almost all of them also touch upon the choices posed by high technology and limited resources in a poor society, raising questions of equity and justice.

The articles here were chosen because they best articulated the major concerns discussed within the journal over these years. Practically all of them refer to problems specific to India and other developing countries where health care professionals work for people whose access to care is limited by their poverty, lack of education and the traditional reverence for doctors. They are also limited by an inaccessible health care system.

Some writers refer to ethics indirectly, as they look at the relevance of technology-driven medicine in a poor country such as India. Some essays have been included specifically because they discuss key controversies from different but important perspectives.

It was difficult to choose just 29 articles from the many essays, reports, narratives and commentaries published in the journal. We

hope that readers of this selection will be provoked into going through back issues of the journal where the battles of medical ethics are narrated in more detail. The last 13 years have produced an extensive documentation of issues and controversies in India. Corruption in the profession continues to be a matter of concern, and the need to focus on personal integrity is as important today as it was in the first issue of the journal. But we are also viewing health care ethics in the larger context of global changes in the health sector, the decline of the public sector, the accelerated development of corporate hospitals, the politics of population control and contraceptive research, the rise in inequities, an increase in conflict and fundamentalism and so on. It is from this perspective that we are beginning to address the ongoing ethical challenges in health care.

The Hippocratic Oath updated

Eugene D Robin

Over the years, IJME has published a number of oaths and codes of medical ethics, from the Hippocratic Oath to Charaka's oath of initiation, to the Islamic and Jewish codes and most recently the Code of Medical Ethics of the Medical Council of India. This adaptation of an updated version of the Hippocratic Oath was published in BMJ, July 9, 1994.

In the name of suffering humanity; with humility, compassion and dedication to the welfare of the sick according to the best of my ability and judgement; I will keep this oath.

I will be honest with my patients in all medical matters. When this honesty reveals bad news I will deliver it with sympathy, understanding and tact.

I will attempt to provide whatever information my patients need so that I can care for them more effectively.

I will provide my patients with acceptable alternatives in diagnosis, medical and surgical treatment, explaining the risks and benefits of each alternative as best as I know them.

I will encourage my patients to seek medical opinions other than my own before accepting that offered by me.

I will allow my patients to make the ultimate decision about their own care. When they are incapable of making decisions, I will accept the decision of their family members or loved ones, encouraging these surrogates to decide as they believe the patient would have decided.

I will provide care to all patients regardless of sex, race, creed, sexual preference, lifestyle or economic status. In particular, I will volunteer some of my time to providing free care to the poor, the homeless, the disadvantaged, the dispossessed and the helpless.

I will not sit in moral judgement on any patient but will treat the illness to the best of my ability regardless of the circumstances. I will be empathetic to patients suffering from illnesses caused by alcohol, drugs or other forms of self-abuse.

I will turn away no patient, even those with dreaded, contagious diseases like AIDS.

Knowing my own inadequacies and those of medicine generally, I will strive to cure when possible, relieve and comfort always.

I shall perform medical tests only if there is a reasonable chance that the results will improve the outcome for my patients. I will not perform any tests or procedures or surgery solely to make money.

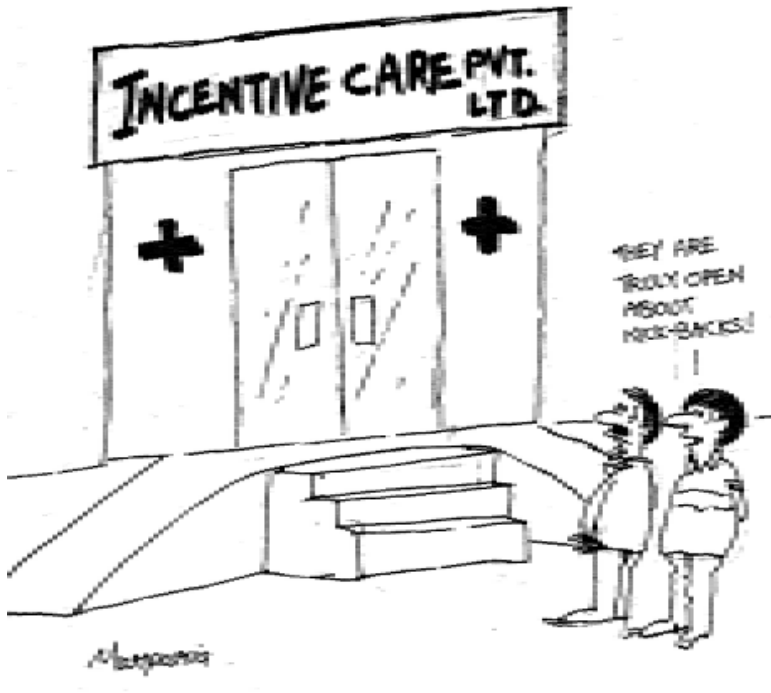
I will freely refer my patients to other physicians if I am convinced that their treatment is better than mine.

