CHAPTER V: WHAT IS INDIAN ABOUT INDIAN MEDICAL PRACTICE?

Any discussion of medical ethics in India will have to take into account both the classical and the contemporary dimension of medical practice. Further contemporary dimension at one level has to be distinguished on the basis of technologically advanced medical practice and the minimal, at times, inadequate health care system prevalent in the villages of this vast country. Technologically advanced medical care is available in the metropolitan cities and patronised by the economically higher classes. The problems and issues faced in the medical practice in this context is the same as the one confronted in the western industrialised countries. In the case of rural poor and economically underprivileged groups, there is the prior question of what type of medical intervention and health care is available. The moral predicaments and dilemmas articulated in the bioethical discourse seem to have no relevance to the populace that is deprived of the medical technology and skills even to deal with common health disorders.

The Indian Tradition

There are definitional problems that have to be clarified before an attempt is made to discuss the possibility of medical ethics in India. The absence of an ethical discourse on lines with the Western tradition is often seen as a stumbling block for a proper understanding of ethics in general and medical ethics in particular. The identification of Hindu ethics and Indian ethics is sometimes seen as another critical problem. In spite of these difficulties, and in spite of the fact that there has been no agreement of what
constitutes ethics in Indian tradition, one may proceed analysing the moral problem arising out of a well-established medical theory and practice that is distinctly Indian (or Hindu) that has existed for over two thousand years. The Ayurveda, (its subsidiary) the Siddha, the Unani (from Ionians?) and the Homeopathic systems have been widely practised in India and have a large following.

And since the contemporary medical practice is seen to be subtly and latently influenced by the classical Indian schools of medical thought and their philosophies, it is necessary that we elaborate at least one of the major school of thought at this stage. The traditional cultural values within which the Indian professional is brought up and the value system imbibed in the professional training of the physicians may give rise to conflict in the medical practice. Analysis of a few Hindu concepts which are part of the value system will suffice to show the latent conflict in the medical practice.

The Indian ‘ethos’ finds its echoes in the parampara (tradition) which has certain continuity both within and outside the Hindu religion. Although at one level, the diversity and diffusion of Indian society make the formulation of moral imperatives that are both universal and binding difficult, the central concepts propounded in Vedic literature find their expression in the contemporary Indian society. The Vedic order (ṛta) interiorised in dharma, together with the belief in karma and mokṣa provide the foundation of Indian ethos.
Further, since there are variety of medical traditions in India, it is often a battle ground of divergent value systems. Although, such a variety of medical systems allows 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. A brief study of assumptions and objectives of Āyurveda as a medical practice is presented in order to compare the allopathic and Āyurveda systems on some common concerns such as attitude towards death and dying.

The Dharmasāstras have ‘sanctified’ life by prefixing it to the four ultimate goals of human life and the fulfilment of these goals, even to the extent of removing all the obstacles that come in its way, is given an utmost priority. Āyurveda, the science of medicine, is considered as sacred and consequently as the most important one as it deals, primarily with human life and the attainment of the goals of life. If one were to look for one specific concern of Āyurveda within the four purusharthaś it would be the concern with longevity.¹

The Āyurveda Paradigm

Āyurveda is an indigenous medical system of the Indian sub-continent that has existed for several thousand years. The system is comprehensive and encompassing the physical, mental and spiritual well being of man in the specific contexts of his environment and his status in the chronological order of existence. In short, “cosmological and ontological speculations about the intrinsic relationship between
matter and life, biological theories concerning embryonic conception, ideas concerning body, life and soul, notions relating to genetics, theories concerning physiology, pathology and food, the rules of health and longevity, ailments with their diagnosis and treatment, poisons and their antidotes and finally, ethics form part of the ayurvedic discourse.\footnote{2}

Concept of health in Āyurveda is explainable (like *prakṛti* in Sāṅkhya is said to be a state of equilibrium between three *guṇas*) as the perfect balance between *vāta*, (wind) *pitta* (bile) and *kapha* (phlegm) and ailment is explained as the result of any one of them becoming more dominant than the other two. The main objective of treatment is to restore the balance between the three elements by restraining the ‘rogue’ element.

Almost all the major constituents of modern bio-medicine are found in the discourse of Āyurveda. There are discussions on therapeutics (*kāyacikitsā*), major surgery (*śalyatantra*), minor surgery (*śālākyatantra*), paediatrics (*kaumārabhyātyatantra*), toxicology (*agadatantra*), geriatrics (*rasāyanatantra*), rejuvination (*vājikaranatantra*), etc. The various authors of Āyurveda texts have taken keen interest in studying the effect of food and drugs on human body as it has been an accepted fact for them that human body is composed of five elements (*mahābhuṭas*) and matter (*dravya*) that form food and drugs. Again, Āyurveda is not attached to any philosophy (*darśana*), either āstika (Vedic) or nāstika (non-Vedic). Consequently, although everyone in ancient India practised Āyurveda, there were no sub-sets of Āyurveda for Jains or Buddhists. The modes of argumentation borrowed from
Naiyayikas may be seen in the discussions, however, there are no specific metaphysical tenets of any darśana seen as predominant in Āyurveda.

