CHAPTER VI: RESUMÉ

Contemporary philosophy transcends both the traditional limits and conceptual articulations available to the discipline. It may be necessary that philosophy be redefined in terms of its interdisciplinary articulations that use philosophical method as a tool to analyse and understand issues in other disciplines. The unique nature of contemporary philosophy is that it enters into a discourse with disciplines whose boundaries were seen as impregnable – one such area is Bio-medicine.

Bioethics as a discipline has its roots in the controversial character of ethics, essentially understood from three perspectives; namely, when there is real inconsistency (and not mere verbal disagreement between two positions); when each of the position is reasonable and supported by argument; and there is a possibility of dialogue between the positions.

In order to understand the evolution of concepts in moral philosophy and their justification within the general framework of philosophy, it is important to distinguish between normative ethics, metaethics and applied ethics (AE). However, at another level the emphasis on this distinction blurs in the context of AE discourse. The development of new AE disciplines seem to have resulted in an integrated discourse wherein questions of right conduct, questions of meaning and questions of contextualising and extending moral concerns are inseparable.
The normative questions of the nature of "what ought I (or we) to do?" raise further questions and moral predicaments that reflect different categories of moral problems. Moral philosophers have identified four types of 'ought' questions and their consequent categories while analysing the nature of normative questions, namely, ought questions arising out of conflicts of interest; ought questions arising out of moral dilemmas; ought questions arising out of ethical disagreements; and ought questions turning on the distinction between duties and other oughts.

In spite of the questions regarding justification being "central and most important" in view of justifying AE, the central questions in metaethics seem to be the questions regarding meaning. As it is a common experience in moral discourse, after a long drawn argument and counter argument, participants of the debate move 'back' to fundamental questions regarding meaning of terms employed in the discourse.

One may ask substantive moral questions in normative ethics, metaethics and applied ethics separately. The issues being complex and interrelated, it is difficult to view them in isolation. It is not correct that metaethical analysis provides better moral judgements in particular situations. The same applies to normative ethics and applied ethics. Further, although it is vital that metaethical clarifications are essential to normative and applied ethics, it is not necessary that one must wait for resolving of all issues before 'doing normative ethics' or 'defending moral judgements'.

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In the introductory chapter, Chapter I therefore, an attempt has been made to clarify some of the theoretical presuppositions of AE and also to distinguish AE discourse from other similar discourses. There has been disagreement within the group of moral philosophers. Although moral philosophers have positioned themselves vis-à-vis the critics of moral philosophy in general and AE in particular, there have been dissenters within this group.

There is no general definitional agreement regarding what constitutes AE. AE is treated by some as that branch of moral philosophy distinct from analytic or metaethics and theoretical normative ethics, which attempts to resolve specific moral issues and morally problematic cases that arise in different areas of practice. Although, moral philosophers engaged in AE have been criticised by their theoretically oriented counterparts, the level of interest and growth of AE discussions has almost questioned the need for a theory. This is particularly when the existing ethical theory seems to have not been effective in providing solutions to practical affairs. There are, however, cases where attempts are made to 'blindly' apply theory without determining the appropriateness of such an exercise.

In spite of sceptical arguments that undermine universalistic claims of contemporary applied philosophy in general and applied ethics in particular, contemporary cultural needs increasingly promote interest in the subject. The reasons for such an interest in AE is due to the fact that the pluralistic society, fragmented by divergent religious and ideological understandings, differing regarding what is moral, social and political
good etc., looks for guidance in its decision making processes. Despite growing interest in the subject, there seems to be growth of critics denying the possibility of AE.

With regard to the language of bioethics, it is important that we consider some of important features that reveal different uses at different times and situations. It is not only that there are polemics in the debates regarding issues in bioethics but some terms have acquired meaning that very often reveal theoretical presuppositions of the philosophers. Probably, one could understand the use of language of the new and emerging interdisciplinary discourses, by referring to the contemporary philosophical developments in linguistic analysis and ordinary language. J. L. Austin's analysis of language in terms of 'infinite' uses of language, one of which is performative utterances may help us to understand the linguistic discourse of bioethics.

A study of the use of the expression "playing God", which has acquired meaning beyond the literal phrase "play God", at first glance, may look like the phrase is used to describe or identify a form of behaviour that has negative moral connotations based upon an absolute moral principle. Both the common-sense use and the professional use by philosophers seem to suggest an all encompassing moral principle.

In the first chapter, the importance of methodological presuppositions in the discourse of bioethics is analysed. There are a number of methods of argumentation that are likely to be encountered in ethical discussion identified on the basis "appeal to
authority”, “appeal to consensus”, “appeal to intuition” or based upon “dialectics” in the process of ethical reasoning. At one level the questions of methods or methodology is essentially linked up with question of nature of the discipline; while at another level the inquiry into the nature of methodology will take us to the contemporary debate between analysis and phenomenology as ‘distinct’ contemporary philosophical methodologies.

