UNDERSTANDING MEDICAL THOUGHT AND PRACTICE

(AN ESSAY ON THE ETHICS OF INFORMED CONSENT)

A Thesis submitted for
the degree of
Doctor of Philosophy

by

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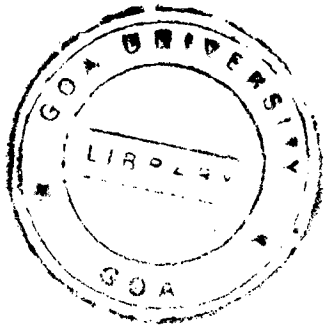
CERTIFICATE

This is to certify that Mrs. Sanjyot D. Pai Vernekar has satisfactorily prosecuted her course of research under the conditions prescribed by the University.

The dissertation entitled "Understanding Medical Thought And Practice (An Essay On The Ethics Of Informed Consent)" is the result of her original work under my supervision. The conclusions of her study are the results of her own research. To the best of my knowledge, no part of this work has been presented to any University for any other degree.



Date: 5/10/98

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DECLARATION

The contents of the dissertation are my findings of research done under the guidance of Dr. A. V. Afonso. I hereby declare that the dissertation or part thereof has not been published anywhere or in any other form. It has not been previously submitted by me for a degree of any University.

Date: 5/10/98

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SYNOPSIS

Informed consent, proxy consent, deemed consent, etc. and ideas that occur in compelling regularity in the discourse of medical practice are to be understood and justified within the domain of applied ethics. Such ethical concerns are at one level, culture determined, and at another level, have universal validity.

Medical practice is a complex phenomenon that has been 'defined' in negative as well as positive terms that depend upon the sensitivity of the society and its implicit and explicit understanding of what constitutes the unique physician-patient healing relationship. As codification of such a relationship in order to streamline the medical practice has not yielded the desired results, State intervened to legislate the relationships.

Although "informed consent" began as a professional 'tool' against litigation and criminal liability, it is now seen as a very important feature of medical practice that legally protects the freedom of both the physician and patient interacting in situations that have created moral predicaments.

Medical practice in India is in a peculiar state as there is on the one hand the influence of Indian 'ethos' and on the other, the influence of the western character of bio-medicine. Analysis reveals both positive and negative influences of *parampara* on contemporary medical practice.

"Pragmatic approach" to informed consent that mediates between paternalism and patient autonomy is the best possible alternative under the circumstances, to overcome the physician-patient 'conflict'. But, above all, medical practice needs to reaffirm its ethical basis both to protect itself and protect the *unique* healing relationship between patient and physician.

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CONTENTS

CHAPTER I: INTRODUCTION

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. It is not the case that traditionally philosophy did not enter into a meaningful discourse with other disciplines such as natural and social sciences, religion and law. But the unique nature of contemporary/recent philosophy is that it articulates and enters into a discourse with disciplines whose boundaries were seen as impregnable - one such area is Bio-medicine.[1]

Traditionally the terminology/language of such a discipline was seen as precise and practitioners of the discipline never recognised conceptual problems entering their field. An interdisciplinary approach to the problems has now given a new dimension to this discussion. 'Clear' and 'distinct' concepts have become 'hazy' and 'questionable', requiring proper articulation and clarification. The new discipline emerging from the discussions such as Bioethics calls for detailed studies of what is both implicit and explicit to the discipline.

The problematics of Bioethics as a discipline has its roots in the controversial character of ethics understood essentially 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.

One should not expect from moral philosophers solutions to moral problems. The maximum that one could expect is a direction to a debate and a pointer towards alternative solutions and possible consequences thereof. Ethical theory is seen as theory about reasons - "reasons for doing or refraining from doing something, reasons for approving or disapproving of something, or reasons for believing or asserting something about morality, virtuous or vicious conduct, good and evil rules, practices, institutions, policies and goals."[2] The task of ethics seen in varied ways, necessarily includes the search for establishment of reasons for various sorts of things connected with conduct and consequently becomes a matter of practical reason.[3]

The most important response at this stage has to be to ethical skepticism, which in its 'crudest' form denies distinction between right and wrong. It is argued that if there is no 'good' moral reason for treating one conduct as better than another, then all conduct is on par, and consequently everything is permissible. Ethical dogmatism on the other hand, 'dogmatically' argues that no reasons need to be given for ethical views. In actual practice, one can find individuals who are morally neutral about some ethical issue or the other. No one has, in practice, been consistently nonethical regarding all issues. Ethical dogmatism, is however quite common among individuals concerned about ethical issues. Ethical dogmatism invariably leads to failure to

recognise varied implications of ethical complexities, and subsequently leads to breakdown in communication.

Applied Ethics In The Context Of Ethical Discourse

The distinction between normative ethics, metaethics and applied ethics (AE) is important to understand the evolution of concepts in moral philosophy and their justification within the general framework of philosophy.[4] However, at another level the emphasis on this distinction blurs in the context of AE discourse. The development of new AE disciplines seems 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. John Ladd has 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.

Ought questions arising out of *conflicts of interests* are reflected in understanding 'subjective values' and the capacity/incapacity on the part of the individual to satisfy one's interests. When an individual is forced to choose between interests, one is faced

with the moral problem of which interest should be satisfied. It is argued that the main function of ethics is to provide objective procedure for settling the conflict. Utilitarianism and Rawl's ethical theory are addressing to these questions.

Ought questions arising out of *moral dilemmas* are reflected in situations where there is a conflict of duty. Such conflicts arise when an individual finds it difficult to perform one's duty without failing to perform another. Such moral dilemmas are common in Bioethics. Moral dilemmas arise when all acts in questions are prima facie duties, whose status is in turn questioned. (Act utilitarians and situationalists do not accept this position).

Ought questions arising out of *ethical disagreements* are reflected in a pluralistic society divided by different ideologies, religions and cultures. In societies where there is disagreement over the rightness and wrongness of various kinds of conduct, an individual is in conflict regarding what he feels or recognises he ought to do and what others want him to do. The main question is whether his duty to respect ethical beliefs of others override his own recognition of his moral duty.

Ought questions turning on the *distinction between duties and other oughts* are reflected in situation wherein one is called upon to mediate or contrast between moral oughts and nonmoral 'oughts'. Some moral philosophers distinguish between moral duties to oneself and to others, thereby widening the scope of moral action to include all human actions. Some others do not recognise duties to oneself.

Philosophers recognise various categories of *metaethical* questions. Broadly, there are questions concerning relation between ethics and conduct; there are questions concerning relation between ethics and facts; and there are questions concerning degrees of generalities regarding ethical propositions - all embracing super principles, moral rules and practices, and individual here and now moral decisions.

General discussions on metaethical theories consider four types of questions that in the ultimate analysis distinguish normative ethics from metaethics. The questions regarding meaning, the questions regarding nature of moral judgements, questions regarding justification of moral judgements and questions regarding interrelation of these issues. Although the questions regarding justification are said to be "central and most important"[5] but for the present study and in view of justifying AE, the central questions in metaethics seem to be 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.

Robert Holmes[6] while analysing the relevance of ethics, points out that although one may ask substantive moral questions in normative ethics, metaethics and applied ethics separately, the issues are so complex and interrelated that it is difficult to maintain their separateness. Holmes argues, that metaethical analysis provides better moral judgements in particular situations is not correct. Similar is the case with normative

ethics and applied ethics. Again, although it is important 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'.

Regarding the relevance of normative ethics to applied ethics, Holmes points out that although every discussion on AE presupposes normative ethics one may wonder whether a specific AE position is due to the consideration of a principle in normative ethical theory or the choice of normative ethical theory is determined by what one thought is morally right to religion, culture et al. Holmes, in conclusion, recognises the fact that solutions in applied ethics are accepted on the basis of undefended normative ethical theory. In fact, such solutions to moral problems are based upon personal moral convictions sometimes influenced by gender, class and racial biases. Holmes concludes that one cannot do neutral ethical *analysis*. In fact, according to Holmes, such an attempt "obscures, rather than avoids, the problems in trying to apply ethical *theory* to practice."[7]

From the above it is clear that the general theoretical problems of normative ethics and metaethics have direct application to human contexts thereby 'creating' applied ethics disciplines. However, there are many critics who feel that there is still serious gap between theoretical and AE. One of the criticisms is that most of the AE discussions presuppose the theoretical position of a school of philosophy or ideology. This makes it difficult to respond to philosophically divergent views. Again, in some cases, the

discussions tend to base themselves on not so clear moral principles 'lifted' from a theory known to be philosophically inadequate. Still again, there are applied ethical discussions that do not make any explicit or implicit reference to any ethical theory.

Presuppositions Of Applied Ethics

It is necessary at this stage to clarify some of the theoretical presuppositions of AE and also to delineate AE discourse from other similar discourses. Although moral philosophers have positioned themselves vis-à-vis the critiques of moral philosophy in general and AE in particular, there have been dissenters within this group as well. James M. Gustafson,[8] Ronald N. Green,[9] and Loretta M. Kopelman[10] have attempted to clarify and lay bare the reasons for doubting the possibility of AE as an independent discipline within the overall intellectual discourses concerning man and nature.

There is no general definitional agreement regarding what constitutes AE. John C. Callahan defines AE 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." [11]

Although, moral philosophers engaged in AE have been criticised by their theoretically oriented counterparts, the level of interest and growth of AE discussions have almost questioned the need for a theory. This is particularly so 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. Donald S. Klinefelter while rejecting scepticism regarding normative ethical theories expressed by Kai Nielsen and others, points out that merely because "no known normative theory has been able to meet all possible objections or silence all its critics, ... (it) is not sufficient reason to regard the enterprise as hopeless or intellectually bankrupt."[12] H. T. Engelhardt[13] argued that in spite of sceptical arguments that undermine universalistic claims of contemporary applied philosophy in general and applied ethics in particular, contemporary cultural needs not only promote interest in the subject, but the interest is growing intense rather than abate.

The reasons for such an interest in AE is obvious. The pluralistic society , fragmented by divergent religious and ideological understandings, differences regarding what is moral, social and political good etc., under the strain of accelerating scientific advancements and technological changes, looks for guidance in its decisions making processes. There seems to be however growth of critics denying the possibility of AE as much as there is growing interest in the subject.

James Gustafson while analysing the medical ethics/Bioethics literature observes four types of discourses, ethical, prophetic, narrative and policy discourse that function morally. *Ethical discourse*, for him, comprises of use of conceptions, distinctions and modes of discourse accepted in the discipline of moral philosophy and moral theology. The purpose of ethical discourse is to decide what one ought to do in particular circumstances in terms of intervention or non-intervention. The *prophetic discourse*

compared to ethical discourse is typified by concern for macro issues and its expressions are generally radical indictments. Underlying these expressions are fundamental issues regarding what is perceived as right and wrong. The prophetic 'exhortations' are usually passionate and employ metaphors and analogies to appeal to hearers' emotions. Gustafson also notices the apocalyptic nature of such a discourse. Gustafson observes *narrative discourse,* used mainly by Christian moral philosophers, is typified by a claim that since we are members of moral communities, our values are shaped by the 'formative narratives' of the community. These narratives are not arguments as in the case of ethical discourse. But since they arise within the context of decision making, they have implicit to them moral reasoning. The politics of biomedical research and the interest of government in medical care resulted in a new discourse, *policy discourse*. The literature on medical policy is not the sole concern of physicians, moral philosophers or religious leaders. The governmental commissions, recognising the interdisciplinary nature of the issues, have their own agenda based upon moral, social and political considerations, thereby creating policy discourse.

Gustafson concludes that ethical discourse is observed to be insufficient, so also the prophetic, narrative and the policy discourses. Each of the discourses contributes in a way to the formulation and resolution of issues in Bioethics in general and medical ethics in particular. He concludes arguing that "the location of choices, of the perceived moral uneasiness or possibilities, licenses each of the forms of discourses described, ... and the location of the uneasiness should determine the concepts,

glance, it 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 allude to an all encompassing moral principle. The phrase "play God" as Edmund L. Erde points out does not seem to be used metaphysically. Even Richard McCormick in *How Brave A New World* seems to allude to an underlying moral principle when he refers to "play God". Erde suspects that the expression "doctors should not play God" is an *imperative* using either descriptive or referential words. For, it is pointed out that although one knows the meaning of the words involved, one does not know the meaning of the whole sentence. One should not assume that the above expression is similar to the expression (doctors should not kill people) as the earlier expression is not a genuine directive with descriptive content. Although at one level the two expressions may perform similar act, however at another level, the two are very distinct in their functions.

Erde points out various meanings of "play(ing) God", such as command, explanation of why an act is forbidden, warning against moral dangers, etc. He also observes that there is no common single meaning underlying the uses. He argues that even if there is 'family resemblance' among the uses, often "when such a phrase is used we do not know what it means".[17] In conclusion, Erde points out that "to say that we do not have a meaning for the phrases is not (as some might mistakenly think) to say that the phrases are useless. They can tell us that we are in for a discussion of matters of reproduction or life and death and as such are just catch phrases. They can warn us to

go carefully and thoughtfully. More likely, however, they are used because they are so charged as to stifle, or at least slant, moral debate just where things are debatable. That is, the phrases are used in such a way that, if they work, the listener feels forbidden to discuss or think further about considering the action. The phrase frames mercy killing, for example, in taboo. But I believe that it is the frame that is wrong, not what is inside. In short, the phrase is used only where a killing (or some other action) might be proposed as a justifiable exception to the general moral injunction against killing (or whatever the other action is), but the speaker does not want to have anyone engage the possibility."[18] Similar analysis for other phrases and expressions will reveal objectives other than descriptive or moral theorising. Richard A. McCormick while noting that *slogans* are used as if arguments, had proposed a set of "rules for conversation" which will help to overcome the subversion of conversation. Avoiding slogans, metaphors, and other uses of language may help the applied ethics debates to be more objective in understanding of the varied moral perspectives.

Theory Versus Practice Of Applied Ethics

Engelhardt not only provides a strong logical argument for AE but shows how in practice, one can respond to those who bring into question the very enterprise of AE. One has to articulate AE in the absence of a single morally canonical sense of practical reason or of justice. He suggests two strategies instead of arguing for the impossibility of AE. One, we can accept plurality of moral rationalities and two, look for deeper structure underlying practical reason or justice. The two strategies, Engelhardt believes, are not mutually exclusive. They may at one level be seen as complementary.

The first strategy leads to abandonment of universalism in ethics thereby rendering AE as explication of particular moral worldview with reference to culture specific foundations. Such an AE "will provide different plausible accounts, which will be convincing only if one endorses the particular initial moral intuitions, thin theory of the good, or notion of proper rational choice that supplied the moral content for the applied philosophy one finally embraces."[19] The inquiry into the deep structure underlying practical reason or justice reveals 'minimal general language for moral strangers'[20] which is due to the universal nature of moral discourse, which in turn depends upon the common universal human nature and its communicative systems. The difficulties encountered in the inter-subjective communication on moral issues may be due to either fundamental grammatical or transcendental (sic. metaphysical) constraints.

All normative ethics is said to "applied" in the sense that ethics is expected to solve practical issues. But, as Klinefelter puts it, "applied ethics would appear to push this claim further in the director of moral casuistry or "quandary ethics" where cases are prior to principles and theories are made explicit only after the fact."[21] Under these circumstances, it is imperative on the part of the moral philosophers (both theoretical and applied) to integrate ('mesh') together the theoretical and applied content "by testing and improving theory and for enabling applied ethics to rise above mere casuistry."[22] As of now, there has not been any visible influence of recent developments in ethical theory on applied ethics, and vice-versa.

The contemporary philosophical developments and the demand for application of ethical theories has given rise to modification and reconstruction of traditional ethical theories. Further efforts are made to develop criterion to test the ability of a theory to resolve problems of application. Such efforts may not succeed in near future given the nature of ethical theory. However this does not mean that AE is not guided by the theoretical considerations and practical objectives while seeking directions of resolution of practical problems.

Moreover, the AE concerns cannot wait for the traditional theory to advance so that a clear criterion is laid for the resolutions of practical problems. Is it proper to look for such an advancement? The nature of ethical theories seem to point out that significant advancement in this direction will occur only if practical resolutions have acceptance among the moral philosophers. Fox and DeMarco suggest two-fold approach to ethics - "philosophers may need to continue their investigations in abstract ethical and metaethical theory - but with the idea of application in mind ....(and) application may need to proceed without complete dependence on existing theory, but not without concern for the generalizability of its arguments and conclusions".[23] There seems to be a dual (negative and positive) dialectical relationship between theoretical ethics and AE. Neither of them can claim to grow on weaknesses of the other, nor can investigation into one be done in isolation from the other. Ethical theory will grow taking into account the consensus AE brings about, and AE will benefit from the advances of theoretical principles developed both at the normative and metaethical level. As a result, "the theory will be more responsive to the complexities of the

genuine moral problems and application ... (will) benefit from the general understanding, rational consistency and co-ordination of judgements which theory can provide."[24] AE is essentially based upon presupposition of plurality of opinions and disagreement while seeking solution to moral dilemmas. It is necessary that AE should seek procedures to change from disagreement to agreement while taking into account the practical political, social, economic and cultural constraints.