That what belongs to all schools of Indian thought (except that of Cārvāka) has been recognised as essential to Caraka and his followers and that includes primarily the doctrine of karma and mokṣa.

Most Indian schools recognise two-fold consequences of any karma: the direct, natural result of that action (phala) and the development of tendency to do the same action (samskāra). The tendency to do an action can be controlled, and such control prevents a man from repeating the actions. This is the path of liberation from all action and consequent rebirth which is identical with mokṣa.

Unlike most or all theorists of karma (for whom the law of karma is immutable), Caraka believes that only the fruits of extremely bad actions cannot be arrested or changed by good conduct. The results of all ordinary actions can be controlled by normal physical ways of well-balanced conduct, the administration of proper medicines etc. This position allows Caraka the ‘space’ to justify the whole theory and practice of medicine. It is obvious that if the ordinary fruits of karma cannot be controlled then illness (one such fruits of karma) will have no cure and illness will have to continue to its logical end, namely, death.
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.

Further, Caraka, as an authority on medicine, believes that medicine in the hands of the physician when used properly or improperly is solely responsible for the success or failure in curing the patient. Consequently, Caraka rejects the idea that all happy or unhappy experiences are due to the ripening of the *karmas* of previous births.

The physician's *dharma* consists of prescribing appropriate diets and medicines to ensure that the patient maintains good health and consequently a happy state of life. Scholars have pointed out that even "the *dharmsāstras* do not deal with the ethics of medical practitioners (*vaidyadharma*). Āpastamba Dharmasūtra briefly refers only to the duties of a king (*rājadharm*). Yājñavalkyasūtra has chapters only on *rājadharm* and *yatidharma*. Even Kautilya's *Arthāśāstra* has nothing to say except on the fines to be levied on physicians for carelessness in treatment and for treating a dangerous ailment without intimating the government. This may be due to regarding the medical profession as being capable of self-regulation and hence not being in need of regulations framed from outside."

Caraka clearly lays down a code of conduct for the physicians and even specifies who are not "deserving" persons to be treated by them. Habitual sinners, persons who are morally degraded and persons who indulge in killing as a profession are regarded as
non deserving persons. It is surprising that 'terminally ill' are also excluded from treatment by Caraka.

Caraka-Saṁhitā has classified ailments into two main categories: curable and incurable. Further curable ailments has been classified into easily curable, curable with some efforts and curable with great difficulties. The incurable ailments have been divided into those that recur from time to time in spite of the treatment and those which are beyond any treatment. In the case of incurable ailments due to which death is certain Caraka demands that no treatment should be given for such ailments.

It is pertinent to note that Caraka envisages that physicians develop four-fold attitude towards the patients; that is, they should be friendly and compassionate towards the sick; they should show happiness while dealing with the curable patients; and they should be indifferent while dealing with those nearing death (prakṛṭistha). In fact, Cakrapānidatta exhorts that the patient nearing death should be ignored, and should not be administered any medicine lest the reputation of the physician is spoiled. (yaśohānyādibhayāt). It is argued that treating incurable ailments leads to loss of money, loss of fame, a loss in getting a good number of patients, the physician gets blamed and it causes a harm to the status of knowledge of the science of medicine.

The most important question is when can a physician detect that a patient is nearing death? Caraka provides symptomatic details regarding patients who are approaching death and Caraka seems to be convinced about the relation between such symptoms
and death. When the physician notices such symptoms he is supposed to stop treating the death-nearing patient.

There are, however, other conditions that seem to offset this seemingly ruthless condition. The physician is not supposed to declare openly that a patient is nearing death and he should not disclose the patient’s condition unless he is asked. Further, the physician should not disclose the condition even when asked if he feels such a revelation would prove harmful to the patient or the relations of patient. Without disclosing the proximity of death the physician should refrain from treating the patient.¹

It is quite surprising that Caraka cites material loss as the consequences for treating a patient who is incurable. Further, the justification of “damage to the fund of knowledge” seems to be far fetched and unconvincing on the part of the physician who is almost regarded as an incarnation of God. While classifying incurable ailments Caraka points out two types of patients; those whose life-span is almost exhausted and are about to die and those whose life-span is not totally exhausted, but whatever span remains one has to exhaust it by getting the sufferings which have a reference to his karma. Until the negative fruits of his past actions are nullified, the individual has to undergo sufferings. Consequently, a patient is left to die with all the agonies and sufferings due to the ailment he suffers from without any treatment or even any consolation.
There are certain methodological questions that Caraka may not be able to solve within the context of ailment. It may be acceptable to classify ailments as curable and incurable. But, how can an ailment be predicted either as curable or incurable prior to the treatment. It is granted that common sense and intuitive insight of an expert may help in such a classification at one level, but can such a classification be rigidly used to deny patients of any or all treatment? Even if it is granted that in the judgement of an Ayurveda practitioner, the parameters to distinguish between curable and incurable ailments are valid, does it morally justify the physician to deny a suffering patient from being treated? This, rather inhuman exhortation cannot be a paradigm in the context of medical ethics. Besides, it is not in consonance with the avowed objective of Caraka’s Ayurveda which describes the physician as the life giver who relieves or rescues the patient totally from the ailments, which includes life-threatening fear of death.