An assessment of ‘method’ in bioethics by surveying almost entire literature on applied ethics reveals that the most prevalent method simultaneously raises the question of value of the discipline itself, as the primary method of bioethics is reasoned evaluation of normative arguments (same as that of moral philosophy). If there has been no consensus or agreement in the parent discipline, namely, general moral philosophy, there is bound to be no agreement in a derivative discipline employing the same method. In brief, bioethics is similar to ethics and ‘involves the self-critical application of modes of moral reasoning.’ It has been argued that bioethics (sic. medical ethics) is a special kind of ethics only in so far as it is related to a particular realm of facts and concerns and not because it embodies or appeals to some special moral principles or methodology. Bioethics is not a new set of principles or manoeuvres, but the same old ethics being applied to a particular sphere of concerns.

In order to show how phenomenology and analysis ‘mesh’ together in bioethical discourse, a brief study of phenomenon of illness is presented. Illness could be understood by providing both a phenomenological description as part of the reflectiv
process and an analysis of the concept as used both in medical practice and common sense experience. Phenomenological approach involves radical disengagement or ‘distancing’ from our immediate experience in order to make explicit and be aware of the nature of such experience. Studies have pointed out that the biomedical model of illness is an incomplete model for medical practice. Illness is essentially ‘illness as lived’ and not a clinically defined disease as ‘a collection of physical signs and symptoms’ that can be measured by pathological tests. Illness was viewed by the positivists as something physical and empirical. It could be viewed as biological abnormality or as a behavioural discontinuity. Biological abnormality is rooted in the idea that distress and disability are based on abnormal processes and changes in the human organism. Illness as a behavioural discontinuity comprises the full range of behavioural responses to pain and dysfunction as determined by social, psychological and cultural factors.

In this last section of the Introductory chapter an attempt is made to juxtapose AE discourse vis-à-vis the traditional normative ethics. Most of the literature available on AE in general and Bioethics in particular has religious presuppositions. The debates often tend to grow on the expected religious or canonical lines. Historically, Bioethics is recognised as part of Moral Theology, which was primarily meant to solve practical moral problems in relation to Christian religious teaching. In due course of time, other organised religions and countries dominated by single religious traditions brought about social and religious legislations to resolve various moral dilemmas.
The foundations of secular bioethics can be laid, if we identify conceptual and value commitments of individuals in approaching and resolving biomedical problems - simply as rational individuals without reference to the special illumination of some divine grace. The logic of pluralism will ensure peaceful negotiation of moral intuitions. At a practical level such a secular bioethics will help in resolving problems of biomedicine wherein individual physicians, nurses, patients and other persons of divergent moral views interact. It will also insure that no particular secular tradition imposes its view on others.

Chapter II discusses issues which may be deemed to be the exclusive domain of medicine. Medical practice could be understood from the point of view of its application. The old saying, “medicine is too important to be left in the hands of physicians alone”, mutatis mutandi can be said of moral philosophers - “ethics is too important to be left in the hands of philosophers alone.”

Medical ethics could be understood by analysing ‘medical malpractice’. This is particularly so when one reviews the law of medical malpractice. Law concerning medical practice has evolved out of societal attempts to control the professions related to medicine and health care. From the Code of Hammurabi to early English common law to modern principles of contract, physicians are deemed to be liable for their acts of commission and omission. Contemporary law, accepts that there is an implied contract, between physician and patient, which enables individuals to file lawsuits against the physician in the event of malpractice.
The concept of “due care” and its consequent legal provisions are important in the context of medical ethics. In this context, the physician is expected to keep up with the advances in medicine in order to avoid causing a disability or death of a patient as if there was negligence on his part. Moreover, when a man claims to possess special knowledge or skill (that of a physician) and upon such a claim offers his services to the society, he is liable to be prosecuted in the court of law if he fails to render proper services. In legal terms, the whole idea is summarised in the concept of “due care” which is the “care” the society expects from each person to meet his obligations to other persons with diligence.

‘Medical malpractice’ is measured in terms of failure to use “due” or “reasonable” skill and care. Three parameters are used to judge “due care”. Firstly, a physician is judged on the basis of skill he has in comparison with other physicians in the same city/place. Secondly, the physician is compared to the degree of care and diligence shown by other physicians in their professional discharge. Thirdly, if the physician claims to be a specialist, he is judged by the skill he possesses matching his claim for being a specialist. The problem of objectively defining what is customary practice, difficulties in acquiring and presenting expert opinion from fellow professionals regarding negligence, etc. have made difficult application of “due care” in negligence law.

Understanding medical ethics essentially involves an analysis of the objectives of medical ethics. For this purpose, one should consider the concrete medical situation,
its problems, possibilities and dangers. Every decision in medical practice involves the 
good of patient, his or her relations and physician. Most problems in medical ethics 
originate due to conflict between the ‘image’ of physician or ‘what a physician ought 
to be’ and ‘what the physician is’. A physician is not (or should not be) a mere 
technician, disposing off medicines and machines towards the palliation or removal of 
disease. Physician ought to relate to the whole patient-person. It is a myth that medical 
ethics is same as the code of conduct laid down by various bodies of professionals or 
institutions.