In spite of the fact that philosophers have attempted to identify various roles for AE and correspondingly identified types[25] of AE, it should be accepted that AE teaching is essential for future professions in all fields of human activity in order to recognise the ethical problems in their respective fields, and provide professionals as well as public by and large with sensitivity and mental disposition to recognise sound moral precepts.

The Method of Applied Ethics

It is pertinent at this stage to recognise the importance of methodological presuppositions[26] in the discourse of Bioethics. There are number of methods of argumentation that are likely to be encountered in ethical discussion identified on the basis of "appeal to authority", "appeal to consensus", "appeal to intuition" or based upon "dialectics" in the process of ethical reasoning. It may be pertinent to note at this stage that at one level the questions of methods or methodology is essentially linked up with question of nature of the discipline. 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.

Ronald M. Green conducted an assessment of 'method' in Bioethics by surveying almost entire literature on applied ethics. His assessment clearly points out 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, how can we expect such an agreement in a derivative discipline employing the same method? In brief, Bioethics is not a different kind of discipline than ethics and "involves the self-critical application of modes of moral reasoning."[27] K. D. Clouser argues that Bioethics (sic. medical ethics) "is a special kind of ethics only in so far as it 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 realm of concerns."[28]

The above methodologically safe positions has been questioned on three grounds: (1) why should Bioethics employ the methodology of normative ethics instead of that of clinical medicine, law, economics etc. all of which contribute to making of Bioethics? (2) Since most of Bioethics has been vigorously discussed in the classrooms and seminar rooms of moral theology, why not Bioethics employ the methodology of theology that involves interpretations of sacred traditions, biblical scholarship and canon law? (3) Since the issues raised by Bioethics are clearly new and the traditional

ethical theory was not equipped with to deal with them, why is it not treated as a new discipline with an entirely new method of its own?

Green responds to these objections by pointing out that in spite of the importance of all the above questions, Bioethics draws most essentially methodology from ethics, on which it depends upon for its reflection. It is true that the new discipline requires interdisciplinary co-operation, but the core of the discipline remains ingrained in ethics. The complexity of cases involved in Bioethics seem to point out to the plurality of methods, compelling writers to reject the idea that all these methods merge into a kind of reasoned moral justification. Whether there is plurality of methods will depend upon one's position regarding the very notion of "applied ethics" which was found to be a problematical concept by Green. It is obvious that "applied ethics" is not applied in the sense of "applied science" or "applied mathematics" where there is a sound body of knowledge that is to be applied to practical issues. At the same time one must remember that ethics by its very nature is a "practical" enterprise whose objectives include transformation of conduct. Besides, as we have argued somewhere else, ethical theories have a dialogical relation to specific cases and instances of moral choice. Green expresses the whole process in most succinct manner when he writes: "... work in Bioethics - as in business ethics or other forms of professional ethics - is always in some sense also "theoretical". It involves the effort to bring theory to bear on difficult instances of moral choice both as a way of resolving these difficulties and as a way of "testing" or confirming theory."[29] It may be concluded that "Bioethics" though not merely a sub-branch of ethics, it is very much part of the theoretical ethics and its

methods and the issues and problems it faces are identical with those of moral philosophy.

In a very interesting argument, Loretta M. Kopelman, argues that "applied ethics" is not a derivative subject, as there is no change when used that what is applied. Kopelman lays down a criterion of "epistemic privilege"[30] to decide what would not be altered in the course of application. After analysing and finding that the claims for epistemic privilege by moral philosophers either in terms of principles, or specific judgements or background theories are untenable, Kopelman finds that even scientific theories cannot have 'epistemic privilege' in relation to moral claims. The "apply" of "applied ethics" does not express a derivative field, but "will have to include the possibility that what is applied can be re-evaluated, challenged, rethought, reinterpreted, or clarified, and that the so called fields are not fundamentally derivative."[31]

Bioethical discussions are the best example of a discourse where the distinction between methods of analysis and phenomenology get blurred and altogether disappears. In the present study the vocabulary and syntax used will neither distinguish the two methodologies nor will any effort be made to suggest that there is a definite distinction between the two.

In spite of the fact that it is customary to distinguish between two types of methodologies, in Bioethics discourse, both seem to be available leading to a belief

that the distinction is neither adequate nor meaningful. The idea of exclusiveness of methodology (sic. discourse or approach) seems to be replaced by an idea of *spectrum* or continuum wherein philosophical traditions are at one end dominated by elements of analytic philosophy and at the other end by phenomenology. No philosophy is either exclusively analytical or phenomenological.

That analytic philosophy was defined in terms of its method, namely *conceptual analysis* seems to be of the past. Philosophers (commonly regarded as analytic philosophers) like W. V. O. Quine and Donald Davidson go beyond the brief of conceptual analysis. Similarly, Edmund Husserl, Martin Heidegger and Jacques Derrida, both thematically and methodologically provide a detailed conceptual clarification *à la* analytic philosophy. On the basis of a survey of problems discussed by philosophers of analytic and continental philosophy, Dagfinn Follesdal concluded that analytic philosophy is a "particular *way of approaching* philosophical problems in which arguments and justification play a decisive role".[32] In other words, the *way of approaching* (the analytic method) may be seen in the discussions of all contemporary philosophers whether analytic or phenomelogist or existentialist or Thomist or hermeneuticist. These philosophers are more analytic or less analytic. Similarly, the phenomenological "bracketing" and "distancing" in the process of reflection in the context of consciousness is common to all philosophers and philosophies, and depending upon their emphases on the process of self-reflection, they may be regarded as more phenomenological or less phenomenological.

The best example of such a 'merging' of the two methodological frameworks, can be seen from the recent discussions on "illness". A brief study of phenomenon of *illness* reveals both the 'meshing' of the two 'methodologies' and the need to concentrate on three-fold discourse in ethics, namely, normative, metaethical and applied. Illness could be understood by providing both a phenomenological description as part of the reflective 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. Such a disengagement will make explicit the essential intentional structures which determine the meaning of such experience. Phenomenologists describe the phenomenon of illness in terms of meanings one subscribes to at pre-reflective and reflective levels.[33]

Phenomenological reflection makes us aware of the complexity of meaning of illness both as 'lived experience' and an 'abstraction from lived experience'. Again, this reflection elucidates invariant features of illness-as-experienced apart from the varieties of its concrete instantiations.

Phenomenologically one will have to recognise illness from different perspectives such as that of physician, patient and relation of the patient. Illness assumes significantly different meaning depending upon the perspective. Again, since physical illness involves *body*, the manner in which the body is understood by all concerned is important to the understanding of medical practice.

Studies have pointed out that the biomedical model[34] 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. Positivism viewed illness 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 disfunction as determined by social, psychological and cultural factors.

Understanding illness has to take into consideration understanding of 'health' or 'wellness'. The preoccupation with 'illness' based upon the new paradigm seems to have blinded the physicians from understanding health. Illness is based upon extreme forms of anxiety (patient anxiety of disability and death and physician anxiety regarding doing his utmost to save the patient) which is only aggravated when health problems are focused on illness rather than on wellness. Modern medical practice has reached a level that a person who is declared to be well is one who is not yet diagnosed (or has not visited a physician).

To make this point clear, study the *risk factor hypothesis*, the most important concept in medical practice. RFH is the central notion in medical practice whereby a physician after studying the measurable risk factors decides about the future course of action

regarding the patient's health. [35] Although in medical practice, cholesterol is seen as single most important risk factor for cardiac problems, there is no known correlation between the two.[36] The studies have concluded that RFH cannot be correct as risk factors measure only phenotype and not genotype, and the linear relation between risk factors and health problem do not operate in a dynamic system like human body.

What is then the alternative to RFH for detecting a disease? The non-western conceptions of medicine seem to suggest alternative to understanding of both illness and *wellness*. Besides, the longevity gene, the environment seems to determine the *wellness* of an individual. It is the environment that contributes towards disease state or alters the genetic disposition for a long life. And central to this, is the role of human mind which is capable of both negative and positive influence on health. In other words, disease is 'disease' in the mind.[37] Holistically viewed and integrating both the knowledge of west and the wisdom of east, disease is due to combination of the inheritance of gene and the presence of environment that either positively or negatively contributes to longevity. Human mind controls the environment thereby either avoiding the disease or postponing its onset. It is important that we recognise that at any given time there are more people who are healthy compared to a small fraction that is ill.

World Health Organisation's definition of 'health' as 'state of complete physical, social and mental well-being' and not simply 'absence of illness and disease' provides a holistic approach of health. There is a tendency to define health in terms of capacity to

work or be functional and efficient. And health, in this sense is seen as maximal efficiency or effectiveness. And the inclusion of mental health in the general concept of health has led to the recognition of importance of environment and social stimulation.

Health being essentially related to the 'body', demands some clarification regarding what constitutes body in relation to health and illness as the "specific nature of man lies in his being in the body and in being through bodily existence open to the Other, ... to the world around him"[38]. One often observes patients being treated in a depersonalised and dehumanised manner in hospitals. Patients' cries of suffering are ignored, and their both explicit and implicit wishes not taken into account while being treated. It is far too often that patients nowadays complain of being treated as a 'piece of meat' while being examined, tested, diagnosed and medicated. Patients complain that they never experience as being treated as persons with respect and consideration.

There are various reasons such as economics of the capitalist system, personal financial considerations of both the patients and physicians, advancement of modern testing procedures and diagnostic techniques that are cited to explain the 'dehumanised' treatment of patients in modern practice of medicine. 'Justifications' are also available for change in physician-patient relationship in modern medical practice. Third-party payment (insurance), governmental programmes involving paperwork and regulations, legislations with microscopic do's and don'ts etc. interfere with free exercise of medical judgement.

The above reasons and justifications have greatly affected physician-patient relationship. However, there are more radical influences that are responsible for the paradigmatic change in the nature of modern medicine. It is essential that we understand the concept of self and human body that medical practice employs in its workings. Michel Foucault regards this paradigm whose roots go back to seventeenth century as "man-the-machine" model. Medical science views body "not primarily as a purposive and ensouled, nor as the scene of moral dramas, nor as a place wherein cosmological and social forces gather, but more as an intricate machine."[39] This model operates according to a variety of physical forces: electrical, chemical, etc. Disease is treated as manifestation of breaking down of the machine, and the duty of the physician is to 'fix it' using the scientific knowledge and rich experience that he has as a 'mechanic'. The "man-the-machine" paradigm explains the "piece of meat" experience of patients and the phenomenon of dehumanisation. If the patient is primarily a body machine in need of repair, the personal interpretations, fears, wishes and sufferings of patients are seen as insignificant to medical practice. However, in the twentieth century, phenomenologists and 'continental' philosophers have attempted to understand and articulate the human body and its conditions in radically different modes, thereby overcoming the "man-the machine" fixation of seventeenth century rationalism.

Alternative paradigms have been suggested in the twentieth century as a result of critique of the Cartesian model. The most important among them is the phenomenological model based upon the radical shifts that occurred in West as a

reaction to positivism and scientism. One can recognise major trends in the twentieth century thought concerning the body. One is the critique of the conventional machine-model, and the other is the phenomenological and sociological critique. Phenomenology seeks to "bracket" all assumptions whether scientific or metaphysical to allow for a direct awareness of the phenomena of our daily experience. The phenomenologists would argue that once we "bracket" the Cartesian assumption that body is like any other physical body in the world, the "lived body" surfaces in our experience. The body is very different from other physical objects as it is capable of sensing and moving, of emotion and cognition that "constructs" the world. A sick body is not a broken or non functional machine, but a self with a world transformed. A 'diseased body' "undermines our sense of self autonomy, our relations with others, our habitual experience of space and time."[40]

There are other critical representations of the machine-model and alternative models which have been suggested by the Marxists thinkers and feminist philosophers. Feminists, for instance, disembodied reason, and directed their attention on the body and aspects of the person associated with the body, gender, emotions, sexuality, reproduction, praxis and the like.

This alternative phenomenological model to the body-machine, tries to "*rehumanise*" medicine as it (the phenomenological model) allows us to understand illness as 'experienced-illness'.

One of the serious objections to Bioethics as a discipline is that issues in Bioethics tend to take the form of dos and don'ts leading to a skewed understanding of 'Bioethics'. Several authors have criticised the discipline as being foundationless and theory free, thereby rendering 'fuzzy' the concerns that have both political and economic implications.

Towards A Secular Bioethics

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, attempts from other organised religions saw both social and religious legislations in countries dominated by single religious traditions.

Paul F. Camenisch[41] in Religious Methods and Resources in Bioethics, has brought out the relationship between Bioethics and various religious traditions from Semitic to oriental religions and laid bare their methodological foundations. Katherine K. Young[42] argues that Hindu Bioethics is framed by the larger concept of Hindu dharma that defines public morality which is considered both as universal and eternal. Shoyo Taniguchi,[43] found the entire Buddhist ethical system directed towards the gradual weakening of one's self-centeredness (*tanha)* which leads to the experience

of happiness at both personal and social levels. The above is attained by the elimination of *taṇhā* and thereby elimination of *dukkha.* John Kelsay[44] finds that Islamic Bioethics reflects the conviction of the continuing validity of the Islamic mission (viz. bear witness against polytheism and injustice by proclaiming values consonant with monotheistic faith) and the struggle of the Islamic community to restore its role of leadership in the world.

Although, there are AE concerns that are primarily secular in nature such as environmental ethics, professional ethics, etc., bioethical discussions have by and large remained rooted in cultural tradition in general, and religious tradition in particular. It is necessary that one clearly understands the religious and secular nature of Bioethics in order to have a significant dialogue within and outside the communities in which the bioethical expressions are founded.

Engelhardt's agenda is to frame a secular Bioethics in the sense that the understanding of issues must be common to all communities, traditions and ideologies. Such a Bioethics must be such that it is 'free from' not only a particular religious community but also from a particular secular community.

The foundations of secular Bioethics can be laid, if we locate "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 ... (and functioning) as the logic of pluralism (will ensure) peaceable negotiation

of moral intuitions". [45] At a practical level such a secular Bioethics will help to resolve problems of biomedicine wherein individual physicians, nurses, patients and other persons of divergent moral views interact. It will also ensure that no particular religious tradition imposes its view on others.

Engelhardt while arguing for secular ethics, agrees that it may not be able to defend *all* the moral pursuits of religious individuals and ideologies. The common minimal ethics that it ensures is seen as the limitation of secular reasoning and it should not be argued that the concerns of religious individuals and ideologies are irrelevant.

Secular Bioethics, as envisaged by Engelhardt, contributes towards a tolerant health care system wherein individuals of various diverse moral perspectives interact. It further insures that people do not run to "false prophets" for resolution of moral dilemmas when the same could be resolved 'through analysis sustained by communities of inquiring individuals'.

NOTES

[1] Biomedicine has developed into a discipline as a result of advancement in research, oriented towards the goals of medicine. The traditional model of medicine dealt with physicians' concern with the patients' illness which was capable of objective verification. And as an extended concern the entire profession of medicine concerns itself with complete physical, mental and social well being. Biomedicine therefore taking into account the traditional medical model at one stage, made its objective applications of natural sciences to medicine. At a later stage, the application of natural , behavioral and social sciences to medicine became the focus of attention of biomedicine. Attempts to incorporate scientific methods in the medical and clinical practice rendered biomedicine as the foundational discipline upon which medical success was dependent.

Contemporary discussions of Biomedicine not only presuppose the above historical stages of development, but focus its attention on the ethical priorities, the societal goals and political experience of contemporary societies. Biomedicine has a multiple of dialectal relationships to society, polity and ethics thereby influencing the future directions of medical practice.

[2] John Ladd, "Ethics: The Task of Ethics", in *Encyclopedia of Bioethics*, (*EB*) Vol. I, p.401.

[3] Kant had to find place for 'ethics' in practical reason as he failed to justify it in his transcendental deduction. Kant does not prove that we are bound by a moral law by putting forth a theoretical proof that we possess a free will. On the contrary he holds that we must possess a free will because of our indubitable recognition that we are in fact bound by the moral law.

[4] Normative ethics is referred to as investigation into the contents of moral principles/virtues in the context of human condition. The resultant systems dictating "what is morally right conduct" are recognized as ethical systems. The prior questions regarding the meaning of moral terms, and their relation/comparison to other concepts are part of metaethical discourse. Although the discussions on meaning of moral terms, relation between subjectivity and objectivity of moral judgment, the problem of relation between moral belief and factual belief etc. are of recent origin (part of analytic tradition) they are logically prior to issues in normative ethics. AE though it lacks definitional consensus has been widely used and the same is reflected in the development of specific ethics such as Medical Ethics, Environmental Ethics, Bioethics, Professional Ethics. The major criticisms against such 'practice' is that applied ethical precepts tend to be of the nature of do's and don'ts and the same are not often justifiable within the context of ethical theory. More specifically, no 'field' of AE theory is 'observed' in most of the discourses of AE. S. R. L. Clark while reflecting on the need for such a theory, compares AE to learning of a craft which is not merely by being taught a set of axioms which include the rules for their own applications but we learn a craft by beginning to practice it. The development of theory for AE though logically prior, is historically later. (S. R. L. Clark, "Abstract Morality, Concrete Cases" in J. D. G. Evans (ed.), *Moral Philosophy and Contemporary Problems*, N.Y., Cambridge University Press, 1987.)