Admittedly, for Caraka the concept of good includes the good of the society at large. The refusal to treat an incurable patient may be justified if the treatment of such a patient were to conflict with that of the good of the society. But, Caraka also refers to pity and compassion for the people at large as part of the science of medicine. Such pity and compassion would definitely include concern for the patient who is suffering the agony of ailment and fear of death.

Besides, when a patient is said to be nearing death, the physician can inform the relatives of the patient about the patient’s imminent death and continue treatment to make the remaining life bearable and happy. Such an attitude instead of harming the
reputation of the physician, may enhance it. Besides, Caraka recognises as the main objective of the science of medicine to provide for a long, happy and good life. The Āyurveda practitioner does not provide his expertise for the sake of wealth or fame but basically in the spirit of social service. And to treat a patient for the sake of reputation is not in consonance with the general objectives of Āyurveda.

Caraka’s argument for rejection of treatment based upon the premise that treatment will not prolong life needs to be evaluated from two perspectives: (a) whether the relation between a certain *rista-laksana* and the proximity of death is a necessary one; and (b) whether an attitude of ‘cock-sureness’ regarding incurability of an ailment is inconsistent with the humility, etc. of the Āyurveda practitioner. Further, even the Oath of Initiation proposed by Caraka recognises the fact that *there is no limit at all to Science of Life, Medicine*. If this is the case, then the entire procedure of distinguishing between curable and incurable ailments seems to be either arbitrary or subjective and to act on the basis of such decisions is unwarranted.

A physician may be mistaken in his prognosis concerning the patient’s ailment and certainty of death. Some of the later commentators seem to be aware of such a possibility and have suggested that the physician should treat the patient so long as he is alive because the patient may recover by chance in spite of the observed *rista*-symptoms.
If Ayurveda accepts and subscribes to the law of *karma*, and consequently justifies withdrawal of treatment on this ground, then it is incumbent on the part of the science of Ayurveda to vigorously pursue in this direction when faced with the challenge of failure. Ayurveda while accepting the factor of fate had suggested ways and means to overcome its negative effects. These include chanting and ritualistically using Mantras, wearing precious stones and some more rituals of pacifying character which are prescribed elsewhere in *Dharmasāstras* and astrology. In spite of all this Caraka did not suggest that since the factor of fate is beyond the human control incurable ailments should not be treated. Caraka was cautious enough to avoid the temptation of absolute fatalism. However, at another level, (even with little or no justification) Caraka does not take up the challenge to administer treatment for incurable ailments.

The most strange thing about Caraka’s demand to withdraw treatment to incurable ailments is that he “condemns” the physicians who administers such treatment, by saying that such a physician is immature and ignorant. The fear of being declared immature and ignorant created a deterrent and discouraged even the most compassionate physician from administering treatment or palliative care for the incurable patients. This aspect remains single most important moral predicament of Ayurveda science of medicine.

Caraka lays down a clear code of conduct for the Ayurveda practitioner when he says that the physician should always remember that his patients trust him completely and hence should always reciprocate this trust by taking utmost care in treating them,
looking upon them as his own children. He should provide proper medical and nursing
facilities to his patients. He should not attend on a female patient in the absence of her
husband or guardian. He should not say or do anything that may cause a mental shock
to the patient or his relatives. He must keep all information about his patients to
himself and should not disclose it to anyone. He must be devoted to his profession
and should keep learning from his experience all his life. He should possess an attitude
of compassion towards his patients and a philosophical outlook in respect of the cases
which prove fatal despite his best efforts. 5

The entire Indian medical tradition and particularly the Āyurveda medical system
seems to ignore the need of obtaining consent from a patient or guardian before
treatment is started6. There is no mention of informing either the patient or the relation
of the patient about the gravity or otherwise of the ailments. Only advise that Caraka
gives, is to be careful while disclosing to the patient the incurable nature of his illness,
as it may shock the patient. It is advised that it would be better that patient’s relations
and State officials be informed. This is done to protect the physician from any
criticisms or punishment one may face on the death of the patient.

The absence of reference to patient’s consent (informed or otherwise) for the type of
treatment administered by the Āyurveda practitioner, should not be seen as a major
difference between the Indian tradition and western bio-medicine. It may be
remembered that the concept of consent (informed or proxy) is of recent origin and is
recognised as the result of legal intrusions in the practice of medicine. The absolute
necessity of informing and being informed regarding the physical health of the patient is a contemporary phenomenon which arose on the one hand to protect the physicians from criminal liability of medical negligence, and on the other hand to protect the patients from being ‘overtreated’ or experimented with.