Medical ethics to a large extent depends upon the level of sensitivity of physicians in a 
certain culture and the nature and structure of a health-care system. Dominant cultural 
values influence the level of ethical sensitivity. In our own culture where values are 
based upon a hierarchy of class and caste, the medical practice may reflect these 
values. In a society highly individualistic, based upon dominant values such as 
efficiency, material comforts, affluence, technological progress etc. an ethics 
programme will reflect the same values.

In spite of there being specific cultural differences in approach to medicine and health 
care, there are certain universal presuppositions in all medical practice whether ancient 
or modern, western or eastern such as “Sanctity of life”, which is a fundamental 
aspect of all medical practice. In this regard, ‘quality of life’ that is sustained is 
important. In fact, the “sanctity of life” does not permit ‘preservation of life, at any 
cost’.

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The concern for health and health care presupposes an understanding of who or what is eligible for health care. It also presupposes a unique relationship between the healer and the patient. In order to formulate a medical ethics programme, we have to clarify the context in which health care system functions.

A positive outcome of growing consciousness of health care among the public is involvement of public in the health care decision making. What is significant is the felt need on the part of policy makers to promote health of its denizens. The development of democratic systems throughout the world have led to policy decisions depending upon the majority of citizens who participate in the democratic processes.

The ethnomedical studies of medical ethics reveal the fact that there are no universal claims in the healing or health care system - the claims are to be interpreted in terms of social customs and traditions. There are two ways this can be elaborated: one by comparing different societies and traditions and two by conducting a comparative study of different systems of medicine.

Ethnomedicine analyses primary concepts of medical ethics. It attempts to understand their meanings in the specific societal context. Further, it evaluates how these concepts function and how the health objectives of the society are realised. Ethnomedicine studies medical practices in different societies taking into consideration social and
cultural factors such as belief systems, attitudes, behaviour and actions relating to illness and attempts to deal with it.

Needless to say, physicians' actions are not merely directed towards alleviation of suffering due to illness but they also carry social functions such as disability determination, social policy related diagnosis, decisions regarding isolation, etc. But many actions of the physicians have social and political implications. These implications have been legitimised by Government when a particular specific tradition of medicine is accepted as the tradition leading to exclusion of other traditions.

All systems of medicine (of elementary societies as well as contemporary advanced societies) recognize sanctity of life, and hence are aware of the potential to exploit, neglect and do wrong. This potential to do wrong is a moral problem inherent to the system of Western biomedicine since it treats life functions as mechanical ones ignoring the social and interpersonal aspects of the individual. This attitude of Western biomedicine in general and medical practice in particular has led to problems confronted by bioethics.

Medicine in general and medical practice in particular is not problem solving activity wherein sickness is looked upon as a technical problem faced by the patient who is considered like a malfunctioning object or machine. Medical practice is a kind of social reality, wherein physicians, patients and others concerned participate. It is argued that medicine as a social reality "casts patients and physicians into nests of social
expectations, treatment obligations, duties, rights and goals” and “medical judgement is not simply descriptive or even evaluative, but performative.” The performative character of medical practice can be observed from the concept of disease. Disease is not, as physicians tend to believe, objective entity or with a single universal definition. To use the language of disease is to place patients within a particular set of medical and social expectations. The classic example is alcoholism and nicotine addiction.

Medical ethics is highly concerned with the physician-patient relationship. Most of the codes of Medical Ethics dwell in detail on the subject of this unique relationship. The relationship is appropriately summarised as that of ‘dependence and trust’ as the physician deals with not only illness and disease but deals with the person with desires, hopes, fears, worries, etc. Confidentiality, understanding, concern, empathy, honesty, trustworthiness, kindness are some of the fundamental constituents of such a relationship.

Rapid changes in medicine and medical practice have compelled professionals and non-professionals to rethink about the nature and function of physician-patient relationship. The traditional moral issues (hitherto seen as objective and universal) seem to seek change in this perspective. For instance, there seems to be accepted consensus regarding the right to accept or reject treatment after the much debated Karen Ann Quinlan case compelling physicians to question their commitment to preserve life at all costs. After the spread of AIDS, the confidentiality of medical information and the role of physician in this regard is questioned. Should the
physicians continue to keep confidential the medical information regarding AIDS at the cost of exposing other individuals to the risk of infection?

Feminists view physician-patient relationship as based upon sex-role stereotypes which sees man as aggressive and rational, agentic (self-protecting, self-asserting, self-expanding) as against women being passive, emotional and communal (participating in society). This labelling of man and woman find its expression in physician-patient relationship, wherein physician is aggressive, rational and agentic and patient is seen as passive, emotional and communal. The physician-patient relationship is temporary unlike the man-woman relationship, which is more permanent. The characteristic feature of medical practice in this relationship is that it tries to negate itself in the process of healing the patient, making him whole, improving his status, removing the inequality. In other words, it attempts to make itself unnecessary by healing the patient. Feminists recognise another feature of physician-patient relationship comparable to the relationship between genders.