[5] Richard T. Garner and Bernard Rosen recognize these type of questions to be central, as these questions would lead to the fundamental issue of justification of moral reasoning as a whole. (*Moral Philosophy*, N. Y., Macmillan Co., 1967.)

[6] Robert L. Holmes, "The Limited Relevance of Analytical Ethics to the Problems of Bioethics", *The Journal of Medicine and Philosophy* (*JMP*), Vol. 15, No. 2, 1990, pp. 143-159.

[7] Ibid. p. 157.

[8] James M. Gustafson, "Moral Discourse About Medicine", *JMP*, Vol. 15, No. 2, 1990, pp.21-142.

[9] Ronald M. Green, "Method in Bioethics: A Troubled Assessment", *JMP*, Vol. 15, No. 2, 1990, pp. 179-197.

[10] Loretta M. Kopelman, "What is Applied about "Applied" Philosophy?", *JMP*, Vol. 15, No. 2, 1990, pp. 199-218.

[11] Quoted in Donald S. Klinefelter, "How is Applied Philosophy to be Applied?", *Journal of Social Philosophy*, Vol. XXI, No. 1, 1990, p16.

[12] Donald S. Klinefelter, (1990), p.18.

[13] Cf. H. T. Engelhardt, "Applied Philosophy in the Post-modern Age: An Augury", *Journal of Social Philosophy*, Vol. XX, Nos. 1 & 2, 1989, pp.42- 44.

[14] James M. Gustafson, (1990), p. 141.

[15] J. L. Austin, in *Philosophical Papers*, Oxford, Oxford University Press, 1979, p.235 defines peformative utterances as "utterance that looks like a statement and grammatically would be classed as a statement, which is not nonsensical and yet is not true or false".

[16] Edmund L. Erde, "Studies in the Explanation of Issues in Biomedical Ethics: (II) On "On Play(ing) God", etc.", *JMP*, Vol. 14, No. 6, 1989, pp. 593-615.

[17] Ibid. p. 608.

[18] Ibid.

[19] H. T. Engelhardt, (1989), p. 46.

[20] Engelhardt by 'moral strangers' means individuals participating in moral debates, but without sufficient moral premises to provide the basis for a resolution of their dispute. Whether there are such individuals who do not have a 'sufficient moral premises' is disputable. In fact, it would be a challenge to communication theory that individuals can come together on a debating table without common premises to proceed.

[21] Donald S. Klinefelter, (1990), p.16.

[22] Richard M. Fox and Joseph P. DeMarco (eds.), "The Challenge of Applied Ethics", in *New Directions in Ethics*, N. Y., Routeledge and Kegan Paul, 1986, p.12. Donald S. Klinefelter defends 'casuist approach' to applied ethics because "it recognizes both our rational quest for certainty in moral matters and the inevitably probabilisitic nature of our practical judgments without throwing out maxims and rules altogether as situationists, existentialists, act-utilitarians and act-deontologists (intuitionists) are tempted to do when faced with "unique" cases." (*Op. cit.* p. 24)

[23] Richard M. Fox and Joseph P. DeMarco, (1986), p. 17.

[24] Ibid. p.18.

[25] James M. Brown analysed the AE investigations as of four types. (1) Application of ethical theory; (2) Sound, well-grounded ethical theory being applied to practical problems; (3) Non-philosophers (other disciplines) supply the problems and philosophers supply and apply the theory; (4) Professional or occupational ethics is just ordinary ethics applied to the professions or occupation

in question. ("On Applying Ethics", J.D.G. Evans, *Moral Philosophy and Contemporary Problems*, Cambridge, Cambridge University Press, 1987).

[26] The methodological presuppositions of the new discipline reflect the traditional disciplines from which the new discipline has emerged. However, the nature of philosophical enterprise leaves a dominating stamp on the framework as rational justification and clarification of concepts within the discourse of ethics (both normative and metaethical) becomes the central objective.

[27] Ronald M. Green, (1990), p.180.

[28] K. D. Clouser, "Ethical Theory and Applied Ethics: Reflections on Connections" in B. Hoffmaster, B. Freedman, and G. Fraser (eds.), *Clinical Ethics: Theory and Practice*, N. J., Humana Press, 1989, p. 116, quoted in Ronald M. Green, (1990).

[29] Ronald M. Green, (1990), p. 186.

[30] By "epistemically privileged principles" Kopelman means that the principles are self-justifying or known by intuition. (Cf. Loretta M. Kopelman, (1990). p. 202.)

[31] Ibid. p. 215.

[32] Dagfinn Follesdal, "Analytic Philosophy: What is it and why should one engage in it?" , *Ratio*, Vol. IX, No. 3, 1996, p.206.

[33] S. K. Toombs points out that at pre-reflective level a patient recognises that 'all is not well' while reporting alien or unusual body sensations. At this level these symptoms are not recognised as signs of illness. At the reflective or intuitive level, the various bodily sensations are seen in a totality that transcends the individual symptoms and recognises them as "disease". (cf. *The Meaning of Illness*, London, Kluwer Academic Publishers, 1993, pp.31-33.)

[34] Biomedical model of illness/disease primarily focuses on the disfunction of the biological organism and patophysiology of the disease state. The roots of this model go back to Cartesian mechanistic model.

[35] Two studies (The Pooling Project Data (PPD) and Helsinki Heart Study (HHS)) have shown that RFH is not a reliable theoretical construct. PPD after analysing 10 studies of risk factors and their capacity to predict future events (hear attacks) it was found that out of people with more than 6 risk factors, over a period of time only 10% suffered a heart attack. Further 60% of those who suffered heart attacks over a period of 10 years, had one or no risk factors. In HHS two groups, (intervention group with all risk factors and the other control group) were studied in a longitudinal study of 20 years. It was found that the intervention group had twice as many total deaths and thrice as many cardiac arrests as compared to control group where no intervention to correct risk factors was made.(Cf. B. M. Hegde, "Wellness - A New Concept", *Journal of Indian Medical Association*, Vol. 94, No. 8, 1996.)

[36] Stehbens in *The Fat Hypothesis of Atherosclerosis* studied cholesterol as *risk factor* and not only found that there is no significant correlation between heart attacks and cholesterol, but found similar relation between TV sets sold and heart attacks, which medicine did not take seriously. (Cf. B. M. Hegde, 1996.)

[37] *Sāṅkhya-Yoga* prescribes yoga as solution to all health problems. It prescribes control of mental states (*Cittavṛttinirodha)* for controlling the desires, anger, hatred, jealousy, frustrations etc. The *yogic* prescriptions of various *prāṇāyāmas*, primarily breathing techniques are meant to avoid diseases and increase longevity.

[38] Bernard Häring, *Medical Ethics*, Slough, England, St Paul Publications, 1972, p.51.

[39] Drew Leder (ed.), *The Body in Medical Thought and Practice*, Dordrecht, Kluwer Academic Publishers, 1992, p. 3.

[40] Ibid. p. 5.

[41] Paul F. Camenisch (ed.), *Religious Methods and Resources in Bioethics*, London, Kluwer Academic Publishers, 1994.

[42] Katherine K. Young, "Hindu Bioethics", in Paul F. Camenisch (ed.), *Religious Methods and Resources in Bioethics*, London, Kluwer Academic Publishers, 1994.

[43] Shoyo Taniguchi, "Methodology of Buddhist Biomedical Ethics", in Paul F. Camenisch (ed.), *Religious Methods and Resources in Bioethics*, London, Kluwer Academic Publishers, 1994.

[44] John Kelsay, "Islam and Medical Ethics", in Paul F. Camenisch (ed.), *Religious Methods and Resources in Bioethics*, London, Kluwer Academic Publishers, 1994.

[45] H. T. Engelhardt, *The Foundations of Bioethics*, Oxford,Oxford University Press,1986,p.11.

CHAPTER II: UNDERSTANDING MEDICAL PRACTICE

In the first chapter an attempt was made to clarify the basic concepts involved in the discussions of applied ethics in general and bioethics in particular with a view to provide clear guidelines for the present discourse on 'medical practice'. The present chapter traverses issues which at one level may be deemed to be the exclusive domain of medicine but at another level, the concerns defy any attempts to limit the discussions. One of the important characters of understanding medical practice is its domain of application. The subtle attempts by each discipline interacting in the medical practice, to make it the exclusive concern of one profession, denies the topic of its problematics. 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."

Understanding Medical Practice From 'Medical Malpractice'

For understanding medical practice, it may be useful to reflect on the idea of 'medical malpractice', as many questions of medical ethics and health care arise in the context of 'malpractice'.[1] This is particularly so when one reviews the law of medical malpractice. Societal attempts to control the professions related to medicine and health care, has led to legislating the medical practice. Such legislations have come to be known as negligence law. In short, "lack of or failure to use professional skill and care, the rubric generally invoked to indicate medical negligence, (is) recognized .... as a ground of liability".[2] 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 lawsuits against the medical practitioners on the basis of the argument that there is an implied contract. At first in America and later on in other countries, "the contractual obligation to possess and exercise ordinary professional skill and care was transformed into an obligation not to be negligent to the patient to whom, by the law of negligence, the physician owed a duty of "due care"."[3] The concept of "due care" has become central to discussions in medical ethics and its consequent legal provisions. A physician who does not keep up with the advances in the medicine, may cause the disability or death to a patient as certainly as if he neglected the patient. Because, 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 services due to neglect. In legal terms, the whole idea is summarised in the concept of "due care" which is the "care" the society expects each person to meet his obligations to other persons with diligence.[4]

'Medical malpractice' is measured in terms of failure to use "due" or "reasonable" skill and care. Generally three parameters are used to judge "due care". A physician is judged on the basis of skill he has in comparison with other physicians in the same city/place. Two, the physician is compared to the degree of care and diligence shown by other physicians in their professional discharge. Three, 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. In broader terms of medical ethics, professionals, namely the physicians, should find ways and means of eliminating medical malpractice. It may be due to the failure of professional associations and of state sponsored professional councils, that the society is compelled to legislate and resort to legal proceedings whenever negligence is suspected. What is of importance is that "professional negligence" may at times border on fraud and cheating. But the areas of professional negligence may be such that they do not necessarily raise legal liability. This is particularly so because medicine is "an art struggling to be a science" which to a large extent depends upon intuition of the physician (in spite of the fact that there are large number of sophisticated diagnostic techniques), and has internal ethical standards more exacting than the law requires. It is the reluctance on the part of physicians to testify critically against one another's acts of negligence (what has come to be known as the 'conspiracy of silence') which is primarily responsible for the governmental interference and frustration among patients and 'judicial activism'.

The physician enjoyed a high status in the society and trust from the patients because of his knowledge and skill in treating the patients, caring and nurturing them. In recent times, there has been awareness among the people, including scientists, that the physicians are not necessarily the most knowledgeable ones in health care. The limitations of physicians as experts in the field of medicine is becoming more and more evident due to the fact that science and technology is becoming widespread and public

by and large is increasingly involved in the same. Consequently, patients have on the one hand expressed their desire to surrender themselves unconditionally to the physician in trust; on the other hand they are sceptical and critical of the healing mechanisms and the avowed expertise of the physician. As David Mechanic puts it: "While they (patients) desire a trusting relationship, they are frequently untrusting and demand greater representation, information, and voice in decisions making. Obviously, patients and physicians vary a great deal, and there are no simple generalisations that adequately describe the variability that is evident."[5]

Nature Of Medical Ethics

Understanding medical ethics essentially constitutes an inquiry into the objectives of medical ethics. And this is possible if we reflect on the concrete medical situation, its problems, possibilities and dangers. In fact, every decision in medical context is a moral decision in which the good of patient, his or her relations and physician is involved. Most problems in medical ethics arise from the 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. According to moral theologian Bernard Häring, medical ethics represents "a systematic effort to illumine the ethos and elaborate the perspectives and norms of the medical profession ... and the morality of the physician lies in the subjective personal realisation of the proper approach to his profession, his living the fullness of his ethos. It is the physician's capacity to act according to a well-informed

conscience and to make concrete decisions with an upright attitude, and with insight and discernment."[6]

Medical ethics to a large extent depends upon the level of sensitivity of physicians[7] in a certain culture and the nature and structure of a health-care system. The level of ethical sensitivity reflects in the dominant cultural 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 our own culture where values are based upon a hierarchy of class and caste, the medial practice may reflect these values. McCormick calls for counter-cultural correctives to overcome such anomalies. Secondly, the nature and structure of health-care system and governmental policies also influence the medical ethics. A health-care system that does not recognise the privileges of rich versus the poor, and instead recognises all individuals as equal and are eligible for the same health-care, is less depersonalising.

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. "Sanctity of life" is central to all medical practice. In ancient Egypt and Persia, the practice of medicine is prescribed in holy books, where, in the struggle between good and evil, the physicians are pitted on the side of good. In the Arab world, the medical practice is based upon Biblical and Koranic prescriptions. In Caraka Saṁhitā, the physician is warned against sins of thoughts, words and deeds.

That life should be protected, body should be healed and made into 'whole' and suffering be reduced till such time 'God' wills otherwise, is the philosophy behind all medical practice.[8] A study of the various codes of conduct and oath/s taken by physicians reflect the metaphysical or religious foundations of medical practice. The Oath of Hippocrates begins with "I swear by Apollo ... and all the gods and goddesses, making them my witnesses,..." In the Oath of Initiation (Caraka Saṁhitā), the first clause reads "The teacher then should instruct the disciple in the presence of the sacred fire, Brāhmaṇas and physicians". In Advice to a Physician, Haly Abbas (Ahwazi), the Persian physician of 10th century, begins: "The first advice is to worship God and obey his commands;..." Although in modern times, explicit reference to God is avoided while framing codes or declarations, the language of such declarations clearly envisage a *more-than-worldly* attitude towards patients. The Declaration of Geneva, for instance, begins saying: "I solemnly pledge to *consecrate* my life to the service of humanity".[9] McCormick recognizes *'sanctity of life'* as the basic value in the practice of medicine on basis of which every decision is taken. With the development of medicine by way of life-sustaining and resuscitative devices, 'sanctity of life' as a value seems to be threatened. Conceptually, the debate regarding 'sanctity of life' has led to recognition that it is not merely physical life that is important, but the *quality of life* that is sustained. It is important at this stage to recognise that the value 'sanctity of life' even questions the idea of *'preservation of life'* at any cost.[10]

Objectives Of Medical Ethics

There has been a mistaken understanding that medical ethics is same as the code of conduct[11] laid down by various bodies of professionals or institutions. The Code of Conduct is insignificant compared to the content of medical ethics. Code of Conduct deals with items such as address advertising, billing procedures, self-aggrandisement, conflicts of interest, professional courtesy, public and media relations, use of secret remedies and healing methods, physical appearance etc. which are often seen as more 'important' issues by the professionals. Even the watch-guard agencies are often called on to settle issues related to these items in the codes rather than take up the more fundamental ethical issues.

The fundamental ethical issues facing the medical practice have also been directly or indirectly incorporated in the various codes of ethics such as *Code of Ethics of American Medical Association, International Code of Medical Ethics of World Medical Association, Medical Ethics of British Medical Association*, etc. Expressed in general terms, these codes make it incumbent on the part of the physician that he or she should preserve human life, should be good citizens, prevent all forms of exploitation of patients, promote the highest quality of health care without discrimination, perform duties accurately and objectively, continue to grow in the knowledge of medicine, render service under all conditions and circumstances[12], promote harmonious relationships with other professionals and expose those who are unethical and incompetent, protect welfare, dignity and confidentiality of patients, etc. It is obvious that what is said to be code of ethics for physicians, is same as what is

expected of all humans beings. And since the medical context is common to all humans, medical ethics cannot be the exclusive concern of physicians. Therefore, the implementation of medical ethics seems to be the bounded duty of every one involved in the medical practice, be he a patient, paramedic, administrator, public citizen or physician.

The objectives of medical ethics education will depend upon the cultural, geographical and economic conditions of the society. In the U. S. A. the Commission on the Teaching of Bioethics identified four goals of medical ethics education, depending upon to whom the education is meant. The first goal is to help students "to identify and define moral issues in a biomedical context", the second goal is to develop "strategies for analysing moral problems in medicine", the third goal is to relate "moral principles to specific issues and cases", and the fourth goal is to train "a small group for careers in bioethics".[13]

The first three goals are meant for all humans who have to take informed decisions regarding moral issues relating to their treatment or health care. It is appropriate that the physician at one level be recognized as not the primary decision maker and at another level one who helps the patients to make decisions regarding their treatment. It necessary in this process that all individuals are capable of recognizing the ethical implications of their decision making processes. The physician must be able to recognise the distinction between technical questions and moral questions. It is only

when a physician is capable of understanding the ethical dimension of medical care that he can guide the patient in making the morally right decision.

Some countries (particularly developed western countries) have recognized the need of a counsellor or consultant who is educated and understands different theories and strategies for resolving ethical conflicts within medicine. Again, the physician must be equipped with knowledge so that he can decide to what extent the information regarding a diagnosis be given to the patient. The same applies to paramedics and others. This task can be carried out only if the physicians, paramedics and others have knowledge of the systems and are capable of relating principles to cases. One of the objectives noted above is to train specialists who will engage themselves in teaching medical and bioethics in universities and professional institutions.