**Death And Dying**

What is unique to the Indian tradition is the attitude to death and dying. The “fear of death” suffered by both patients and physicians in the western model of bio-medicine seems to be absent in the Indian counterpart, particularly Āyurveda.

In classical tradition, euthanasia in the sense of “freedom to leave” or depart from the present life (referred metaphorically to ‘discarding of one’s clothes’) was practiced among the old and the sick. Euthanasia has never been viewed as ‘mercy killing’ of another person, instead it is regarded as a freely willed choice to ‘leave the body’ by a person suffering from incurable disease or very old age. Such self-willed termination of life was categorised into three types: suicide, heroic, voluntary death (*mors voluntaria heroica*) and religious death (*mors voluntaria religiosa*). Fasting to death (*sallekhanā* or *samādhimarāṇa*) is not considered as suicide but merely giving up of the body due to calamity, famine, old age and decay, painful and incurable disease, for the sake of *dharma*.

The Vedic society had a positive attitude to life and consequently life was never despised or renounced. The Vedic people under the Brahmanical influence attached
great value to prosperity, progeny and long life. They also performed elaborate sacrifices for specific purposes (such as material and non-material gains). They viewed in a similar manner the voluntary self-willed sacrifice of one’s own body with the objective of obtaining freedom, mokṣa or liberation from cycle of birth and death. Consequently, praṇavāsana (abstaining from food and awaiting in a sitting posture the approach of death) is a hallowed practice among the Hindus.

Jainism recognised sallekhanā (fasting to death as a means to remove those karmas that remain even after ascetic purification) as a supreme religious act. Even the Buddhists who discourage self-willed death due to their rejection of all forms of violence (ahimsā) only encouraged meditation on death. There are indications that the monk Vakkali was not condemned when he committed ‘suicide’ in the face of severe illness.  

The fear of death is lessened when the individual prepares for natural death by recognising its imminent approach. Participation of the will in the dying process provides mental calm and ultimately peace to the individual. The religious perspectives of the ancient Indian tradition and their attitude towards death and self-willed death seem to have ‘carry over’ effect on the contemporary Indian medical practice.

The bioethical controversies that have been subject of discussions in the West tend to remain for the traditional Indian a theoretical controversy that has very little or no bearing on his socio-religious tradition. As seen above, the concept of karma, dharma
and *mokṣa* (whether explicit or implicit) seem to develop an attitude in patient that helps him to overcome the "fear of death".

Prakash N. Desai's narration of an incident during his grief at the loss of relation, in an obvious manner expresses a radical difference between the philosophy of life and death implicit to the Western tradition and its Indian counterpart.⁹

Not too long ago I was grieving over a personal loss and observed these two distinct but related attitudes. Letters and telegrams that came in from far flung relatives made a special note of the undecaying character of the *ātman*, the self of the deceased, and included quotations from the scriptures. A seven year old granddaughter of the deceased remained somewhat unaffected for the first few days. Then on the occasion of the gathering of the clan as part of the mourning ritual, the young girl suddenly realised the implications. For the next few days she carried around on her person a drawing she made of her grandfather, and asked questions both at home and school about the fate of those who die. Then, a week or so later her grief was resolved. She came home from school one day and announced to the entire family that her grandfather will soon be reborn, and someone, one of her cousins or aunts, will be pregnant with a male baby and that would be her grandfather. In a flash I, too, realised that in her child-like simplicity she had captured the age-old Hindu idea of rebirth - that death was denied.

**The Modern Indian Scene**

In the contemporary context, however, the influence of western bio-medicine, 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.¹⁰
Further, the influence of classical tradition helps to mitigate the problems faced in bio-medicine under the influence of Western tradition. One can also observe the ‘remnants’ of classical Indian tradition functioning as obstacles for a proper medical intervention. For instance, like the place of palpation as an investigative tool was undermined due to taboos against touching and caste contamination in ancient India, modern physicians very often tend to discriminate on the basis of caste in India.\textsuperscript{11}

In Chapter Three while defining consent in medicine it was pointed out that there is no simple and well defined idea regarding what constitutes consent in medicine. It was also pointed out that medicine at one level appropriates the legal use of the term and at another level recognises the inadequacy of the legal doctrine while attributing both implicit and explicit meanings to the term.

Consent in medical practice may be implied or expressed. Implied consent is a consent which is not written, that is, its existence is not expressly asserted but nonetheless it is legally effective. Express consent is a consent that is written or oral, and its existence is expressed in distinct language. The more specific concept is however informed consent as consent in itself has no specific implications to the bioethical problems. Informed consent has a rather complex and at times naïve meaning. There are societies which do not attempt a particularly clear definition of informed consent, particularly third world countries wherein legal system is not so mature.