“Chronic illness” is one area of bioethical concern that has been left out from the mainstream discussions. At one level chronic illness is considered as a grade of illness, at another level it must be recognised as a distinct type that demands a distinct approach. More people suffer from chronic illness than illness leading to sudden death or rapidly progressing fatal illness. Patient suffering from chronic illness increasingly and permanently depend on physicians and others for survival. Some chronic illnesses are related to old age where there is distinct reduction in physical and intellectual
abilities. Due to tremendous advancement in medical science, human life expectancy has increased resulting in more elderly people living in the world thereby accentuating the problem of chronic illnesses. This calls for a new public health policy with increasing and prohibitive costs.

The above autonomy paradigm does not present the true nature of physician-patient relationship. The intensity and complexity of interaction between the patient and physician cannot be explained by a simplistic contractual view. The consumerist criteria cannot be applied to medicine and medical practice (in spite of its limitations and abuses). A physician is not a professional contractor who offers his services for a fee to a medically literate or illiterate client. Medical profession is undermined by the terms 'service', 'consumer', 'contract' etc. Whether the notion of autonomy model allows physicians to *limit* or restrict the extent of health care calls for reflection within the general ambit of rights and needs.

The unique physician-patient relationship has been 'strained' by the juxtaposing of 'patient autonomy' and 'professional autonomy' of the physician justified in the principle of paternalism. The mediating concept between the two, namely, consent, and its varied types determines whether the actions of physicians are justifiable or not. In Chapter III, an attempt is made to understand the crucial concept of consent and its centrality in the understanding of medical practice.
The *doctrine of informed consent* was introduced with the objective of protecting patients' rights and to ensure that the patients are not exploited by the physicians. It highlighted physicians' duties to inform the patients of the benefits and risks of treatment or of non-treatment of disease, the patient is suffering from and obtain permission of the patient to proceed with the treatment. With the exception in case of surgery, there has been little or no compliance of the doctrine. Although the doctrine has been in force for more than half a century, there has been lot of confusion in the legal circles regarding the implications of such a doctrine.

The legal doctrine, *ab initio* seems to go against the rights of the physicians. Even the *Oath of Hippocrates* never envisaged that the patients be informed about their illness. Instead, physicians were debarred from informing or showing any signs of the type of illness or symptoms or mode of treatment to the patients.

Information supplied to patient regarding the extent of disease, type of medical intervention and plausible consequences of the same form the basis for legally establishing medical negligence. In this context, patient's *competence* to consent is to be judged as per the legal doctrine. Individuals under stress and strain due to pain and suffering or due to reactions to a particular drug have reduced capacity to understand and make decisions. Persons with marginal capacities to understand and make decisions are, in practice, treated as competent to consent. While deciding whether there was negligence on the part of physician, judges take into consideration
competence or capacity to consent in the light of specific situation and prevalent conditions.

Informed consent is justified by principles of autonomy and beneficence. That is (1) it respects the freedom of the individual involved and provides authority for common endeavours; (2) it recognises that individuals are often the best judges of their own best interest; (3) even if they are not the best judges it acknowledges that the satisfaction of choosing freely is often preferred over having the correct choice imposed by others; and (4) it reflects the circumstance that the physician-patient relationship may often be such as to bring about a special fiduciary relationship that creates an obligation to disclose information.

The principle of patient autonomy though envisaged as a positive contribution to patient’s well-being, its origin must have had a negative basis as there were threats to physician’s freedom in medical practice. The purpose of ‘informed consent’ in physician-patient relationship is often viewed negatively. It is seen as a measure of control on the actions of physicians and enabling and empowering a patient population that has been mute and powerless in the face of medical practice and authority.

Informed consent does make positive contribution to physician-patient relationship. It leads to patient’s participation in his own care. To see the issue as a threat to paternalism is a misconstrued notion. The information supplied by the physician should be such that patients understand the implications of the diseased state and the
treatment prescribed as well as the possible disabilities that may result while fighting the disease. The information disclosed should however not cause psychological tension to the patient.

There are serious implications of medicine as a science, on informed consent. Unlike some of the other subjects such as physics, medicine relies on statistical data collected by medical researchers and practitioners in their interaction with patients. In fact, even when a new drug is approved for marketing, the clinical trials are statistically calculated. When a patient is expected to give his consent on the basis of information provided to him, he may be inclined to give unduly more attention to a smaller statistical probability of fatality than to the larger probability of recovery.

Experimentation is essential for the progress of medical science. Experimentation involves, besides the rational well informed adults, persons without rational capacity to consent. Hence ‘proxy consent’ plays an important role. For instance, research in paediatrics is impossible without deemed or proxy consent. Similarly, research in areas like neuro-surgery, cancer, etc. cannot progress without experimentation.