McCormick claims that a medical ethics programme will depend upon what is recognized as the purpose of such a programme and how one assesses the contemporary medical situation.[14] There are a whole series of presuppositions for such a programme that need to be explicit or clarified before any attempt is made to implement a medical ethics instruction. As mentioned earlier, the most important among them is the idea of what a physician ought to be and what is medical ethics about. McCormick adds to these a whole set of presuppositions which take into account the cultural prerequisites, the political system, etc. Although at one level, medical ethics will have the universalistic character, at another level it will be contextualised within cultural parameters of the society. How medical policies and

decisions are made, the structure of heath care system, level of ethical sensitivity , assessment of strengths and weakness of medical students are some of the parameters that have to be taken into account for a medical ethics programme.

One of the most fascinating aspects of McCormick's study (not expressed in most of the discussions by other authors - orthodox or liberal, religious or secular) is that he attempts to lay down a definite programme wherein we can carry out a "dialogical process that includes : *communal* discussion of a *rational* kind that attempts to reinterpret the meaning of these values in a new set of medical and cultural circumstances"[15] so that cultural, geographical and barriers of time are overcome and at no stage there is breakdown in communication between the moral philosophers or community by and large.

The value of 'sanctity of life' together with the value and meaning of sexuality and family, the value of the personal physician-patient relationship, and individual and social justice in health-care delivery are the values McCormick recognises as the central tenets of a medical ethics programme.[16] The discourse on sanctity of life that occurs practically in every bioethical issue, determines the nature and development of bioethics, whether religious or secular.

Many of the issues that have been highlighted in the medical ethics programme is related to meaning of sexuality and family as the same determines the quality of life we lead. Contemporary moral discussions in general and bioethical discussions in

particular are influenced by the developments in biomedicine and biotechnology. The separation of procreative processes from sexual relationships has resulted in various possible scenarios. The traditional moral philosophy and theology seem to be most affected by the separation between sexuality and family, namely, separation of sexual expression and procreation through effective contraception, etc. and achievement of procreation apart from sexual expression as in the case of *in vitro* fertilisation.

The relationship between physician-patient has been the most discussed topic in medical ethics. Detail articulation of this unique relationship is available in most of the Codes of Medical Ethics, ancient or modern. 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 essential tenets of such a relationship.

McCormick and others while highlighting individual and social justice in health care, point out to two 'rights': the right of the individual for proper health care and the physician's right to autonomy. Within these two 'rights' there arises the ethics of group practice, voluntary medical work for the poor, fee structures, racial, class or caste discrimination in medical education and hospital care, etc. There has been considerable consternation among the professionals as well as policy makers regarding the physician's right to autonomy. While on the one hand physician's autonomy is said to have led to growing malpractices in the field of health care, one should remember

that the loss of autonomy will lead to more serious consequences such as third party intervention in the physician-patient relationship and the subsequent dangers associated with it, legal processes that one will have to undergo and the subsequent waste of time and energy on the part of the professional, lack of interest in specialisation and consequently disinclination on the part of professionals to promote advancement in medicine, governmental involvement and subsequent lack of personal initiative on the part of the physicians or health providers.[17]

Medical ethics programme in brief has to take into account multiple perspectives, patients, relation of patients, physicians, administrators, policy makers and public by and large, but not necessary in the order stated above. But if the interest of patients is not deemed primary, the medical profession as a whole will suffer. In fact, most, if not all, medico-moral problems arise due to skewed approach, in which the patient is treated as less significant in the overall health concerns.

Concern For Health And Health Care

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. A clarification regarding the context in which health care system functions is also necessary to formulate a medical ethics programme.

The involvement of public in the health care decision making is seen as a positive outcome of growing consciousness of health care among the public. Besides, the

development of democratic systems throughout the world has led to policy decisions depending upon the opinion of majority citizens who participate in the democratic processes. What is significant is the felt need on the part of policy makers to *promote* health of its denizens. McCormick's analysis of *moral responsibility for health*, discusses eight aspects that should be kept uppermost in mind while arguing for a bioethics programme.

Responsibility for health depend upon our understanding of what constitutes health which has undergone change in the history of medicine. Besides the evolution of the concept of health from identifiable *degenerative* process, *statistically defined* concept, concept based upon *functional inability* to the modern definition of *total well-being*, there are at any given time various conceptions of health depending upon the societal process. One of the features of contemporary understanding of health is that it is linked up with 'unhealthy' demands made on the society by way of cosmetic surgery, etc.

Cultural priorities also determine one's conception of health. There are according to McCormick, two types of structures, viz. *operational* (laws, welfare system, tax system etc.) structures and *ideological* (societal, economic and political beliefs) structures, that determine health care system and its functioning. Health is very much affected by the life style of the people of the society, by the emphasis the society lays on leisure, sports, etc. Another offshoot of the cultural priorities is *public morality*. In a society that has developed secondary values based upon the interest groups of

various individuals, there is danger of individuals (patients) being mistreated. McCormick points that under such a system where group practice, insurance coverage etc. function, the poor, retarded, elderly patients are likely to suffer most.

One of the most important distinguishing mark of contemporary health care and medical ethics is the shift from concern for *life as life* to *quality of life*. The question today is not merely preservation of life or avoidance of disease, but what type of life. This dimension of quality of life gains prominence particularly in the case of comatose patients, extremely defective new-borns, mentally retarded children, etc. To what extent health care should be extended to such 'patients' is a dominant moral question. Compounded with this is the problem of magnitude of the health system. Contemporary health care system has grown so large by way of number of patients it caters for and the detail regulations governing it, that an individual is more often treated against his will or without his or her permission. The lesson that the medical community has learnt from the famous Karen Ann Quinlan case is that when a health care system grows large, it tends to be indifferent to patients' desires and interests. Patients and guardians of patients are made to struggle to subtract themselves from the systematic or institutional treatment and to assert the fact that when a patient enters a hospital or puts himself in the hands of the physician, he engages his services and does not abdicate his right to decide his own fate.

McCormick refers to *moral conviction* as one of the dimensions of responsibility for health. He refers to 'sensitivity' and 'emotional involvement' of individual members of

the society, which is particularly important in the case of health care of elderly, infants, retarded and the poor. "Passions", points out McCormick, " is the beginning of any true moral responsibility and therefore of responsibility for health. It is the inner identification with the suffering and the downtrodden. It is that personal start up that gets us off-center a bit - self-center - and propels us to examine our consciences, comforts and priorities."[18] That culture and social factors play a very significant role in determining the health care system and medical ethics is obvious from comparative studies available in various journals of bioethics and biomedicine.

Ethnomedical Studies Of Medical Ethics

The ethnomedical studies of medical ethics have been pointing to the fact that there are no universal claims in the healing or health care system - the claims are to be understood 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 studies medical practices in different societies, taking into account the social and cultural factors. These include belief systems, attitudes, behaviour and actions relating to illness and attempts to deal with it. Ethnomedicine analyses primary concepts of medical ethics and 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 is realised. Horacio Fabrega discusses "the *objects* of concern (e.g. illness, disease), the culture-specific *conceptualisations* about them (e.g.,

explanatory models, theories of illness), the *values* and *symbolic meanings* surrounding illness and how these develop and are manifested (e.g. semantic illness networks, idioms of distress), the *persons* who treat illness (e.g., practitioners, shamans), and the *social practices* and *institutions* that embrace all of these (e.g., social relations of sickness, mode of production of medical knowledge) ...*medical ethics*, the precepts and standards of how practitioners should conduct their work given their status in the society."[19]

Ethnomedical perspective presupposes cultural relativism and consequently on the basis of variation in beliefs, feelings, behaviours, traditions, social practices etc. of the diverse people's and societies, argues for culture specific 'medical ethics'. As Fabrega argues: "The critical 'objects' that medical practitioners deal with, namely, persons and illnesses, are culturally constituted and epistemologically related: viewed generically, illness is a state of social/psychological/moral disarticulation, and healing is the process designed to undo this."[20]

Fabrega, after conducting a comparative study of culture specific medical ethics observes that contemporary European societies are dominated by the biomedical theory of illness, identified as: "the real or possible existence of an underlying state of *disease* (disordered physical-chemical or physiological systems) ... all important in the professional conceptualization".[21] In such a model of understanding illness, lay theories (what bioethicians will recognise as patient perception of illness) are neglected. Fabrega, like phenomenologists points out that "physicians pursue their

tasks by developing an alliance with the person ill and attempting to conduct a dialogue with him/her about a *disease*, which is seen as housed in the abstract and/or objective body. To the patient, on the other hand, the behavioural and phenomenological illness is the key concern, and it is part of his/her subjective body. In short, the body of the person and the body the physician diagnoses and treats are in some ways ontologically distinct."[22]

That the actions of the physicians are not merely directed towards alleviation of suffering due to illness and that physicians carry social functions such as disability determination, social policy related diagnosis, decisions regarding isolation is obvious. 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 which treat 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. In words of Fabrega ,Western biomedicine has demonstrated that it has the "capacity (1) to alter the way bodies function as well as (2) the way in which lives can be sustained and lived; (3) to promote ugly and traumatic terminalities

of life; (4) to transform images of persons who live as less than whole objects; and (5) to create possibilities for human experimentation."[23] In view of far reaching consequences of biomedicine and medical practice, medical ethics will have to involve not only physicians but also sociologists, politicians, economists, religious persons, community representatives, and moral philosophers. In fact, physicians form a very small segment of persons involved in the medical practice and have limited understanding of problems and issues involved in biomedicine and biomedical and ethical issues.

As much as social scientists have a significant role to play in the biomedical processes and its consequent ethical developments, physicians have a distinct social role to play within the context of medical practice. In fact the historical, social and cultural dimension of medicine is not an incidental one, it is essential to the ethical problem and its resolution. Robert B. Pippin[24] while analysing the problem of social authority of the physician pointed out that the physician has the "authority" what to do and what not to do with the patient, make decisions regarding the state of the patient, for e.g. whether he is serious, whether he will recover from illness etc. And in order to exercise this authority, the physician should be knowledgeable about the drugs and treatment, must be able to diagnose the illness, be able to determine who is sick and who is not. Certain actions of the physician are permitted by law. For example, dispensing drugs and medicines, certifying extent of injuries etc. are recognised and accepted by law. In short, a physician has authority not only because he is authorised or permitted to intervene in the case of an ill person, but more significantly because "of a belief in the

physician's superior expertise, and because of some sort of trust that a physician will make use of such expertise beneficently, in consideration only or mostly of the patient's welfare and/or autonomy, and not for a mere profit, or in consideration only or mostly, of the outcome of some peer panel's evaluation..."[25] The social authority the physicians enjoy depend upon the willingness of the society to 'create' positions of authority, and provide 'legal sanction' in some cases. Evidence suggests that physician's social authority has undergone a dual transformation due to advances in biomedicine and patients' awareness of his own right of self-determination. Advances in biomedicine have led to ethical dilemmas that 'defy' easy resolution and calls for deeper moral considerations regarding the status of patient and the nature of treatment. Societal awareness of such radical changes in the norms of treatment and its implications has resulted in patients' (guardians') demand for more meaningful and significant involvement in the treatment of the patient as they have the fundamental "natural right" to know, accept or reject treatment dictated by the physician. Compounded with this 'right to information' regarding one's illness and treatment, is the awareness of undesirable changes observed in the medical practice by way of illegal and forced organ transplants, female foeticide, post sex determination tests, admissions on payment of huge capitation fees, redundant referrals, second opinions, unnecessary caesareans, etc. All this has led to, on the one hand creation of legal provisions specifying areas of social authority, and on the other hand sanctioning of restrictions in order to curb the growing tendency on the part of physician to misuse authority.

The question of social authority tends to be more specific if we reflect upon the nature of social reality that medical practice is. 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. It is a kind of social reality, wherein physicians, patients and interested others participate. Mark J. Cherry defines medicine as a social reality that "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."[26] 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. As Cherry puts it: "To use the language of disease is to place patients within a particular set of medical and social expectations"[27]. The classic example of alcoholism and nicotine addiction as a disease that is open to diagnosis and treatment as in the case of other diseases, highlights the nature of involvement of social meanings in the medical conceptualisation of reality. Alcoholism and nicotine addiction as drug addictions are serious health problems understood within the framework of social expectations and value presuppositions. The cultural differences of the physicians, the varying moral and evaluative presuppositions in the understanding of alcohol consumption or smoking tobacco as a moral defect, a recreational activity or an expression of personal freedom, result in significant changes in the approaches to disease in medical practice. Medical practice is thus seen to include wide range of considerations, medical, moral, social, religious etc. In brief, the social reality of medical practice is "constructed within the interaction of physicians,

patients, institutions, and society, with the acquisition and allocation of health care resources, and definitions of death, futility, and disease".[28]

Another important dimension of medical practice is the interpretative character of illness and disease. In the first chapter, there have been attempts to show how 'objective' illness diagnosed by the physician is different from 'perceived illness' by the patient. At this stage, it is pertinent to analyse what constitutes 'objective' illness and how objective it may be. The debate regarding the nature of medical diagnosis poses the question whether diagnosis without physicians is possible. The 'standard view' that physicians are indispensable for diagnosis of illness/disease has been questioned by many scholars. James G. Mazoué in "Diagnosis without Doctors" studies the arguments put forward by various exponents of 'standard view' and concludes that although the existing diagnostic systems do not make a definitive diagnosis, it is not technically or practically impossible to develop such a diagnostic software. He further hopes that the pace of current research if maintained will ultimately develop a software that challenge "the physician's traditional role as the primary locus of medical decision making."[29] Mazoué while challenging the 'standard view' studies technical difficulties, semantic problems, practical issues and valuational concerns which form the basis of arguments in favour of 'standard view'. The *technical* difficulties expressed regarding the existing diagnostic programmes, namely, that they are unable to understand the pathophysiological causes of a disease process, temporal evolution of the disease process, failure of mathematical models to take into account the interdependence of clinical parameters, and unable to recognise the involvement of multiple disease

processes in clinical presentation, according to Reggia and Peng,[30] do not exclude the possibility of developing more comprehensive models of diagnostic reasoning. Secondly, 'standard view' believes that the existing diagnostic programmes cannot get meaningful information from patients without the involvement of a medical practitioner. There is, in short, a *semantic* gap between the medical world and the diagnostic tools. It is only the involvement of human interpretative mind (of medical practitioner) that can bridge this gap. Mazoué[31] argues that new programmes, some of them are already in use, are expected to clarify the 'fuzzy' medical terms and eliminate the uncertainties surrounding their use. Thirdly, the *practical* difficulties encountered to create a centralized knowledge-base for diagnosis by computer will make it impossible to implement such a programme. Such a programme will not be cost-effective, will be vulnerable to tampering, and incapable of controlling inconsistent information. Mazoué responds to these practical problems by arguing that all the three difficulties listed above can be effectively dealt[32] with. The diagnosis by computer, the 'standard view' argues, cannot account for the 'correct' *clinical decision* that the practitioner has to make. Such a decision does not depend merely upon diagnosis, but also on estimate of success, benefits, costs and risks and also the patient's perspective of illness. The above *valuational concern* has not been taken seriously by the anti 'standard view' theorists, who even dismiss the concern for *patient's perspective* by arguing that the persons who assist the patients in making medically informed decisions do not have knowledge regarding the pathophysiological causes of disease.[33]

Randolph A. Miller,[34] while criticising Mazoué's critique of 'standard view' points to different definitions of 'diagnosis' which cannot be accounted for. A simplistic definition of diagnosis as 'the placing of an interpretative, higher level label on a set of raw, more primitive observations' may justify 'anti-standard view' as automated systems will outperform medical practitioners. Defining diagnosis as "a mapping from patient data (normal and abnormal history, physical examination, and laboratory data) to a nosology of disease states" is an inadequate description of diagnosis.[35] A more exhaustive definition is that diagnosis is "the process of determining by examination the nature and circumstances of a diseased condition" [36] The diagnostic process requires that the physician knows about the patient's life history, the state of the person before the illness and after the illness as well as the patient's response to the illness he is suffering from. All this analysis cannot be undertaken by an automatic system, it does require a physician to undertake this task.

Mazoué's claim that "we are fast approaching the point at which it would be more correct to refer to *human-assisted computer diagnosis* rather than computer-assisted diagnoses made by practitioners."[37] is based upon the man-the-machine model. Human diagnosticians (physicians) play an important role in interpreting the history of the patient, the impact of illness on the patients' life, etc. This cannot be undertaken by a machine (computer) however sophisticated it may be. It is difficult to visualise "human-assisted computer diagnosis" becoming a reality for the next decades, since there are limitations as far as the functioning of the machines vis-à-vis diagnosis is concerned. As of now, there is no software that can make diagnosis and consequently

replace the physicians. It is granted that computer based diagnostic support systems would add to the list of facilitating techniques, but cannot carry out the essentially interpretative activity of diagnosis. 'Diagnosis' is an *art* of interpretation that is acquired through a long process of apprenticeship under the guidance of experts or senior colleagues. For that matter, even medicine as a whole is regarded as an art trying (sic. pretending) to be a science. The essential nature of medical practice, from diagnosis to treatment, is the unique interaction between the physician and the patient.