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The contemporary Indian medical practice is determined and directed by the guidelines of Indian Medical Council, and in recent times by the judicial pronouncements that come either by way of new acts of various legislatures or judgements of the courts. As mentioned above, judicial interventions have both positive and negative impact on the medical practice. The positive contribution of the judicial intervention is necessary to control malpractice in medical profession and in the absence of any self-control by the professionals themselves, the patients have no protection. But such judicial interventions have resulted in 'judicial activism' that has injected 'hermeneutics of suspicion' in the unique physician-patient relationship. A brief review of the medico-legal cautions that Medical Council of India gives to the professional fraternity will be of significant importance to evaluate the role of informed consent in the medical practice in India.

In India (like in the case of other countries) a physician who is entitled to examine and treat a patient and issue medical certificates (of being fit or otherwise) is advised to be careful lest he becomes a victim of litigation. Let alone treatment, a patient or for that matter any individual cannot be examined without his or her consent. Such a consent is ordinarily implied the moment a patient approaches the physician with a complaint of ailment. But when the procedure of examination is a complex one and involving risk to the patient, etc. (in other words, not an ordinary examination) specific consent must be procured. Indian Medical Association cautions its members to strictly adhere to these norms 'to avoid future troubles.'
There are two types of consent: oral and written. Again, ordinarily oral consent is sufficient in medical practice. However, professional bodies have suggested that to avoid future litigation and to prove with proper evidence, written consent be taken for medical examination, certification and treatment. The consent form must specifically state that the person wilfully and voluntarily submits himself for the medical examination, certification and treatment immaterial of whether the results and consequences of the said examination, certification and treatment go in his favour or not. Oral consent, where there are proper witnesses, is equally valid as written consent, but the latter has the advantage of easy proof and of a permanent nature.

It is abundantly clear that such a consent has to be informed consent and as such the patient should know the consequence, financial implication, etc. of the medical examination and treatment. Therefore, to be legally valid, the consent must be informed and intelligent. In other words, the consent must be given after understanding what it is given for and risks involved, as every adult individual with sound mind, has the right to know and can decide what is in best interests of the individual. It is therefore imperative that the physician gives reasonable information to his patient about the (a) diagnosis (b) nature of treatment or procedure (c) risks involved (d) prospects of success (e) prognosis if the procedure is not performed, and (f) alternative methods of treatment. 13

In medical practice, law makes it imperative (1) that the patient be fully informed of every risk and factual material for the making of a proper consent, and (2) the consent
itself be based upon such material disclosure. Medical Council of India as well as legal professionals recognise and accept exceptions based upon therapeutic reasons, namely, individuals who suffer from extreme forms of anxiety are not patients who should be informed about the status of illness and the various treatment and alternatives thereof as such information may cause considerable harm to the patient’s well-being. In such cases proxy consent must be obtained from a responsible relation or “obtain medical consultation and chart the intentional omission and the therapeutic exception-basis in regard thereto.”

What can be told to the patient and how it should be told is generally left to the professional ethics and common sense of the physician. However, there are certain guidelines given by Indian Medical Association in this regard: "If the risk of untoward result is statistically high, the patient should be informed regardless of the effect on his morale. If the risk is statistically low, but the consequences of a rare untoward occurrence may be severe, the patient should likewise be informed. On the other hand, if the statistical risk is low or the severity of the risk is not great, the physician may safely tailor his warning so as not to excite the patient’s fears.”

In spite of the fact that the individual adult patient with sound mind is recognised as consenting individual and his consent is final, there are situations in which a consent is deemed invalid. The consent is invalid when (a) that what is consented is in itself unlawful, (b) the consent was given by one who had no legal capacity or authority to
give it, (c) the consent is not an informed consent as the information is not adequate, and (d) the consent was obtained by misrepresentation or fraud.

The concept of written, witnessed, or express consent in hospitals both private and public has assumed considerable importance due to biotechnological advances that have seen radical changes in diagnostic techniques and investigative mechanisms. In other words, implied consent cannot assume that sophisticated radiological investigations or cardiac catheterisation can be done on the patient which involve great risk to the patient. The patient (or his guardian) has to give express consent for each and every sophisticated procedure of investigation and has the option to decline such procedures if he so wishes.

Hospitals under various circumstances obtained expressed written consent in a form thereby giving the hospital authorities and surgeons permission to do whatever the physician or surgeon thinks best for the patient under the circumstances. Most hospitals in India have such forms both for sophisticated investigations and treatment (including surgery) which are written in legal language, most often unknown and not understandable to the patients or their guardians. The forms are most often printed in fine print that no one in their anxiety has the inclination or the capacity to understand and one is made to sign under hurried conditions. It is not surprising that the courts decline to value such consent forms when the patient or relations of patient proved that the procedure or surgery was not properly conducted as originally envisaged or consented to. To hood-wink the patient, some hospitals included in the consent form
everything that the hospital and the surgeons are capable of doing that may include even post-mortem.

There is another aspect that needs to be looked into at this stage. The anaesthesiologists, who appear on the scene for the first time on the eve of the surgery are given the task of explaining to the patient the type of surgical procedure due to be performed. The anaesthesiologists are made responsible for ensuring that the consent forms are signed by the patient (in the presence of a third person and of course the nurse on duty). It is not surprising, therefore, that very often patients tend to feel uneasy by the strange intrusion of a ‘third person’ who at no stage has been involved in the physician-patient relationship and who plays the crucial role of informing him about his or her impending treatment and seeks written consent.

