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MEDICAL ETHICS IN AYURVEDA

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INTRODUCTION

The beginnings of recorded medical practice in India date back to the advent of Aryan invaders. Originating in Central Asia, they settled in the northern Indian plains around 1500 BC. They brought with them, in Sanskrit, the beginnings of the *Vedas*. The three principal *vedas* were *Rig*, *Sam* and *Yajur*. A later addition - the *Atharva Veda* - is the principal source for information on medicine during the early *Vedic* period.

Much useful information is also to be found in the similar Ayurvedic classics - *Caraka Samhita, Susruta Samhita* and *Bhela Samhita* (around 600 BC). The early *Vedic* healers were members of the priestly community. The medicine they practised and taught was heavily influenced by the philosophy of the times. Medical works also emphasised the concept of the cycle of life-death-rebirth. The student was taught that the goal of the savant was to break this cycle and attain union with *Brahman* - the Universal Spirit or God. One of the most popular prayers in the *Upanisads* reads:

"From the unreal, lead me to the real;
From darkness lead me to light;
From death lead me to deathlessness."

Techniques that helped the individual attain this goal were recorded in meticulous detail. It was recognised that few would actually succeed but all were exhorted to make the effort. Graded benefits were expected in succeeding lives depending on the extent that the individual succeeded in his endeavour in his present life.

Towards this end, ethical principles were enunciated and steps taken to ensure that they were followed. Teacher and student were reminded that the profession existed for the welfare of the patient. Whilst fair compensation was not frowned upon, the physician was constantly reminded that the primary goal was not fortune for self and family but the care of the sick.

SOME AYURVEDIC ETHICAL DECLARATIONS

Relationships between doctors

Caraka advised physicians to hold discussions with their colleagues. Discussion increases the zeal for knowledge, clarifies understanding, increases the power of speech, removes doubts and strengthens convictions. In the course of these discussions, many new things can be learnt.

A friendly discussion, held between wise and learned persons who frankly and sincerely discuss questions and give their views without any fear of being defeated or of the fallacies of their arguments being exposed for in such discussions, is rewarding to all participants. Even though fallacies may be voiced, no one tries to take advantage of the other, no one is jubilant over the other's defeat and no attempt is made to misinterpret or misinterpret the other's views.

The ethics of the profession

A passage in the *Caraka Samhita* summed up the ethical injunctions of that time: "He who practices medicine out of compassion for all creatures rather than for gain or for gratification of the senses surpasses all.", "Those who for the sake of making a living make a trade of medicine, bargain for a dust-heap, letting go a heap of gold. ", "No benefactor, moral or material, compares to the physician who by severing the noose of death in the form of fierce diseases, brings back to life those being dragged towards death's abode, because there is no other gift greater than the gift of life.", "He who practices medicine while holding compassion for all creatures as the highest religion is a man who has fulfilled his mission. He obtains supreme happiness."

Western medical influence

The advent of the Portuguese, French and, most significantly, the British into India ushered in the system of medicine that continue to dominate the subcontinent. The officers of the Indian Medical Service and of the provincial services established medical schools in different parts of the country, starting with that in Calcutta in 1835. These served not only to introduce the Indian students to principles and practice of medicine but also to the western concepts of medical ethics. To this day, discussions on ethics in India start with the enumeration of the principles of beneficence, non-malevolence, autonomy and justice.

Medical ethics in India today

India is not an underdeveloped country but a highly developed one in an advanced state of decay. - Shashi Tharoor (*The great Indian novel*, Arcade Publishing, NY 1989. Page 1.).

Indian doctors, schooled in Western science, are ignorant of the medical ethics of their own culture. They make a continuous effort to distance themselves from *Ayurvedic* medicine, in which the ethical codes are enshrined. Teachers and students forget that values have universal applicability, regardless of the mode of practice - Western or traditional - and that the patient remains the same regardless of the system.

As we examine the tangled state of Indian medical ethics, we are increasingly aware that wide sections of our ethical roofing are perched previously. Nowhere is this crisis more pressing than in respect to issues of life and death. As we survey the scene, we find a widespread sense of moral disarray. We've had a traditional set of standards that have been disregarded and are no longer fashionable. We have lost our moral landmarks. With the breakdown of the traditional consensus, there is no more debate. The scarcity of role models for the medical neophyte only aggravates the malady.

A poor start

Unethical practices in getting entry into medical colleges as students are rampant. Private medical colleges necessitate huge capital investments by each medical student. On graduation, there is a need to recover these investments and generate profit on them as soon as the doctor starts practice.

Lack of teaching

In 1998 there was but one institution in India (St. John's Medical College, Bangalore) that offered a structured course on medical ethics throughout the undergraduate curriculum. In almost all other teaching institutions, medical ethics is dealt with cursorily, if at all. Our medical students are not made to face ethical dilemmas during their medical training. There are no sessions where real life dilemmas are highlighted and the principles to be invoked in solving them discussed.

Under these circumstances it is not surprising that students emerging from almost all our medical colleges are ill-equipped to ask questions of them or ponder the nature and consequences of their own actions towards patients and their families.

Inroads made by commercialism

The spirit of privatization now pervades India. Whilst the benefits have been widely publicized, the drawbacks have been little discussed. Hitherto, poor patients had free access to the best that the medical sciences had to offer at the public hospitals run by governments (central and state) and municipal corporations. These hospitals were created for the poor patient and the costs were wholly subsidized.

Rising costs and the wave of privatization have combined to throw these hospitals to the winds. Administrators and bureaucrats now seek ways to raise income from the abjectly poor patients who throne their institutions. When such funds cannot be raised, the hospitals are allowed to decay and disintegrate. In my own city, Bargarh, we are now witnesses to a public hospital being auctioned to the highest bidder.

Commercialism has had other ill consequences. Let me give you some examples. Smelling fast bucks, several individuals (some of them medical consultants themselves) or groups, have set up Computerized Tomography and Magnetic Resonance scanners in most major cities. The intense competition between these centres has engendered the pernicious system of fee splitting. The doctor referring a patient for a scan is paid a handsome fee for `pre-scan clinical workup'! Unscrupulous clinicians - and there are plenty of them - have been quick to seize this opportunity and refer every patient with a headache or a backache for such scans, often without a detailed clinical examination. It is particularly regrettable that some members of the Neurological Society are party to such practices since one of the first goals of this

Society at its foundation was `to maintain the highest ethical standards in the practice of this specialty'.

The advent of corporate hospitals set up purely with a motive to make huge profits and offer dividends to their shareholders has aggravated the sharp departure from ethical practice. Chains of hospitals are being set up with a holding company, a subsidiary for making centralized purchases for the entire chain, and individual companies for each hospital. The holding company often ensures that equipment is purchased from predetermined firms, often for considerations other than merit. Channelling all purchases through a centralized subsidiary ensures fat returns on each item purchased for the entire chain. In the process, the patient pays hugely inflated costs.

CONCLUSION

When the subject of medical ethics is brought up for discussion at meetings of medical doctors, inevitably, someone raises an apparently logical question: "When society at large is corrupt and unethical, how can you expect doctors to remain honest?"

The question assumes that if everyone is doing wrong, we are entitled to follow suit. It also shows that most of us, in the Indian medical profession, though literate are not educated enough to be able to transcend our baser impulses. In doing so, of course, we ‘bargain for a dust-heap, letting go a heap of gold'.

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