Physician-Patient Relationship

Rapid changes in medicine and medical practice has 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 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. Similarly, after the spread of AIDS, there is radical questioning on the question of confidentiality of the medical information and the role of physician in this regard. Are the physicians to continue to keep confidential the medical information regarding AIDS at the cost of exposing other individuals the risk of infection?

One of the central issues that dominate discussions on medical ethics is physician-patient relationship. Every Code of Ethics devotes considerable part to this

unique relationship the features of which seem to render medical practice ethical or unethical.[38] The physician-patient relationship is described in terms of *dependence* and *trust*. As McCormick points out, "doctor treats not only a disease or a wound, but also a person with human hopes, desires, fears, failings, and worries."[39] The understanding nature of this relationship is intimately bound with the medical practice, so much so that the medical practitioners are weary of governmental or legislative intervention. Eric J. Cassell[40] describes the characteristic features of physician in therapeutic relationship. The physician has the technical expertise, training and experience together with the system of reasoning, knowledge and care because of which medicine is capable of removing the mystery surrounding the illness. Secondly, the physician's interpretations of illness are culture determined and hence the patient and physician are bound within a belief system. Such a belief system is true for the period but invariably inadequate as science progresses. Thirdly, the physician consciously or unconsciously addresses to issues in the healing process which go beyond the casuistic doctrine. He brings in the system of relationship, personal, moral and other concerns for the patient. Fourthly, the physician's capacity to be involved in technical as well as moral aspects of the medicine affords him to legitimise the role of patient as 'sick' person in the society. His decisions makes it possible for the sick to re-enter the society as healthy person. And finally, physician in his continuous and at times long interaction with the patient, transmits his beliefs to the patient. Different physicians may transmit different beliefs to the patient and in turn be influenced by the beliefs of the patient. There is, in other words, a mutual influencing between patient and physician in this therapeutic interaction.

The patient in therapeutic relationship with the physician seems to depend upon his upbringing from infancy wherein he learns to recognise and express those symptoms which are seen as problems by the physicians. Secondly, the patient being unable to lead a normal life enters into relationship with the physician with honesty, sincerity and trust and makes his body accessible to the physician in ways one does not accord access to strangers. Thirdly, the patient bestows on the physician the monetary benefits that are in consonant with his work. Fourthly, as a matter of control the patient seeks second opinion from specialists, questions the diagnosis and treatment so that there is compulsion on the part physician to review, consult and improve his knowledge .

The problems related to physician-patient relationship has implications for other issues such as patient's right to be informed, confidentiality, canon of informed consent, etc. Some of these issues shall be discussed in the next chapter. The physician-patient relationship is strictly governed by the code of confidentiality. The Hippocratic oath refers to *confidentiality* as "whatsoever (I) shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets."[41] Confidentiality has come under strain in recent past due to various changes in societal conditions and medical practice. The introduction of group practice, referrals, taped or recorded interviews with patients, etc. all contribute towards dissipation of confidential information the patient provides to physicians. Secondly, the hugeness of the system, mechanisation and depersonalisation of health care, etc. is

another cause of undermining of confidentiality. Thirdly, the involvement of paramedics and non-medical personnel in collection and preservation of medical records, creates a situation in which confidential material reaches to people other than physicians. The above changes in medical practice leads to 'deprivatisation' of physician-patient relationship. But the most important of all these changes is the 'casual' attitude on the part many physicians while dealing with confidential information.

Contemporary medical practice has changed from being 'private practice' to 'impersonal' hospital based public health care system wherein physicians do not or need not interact with the patients. Besides, there are areas of human development where there is felt need of confidentiality vis-à-vis relations of patients in the new social order. For example, adolescent children do not wish that their parents know about their health problems such as resultant from their sexual behaviour. The question is whether the physician should keep information regarding the minors confidential from the parents. Or, should the physician keep confidential the information regarding heart problems of a pilot from the security or that an individual is HIV positive from the fiancé of the person. These are not merely moral dilemmas but issues that go to the very centre of physician-patient relationship. Another important aspect of the physician-patient relation comes out of the Karen Ann Quinlan case. The parents struggled to subtract their daughter from jurisdiction of the physicians, who kept physically alive brain dead Karen with extraordinary life systems to which she was plugged in. The main question in the case was whether the physicians have the *right* to

treat the patient unasked? The ending of the case only reasserted the fact that an individual has an obligation to care for his health, and consequently the right to basic health care. But when an individual approaches a physician for treatment, he does not *abdicate* his right to decide his own fate. The implication of the case is such that the subtle physician-patient relationship underwent changes. Patient's right to self-determination vis-à-vis physician was upheld whereby it was felt that the position of physician was weakened.

Some professionals in the field, however, seem to have different approach to this issue. Any negotiation with a particular patient regarding his or her treatment, will involve the physician in negotiation with the profession itself. The professional may argue that if a patient wants to be treated, he or she better not ask questions, and in this way would get the best of treatment and the physician will have time to treat other patients. Such an attitude among the professionals clearly asserts the autonomy of the profession and raises serious questions regarding the fundamental freedom of the patient to choose treatment. But in a system wherein physician dominance over the patient is reinforced, it is necessary that a balanced approach be followed.

More light will be thrown on physician-patient relationship if we turn our attention to physicians as professionals and their perceived role. As professionals, physicians are interveners in the basic concern of man, namely, death, deformity and disability. It is not surprising then that the role of healer in the primitive society and physician in the contemporary society seems to coincide. The healer in the primitive society (where the

distinction between physical illness and spiritual decay did not exist) acted not only as a physician but also as a priest. Contemporary medicine seems to have become so powerful that it appropriates to itself the role of taking care of life and death, to such an extent that almost magical properties are assigned to it.

The more sober members of the profession see their role as meeting the health care needs of individuals, meeting the health care needs of societies, gain income, prestige and respect from the profession, creating future professionals and 'create' and acquire new knowledge for the benefit of mankind. [42] The goal of 'doing the best' for the patients or avoiding unnecessary harms justifies the practice of experimentation and consequently advancement of knowledge of medicine. Engelhardt points out that these objectives of medical profession is the "utilitarian understanding of the obligations ... intertwined with the focus on individualistic and often deontological obligations to particular patients."[43]

While discussing the notion of social authority of the physician we have seen how such an authority is based upon societal/legislative sanction and the healing capacity of the physician. Social authority of the physician also affects the physician-patient relation in a significant manner. Although some sort of uncompromising respect for the patient, however illiterate or superstitious and irrational he may be, is the basic presupposition of medical practice, there is however some form of domination which does not go along with the respect for the patient. In fact patient is situated in a condition of uncertainty wherein patients have unsuspected trust on all that is related to medical

practice and physicians. This trust reinforces the authority of physician[44] vis-à-vis the patient. But such an authority as a representative of institutional power (political, social or economic) would render the physician-patient relationship suspect. It would be, therefore, necessary to distinguish between the legitimate authority of the physician and other forms of authority linked to maintenance of power or class interest with or without involvement of physicians.

One of the issues that has become focus of attention in physician-patient relationship in recent times is the understanding of body from women's point of view. It has been a source of controversy whether the understanding of body that is available in the bioethical discourse in general and in the context of therapeutic relationship in particular is a gender bias understanding.[45] It is the sex-role stereotypes that seem to determine the physician's attitude towards women patients. This is clearly reflected in the health care practices and even the cultural reflections of certain communities. It is not that women patients outnumber men patients in the general health care system because women have longer life span than man. The most crucial distinguishing mark between men and women, namely, women have to perform a positive 'life-affirming feat' of bearing and nursing children, is often regarded as an illness rather than a normal human phenomenon. Physicians seem to be influenced by folk lore and primitive societal norms while dealing with changes that occur in woman's body both as a preparation and actual performance of life-affirming feat. Feminists have even highlighted the fact that there are more men in the medical profession than women and this is so even in specialised field of gynaecology.

The traditional model of physician-patient relationship is viewed by feminists 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 seem to 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 whereas the man-woman relationship 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 (redundant) by healing the patient. Feminists recognize another feature of physician-patient relationship comparable to the relationship between genders. In words of Mary B. Mahowald, "just as a man needs a woman so as to express his (hetero)sexuality, so the doctor needs a patient in order to be a doctor and vice versa. But the woman or the patient is essentially a receptor of the other's strength or expertise or sexual drive. Accordingly, "complementarity" here describes a fundamentally inegalitarian relationship: the woman and the patient are similarly passive and vulnerable."[46] We have seen how paternalism practiced by physicians ignores the patient autonomy and consequently reinforces inegalitarianism wherein physician becomes independent agent and patient dependent communal. It is obvious that the paternalistic model is inadequate and threatens patient autonomy leading to many of the moral issues faced by modern medicine. Alternatively, patient autonomy

model with its emphasis on informed or proxy consent, is also inadequate as the roles get reversed thereby questioning the autonomy of medical profession and health care decisions. Mary B. Mahowald proposes 'collaborative model' as alternative to paternalism and patient autonomy model.[47] In most general terms, collaborative model envisages that physicians respect the autonomy of the patient and patients respect professional autonomy of the physician. This model on the one hand rejects the idea that the physician is solely responsible for patient and consequently he is superior to the patient, on the other hand, recognizes usefulness of patient's experience and reflection for the medical practice. Patients while asserting their right to self determination in health care matters, recognize that the health professionals are endowed with knowledge and expertise that is beneficial to them and any questioning of this expertise may undermine the profession. In short, physicians and patients "manifest both passivity and aggression, emotion and reason, community and agency - all of the attributes stereotypically assigned only to one sex or the other."[48]

One area of bioethical concern that has been left out from the mainstream discussions is "chronic illness". At one level chronic illness is understood as a grade of illness, at another level it must be recognised as a distinct type that calls for a distinct approach. In terms of numbers more people suffer from chronic illness than illness leading to sudden death or rapidly progressing fatal illness. Some chronic illnesses are related to old age where there is distinct reduction in physical and intellectual abilities. The most important characteristic of chronic illness is increasing and permanent dependence on physicians and others for survival. The problem of chronic illness has been accentuated

by the fact that there are more and more elderly people living in this world than ever before because of advances in medical technologies. This has led to a large population of elderly people all of whom have to be considered as suffering from "chronic illness" and which calls for a new public health policy with increasing and prohibitive costs.

Addressing to the questions of understanding the meaning of chronic illness and the ethical implications thereof, B. Jennings, D. Callahan and A. Caplan demanded special attention and support for chronically ill patients so that they can live a meaningful and satisfying life. They argued that the lack of proper understanding of chronically ill patients is due to the model of medical enterprise we have developed based upon acute illness. The above authors identified three related models to the autonomy paradigm on the basis of which medical practice has so far been articulated. "Medical model" defines illness as a sudden threat to the individual who is normal and healthy, and medicine has to intervene to remove this threat. Secondly, "individualistic model" of person recognises individual as autonomous or free from external constraints, and prior and independent of social milieu. And finally "contractual model" which sees that a patient (who is rational and self-interested) when threatened by illness makes a contract with the physician and temporarily submits to his authority in order to be cured from illness.[49] The three authors had concluded that the dynamic and transformational aspects of chronic illness requires that we change the notion of patient autonomy and physician's duty to respect or enhance autonomy. In brief, the autonomy paradigm was regarded as inadequate for chronic care.

It is true that there has been tremendous strain on health care services, particularly during the last decade of the century. The situation both in the developed and underdeveloped countries is going to be more acute during the next century. The demographers predict that there would be large populations (almost one third of the total population) who are senior citizens most of whom with problems related to old age and chronic illnesses. Governmental agencies have demanded that professionals and others re-examine or revise our understanding goals of medical practice particularly vis-à-vis medicine.

Daniel Moros and others while pointing out that the autonomy paradigm is itself misconstrued, the distinction between *acute* illness and *chronic* illness is not as radical as it is made out to be. In words of Daniel Moros: "The doctor provides acute care to many individuals - some young, presumably 'normal' and healthy - others elderly, independent but fragile - some with ongoing, identifiable but at the moment quiescent illness - others struggling with active disease and disability, and in this latter group new difficulties may be part of the ongoing disease process ... or some unrelated problem."[50] For example, a person with pulmonary disease develops an acute pneumonia or when a trauma or burn case after undergoing amputation undergoes reconstructive surgery for years, a woman treated for carcinoma of the breast, has a relapse after many years and has to undergo long drawn treatment. The above cases clearly demonstrate that the distinction made by Jennings, Callahan and Caplan between chronic illness and acute illness is unacceptable. A distinction between chronic illness and acute illness may be made on the basis of costs and/or benefits to

the patient and implications to the society - but no new ethical implications can be drawn from such a distinction.[51]

Further, 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 simplistic contractual view expressed by Jennings, Callahan and Caplan. Again, medicine and medical practice (in spite of its limitations and abuses) cannot be measured in terms of consumerist criteria. A physician is not a professional contractor that offers his services for a fee to a medically literate or illiterate client. The terms 'service', 'consumer', 'contract' etc .undermine the medical profession and is capable of imbibing suspicion in a rather unique physician-patient relationship. 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. There may be conflict between the rights of the patient and that of physician regarding the extent of medical intervention, but to assume on the basis of 'autonomy principle' that physicians can or may decide to intervene or not to intervene or to what extent they may intervene, is the source of the malpractices and abuses in the profession. It is precisely because of this that one is compelled to believe that "medicine is too important to be left in the hands of doctors alone."

NOTES

[1] Roy A. Sorensen in "Rationality as Absolute Concept", while trying to define what is "rationality" had proposed that a negative model of understanding may be more enlightening than a positive articulation. Sorensen recognised many concepts in ethics are better explained with negative 'definitions' of the nature of 'what a thing or concept is not'. For instance, 'health' is understood in terms of absence of diseases, 'peace' in terms of absence of violence and 'liberty' in terms of absence of coercion and obstacles'.(*Philosophy*, Vol. 66, No.258, 1991, pp.473-486.)

[2] George H. Hauck and David W. Louisell, "Medical Malpractice", *Encyclopedia of Bioethics (EB)*, Vol. 3, p.1020.

[3] Ibid.

[4] Cf. H. H. Titus, *Ethics for Today*, N.D., Eurasia Publishing House, 1966, p.223.

[5] David Mechanic, "Therapeutic Relationship: Contemporary Sociological Analysis", *EB*, Vol. 4, p. 1669.

[6] Bernard Häring, *Medical Ethics*, Slough, England, St. Paul Publications, 1972, p.25.

[7] Richard McCormick in *How Brave a New World - Dilemmas in Bioethics,* N.Y.,Doubleday & Co., 1981, says that one's outlook to life, death, suffering and eternity, rather than indoctrination is the basis of medical ethics.

[8] For a brief discussion on the religious significance of teaching of medical ethics see articles by Lucille F. Newman, Darrel W. Amundsen, S. P. Asper, and Fuad Sami Haddad, Seymour Siegel, O. P. Jaggi, and others in "History of Medical Ethics" ,*EB,* Vols., 2 & 3.

[9] The exception to all this would be *Oath of Soviet Physicians*, approved by Soviet Union in 1971 which makes no reference to any religious beliefs or practices.

[10] cf. Richard McCormick (1981), p.21.

[11] It is important to distinguish between Code of Ethics and code of conduct. The code of conduct is essentially meant to protect the professional interest of its members and ensure that no services rendered are inappropriate to the profession. It insures that other professionals in the field do not get bad reputation due to malpractices by some. Bernard Häring distinguishes between *ethos* ("comprises of those distinctive attitudes which characterise the culture of a professional group in so far as this occupational subculture fosters adherence to certain values and the acccptance of a specific hierarchy of values"), *ethical code* ("concrete effort to ensure definite norms" to foster and guarantee the ethos), *medical ethics* ("represents a systematic effort to illumine the ethos and

to elaborate the perspectives and norms of the medical profession") and *morality of the physician* (physician's capacity to act according to well-informed conscience and to make concrete decisions with an upright attitude, and with insight and discernment").(Bernard Häring, (1972), pp. 24-25) It is obvious that there is overlap between ethical concerns and nonethical ones in the discussions of medical ethics. Bernard Häring's distinctions though significant at one level, are best understood in terms of twofold concerns observed in the discussions on medical ethics, namely, those expressed in Code of Ethics and Code of Conduct.

[12] Developments in biomedicine, biotechnology and medical technology in the recent past not only highlight the need for rewriting of the medical ethics codes, but calls for rearticulation of the problems and issues which were deemed to be unquestionable truths. The 'factual' presuppositions of many ethical codes based upon certain metaphysical beliefs undergo changes, there is need of reorganizing our knowledge of what constitutes the moral practice. *In-vitro* fertilisation in late sixties and cloning in recent times, has 'undermined' the metaphysical presuppositions of human sexuality and family.

[13] Robert M. Veatch, "Medical Ethics Education", *EB*, Vol. 2, p.873.

[14] cf. McCormick ,(1981), p.18.

[15] Ibid. p. 21.

[16] Ibid. pp. 24-29.

[17] Ibid. pp. 29-30.

[18] Ibid. p. 45.

[19] Horacio Fabrega, "An Ethnomedical Perspective of Medical Ethics", *The Journal Of Medicine And Philosophy (JMP)*, Vol. 15 , No.6,1990, p. 594.

[20] Ibid. pp. 594-95

[21] Ibid. p. 609.