Informed consent, it may be recalled, postulates that (a) the person whose treatment (or participation in research or experimentation) is sought, must be competent to give consent; (b) such consent should be given after the consenting individual has full knowledge of the risks and benefits of the proposed treatment or experiment; and (c) the consent should be voluntary and not with force, duress or deceit - direct or indirect. While accepting the conditions of informed consent, the moral duty on the part of the physician should not be lost sight of. It is not merely the question of law that we are dealing with. The physician must provide the patient with reasonable information about the possible risk of a particular medical intervention or experiment. Although it is not possible to provide an exhaustive list of dos and don’ts in such
matters, one can give a set of premises on the basis of which the principle of informed consent functions.

(1) Ordinarily, when a patient calls on the physician with his complaints, his consent for necessary medical examination is implied. Such a deemed consent may also be assumed under emergency conditions. However, major interventions (such as amputations, etc.) should be postponed if the patient is unconscious and cannot give consent.

(2) Again, consent is implied when a patient visits a physician. It is however limited to ordinary examination. If extraordinary procedures are required, or if examination of specific nature (such as virginity test, age determination test, et al) is to be conducted then written consent from the patient be obtained.

(3) Further, it should be noted that examination without the consent of the patient is regarded as trespass or assault (even indecent one). The exception to this condition has been laid down in Section 53(1) Cr.PC. which makes it mandatory on the part of the physician to carry out examination under Court orders or at the request of investigating officers. Section 53(2) demands that in case the individual to be examined is a female, such an examination must be conducted under the supervision of a female medical practitioner.

(4) The consent in any case cannot be fraudulently procured or by pressure or misrepresentation. It must be purely voluntary.

(5) Provision of written consent has been made wherein doubt arises regarding the possibility of change of opinion on the part of the patient after having given oral
consent. This will ensure that the physician need not entirely depend upon uncorroborated memory to defend himself from disgruntled patients.

(6) The consent should be broad enough to cover all medical interventions contemplated, but should not be 'blanket consent' often resorted to by hospitals.

(7) Proxy consent (by parents or guardians) should be obtained in case of patients incapable of giving consent or are minors. A 12 year old is regarded as consenting individual in the case of examination and treatment.

(8) A medical examination must be preferably conducted in the presence of a third person, preferably a nurse. This is particularly so in the case of female patients.

(9) Consent of the spouse must be obtained in the case of sterilisation, hysterectomy, artificial insemination, etc., as the rights of the spouse are involved in such cases.

Professional bodies of the physicians have provided its members with illustrative cases to understand the nature and need of following guidelines regarding informed consent. Such illustrative examples provide evidence of problems the physicians faced while performing their duties.

The nature and understanding of consent, informed consent, deemed or implied consent, proxy consent in the contemporary Indian medical context does not differ substantially from that of its Western counterpart. There are certain cultural variations that have entered into the medical practice due to the laws framed by the State. It is not surprising that consent from spouse (mostly understood as husband) 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).

Again, in spite of Vedic, Upaniṣadic sanctions against abortion from 1972 Indian physicians zealously perform abortions within the first trimester as method of family planning and consequently for ‘the greater good of the country’. Again, all this in spite of Medical Council of India affirmation in the Code of Medical Ethics that “I will maintain the utmost respect for human life from the time of conception”.¹⁶ The opposition among the minority physicians and their refusal on ethical grounds to conduct abortion are often seen as anti-nationalist attitudes. Some Government hospitals have made it mandatory for the Master in Surgery students to conduct at least two abortions as part of their practical programme.

Consent in case of mental illness has been a source of much consternation between government, medical fraternity and social activists or intellectuals. Since minors and mentally ill are categorised as persons who are unable to give consent on their own, the required consent must be obtained from the guardians. Mental Health Act 1987 allows a mentally ill person to voluntarily seek institutionalised treatment but when it comes to discharge, the head of institution can refuse on the ground that it is not in the interest of the patient. The authority can constitute a medical board to examine the request and such a board can decide to retain the patient for ninety days at a time. All this in spite of the fact that Indian Lunacy Act of 1912 envisages that a boarder had to be discharged within 24 hours of his or her seeking discharge. This is because, medical
perspective towards mental illness has argued that mental illness is an unique type of illness and under the Mental Health Act it has managed to give mental health professionals and psychiatrists power to involuntarily admit persons with mental illness for a period of ninety days at a time. This power has almost negated the principle of consent in the case of mentally ill persons.

It is necessary at this stage that attention be given to civil libertarian standpoint that questions such power, particularly when the very definition of mental illness and the mode of determining the same is very vague. It is feared that individuals will become victims of mental health system and therefore it is necessary that judicial procedures be laid down so that no involuntary commitment to mental hospitals is done by the mental health, police or civil authorities.