An attempt is made in this chapter to strike a balance between the extreme positions of moral theologians and laissez faire scientifically inclined physicians who feel that ‘all is fair’ in scientific experimentation as long as some benefit can be derived out of it at some stage.
The basic concern of all medical practice was to promote well being of the patient. However, at times the interest in biomedical research has created conditions whereby physicians tend to regard patients as “guinea pigs”. The main objective of Nuremberg Declaration and Helsinki Declaration is to avoid the exploitation of patients in the name of experimentation. Informed consent is deemed essential for experimentation. In order to ensure the fundamental objective of medical profession, legislation controlling research and experimentation and institutionalisation of controlling bodies came into existence.

In the past, paternalism practised by medical practitioners was based upon beneficence. In the contemporary scenario, medicine has evolved as an enterprise pursued by physicians who develop only transient relationship with the patient. In this context, patient autonomy and informed consent are viewed as ‘antidotes’ to arrogant physicians and they aid in protecting the rights and freedom of the patients.

Under the influence of paternalism, patient’s freedom in health care has been threatened and thus patients are compelled to assert the freedom as freedom from interference, legitimised by informed consent. Patients require freedom, not only to accept or reject medical help, but also to decide to what extent the medical intervention and care should be accepted or restricted. The assertion of freedom in this sense was partly due to the legal battles fought in Karen Ann Quinlan case and others.
The actual reality of how informed consent is obtained and the mode of communication between physician and patient is not reflected in the theoretical studies in this area. In order to have a proper understanding of this, one has to study the actual hospital situation and medical practice involving both simple and complex medical interventions.

It is evident from the empirical studies that informed consent process is not taken seriously by most patients. The consent forms are hardly read and generally patients feel that the signature is just obtained on the form for physician's protection. Besides, the consent forms contained detail legal clauses, mostly in fine print that patients or guardians in the state of anxiety did not have the inclination to read. Typically, the form is pressed into the hand of the patient and he is asked to sign the form in a most hurried manner thereby even casual attempt to read what is printed may seem to be the cause of lack of faith in the physician present.

On the contrary, there are studies that point out to patient's interest and participation in decision-making concerning the illness. Often, physicians underestimate the patient's desires and capacity to understand the implications of the directions of treatment.

Medical practice in hospitals with bureaucratic involvement differs from private practice where the relation between patient and physician is direct. In the former case, the hospital rules and regulations to a large extent interfere in the physician-patient
relationship thereby undermining the informed consent requirement. Consent forms are procured after providing minimal information primarily as a means of protecting the hospital administrators and the physician, without any involvement of the patient in the decision-making process. In the case of private practitioners, although the physician is concerned about protecting himself from future legal liability, there is patient involvement in the decision-making process on the basis of *reasonable* information and understanding.

In the concluding part of the chapter, some informed consent models are evaluated. Stephen Wear’s medical management model (MMM) of informed consent is not just a doctrine, it is an intervention with an objective, namely to the course of disease. Patient can ‘authorise’ the physician to take appropriate course of action by having sufficient detail regarding his situation, prospects and choices. However, the patient should be ‘competent’ to consent to treatment. MMM of informed consent can be regarded as ‘tool for medical management’. Informed consent for Stephen Wear is a minimalist notion in law, understood in context of tort law on malpractice rather than a positive contribution to enhance patient autonomy.

In the linguistic model of informed consent, when the patient uses the words like “I consent”, “I refuse”, it reduces informed consent to a language act and a linguistic process. Certain conditions must be fulfilled in the context of the model of informed consent. (1) The patient can give consent only if he has information necessary to make the decision. (2) The patient should be able to comprehend the information disclosed.
(3) The patient should voluntarily give his consent and not under any compulsion or coercion to do so. (4) The patient should be competent to give the consent. (5) Finally, the patient should consent to the intervention of the physician. The physician acts as the informer, while the patient is the one who consents or refuses.

The analysis presented in this chapter has brought out some of the special features of informed consent and their unique role in medical practice. Informed consent is seen as 'educated consent' and the burden of this education falls on the physician who ultimately decides what is best for the patient. Hence, the question that may be uppermost in mind of the reader, is whether a legitimate informed consent is ever possible. The dialogue between the physician and patient has to consider patient's individual priorities, needs, concerns, beliefs, fears, expectations, etc. A solely or overly legalistic interpretation of informed consent will lead to undermining of 'person' status of the patient. Informed consent is not only an expression of patient autonomy but essential for ensuring enhancement of medical care. There are a number of difficulties encountered in the process of informed consent.

There are situations in which the autonomy of the patient has not been enforced within the existing locus of physician-patient relationship. Instead, intervention of 'significant others' becomes imperative and the relationship between the patient and physician takes a different dimension. In Chapter IV the notion of proxy consent both in therapeutic and non-therapeutic conditions is analysed.
Proxy consent depends upon the principle of beneficence and consequently the consenting subject is deemed to be one who has the best interest of the patient. The justification of proxy consent is based upon a very simple logic and the clinical practice throughout the history of medicine. Parental consent (vicarious) is required and sufficient for therapy for child’s own good, guardian consent is required for the ward who is not capable of taking care of oneself, presumed or deemed consent is resorted to by the physicians in emergency cases where there is no time to seek informed consent.