[22] Ibid. pp. 609-610.

[23] Ibid. p. 612.

[24] Cf. Robert B. Pippin, "Medical Practice and Social Authority", *JMP*, Vol. 21, No.4,1996, p. 420.

[25] Ibid. p. 420.

[26] Mark J. Cherry, "Bioethics and the Construction of Medical Reality", *JMP*, Vol. 21, No. 4, 1996,p.357.

[27] Ibid. p. 361.

[28] Ibid. p. 368.

[29] James G. Mazoué in "Diagnosis without Doctors", *JMP*, Vol. 15, No. 6, 1990, p. 575.

[30] J. A. Reggia and Y. Peng, "Modeling diagnostic reasoning: A summary of parsimonious covering theory" *Computer Methods and Programs in Biomedicine*, 25, pp.125-134, referred to in James G. Mazoué, (1990), p. 562.

[31] Cf. James G. Mazoué, (1990), p. 563.

[32] Ibid. p.564.

[33] Ibid. p.565.

[34] Randolph A. Miller, "Why The Standard View Is Standard: People, Not Machines, Understand Patients' Problems", *JMP*, Vol. 15, No. 6, 1990, pp. 581-591.

[35] Cf. Ibid. p. 583.

[36] Ibid.

[37] Ibid. p. 588.

[38] For historical description of physician-patient relationship refer to Pedro Lain Entralgo, "Therapeutic Relationship: History of the Relationship", *EB*, Vol. 4, pp. 1655-1662.

[39] Richard McCormick ,(1981), p. 27.

[40] Eric J. Cassell, "Therapeutic Relationship: Contemporary Medical Perspective", *EB*, Vol. 4, pp.1673-1674.

[41] H. T. Engelhardt, *The Foundations of Bioethics*, N.Y., Oxford University Press, 1986, p. 297.

[42] Cf. H. T. Engelhardt, (1986), p. 254.

[43] Ibid. p. 255.

[44] Robert B. Pippin points out that (a) conscientiousness about patient autonomy, (b) a general good faith dedication to fairness and social justice in the institution of health care, and (c) a general watchfulness about various forms of bias and prejudice already built into the language or discourse of health care negotiations, are the salient features of the authority the physician exercises over the patient.(1996), p.432.

[45] In this chapter, the feminist perspective that is being referred to is only in elation to physician-patient relationship. No attempt is made articulate the complex problems that gender studies have thrown up and the vast literature that has developed around this theme.

[46] Mary B. Mahowald, "Feminism and Medicine", *Journal of Social Philosophy*, Vol. XVIII , No. 1, 1987, p. 4.

[47] Historically, *liberal feminism* discourages paternalistic model and consequently disfavours patient autonomy as it would result in lack of respect for women physicians. *Radical feminism* advocates patient autonomy exclusively in the context of women on the ground that women should care for their health, this is particularly in the case of reproductive processes. The socialist or Marxist feminism favours the *collaborative model*.

[48] Mary B. Mahowald, (1987), p. 6.

[49] Cf. B. Jennings, D. Callahan and A. Caplan, "Ethical Challenges of Chronic Illness", *The Hastings Center Report*, 1988 (Special Supplement), p. 8, discussed in Daniel A. Moros, Rosamond Rhodes, Bernard Baumrin, and James J. Strain, "Chronic Illness and the Physician-Patient Relationship: A Response to the Hastings Center's "Ethical Challenges of Chronic Illness"", *JMP*, Vol. 16, No. 2, 1991.

[50] Daniel A. Moros, Rosamond Rhodes, Bernard Baumrin, and James J. Strain, (1991), p.166.

[51] Cf. Ibid. pp. 168-175.

CHAPTER III: INFORMED CONSENT AND MEDICAL PRACTICE

In the last chapter attempts have been made to lay down a general framework within which the medical ethics functions. In this context, the unique physician-patient relationship was discussed. But the most important problem in the juxtaposing of patient and physician is the issue of patient autonomy versus 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 the present chapter an attempt is made to understand the crucial concept of consent and its centrality in the understanding of medical practice.

Issues in bioethics tend to be sensationalised and gain status depending upon the dilemmas associated with it. In comparison the issue of consent seems to have very little interest except with reference to other issues where the question of consent becomes pre-eminent, but even then it is discussed as a secondary topic to main issues such as euthanasia, experimentation, abortion, etc. The question of consent may occur secondary to other issues, however, it is deemed implicit to all topics of biomedicine.

There is no simple and well defined idea regarding what constitutes consent in medicine. Medicine has at one level to depend upon legal use of the term and at another level the legal doctrine is not adequate enough to account for the implicit and explicit meanings that medical practice attaches to the term. *Consent* in legal

terminology means "voluntary agreement compliance or permission. Section 13 of the Indian Contract Act lays down that two or more persons are said to consent when they agree upon the same thing in the same sense."[1] Consent 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.

Doctrine Of Informed Consent

The doctrine of informed consent was introduced with a view to delineate 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. The objective of the doctrine was to protect patients' rights and ensure that the patients are not exploited by the physicians. Although the doctrine has been in force for almost half a century, there has been lot of confusion in the legal circles regarding the implications of such a doctrine. Besides, in practice, there has been little or no compliance of the doctrine, except in the case of surgery on the patient.

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. Hippocrates had ordered the physicians to "Perform (these duties) calmly and adroitly, concealing most things from the patient while you are attending to him. Give necessary orders with cheerfulness and serenity, turning his attention away from what is being done to him; sometimes reprove sharply and emphatically, and sometimes comfort with solicitude and attention, revealing nothing of the patient's future or present condition."[2] Even other codes promulgated by the association of medical practitioners have never envisaged the need for complete disclosure. In the case of research, there has been indications that consent of the patients be obtained and that the patients be fully aware of the implications of the treatment sought to be administered. But in the case of mere therapy, there has been no statement from any authority that makes it mandatory that the patient be informed and informed consent obtained before any medical intervention is carried out.

Scholars of the subject have pointed out that in many cases the legal doctrine of informed consent is bogged down in rhetorics and common place clichés that often do not have legal interpretation and binding. Some even conclude that "informed consent" is a creature of law and not of medical practice, and that the judges ruling in many cases are not aware of the medical tradition right from Hippocrates to contemporary medical codes. Even when judges took up legal matters in relation to

'informed consent' there were no precedents to fall back upon nor there were theoretical and practical guidance from the medical profession that the judges could follow. In due course of time, more specific guidelines were developed within the context of tort law. If the medical profession had voluntarily been more open to patients' desires and concerns as a matter of its own practice, then the judges and legislators would not have intervened. Medical practitioners would not have been advised by lawyers and judges as to what should be their attitude to patients. It is the reluctance on the part of physicians to critically evaluate their acts of negligence (what has come to be known as the "conspiracy of silence") which is primarily responsible for the governmental interference and frustration among patients, and has led to 'judicial activism'.

The question whether there was negligence on the part of the physician is to be decided legally on the basis of information supplied to the patient regarding the extent of disease, type of medical intervention and plausible consequences of the same. One of the important questions in tort law is whether the patient was competent to understand the information given to him and consent to the medical intervention proposed by the physician. Legal doctrine has laid down certain criteria to judge the *competence* to consent. 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. Competence or capacity to consent should be assessed individually in terms of the situation and judges do take into account

specific conditions while deciding whether there is negligence or not on the part of the physician.

Legal doctrine also lays down certain criterion for judging what level of disclosure is deemed adequate. Disclosure may be of *professional standard* ("is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances"), *reasonable person standard* ("average reasonable person" could deem relevant or material to the decision at hand), and *subjective standard* (takes into account "idiosyncratic views and character of the individual patient in determining disclosure").[3]

Engelhardt summarises the complex justification for informed consent in the following: Informed consent (1) "respects the freedom of the individual involved and provides authority for common endeavours; (2) it recognises that individual 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. One can thus give a justification for the practice of free and informed consent on the basis of the principles of autonomy and beneficence."[4] The seemingly clear cut guidelines seem to lead to many problems as individuals do not necessarily choose according to their best

interests. And in case of proxy consent, some guardians do not act with moral authority or their actions cannot be deemed to be extensions of individual's freedom.[5]

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 seen in negative terms. It is viewed as 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. In Stephen Wear's terms: "(It) is the cutting edge of the patient autonomy movement".[6] It is in this sense that there is insistence on the part of legislators and controlling authorities that consent is a prerequisite to all medical interventions, particularly when they are of serious nature.

In legal terms, informed consent involves information regarding (a) "diagnosis for which further investigation or intervention is proposed",(b) information regarding "the recommended intervention coupled with the significant benefits and risks attendant to it", (c) information regarding "the results or prognosis if no intervention is attempted" and (d) information "regarding any significant alternative modalities with their attendant risks and benefits".[7] This information, however, is to be provided only under certain conditions and informed consent be obtained. In other words there are situations in which the informed consent cannot or need not be obtained. For example, under emergency conditions when immediate medical intervention has to be taken the

physician under *emergency exception* may act without the informed consent. Similarly, when the patient gives up the right to be informed i.e. *waiver exception* and the physician is permitted to take all necessary steps on behalf of the patient. Again, in *therapeutic privilege exception*, the physician may not seek informed consent as he is convinced that disclosure may cause physical or psychological harm to the patient.

There are however areas of informed consent that have positive contribution to make to the physician-patient relationship. Informed consent does improve the care of patients. It performs this task "by facilitating autonomy through the provision of choice, and by increasing the patient's participation in his own care."[8] To see the issue as a threat to paternalism is a misconstrued notion. The information supplied by the physician concerning the patient's state of health must be such that the patient understands in his *own way* the implications of the diseased state and the implications of the course of treatment prescribed and plausible functional disabilities that may result while fighting the disease. Understanding in one's '*own way*' implies that the patient must not be kept in the dark about the painful truth of risks or suffering, nor should every detail of risk and hazards be given to the patient. The patient must know only those risks and hazards that any rational human being, can in the same position, take in, without unnecessary psychological tension.

Informed consent presupposes patient's capacity to know the subtle problems regarding disease and general presuppositions of medicine. In the general understanding of medical practice, informed consent cannot be deemed to medical

education, wherein patients are taught to recognise the seriousness of disease, the risk involved, what medicine can do and what it cannot do, the ethics of medical profession etc. Physicians, and more particularly, specialists, tend to be 'dismissal' of patient's right to information not on theoretical grounds or justification of paternalism, but because of their own inability to communicate with patients whose level of medical education makes it impossible to understand the presuppositions of medical practice. In fact, the most important problem faced by physicians dealing with more serious disease is that patients (and relations of patients) do not understand that medicine is not a science as physics and that decision regarding medicine is primarily a science of competing probabilities. And like science has paradigm shifts[9], medicine does undergo shifts in interpretation of disease and symptoms of disease.

Is it possible to have 'informed consent' on the part of the patient who is both physically and emotionally disturbed due to fear and uncertainty? Although legal definition of consent may make it mandatory on the part of the patient to give informed consent, it is questionable whether the consent is morally valid. The pain and suffering, the distress and anxiety, past experiences regarding disease may cloud the patient's rational abilities and hamper an objectively evaluated consent that is in his best interest. In the case of consent on behalf of someone else (proxy consent) the problems get more compounded and decisions regarding the course of medical intervention become uncertain and ambiguous. Such a situation compels medical practitioners assert their right to determine the type of medical action deemed right.

The nature of medicine as a science has a very serious implication for the informed consent. As mentioned earlier, medicine is not like physics and the casuistic approach to disease is not based upon laws of nature that are deemed absolute. Medicine is statistical in the sense the law like statements in the medical discussions are based upon data collected by medical 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, his attention may be focused on the negative percentage. In other words, the patient who is emotionally affected by the disease and is frightened of being disabled, will not 'see' that there are 90% chances for his recovery, but notice that there are 10% chances of being disabled for life or the disease may prove fatal. There may be greater harm in informing the risk of small statistical probability, which may be seen as a large threat to life.

Consent In Experimentation And Research

The question of experimentation in medicine is inseparable from that of medical practice, as there can be no progress without research and experimentation in the various fields. Besides procuring consent from rational well informed adults, there are areas where the experimentation by its very nature calls for 'proxy consent' and the 'objects' to be studied or experimented with are not adults with rational capacity to consent. Research in paediatric for instance is impossible without deemed or proxy consent. Similarly there are a number of other areas such as neurosurgery, cancer, etc. that need experimental situations to progress both in terms of diagnosis and cure.

Medicine, is relatively underdeveloped science (compared to physics, chemistry or even biology) and requires constant experimental inputs to solve problems and make progress.

That paediatric medicine needs human experimental inputs is obvious from the fact that experimentation with animals and adults are not useful as metabolistically they (adults/animals and children) differ significantly. Further children are not capable of giving 'informed consent' and parents are not always accepted as legally or morally capable of giving consent on behalf of the child. The Nuremberg Code[10] clearly makes it mandatory that all experimentation be conducted after informed consent is obtained, almost excluding any experimentation with children and mentally ill persons. Even the *International Code of Medical Ethics* categorically excludes experimentation with children except for therapeutic purpose. As H. K. Beecher argues: "Under *no circumstances* is a doctor permitted to do anything that would weaken the physical or mental resistance of a human being except from *strictly* therapeutic or prophylactic indications imposed in the interest of his patient."[11] If the above is taken literally, children together with mental patients are excluded from experimentation. The World Medical Association recognised the inadequacy of the codes and in its *Principles for Those in Research and Experimentation* stated that in the case of experiments with patients who are not capable of understanding implications or nature of experimentation, consent may be obtained from the individual who is legally responsible for the patient. Critiques, however question whether this provision is for experimentation that goes beyond therapeutic purposes or patient's good.

The *Declaration of Helsinki* was however explicit regarding the experimentation with children when it was argued in clause 3a that clinical research on legally incompetent may be undertaken with the consent of the guardian.[12] After this practically all the declarations and codes recognised the validity of proxy consent. Proxy consent was recognised as valid with regard to both established therapeutic procedures and as well as experimental therapeutic procedures. After the explicit reference to experimentation with children and mental patients, experimentation for the purpose of accumulation of scientific (sic. medical) knowledge became an accepted norm.

Moral theologians and those with orthodox Christian orientations argue that the law which tolerates proxy consent to any purely experimental procedure is without moral sanction as under this condition a human being is treated as a *means* only.[13] It may be useful if we understand the logic behind consent, legitimate consent and proxy consent so that 'dogmatic' and intransient positions are avoided.

To begin with, parental consent is morally justifiable in the case of the child as the parents recognise what is in the best interests of the child. And since life and health are the 'goods' that any child (if it was capable of deciding) would choose as goods of life and self-preservation, parents who decide the same for the child are performing a morally legitimate act. For example, parents may decide that a particular medical intervention has to take place for the survival of the child, the same is legitimate decision as it is beneficial for the child's self-preservation.

In non-therapeutic conditions, there are two possible arguments (premises) that one may resort to. As McCormick would argue, experimentation for non-therapeutic purposes may be treated as an "affirmation of one's solidarity and Christian concern for others (through advancement of medicine)".[14] In the case of a more secular position, experimentation for non-therapeutic purposes may be treated as a participation in common concern for growth of medical knowledge for the sake of mankind, part of which knowledge has already been used for the survival of the experimented individual. In any case, to be an experimental subject involves three different problems: some degree of risk, pain and associated inconvenience. To accept this would be an act of Christian charity or concern for future mankind. In short, proxy consent is morally justifiable provided in the case of both therapeutic and non-therapeutic experimental situations, the conditions laid down (in various declarations) for experimentation are strictly adhered to.

Patient Autonomy And Critique Of Paternalism

The basic concern of medical practice was to protect the patient and promote his well being regardless of all implications. Biomedical research however developed interests sometimes contrary to the medical practice and at times the interest of advancement of medical knowledge at all cost became the credo. Under these conditions physicians involved in biomedicine began to regard patients as "guinea pigs". Whether it is *Nuremberg Declaration* or *Helsinki Declaration*, the main objective of such documents was to ensure that no exploitation of patients is carried out in the name of

experimentation. And even if experimentation is deemed as necessary, then informed consent is to be procured. Legislation controlling research and experimentation and institutionalisation of controlling bodies came into existence to ensure that the fundamental objective of medical profession is upheld.

The paternalism based upon beneficence was commonly practised by the medical practitioners. It is only in the current 'over treating' scenario that medical practice seems to recognise patients and physicians as moral strangers. Physician is not necessarily seen as wise and beneficent as in the past. This is because medicine is today an enterprise pursued by physicians who develop only transient and temporary relationship with the patient. It is in this context that patient autonomy and informed consent are seen as, 'antidotes' to arrogant physicians and necessary mechanisms for protecting the rights and freedom of the patients.

While it is always argued that patients have freedom to seek or reject medical intervention, the question whether this freedom is respected in the medical practice has been debated. Besides, freedom is not freedom to choose medical help or not, but freedom to decide to what extent the medical intervention and care should be accepted or restricted. Under the influence of paternalism, this freedom in health care has been threatened and therefore patients are compelled to assert the freedom as freedom from interference, legitimised by informed consent. As pointed out in the earlier chapter, the assertion of freedom in this sense was partly due to the legal battles fought in Karen Ann Quinlan case and others.