With regard to research with human subjects, Mental Health Act has one single provision; otherwise, such research is governed by Indian Council of Medical Research Guidelines framed by Justice Khanna Committee in 1980. This single provision makes it mandatory that whenever a person with mental illness is able to give consent for therapeutic or non therapeutic research, such research be conducted only with his consent. And in case the patient is unable to give consent, such a consent must be obtained from his parent or guardian. The procedures laid down in Mental Health Act do not distinguish between experimentation and therapeutic research. If clinical experimentation is altogether banned when there is no therapeutic benefit, there would be no advancement in the field of a hitherto nascent science. Of course,
one cannot allow unregulated research and experimentation with the mentally ill persons. The nature of science demands that a balance be struck between autonomy of the mentally ill person on the one hand and on the other hand the larger social interest in promoting research in mental illness.

No other issue has raised so many moral, legal and social questions as organ transplantation. In India, the very mention of organ transplantation conjures up images of shady world of exploitation involving underworld, businessmen and medical professionals. In the absence of ethical guidelines among the professionals and on the basis of available information, the State has promulgated Transplantation of Human Organs Act (1994) that legislate very strictly organ transplantation. In the present state, even the most altruistic and self-sacrificing act on the part of a donor is looked upon with suspicion and such acts have been now criminalised.

The act allows an individual to donate his organs and also permits his relatives to gift them after his death. It also allows a donor to authorise in writing before his death in the presence of two or more witnesses the removal of any human organ of his body after his death for therapeutic purposes. Once such authorisation is given, any person who is “in lawful possession” of the dead body of the donor (unless the authorisation is understood by him as withdrawn) must permit a registered medical practitioner all facilities for the removal of the donated human organ. Even if no written authorisation is given, if there is no objection expressed or may be expressed by the relations of the
patient, the person in lawful possession can authorise the removal of organs for therapeutic reasons.

It is indeed odd that the expression “lawful possession” can only be negatively interpreted in the sense that anyone who is in possession of the body but not for the purpose of internment/cremation, etc. is in lawful possession. This clearly creates an anomalous situation in which those who are ritualistically in possession of the body, have neither the power nor the authority to donate the organs. It suffices to note, in India, a deceased person is almost entirely controlled by ritualistic obligations.

The Act also recognises ‘brain death’ in order to facilitate removal of some vital organs such as heart, liver, etc. which require that they be removed before death in cardio-pulmonary sense has occurred. The act therefore defines death in both senses - cardio-pulmonary and brain stem death. And in order to avoid the misuse of the Act, the onus of declaring death is placed on a board of medical experts. The Act also makes an effort to prevent commercialisation of human organs. Hence, justification in front of authorisation committee is made mandatory for live donations of organs by persons other than relations. Ritualistic religious practices, superstitions, ignorance, and ethical indifference seem to be main reasons for not creating a statute that provides compulsory removal of cadaver organs.

There is a general belief among the physicians in India that because of large scale illiteracy, patients cannot make a reasoned choice and consequently paternalism is
reinforced. In an experiment conducted by R. Srinivasamurthy et al\textsuperscript{17} at the National Institute Of Mental Health And Neurosciences (NIMHANS), Bangalore, it was observed that 99\% of individuals participating in a drug trial gave a clear informed consent to participate or not. Further, it was noticed that the extent of understanding and decision making on the part of the patient was proportionate to the extent of information provided rather than the social, economic or educational background of the patients.

One case probably uniquely expresses the status of informed consent doctrine in Indian medical practice. The case pertains to a patient who suffered from perforated appendix and who required immediate surgical intervention to survive. The surgeon on duty did not conduct the operation on the ground that no consent from the patient was available and the patient died the next day. In the petition filed in the court of law both the surgeon and the State of Kerala were made respondents by the dead patient's relatives. The court rejected the plea of the surgeon and gave the verdict in favour of petitioner. Kerala High Court upheld the lower court decision based upon the evidence of two expert witnesses (surgeons) who said that they would have operated on the patient without explicit consent.\textsuperscript{18}

Consent debates in relation to euthanasia are on similar lines as in the West. However, the responses to a survey of 200 medical practitioners conducted by Society for Right to Die with Dignity, Bombay\textsuperscript{19} seem to suggest an anomalous position taken by the physicians. While 90\% claimed awareness of the debate, and 78\% uphold the right to
euthanasia in case of terminally ill, 41% argued that the written consent (i.e. Living Will) should be respected. A large majority (70%) expressed apprehension of the abuse of law if voluntary euthanasia is legalised.

A Pragmatic Approach

The age of strong paternalism is over and the physicians should not attempt to retrieve the 'lost prestige' by reasserting the age old adage that "doctor knows the best". This is particularly so because there is both greater awareness among the general public regarding medicine and medical interventions and the profession itself has diversified into specialisations that have brought about non-medical fraternity (such as researchers, biologists, pharmacologists, biochemists, etc.) at the centre of medical practice. And every honest physician knows that the most sure medical intervention may not be the best in a specific case and that the science of medicine at best depends upon the 'intuition' of the physician and help from God. Being aware of the inherent risks involved in the interventions, and the possibility of the best of medicine worsening the condition of the patient, physician, both for their own sake and for the sake of the patient, inform the patient the pros and cons of the proposed treatment. In short, this is the best and the most pragmatic approach one can take regarding informed consent.