There are four different situations under which guardians are called upon to give proxy consent. Proxy consent is composite of practices: (1) the choice of authorised agent on behalf of an authorising individual; (2) the choice of parents (or their assignees) on behalf of infants they have produced; (3) the choice of guardians on behalf of unemancipated minors whom they are rearing; (4) the choice of guardians in terms of the best interest of another as understood within a particular moral community; and (5) the choice by a guardian in terms of the best interests of another as understood with reference to what a rational and prudent person would choose.

An explanation of the five contexts is provided so that a proper understanding of what is proxy about proxy consent is made available. To begin with the logic of informed consent applies to proxy consent as well. Since the individual giving the consent is other than the patient, the problems and moral tensions involved in proxy consent are further compounded. The responsibility involved in proxy consent varies from the
case of an adult, who specifically appoints a proxy, to the guardian, for whom it may not be that their actions are in the best interest of the patient.

The principle of paternalism is based upon the practice of paternal administrator, regulator who knows (like the father in the case of his child) what is in the best interest of the individual. Patients under the stress of the disease want to be treated as children by health professionals. As such, the principle of paternalism is not invoked by physicians alone in medical practice. Paternalism is unavoidable in case of infants and the very senile. It is no wonder that the paternalistic attitudes and roles are reversed in the life span of a family.

Three different forms of paternalism are recognised, namely, paternalism of incompetents, fiduciary paternalism, best interests paternalism. Paternalism of incompetents refers to the paternalistic attitude towards individuals who have never been competent, such as infants or severely mentally retarded individuals. Fiduciary paternalism refers to paternalistic attitude towards individuals whose decision making is left to others not because they are the best judges, but because they are compelled to take decisions. Explicit fiduciary paternalism presupposes an explicit permission to another individual to make decisions as in the case of physician-patient interaction wherein the physician is explicitly asked by the patient to act in his best interests. In the case of implicit fiduciary paternalism the patient may not have explicitly authorised an individual to decide on his behalf. But there is an implicit presumption that the other will make certain sort of decisions on his behalf. Short terms paternalistic interventions
(like public intervention in case of accident victims) are justified on the ground that reasonable and prudent individuals would act in a particular manner under certain circumstances. *Best interest paternalism* (also called strong paternalism) refers to attitude of individuals who under circumstances override the competent refusal of an individual in order to achieve the best interests of the patient.

Proxy consent by guardians is inevitable in case of foetuses and new-borns since these are not yet persons in strict sense and also are not bearers of rights that we accord to persons. There are cases in which foetal surgical intervention is sought in the best interest of foetus - but this amounts to intrusion into the mother's body. The idea of proxy consent must have a comprehensive connotation to account for all types of cases, and should not treat some situations as 'exceptions to the rule'. For a comprehensive understanding of proxy consent, a review of legal exceptions to the rights of proxies (parents, guardians or others) is necessary.

One of the major legal exceptions to the rights of parents/guardians is in case of an emergency that if there is threat of permanent disability or death, the patient may be treated without consent on the presumption that any prudent individual would choose such mode of treatment. This presumed consent is justified since any delay in treatment while awaiting consent may prove to be fatal.

Similarly exceptions are envisaged on the ground of public welfare which allows physicians and others to treat minors for drug addictions, etc. It is possible that minors
who have emancipated from the guardians under certain circumstances may not depend upon proxy consent of parents for treatment. The moral right and responsibility of parents are upheld so long as they are competent to morally and legally carry out their responsibilities. The parental rights and moral responsibility for children, enforced by the society are restricted within the norms of community, society and the economic goals of the state.

There is however a further conflict between the rights of parents and the rights of children ‘to be left alone’. The major issue in this conflict is not so much the minor’s emancipation from the guardian or parental controls but what is perceived as in the best interest of the ward. There are some grey areas of medical intervention which throw up conflicting understanding of what would be in the best interest of the ward. For example, in the case of reproductive choices, mature minors reject parental authority in medical intervention and assert their right for consent.

Discussions on legal, moral and medical aspects of non-therapeutic experimentation with children range from outright condemnation to legal, moral and social justification on ‘humanitarian’ grounds. It has been argued by some moral theologians, that to attempt to consent for a child to be made an experimental subject is to treat a child as not a child but as an adult person who has consented to volunteer in the common cause of medical research. If the ground for this is presumptive or implied consent of the child, then that amounts to a violent and false presumption.
Medical practice assumes that experimentation with children without consent is permissible to promote social good and benefit to mankind. Such a position is justified on the ground that health care professionals treat patients not only for their own good but for the good of profession. It is argued that for medical knowledge and skills to be passed on to a new generation of professionals, patients function as a medium. Research and experimentation is essential for advancement of medical knowledge. The conflict between principle of autonomy and beneficence, paternalism cannot come in the way of advancement of medical knowledge.