Theoretically a patient suffers from dual deprivation of freedom in a diseased state. First, he is deprived of his freedom to function normally due to illness and secondly, under the influence of paternalism, the physicians deprive the patient of his freedom to choose the type of treatment etc. The defenders of paternalism cannot *a priori* assume that the patient has either lost the abilities to understand, evaluate and make choices or the same have been diminished due to fear, stress, pain, confusion etc. [15]

Clinical decisions involve value judgements regarding the risk, benefits, price, societal cost, etc. Informed consent could or should be used to decide what course of action the physician should take as the decision will have to depend upon the value of the patient. This is pre-eminently important in the context of secular and pluralistic societies where the value system of the patient and physicians do not necessarily coincide.

Stephen Wear has a dissent even while clarifying and defending informed consent. While agreeing that paternalism in contemporary 'assembly-line' medical practice may have lost justification, and alternatively, it may not necessarily involve 'across-the-board' provision of informed consent, Wear argues that the need for understanding the risky interventions, etc. is not to decide 'treat or not to treat' "but to appreciate and adapt to the threatened or actual changes in ... (the life) circumstances."[16]

There is another aspect of informed consent that needs to be understood. The moral and legal justification for informed consent seems to come from extraordinary cases, either involving terminal illness or involving extraordinary medical interventions. In majority of cases, neither the patients want to know the details of their illness nor want to get the expert and specialised knowledge that physicians use in clinical decisions. Even the most educated patients seem to have disinclination to understand the various details about their illness. They (the patients) seem to be content with the physician's understanding of the problem and the course of medical intervention he prescribes. Majority of the patients seem to have 'faith' in the ability of the physician and the physician's implicit concerns for the health of the patient. In other words, the principle of beneficence seem to be still widely accepted, to the extent that any negative implications of the treatment are seen as mistakes or 'hand of God'.

Due to the problems discussed above and some others that we shall see in the next section, physicians and moral philosophers began to suspect the character of informed consent. One wonders whether informed consent comes in the way of the healing process as it interferes in the unique physician-patient relationship and also creates a mental burden to the patient during a period of tension and anxiety. In other words, the question is whether informed consent is a myth and a harmful one for health care.

Alan Meisel and Mark Kuczewski[17] identified eight 'myths' about informed consent. There is insistence that a patient/guardian sign a consent form, which is treated as informed consent. It is true that physicians and medical administrators feel secure

when signature is appended on such a form (often labelled as informed consent form), but it does not follow that merely signing a form is 'informed consent' as the form even if it contains some details of sickness, risk, etc., the same may not stand scrutiny of law. In other words it does not follow that the patient really understood or was made to understand all the implications of medical intervention for which he has given sanction. It is, therefore, a myth to assume that the physician can conclusively argue that the patient, just because he signed the form, gave informed consent.

Another myth is to assume that informed consent is obtained just because a consent form is signed –it is possible that the signature may have been obtained on the ground that a medical *Miranda warning* was given, and not that the patient was told about the therapeutic options and the varied consequences of these options. It is necessary that the risk of treatment be informed to the patient, but this is not sufficient to claim that the resultant consent is informed consent. The third myth, called *'medical cafeteria'* myth by Alan Meisel and Mark Kuczewski assumes that merely informing the patient all the therapeutic options and leaving it to the patient to make the choice, implies informed consent. Informed consent involves "shared or collaborative decision making..." (and) "in selecting and revising treatment goals, physician and patients need to form a partnership".[18]

The fourth myth is regarding the quantum of information to be supplied to the patient. It is a myth to assume that all the information regarding the treatment should be given to the patient. What is mandatory is that reasonable amount of information should be

given and not information *à la* Physicians' Desk Reference. Fifth myth is regarding the time of disclosure of information. The term informed consent unfortunately turns out to be information after consent. In other words, most of the time, information regarding the consequences of treatment is given to the patient only when he or she refuses or questions the nature of treatment. It may be noted that physicians are expected to obtain not only informed consent but also informed refusal. The sixth myth is regarding complexity of information and the capacity to understand the same on the part of the patients. There are two extreme positions taken in the understanding of informed consent. It is either claimed that patients are frightened by the complex and difficult information provided and consequently no information should be provided ; or, that all information should be provided and the patients' choice should be respected without suspicion regarding his capacity to understand. To assume either of the two exclusively is a myth.

Again it is a myth that patients must be given information whether they want it or not. Both legally and morally, a patient may opt for waiver regarding informed consent and therefore to compel patients to receive information and make decisions would amount to disrespecting their dignity. Further, to waive the right to decide does not imply waiver to right to information.

Finally, it is a myth to assume that the physician can deny information if he believes that the patient will undermine the goals of informed consent. This is unacceptable as physicians have no right to withhold information on the ground that the patients will

again ironic that the 'physician arrogance' is more expressed in the public health care system than in the private physician-patient interaction.

Physicians should not be averse to both informed consent and patient autonomy. Medical practitioners should realise that it is patients who are responsible for their health, and it is they who can make decisions about the treatment they should get. This is justifiable even within the principle of beneficence as informed consent must be obtained in the best interest of the patient. Besides, informed consent brings about a healthy relationship between the physician and the patient who cease to be 'moral strangers'. The physician tries to understand the patient, determine whether he is competent to consent and also remove the fears and anxieties the patient faces.

Implications

The proponents of informed consent argue that the procedure if followed helps the patients to cope with the disease, adapt to the changing environmental conditions and one's interaction with it, helps to reduce the pain and anxiety associated with the disease, and enhances the acceptance of treatment. In spite of the difficulties expressed by critics that there cannot be informed consent as the patient can never be expected to fully understand the nature of risks involved in the treatment, it may be argued that some degree of understanding is better than none at all.

The opponents of the informed consent argue that such a procedure will not be effective and at best marginal. Besides, a patient suffering from illness is prone to fear,

stress and anxiety, and many other factors that will diminish the patient's ability to understand, evaluate and decide. There are also factors that are part of the treatment procedures such as drugs, diagnostic procedures, etc. that will make it difficult for the patient to apply his mind to give informed consent. Asking for informed consent from a patient suffering from a serious illness may be construed as adding to the psychological tension of the patient.

Which side does the balance tilt in judging the protagonists and critics of 'informed consent'? The following statement of Stephen Wear is an eye opener for those who want to take sides in the debate:[21]

> Begin with the uncertainties, possibilities and probabilities inherent in many clinical situations. Next, add a viable alternative treatment or two with multiple branches for the decision tree depending on further diagnostic results, complications, or the degree to which the patient does nor does not respond to initial interventions. Then, add the idiosyncrasies of the effects on and responses of individual patients to illness and treatment. Finally, place all this within a continually evolving clinical picture that might challenge the most experienced clinician. At some point we should surely wonder if talk of the "essentials" of the decision is not just a ridiculous shorthand for situations whose concurrent complexity, ambiguity and uncertainty admit of no clear, simple, or static vision. The technical language of the profession, which supposedly can have no place in informed consent, may then instead seem absolutely necessary for the project of conceptualization, not to mention evaluating and making decisions about what has thus been so precariously fashioned. But where, we must ask, does that leave the patient, assaulted by illness, a stranger in a strange land, when he finally steps up to the podium to render judgement?

In spite of the convincing point that Stephen Wear makes, is/are there any benefit/s of informed consent?

There are normal situations in medical practice that do not seem to require any intrusion of informed consent, and at best such mediations can have negative impact on the physician-patient relationship. Again, at times in 'normal' situations, both physicians and patients may find informed consent as redundant and waste of time. To claim that the patient should participate in the decision-making in the cases where the risks are insignificant, such demands are exaggerated claims. However, there are some abnormal, extraordinary and grey areas in medical practice that may involve alternatively positive or negative reactions on the part of patient and physician.

For instance, in the case of chronic and terminal illness, there is need of patient counselling and consequently the patient should be informed of the major risks, limitations and uncertainties of medical intervention, etc. so that he or she can cope with the outcome of the treatment. There are also issues which may be based upon personal values and which are of great significance to the patient and the same should be known so that patient can decide the course of action he/she feels is the best.

The benefits of informed consent can be expressed in terms of criteria laid down for informed consent. If the informed consent is legitimate and creates no tension between patient and physician, it does not create undue anxiety and fear in the patient, it does not interfere in proper care of the patient by the physician, then the same is to be regarded as a legitimate informed consent. Proponents claim that in spite of all the problems discussed above, informed consent helps to bring about a relationship going beyond being 'moral strangers' and the same will be useful for future occasions if not

the present one. Again, in informed consent situation, the patient may be able to understand better the course of disease, the treatment and the potential risks involved. Consequently, the patient will cope with the results better when they are below one's expectation. There are situations in which the patient when presented with a course of treatment and alternative to it as no intervention, will be able to understand and appreciate the consequences of treatment versus non-treatment. This understanding even if not useful for the present illness, it will serve the purpose in the future. The interaction prior to informed consent, will help the physician to have an insight into the patient's personal problems, value system, misconceptions, fears and hopes and assist the patient to be more responsive and forthcoming with information useful for treatment.

J. Katz's [22] after studying mental patients proposed a model of informed consent which emphasised the need of a dialogue between the patient and the physician. Katz calls it a duty or an obligation to converse, which includes self-reflection and reflection on others. To remain silent on the part of the physician is construed by Katz as abandonment of the patient and dialogue is construed as attempts on the part of the physician to enhance autonomy of the patient from various factors both conscious and unconscious. Instead of seeing informed consent as an attempt to diminish physicians' privilege to treat the patient on the basis of what is viewed as best for the patient, the physician should see the dialogue as part of his responsibility to prepare the patient for treatment and get rid of anxiety due to the unknown consequences of suffering and

treatment. But overall Katz's concern is with the psychodynamics between the patient and physician and not so much with the communication process itself.

Stephen Wear's Model Of Informed Consent

For Stephen Wear informed consent is not just a doctrine, it is an intervention with an objective, namely to the course of disease. And this is achieved by giving the patient sufficient detail regarding his situation, prospects and choices so that he can 'authorise' the physician to take the course of action suggested. It is needless to say that the patient should be 'competent' to consent to treatment. Stephen Wear's medical management model (MMM) of informed consent can be regarded as 'tool for medical management'. The MMM is a product of three interesting theses Wear has framed: a unique account of informed consent as a central 'doctrine' in clinical practice; informed consent with three stages of information dissemination; and analysis of 'competence'.

Informed consent, as we have seen earlier, 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. Wear argues that informed consent has not developed from the principle of 'self-determination' but from an extension to the 'clinic of legal protections'. He argued that if it was self-determination that was the foundation of informed consent, then the legal system would have been more specific on disclosure requirements, etc. It is therefore clear that although there are ethical claims in the informed consent, it is based on *minimalist* notion in the law.

Stephen Wear also evaluates *moral pluralism* that is seen as a basis of global requirement of informed consent. It is true that the pluralistic character of medicine and contemporary society where people have divergent views regarding life, health and death, people are unlikely to understand each other's moral views. In such conditions physicians often do not take into account the moral views of the patients. But Stephen Wear points out that this is not the reason why informed consent is imperative. Informed consent is a must because no one else can speak for the patient except the patient himself. Consequently, moral pluralism is an insufficient reason for the global requirement of informed consent.

Stephen Wear is aware of the complexity of decision making in medical practice and the problems that are posed by patient autonomy and the principle of beneficence. Instead of posing the various principles in contrast to each other, Wear's constructive position regarding informed consent assumes: (a) we must proceed as though all theoretical arguments for patient autonomy and freedom are insufficient; (b) informed consent is linked to the principle of beneficence in the context of physician-patient encounter; (c) 'shared decision making' does not explain the core meaning of informed consent, there are other values that influence the clinical encounters; and (d) informed consent helps to develop a relationship beyond "moral strangers", helps the patient to realistically appreciate his situation, helps the physician understand the patient and the life meanings, and finally helps the physician in understanding patient's misconceptions, fears, hopes, etc. in relation to medical intervention.[23]

Stephen Wear's MMM must be understood within the general framework of informed consent. He recognizes three stages in the process of disclosing of information. In *comprehensive disclosure stage*, the patient is given detailed information of the risks and benefits of a particular direction of treatment, so that the patient does not have vague or ambiguous notions. Secondly, there is *core disclosure stage* where the patient is provided with the essential information. And the last stage consists of *assessment of treatment* options in the light of patient's choice. Stephen Wear ends his analysis of informed consent as *informed consent event* by claiming that it is most effective, efficient and comprehensive synthesis as against the conversational or process-oriented model.

The third characteristic of Stephen Wear's model of informed consent is *competence*. Competence is assumed in clinical encounter and is assessed in terms of scale of competence measured in terms of certain favourable features. The most crucial among them is the capacity to decide on the basis of risk-benefit ratio. Stephen Wear disagrees with this assessment criteria as it fails to account for patient's own values. Wear believes that the direct correlation between the favourability of a decision and an assessment of competence goes against the legitimacy of competence. There is opportunity for the physicians to overrule the decision of the patient if the same is viewed as against the best interest of the patient, but to make the "assessment dependent on the physician's own preferences would go against the ... pluralism of values and consequently against the basic value of being treated as competent."[24]

Stephen Wear is aware of the problems in determining competence and consequently patient's autonomy. But in order to uphold patient's *effective* autonomy (and not merely abstract principle of autonomy), Wear puts the onus on physician that he should work with the patient and enhance patient autonomy by removing misconceptions, confusions so that patient's own values can prove decisive.

In short, Stephen Wear's MMM takes a realistic position regarding paternalist and autonomist approaches wherein in spite of deficiencies in the actual practice of patient autonomy, he emphasises the need for effective autonomy by demanding that physicians must in ultimate analysis take into account the values and decisions of patients. This is particularly important in view of "assembly-line" features of modern medicine that make almost impossible informed consent.

The Language Of Informed Consent

In Chapter I, the role of language in bioethical discourse was introduced. In this chapter a more detailed study of the influence of language and linguistic structures on informed consent is undertaken. Even a cursory glance at the informed consent discourse will suffice to raise the doubts regarding the objectivity of the legal and moral claims. The language is so imprecise and emotive that specific connotations of what the terms mean is seriously questioned. Alternatively, philosophers began to look at the informed consent as part of the performative speech-act rather than a description of the processes involved in medical practice. As Jan Marta[25] notes that informed consent is a performative speech-act which is the result of a series of

communication acts which together constitute a dialogic, polyphonic, heteroglossial discourse.

When the patient uses the words like "I consent", "I refuse", it reduces informed consent to a language act and a linguistic process. It may be recalled that the model of informed consent requires that certain conditions must be fulfilled. Firstly, the patient can give consent only if he is disclosed the information necessary to make the decision. Secondly, the patient should be able to comprehend the information disclosed. Thirdly, the patient should voluntarily give his consent and should not be under any compulsion or coercion to do so. Fourthly, the patient should be competent to give the consent. Fifthly, 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.

In ideal terms, informed consent is a positive reinforcer to patient autonomy. It however is seen as inadequate as it does not take into consideration the fact that sometimes the patient may not comprehend or may misunderstand the information disclosed to him. The roles could also be interchanged. Even the roles of physician and patient may be interchanged as patient could act as informer and physician as consenter.

Katz's conversational model of informed consent that we referred to above, is concerned with patient physician dialogue. H. Brody[26] who takes off from Katz's 'conversation metaphor' and introduces 'transparency metaphor' regarding clinical

thinking, focuses his attention on *cognition* as being an important factor rather than emotion when a patient takes a decision. In this model, physician discloses the information and the patient questions the physician till such time the patient has understood the disclosed information.

A. R. Dyer[27] attempting to take the best from Katz and Brody, proposed a psychotherapeutic model of informed consent wherein the function of the physician is to understand the patient as a person and not merely communicate with him at the cognitive level. Dyer's objective in the model was to resolve the dichotomies between patient's autonomy and physician's paternalism and beneficence. R. F. Faden and T. L. Beauchamp[28], proposed a model of informed consent that changed from 'disclosure' to 'effective communication' in which information is disclosed to the patient step by step so that the patient comprehends and assimilates what is conveyed to him.

Almost all informed consent models focus on the cognitive aspects , namely those of disclosure and understanding. Even when the primary focus is 'communication', in the ultimate analysis, the content of the disclosure gains importance. The linguistic factors together with the emotive and socio-cultural factors of communication are either ignored or marginalised. Jan Marta studied theories proposed by J. L. Austin, Roman Jakobson and Mikhail Bakhtin and noted that informed consent could be viewed as a performative speech-act, an act of communication. Such an account would take into consideration the emotive, socio-cultural as well linguistic aspects of informed consent. The performative speech-act in informed consent is "I consent" where the

focus is on the "I", i.e. the person who consents. The patient is the one who is responsible for making the decision. However, in cases where the patient is incompetent to consent, some other individual acts as the patient's proxy.