I will freely furnish copies of medical records to the patient or, when authorised by the patient, to the family, upon request. I will do unto patients and their families only what I would want done unto me or my family. I will not experiment upon patients unless they give truly informed consent. I will strive to instruct patients fully so that truly informed consent is possible.

I will remain a student all my professional life, attempting to learn not only from formal medical sources but from my patients as well. I will apply the lessons they provide to the care of other patients.

I will treat my professional colleagues with respect and honour; but I will not hesitate to testify openly about physicians and medical institutions that are guilty of malpractice, malfeasance, cupidity or fraud.

I will defend with equal fervour colleagues who are unjustly accused of malpractice, malfeasance, cupidity or fraud.



Medical ethics in India: ancient and modern

C M Francis

In this essay a medical teacher and ethicist contrasts the primacy of autonomy in the western tradition with the primacy of collective decision-making in the Indian tradition. The writer is concerned less with doctors' actions than their character. He sees the professional and personal lives of a doctor as one. He links ethics as discussed in the Indian texts to current issues such as abortion, euthanasia and sex selection. This essay is the starting point for further discussions on issues such as the relevance of ancient teachings today. It is also worth noting that the neglect of Indian systems of medicine has resulted in little research and innovation in indigenous systems, both in their practice and in the development of the philosophy behind it.

Introduction

Ancient Indian thought, 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, *dharma* (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 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 per cent 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." 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 sarvabutanam anabhidroha* (1), 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 a healthy lifestyle; 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), *manasuddi* (pure mind) and *desasuddi* (clean environment).

Ayurveda calls upon the physician to treat the patient as a whole: "*Dividho jayate vyadhih, Sariro manasasthatha, Parasparanz tavorjanma, 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,*

Sukham ca na vina dharmat, thasmad dharmaparo 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 practises not for money nor for caprice but out of compassion for living beings 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.”

Informed consent

There is a general belief among doctors in India that in a conflicting situation it is not possible to get informed consent because of rampant illiteracy. They believe that 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 colleagues (4) at the National Institute of Mental Health and Neurosciences, Bangalore, conducted a study into the relevance of obtaining informed consent. Almost all (99 per cent) of the subjects invited to participate in a drug trial were clear about whether or not to participate. Patients’ 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 relatives 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 by the doctor. Two specialist surgeons who were called as expert witnesses stated that they would have operated on the patient without 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 (5). 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 the patient's death. 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 the 'goodness' of the doctor is slowly giving way to the concept that making the decision is the right of the patient.

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? 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' or 'human being'?

According to ancient Samkhya philosophy, there are two ultimate principles in the universe: *purusha* (soul) and *prakriti* (the body). The soul is immutable (*kutastha*) and imperishable (*nitya*) (6). 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 of 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 in spite 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.

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 1,000 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 (eg 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." (7)

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?” (8)

India does not allow suicide or aiding and abetting suicide. This is being questioned. The Law Commission in its 42nd 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 among our ancient physicians there were advocates 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 motherhood

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 *Charaka 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 the husband or an 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 10 per cent of the institutions in the country.

Dealing with instructions to medical students, Charaka (9) 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 patient, whatever the provocation, 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 practise 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 household.

“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:

- study (*adhyayana*), earnest and continuous;
 - teaching (*adhyapani*), after examining the student and ascertaining his character, ability, health and interest and imparting lessons concerning life in general, the medical profession, medical ethics and the science of medicine; and
 - 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 is 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.”
- (10)

One major problem in the country today is the development of capitation fee medical colleges, where the admission of students is based upon the payment of a large sum (mostly in the form of unaccounted money) by the student or parent. Today the fee varies from Rs 20 lakh to Rs 30 lakh. 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 are a small number of transplants where close relatives donate their kidney. This is possible because of 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 were a large number of patients with end-stage renal disease in the rich Middle East, in addition to 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 ethics of robbing a kidney from an unsuspecting person.

It is often the illiterate people of the slums of Bombay, Madras and other places who 'donate' the kidney. At times, even knowledgeable 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 that a disease is incurable 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*) (3). 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 prakritheshu*). (8)

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 (5). 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 incidentally 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 (2). 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 per cent of doctors favoured telling the truth, while 30.8 per cent did not believe in telling the truth to terminally ill patients (11). Most of the doctors favoured involvement of 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.

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Condensed from an article published in two parts: in Volume 4, Number 4, October-December 1996 and in Volume 5, Number 1, January-March 1997.