It is obvious from the history of medicine that both the extreme positions are undesirable. A brief analysis of the positions will help us to find a prudent via media that does not allow humans to be treated as instrumental values, and at the same time allows the possibility of research and advancement of medical knowledge.

Experimentation and research with human foetus raises issues radically different from experimentation with infants and other human beings. It is essential to understand the concept of 'person' before dealing with the experimentation with foetus. An important issue in this regard is whether we recognize foetus as a person and accord him the moral values that we accord to adult humans and infants. This issue must be clarified before proceeding with the question of whether foetal research should be permitted as a public policy and whether such actions are morally permissible.
Moderates employ an understanding of social good to argue for non-therapeutic experimentation with human beings. They say that personal good is not to be conceived individualistically, but socially, that is in relation to others. One expresses such a concern when one consents to donate an organ without endangering one’s own life. Taking some degree of risk, pain and inconvenience is deemed as an act of concern for ‘others’.

‘Person’ is a ‘thing’ but is different in the sense that he/she is not treated as such. The distinction between ‘Person’ and ‘thing’ is not a distinction in terms of set and subset; but is significantly understood in terms of attitude. Common sense and law (judiciary) recognizes differences between humans, in spite of the ‘principle’ that “all men are equal” (apparent from divergent capacities). Similarly, in the context of bio-ethics, not all humans are equal. For example, competent adults, mentally retarded adults, children, infants, foetuses, etc. are unequal in various ways. There is, therefore, a need of deciding the moral status of persons and mere biological life. The question is to assess the moral significance (rather than emotional relating) of different categories of human life and animal life as well.

Persons are ‘persons’ when they have characteristics of persons, when they are self-conscious, rational and in possession of a minimal moral sense. Since persons are central, the moral discourse will be person-oriented and hence rational arguments would be person-defined. Infants and foetuses are regarded as potential persons. In the strict sense, persons are ‘persons’ as moral agents. However there are various other
dying patient or person condemned to death. Since it is immoral to conduct experimentation with these categories of humans, similarly experimentation with living foetuses is morally unacceptable. Third position holds that foetus being a fellow human being, be treated in the same way as one treats a child. In brief, this position is an extension of experimentation with children. Experimentation with children is morally permissible if there is no discernible risk or discomfort for the child or foetus, the experiment is genuinely necessary for medical knowledge and will give benefit to foetuses and children and appropriate consent is obtained.

In Chapter V, an attempt is made to study the Indian medical practice by taking into account both the traditional and contemporary discussions. The contemporary dimension could be distinguished on the basis of (a) the technologically advanced medical practice that is available in the metropolitan cities and availed by a few well-to-do persons and (b) the medical practice prevalent in the villages and rural areas and availed by the poor and economically backward classes. The various moral dilemmas articulated in bioethics seem to be irrelevant to the populace who are unable to avail of the medical technology and skills even to cure common disorders.

There arises a conflict in medical practice due to the difference in the traditional cultural values within which the Indian professional is brought up and the value system imbibed in the professional training of the physician. Analysis of a few Hindu concepts will reveal this conflict in the medical practice.
The tradition (parampara) plays an important role in the Indian ethos. Although at one level, the diversity and diffusion of Indian society makes the formation of moral imperatives that are both universal and binding difficult, the central concepts propounded in the Vedic literature find their expression in the contemporary Indian society. The Indian ethos is based on the concepts like dharma, karma, moksa etc.

There are a number of medical traditions prevailing in India. Although, such a variety of medical systems allow the possibility of different types of medical interventions, at the same time it highlights the inadequacy and limitations of any one of them. This tends to help reduce the arrogance of medical practitioners. An attempt is made to study the system of Āyurveda so as to compare the allopathic and Āyurveda systems on issues like death, dying etc.

Āyurveda, an ancient medical system that has existed for several thousand years is comprehensive as it deals with physical, mental and spiritual well-being of man in the specific context of the environment and his status in the chronological order of existence. Caraka and his followers accept the doctrine of karma and moksa which is prevalent in all schools of Indian philosophy (except Carvaka). While rejecting the thesis of the immutability or inevitability of ripe karma, Caraka argues that the effects of all ordinary kinds of karma can always be modified or even wholly avoided by using the knowledge of the science of Āyurveda. Caraka rejects the view that all happy or unhappy experiences are connected with the karmas of previous births. He believes that proper or improper medical treatment alone can bring about success or failure in
curing a patient from the illness. Moreover, it is the physician's dharma to prescribe appropriate diet and medicine to ensure that the patient maintains a healthy life. Caraka has spelled a clear Code of Conduct for the physicians. According to him, habitual sinners, morally degraded persons etc. do not deserve to be treated by the physician. Further, it is pertinent to note that he excludes terminally ill patients from treatment.