Almost all patients, even the most educated believe that the physician knows more than they do. In their anxiety, some patients may tend to ask more detailed information because of their anxiety syndrome which increases under duress. All the patients,
educated or not, are definitely influenced by the physician’s advice on the advantages or disadvantages of a particular mode of treatment. There are special situations in which the patient surrenders to the physician requesting him to do what is in the patient’s best interest without ever conveying to him the type of treatment to be administered. Ordinarily, it is necessary that the choice of treatment be left to the patient on the basis of information provided to the patient. Take the case of thigh-bone fracture where surgical intervention is immediate relief as against a long protracted non-surgical treatment that keeps an individual in bed for long period of time. But the patient should be made aware of the inherent risks of anaesthesia and other complications that can arise during the operation. Since the patient’s information is limited to the extent of his experience with his fellow patients, he may not take into consideration the various risks involved with the types of treatment administered. He therefore will and has to depend upon the advice of the physician.

Again, the extent to which the physician should provide information to the patient depends upon various factors, such as the anxiety level of the patient, the type of ailments he is suffering from, the role patient’s relations or guardian plays in the process, etc. It may be in future, that a time would come when all patients would be increasingly willing to take their own decisions regarding their treatment. But as of now, a pragmatic balance between paternalism and patient autonomy will have to be maintained in medical practice. Because, neither the physicians (medical professionals) nor the patients seem to know what exactly constitutes informed consent that can be used in all and every medical situation. One may provide some heuristic devices that
may be of some help both to the physician and patient while meeting the legal requirement of consent. In other words, explain to the patient in clear and simple language (depending upon the level of understanding of the patient) the alternative methods of treatment available. Secondly, explain in an unbiased manner the advantages and disadvantages of the different methods, including the economics of such treatment, probable risks and short term and long term effects of the treatment.

The complexity of medical system has created specialised professionals that do not or hardly interact with the patients. In a typical hospital situation, different professionals interacting with one another decide what mode of treatment should be given to the patient. There is, in such a situation, no single individual physician that directly relates to the patient to inform him the directions of treatment. Instead, it is left to paramedics (nurses) interacting with the patient to carry out the 'sacred' duties of the physicians. In some cases the anaesthesiologist gets involved whenever there is need of surgical intervention. It is necessary that some changes are brought about in this impersonal world where physician-patient relationship tends to be 'mechanical' and medical practice tends to create anxiety in the patients. To reduce the 'anonymity' of specialised professional vis-à-vis patient, the pragmatic approach to consent would be to find a greater role to the family physician even in hospital context. Specialisation and super specialisation has turned medicine into a science and consequently the physician has adopted the role of a scientist or technologist rather than that of a therapist. This has not only brought about a shift in the physician-patient relationship, but has given rise to a plethora of problems that called upon the intervention of State.
It is not surprising that Supreme Court has finally ruled that medical services come under the Consumer Protection Act. Legislations cannot provide full-proof protection either to physician or patients because, law always lags behind ethical requirements. Medical practice needs to reaffirm its ethical basis both to protect itself and protect the unique healing relationship between patient and physician.

NOTES


6 Katherine Young holds that the traditional Indian concept of self-willed death could be compared to the modern view of euthanasia as compassionate murder by pointing out that the traditional Indian public declaration of intention (saṃkalpa) is similar to the notion of patient’s consent prevalent in the realm of modern medical practice. The question however arises whether saṃkalpa, which is a wish or desire for something material or an extraordinary gain could be compared to the wish to die.


8 for the story of Vakkali refer to Somyutta iii, 123, as narrated in Katherine K. Young, (op cit.).


10 Studies such as that of Prakash N. Desai (op. cit.) inadequately portray medical ethics in India as uniquely Indian based upon Dharmasāstras and explain some of the features of contemporary
Indian medical practice as part of the tradition. For instance, while dealing with abortion Desai after discussing śṛti literature focuses on the legalization of abortion in India in 1972, without attempting to understand that the underlying logic of the legalisation was political and not moral, and ignores obvious metaphysical reasons for absence of “much religious controversy”. Again, while discussing death and dying, Desai refers to physician’s duty to “nurture the will to live in the dying”, which one may note is part of the contemporary medical practice.


12 It is quite distressing to note that almost all items of medical ethics that relate to the rights of patients or relations of patients are reduced to questions of medical malpractice. Even the professional bodies of medical practitioners in their journals and magazines caution the physicians to be careful lest they are in legal difficulties later on. There is hardly any advice given to the members that “one (physician) ought to behave in so and so manner, because that is his moral duty”. (Refer to *A Review Of Medical Ethics And An Update*, Indian Medical Association Publication, 1990)


14 Ibid.

15 Ibid.