Caraka lays down a clear code of conduct for the Ayurveda physician. The physician should reciprocate the confidence reposed in him by his patients by taking utmost care in their treatment as if they are his own children. He should attend to a female patient in the presence of her husband/guardian. He should abstain from disclosing anything that can harm the patient or his relatives. Maintaining complete confidentiality about the patients' information is also necessary. There has to be an attitude of compassion towards the patients and the physician should possess philosophical outlook in respect of unsuccessful cases despite best efforts on his part. The physician should be devoted to the profession and should keep learning from his experience all his life.

The Indian medical traditions in general and Ayurveda in particular ignore the need of obtaining consent from patient/guardian in the context of treatment. The need is not felt of informing the patient or his relation about the gravity or otherwise of the illness. Caraka advocates caution in revealing incurable illness as it may prove to be shocking to the patient. In order to protect oneself from any criticism/punishment, the physician
is advised to inform the patients' relations and state officials about the illness of the patient.

The absence of reference to patient's consent (informed or otherwise) for the type of treatment administered by the Ayurveda practitioner should not be viewed as a major difference between the Indian tradition and western bio-medicine. The concept of consent (informed or proxy) is a relatively recent one arising out of a necessity to protect the physician from criminal liability and the patient from being overtreated and experimented with.

The attitude to death and dying is however unique to the Indian tradition. The "fear of death" suffered by both patients and physicians in the western model of biomedicine seems to be absent in the Indian counterpart, particularly Ayurveda. The concept of karma, dharma and moksa in the Indian tradition help the patient in overcoming the "fear of death".

In the contemporary context, however, the influence of western biomedicine, judicial institutions and allopathic medical system and practice does create a climate that is neither purely Indian nor western, resulting in controversies that need to be resolved. Contemporary Indian medical practice is guided by the Indian Medical Council and in recent times by the new acts of the various legislatures or the judgements of the courts. While judicial intervention controls malpractice in the medical profession and
provides protection to the patients it has an adverse impact on the physician-patient relationship – that is the patient looks upon the physician with suspicion.

In the evaluation of the role of informed consent in the medical practice in India, it is worthwhile to review the medico-legal cautions given by the Medical Council of India. In medical practice, law makes it mandatory that the patient be given complete information for making a proper consent and that consent be based on this disclosure. In exceptional cases such as in case of patients who suffer from extreme forms of anxiety the information should not be disclosed, since revealing the reality of illness may cause harm to the patient. In such cases, it is acceptable to obtain proxy consent from a responsible or close relation.

The nature and understanding of consent, informed consent, deemed or implied consent, proxy consent is similar in both the contemporary Indian and Western context. There are certain cultural variations that have entered into the medical practice due to the laws framed by the state. The consent from spouse is mandatory in case of abortion, sterilisation, etc. The status of women being secondary to men seems to constantly reflect in the legislations. In spite of avowed gender equality, the status of women is considered as secondary to men.

Minors and the mentally ill are considered as incapable of giving consent and hence in such cases consent should be obtained from the guardian. However, as per a single provision in the Mental Health Act, whenever a mentally ill person is able to give
consent for therapeutic or non therapeutic research, it is mandatory to obtain the consent from such a person. And if the patient is unable to give consent, the same should be obtained from his parent or guardian.

Organ transplantation has raised many moral, legal and social questions. The extent of exploitation is so alarming that even a genuinely self-sacrificing action on the part of a donor invites suspicion. Transplantation of Human Organs Act (1994) permits an individual to donate his organs and also permits his relations to gift them after his death.

Physicians can no longer assert the old adage “doctor knows the best” due to the fact that there is increased awareness regarding medicine and medical intervention among the general public. Non-medical fraternity such as researchers, biologists, pharmacologists, biochemists etc. are now at the centre of medical practice. The physician is aware of the fact that even the most sure medical intervention has certain risks. As such, physicians in their own interest and for the sake of patient should inform the patient about the pros and cons of the proposed treatment. This is the best and most pragmatic approach towards informed consent. Neither the patient nor the physician seems to know what exactly constitutes informed consent that can be used in all and every medical situation. The extent to which information can be revealed to the patient depends on various factors such as the type of ailment patient is suffering from, patient’s sensitivity, the role played by his relations etc. In future, the patients would be willing to take their own decisions regarding treatment, but as of now, it is
necessary to maintain a pragmatic balance between physician paternalism and patient autonomy.

Specialisation and superspecialisation has changed the role of the physician to that of a scientist or technologist. Physician-patient relationship tends to be mechanical and impersonal. This gives rise to a number of problems which require the intervention of the State in the medical practice. In view of negligence and malpractices in the medical profession, a dire need is felt to provide protection to the patients. The Supreme Court has finally ruled that medical services come under the Consumer Protection Act. Legislations cannot provide full proof protection either to the physician or the patients, because law always lags behind the ethical requirement. In order to protect the unique healing relationship between the physician and patient, it is necessary that medical practice reaffirms its ethical basis.