Depending upon the illocutionary force, the performatives are classified into five kinds: (1) there are verdictives (giving a verdict, making a judgement, etc.), for example, "I convict"; (2) exercitives (exercising a power, right, influence, favour or not), for example, "I appoint"; (3) commissives (promising, undertaking), for example, "I promise";(4) behavitives (performing an attitude or social behaviour), for example, "I apologize"; and (5) expositives (making clear how the utterance fits with others), for example, "I affirm".[29] In this categorisation, the performative "I consent" fits into the class of exercitives, whereby when one says "I consent", one exercises a right or advocates what should be done and gives a decision about a certain course of action to be taken. However, though primarily an exercitive, the act "I consent" exhibits the qualities of the other four kinds of acts, that is, it is a commissive by the fact that it commits the patient to a certain course of action and the physician is committed to its execution. It is also based on a verdict pertaining to the utterance made in the 'informing part' of the informed consent. It falls in the category of expositive as it constitutes a comment on how this utterance fits into the whole conversation. By the fact that it communicates any attitude, it is a behavitive.

The act of "I inform" on the part of the physician is also a perlocutionary speech-act in so far as it produces effects on the feelings, thoughts of the patients. It is an

expositive perlocutionary speech-act, as it exposes a subject. The act is also illocutionary in so far as the "I inform" is expressed in a conventional or ritualised way. The act of informing is more than what is being legislated in the informed consent - there are both subtle and obvious elements of persuasiveness. As Marta has argued: "Despite standards and guidelines, physicians have the same capacities for speech as other human beings, and thus are somewhat loose rhetorical cannons on the informed consent deck. But then so are patients, who also provide information to physicians. This is part of what constitutes the humanness, even the humanness, of the interaction."[30] The fact is that both the physician and the patient contribute to the meaningfulness of informed consent. Once the patient gives his consent for a particular action, the physician should consent and agree to implement the decision of the patient.

Roman Jakobson[31] goes a step further while focusing on *communication as an interdependent linguistic endeavour* and observes informed consent as a 'communication act'. Jakobson holds the view that in the process of informed consent, both the physician and the patient play an important role. The physician informs the patient of the possible risks and benefits depending on which the patient agrees or refuses to the treatment. Thus there is a continuous dialogue between the physician and the patient This dialogue occurs through language which for Jakobson is "a socially constructed material of which communication is made. Language is visible but not an obstruction, present but allowing for, creating and mediating the process and act of informed consent."[32] However, there are certain problems which arise as far as

the communication aspect of informed consent is concerned. The problems could be either in sending the message or in receiving the message. The sender and the receiver both have cognitive, emotional, linguistic and hermeneutical abilities. Jan Marta emphasises the hermeneutical character of informed consent when she/he writes: ""Consent", "refusal" seem more adversarial, a "negotiated" contract more relational, and "choice" more independent. These connotative semblances of meaning structure the interaction of sender and receiver, and the resulting informed consent message."[33] The message which is sent should be understood by the other, the information should be free from medico-legal jargon so that it could be understood by layman. The roles of sender and receiver are exchanged between the patient and the physician.

Mikhail Bakhtin[34] while trying to unite Jakobson's codes and contexts and Austin's social construction of performatives, highlights the plurality of social discourse reflected in the individual's utterance. Bakhtin uses the concept of *heteroglossia*[35] and argues that this makes the informed consent to be inclusive of the codes and contexts that make up the social discourse. Using the concept of *polyphonia*[36] Bakhtin points out that multiplicity of social *voices* that occur in a discourse have an unique relationship of influencing and changing the meaning of each other's (the speaker and spoken to alternating their roles) values, options in order to consent to, or refuse a medical intervention. Individual and social discourses are in a dialogical relationship with each other, and resolve their duality without one undermining or eliminating each other. This model of the individual and social discourses seem to reflect in the physician-patient relationships in informed consent. In the informed consent situation,

the physician and patient who have distinct roles, value system, attitudes, etc. maintain their distinct character even when they enter into a dialogical relationship of interdependence and share the responsibility for the health of the patient.

Jan Marta concludes the analysis by submitting that informed consent is a "performative speech act resulting from a series of communication acts, which together constitute dialogic, polyphonic, heteroglossial discourse."[37] Further the linguistic model of informed consent is better than a simple disclosure model, as it shows equal respect for patient and physician without treating informed consent as a battle ground.

The above analysis has brought out some of the special features of informed consent and their unique role in medical practice. Importantly, the question that may be uppermost in mind of the reader, is whether a legitimate informed consent is ever possible. The doubts are due to the fact that often informed consent is seen as 'educated consent' and that the burden of this education falls on the physician who ultimately decides what is best for the patient. Ignoring the 'inputs' of the patient in the process of dialogue between the physician and patient such as patient's individual priorities, needs, concerns, beliefs, fears, expectations, etc. is almost turning blind to the realities of modern medical practice that is accountable to legal and societal controls. A solely or overly legalistic interpretation of informed consent will lead to undermining of 'person' status of the patient. One need not deny the difficulties encountered in the process of informed consent to affirm the primary necessity of

informed consent for the ensuring greater respect for the patient and enhancement of good medial care. Informed consent is justifiable not only as an expression of patient autonomy, but as a mechanism to enhance the principle of beneficence.

NOTES

[1] C. K. Parikh, *Parikh's Text Book of Medical Jurisprudence and Toxicology*, Bombay, Medical Publications, 1981, p. 610.

[2] Quoted in Jay Katz, "Informed Consent in Therapeutic Relationship: Law and Ethics", *Encyclopedia of Bioethics (EB)*, Vol. 2, p. 770.

[3] Stephen Wear, *Informed Consent*, Dordrecht, Kluwer Press, 1993, pp.12-13.

[4] H. T. Engelhardt, *The Foundations of Bioethics*, Oxford: Oxford University Press, 1986, p.262.

[5] Cf. Ibid. pp. 262-263

[6].Ibid. p. 2.

[7] Ibid. p.6.

[8] Eric J. Cassell, "Informed Consent in Therapeutic Relationship: Clinical Aspects". *EB*, Vol. 2, p. 767.

[9] T. S. Kuhn while understanding science and the major revolutions in science had coined the term 'paradigm shift' to explain how and why scientists in one generation almost totally reject the 'firm' beliefs of previous generation. Within a paradigm, he had argued, 'normal science' expresses no contradictions and progresses. Medicine, 'an art, struggling to be a science', has more of such radical shifts in interpretation than any other science. In a casuistic approach, the causes of disease identified during the previous generation make place for new causes with advancement of knowledge. Besides, medicine may be regarded as an empirical discipline, but unlike other empirical disciplines, it cannot be an experimental science as not experimentation with crucial cases is ever allowed.

[10] The *Nuremberg Code* in the first clause argues that "voluntary consent of the human subject is absolutely essential" and further explains that "human subject must have the legal capacity to give consent, able to exercise free power of choice without intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision." Appendix, *EB*, Vol. 4, p. 1764.

[11] H. K. Beecher, *Research and the Individual*, Boston, Little, Brown, 1970, p.236, quoted in Richard A. McCormick, *How Brave A New World,* N.Y., Doubleday and Co., 1981, p. 53. (emphasis is mine).

[12] Declaration of Helsinki, *EB*, Vol. 4, p. 1770.

[13] Paul Ramsey, R. E. W. Fisher, Bernard Haring would find it unreasonable to legitimise experimentation with children when the procedure will involve harm or pain to the child without any direct or indirect benefit to the experimented child. For these moral philosophers, humans can never be treated as instrumental ends even if it is for the sake of another human being.

[14] Richard A. McCormick, (1981), p. 63.

[15] Cf. Stephen Wear, (1993), p. 33.

[16] Ibid. p. 37.

[17] Alan Meisel and Mark Kuczewski, "Legal and Ethical Myths About Informed Consent", *Archives of Internal Medicine*, Vol. 156, No.22, 1996 (Web Site of Center for Clinical Ethics and Humanities in Health Care , U.S.A.).

[18] Ibid.

[19] Cf. Stephen Wear, (1993), p.44.

[20] Ibid. p. 44.

[21] Ibid. p. 52.

[22] J. Katz, *The Silent World of Doctor and Patient*, N. Y., The Free Press, 1984.

[23] Cf. Stephen Wear, (1993) p.60.

[24] Ibid. p. 115.

[25] Cf. Jan Marta, "A Linguistic Model of Informed Consent", *The Journal of Medicine and Philosophy (JMP)*, Vol. 21, No.1, 1996, pp.41-60.

[26] H. Brody, "Transparency: informed consent in primary care", *Hastings Center Report*, Sept.-Oct., 1989.

[27] A. R. Dyer, *Ethics and Psychiatry: Toward Professional Definition*, Washington, American Psychiatric Association Press,1988, quoted in Jan Marta, (1996), p.42.

[28] R. F. Faden and T. L. Beauchamp, *A History and Theory of Informed Consent*, N. Y.,Oxford University Press, 1986. Quoted in Jan Marta, (1996), p.43.

[29] Cf. Jan Marta, (1996), p.46.

[30] Ibid. p. 48.

[31] Roman Jakobson, *Selected Writing Vol. II Word and Language,* The Hague, Mouton,1971. Cited in Jan Marta, (1996), p. 49.

[32] Jan Marta, (1996), p. 49.

[33] Ibid. p.51.

[34] M. N. Bakhtin, *The Dialogic Imagination: Four Essays*, M. Holquist (ed.,) C. Emerson and M. Holquist (trans.), Austin, Texas, University of Texas Press, 1981, studied in Jan Marta, (1996).

[35] *Heteroglossia* refers to the various language approaches or perspectives that pervade the society and social discourse.

[36] *Polyphonia* refers to the multiplicity of social voices which embody or give utterance to, the multiple languages and perspectives of *heteroglossia.*

[37] Jan Marta, (1996), p. 56.

CHAPTER IV: PROXY CONSENT IN MEDICAL PRACTICE

In the last chapter the centrality of informed consent in the medical practice has been analysed while focusing on the theoretical as well as practical issues involved in the physician-patient relationship. It is obvious from the previous discussion that context of informed consent does not exhaust the world of medical practice. 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.

The justification of proxy consent is based upon a very simple logic of clinical practice throughout the history of medicine. Parental consent (vicarious) is required and is deemed sufficient for therapy for child's 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. Proxy consent therefore depends upon the principle of beneficence and consequently the consenting subject is deemed to be one who has the best interest of the patient.

Engelhardt analysed the context of proxy consent by listing situations under which guardians are called upon to give consent. He says "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."[1]

A brief explanation of the five contexts that Engelhardt refers to is necessary for a proper understanding of what is *proxy* about proxy consent. To begin with it must be noted that the logic of informed consent applies to proxy consent as well. And the complex problems and moral tensions involved in informed consent are also involved in the proxy consent and more so, since the individual giving the consent is other than the patient. There is certain gradation of responsibility involved in proxy consent *from* the adult who specifically appoints a proxy to a guardian for whom it may not be that his actions are in the best interest of the patient.

If the individual has specifically appointed a proxy with clear instructions or with a blanket instruction to act in his (patient's) best interests, the proxy is seen as an "extension of the freedom of the first".[2] The above situation is very uncommon as in most cases there are no advance directives or instructions on behalf of the patient. The guardians may be called upon to decide both for competent and non-competent or for those who have never been competent, and such guardians cannot be regarded as extension of another individual's freedom. The moral authority of such individuals may

be due to their being parents (having given birth to the child or adopted[3]) and their decisions (for instance, to refuse treatment for severely defective new-born or refusal of cosmetic surgery on grounds of religious convictions) are necessarily seen as that what would be in the best interests of the individual. The best interests of individual in such cases are seen as best interest of the community or according to values of the society etc. The justification for such decisions is seen as a reconstruction of what the individual would have wanted, if he/she were to have a value system of a particular community. Again, there would be cases wherein a guardian may in absence of any instructions, choose what any rational and prudent person would choose immaterial of the particular community he or she belongs to. There is, therefore, a case for secular ethics based upon a universal value system within the specific and particular communities and their value systems.

Making Choices For Others: Three Forms Of Paternalism

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. The principle of paternalism is not invoked by physicians alone in medical practice, even patients under the stress of the disease want to be treated as children by health professionals. Paternalism is unavoidable as the same is resorted to in case of infants and the extremely senile individuals. It is not ironic that the paternalistic attitudes and roles are reversed in the life span of a family.

Engelhardt recognises three different forms of paternalism, namely, *paternalism of incompetents, fiduciary paternalism*, and *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 patient's 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 others will make certain sort of decisions on his behalf. Short term 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.

The principle of autonomy and beneficence come under strain in proxy consent particularly in the case of minors. The tension seems to be based upon the conflict between autonomy and beneficence. Among the five different grounds on the basis of which proxy consent was justified (see p. 108), the first three grounds are based upon argument of *'being in authority'* and the next two (fourth and fifth) are based upon

'are authority'. In the case of 'being in authority', the proxies claim the right to be respected, not because theirs is the 'best choice', but because others cannot intervene with the patients without their permission. Those who 'are authorities' (as against 'being in authority' - autonomous) claim the right to decide because they know what is the best (beneficence). The issues become more complex when we consider various types of 'individuals' that are treated as patients, namely, new-borns and foetuses, severely mentally retarded, comatose patients, individuals suffering from last stages of Alzheimer's disease, terminal patients, patients with rare and unknown diseases, etc.

Proxy Consent And Emancipation Of Minors

To begin with , proxy consent is given by guardians in the case of foetuses and new-borns. 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'. A review of legal exceptions to the rights of proxies (parents, guardians or others) is necessary for a comprehensive understanding of proxy consent.

One of the major legal exceptions to the rights of parents /guardians is in relation to emergency. It is obvious that when threat of permanent disability or even death is possible physicians and others may treat the patient without consent. This presumed consent is justified on the ground that any reasonable or prudent individual would

choose such mode of treatment. In such situations physicians assume deemed consent till such time guardians who are in authority arrive on the scene.

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

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 minors 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 reproductive choices, *mature minors* reject parent authority in medical intervention and assert their right for consent.

Engelhardt, while granting autonomy to parent/guardians in decisions regarding their wards lays down criteria for intervention on behalf of the ward. Such interventions are based upon principle of beneficence and/or concern for autonomy of the ward. When

there is clear and convincing evidence that the guardian's acts of commission or omission are contrary to the best interest of the ward, intervention on behalf of the ward is justifiable. For instance, when such actions or inactions injure the body or the mind of the ward judged by the standard of a reasonable and prudent person, intervention by the physicians, etc. on behalf of ward is a must.[4]

Proxy Consent And Experimentation

We have seen in the earlier chapter that it is necessary that non therapeutic research with children be carried out for advancement of medical science. Discussions on legal, moral and medical aspects on non-therapeutic experimentation with children range from outright condemnation to legal, moral and social justification on 'humanitarian' grounds.

Paul Ramsey in *Patient as Person,* argued that "to attempt to consent for a child to be made an experimental subject is to treat a child as not a child. It is to treat him as if he were an adult person who has consented to become a joint adventurer in the common cause of medical research. If the grounds for this are alleged to be the presumptive or implied consent of the child, that must simply be characterised as a violent and false presumption."[5]

Taking into account the various issues relating to social good, medical practice on the ground of common benefit to mankind assumes, that experimentation with children without consent is permissible. 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 medical knowledge and skills must be passed on to a new generation of professionals and in this process, patients function as a medium. If medical knowledge is to increase and new problems are to be tackled, research and experimentation is a must. The conflict between principle of patient autonomy and beneficence as well as paternalism cannot come in the way of advancement of medical knowledge.

That the two extreme positions are both undesirable for the medical practice is obvious from the history of medicine. 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.

The theoretical implications of parental consent is required for child's own good. This vicarious consent is also a sufficient ground for directing the medical intervention in the case of a minor. The context within which such a consent is procured or given is close to the concept of *presumed consent*, as it is presumed that the course of actions would be what the child wishes, or would wish if the child was competent to decide for itself. McCormick relies heavily on traditional moral argument when he argues that the "what the child would wish" assumes that if he were capable of a choice, what he would choose would depend upon his moral oughtness. In other words, what the child would do is such that if he was capable of making a choice, he would choose what he

ought to choose as a morally obliged person. The natural law tradition argues for certain values that we uphold, and the knowledge of which is available to human reason without divine or non-natural intervention. In short, the 'construction' of child's wishes is not the result of adult capriciousness and arbitrariness, but based upon the facts "(1) that there are certain values definitive of our good and flourishing, hence values that we *ought* to choose and support if we want to become and stay human, and that therefore, these are good also for the child; and (2) that these "ought" judgements, at least in their more general formulations, are a common patronage available to all men, and hence form the basis on which policies can be built."[6] How does this help the traditionalists to justify experimentation with children?

The first premise for developing the argument from traditional moral perspective is to expand the scope of all that is good for human life in one's own case, to that of all human beings. Individual *ought* to take into account the efforts that go into realising the good of others. And since, when something is factually good, we say that we ought to do so, and if this is true of all of us, with certain restrictions it must be true of the infants. In short, if maintenance of health, control and cure of disease and growth of humans as humans are values that we share and struggle to realise, the experimentation with infants (if absolutely inevitable) should be considered as part of this objective and consequently morally justifiable.

McCormick employs an understanding of social good to argue for non-therapeutic experimentation with human beings. He says 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 for the sake of others, McCormick recognises as an act of concern for 'others'.

That infants are different from adults is obvious from the fact that the decisions of consenting adults (in the case of organ donations or participation in human experimentation) depend upon the individual personality. An adult can be said to be mature, voluntary, recognises personal individual good from personal social good, and has a value system that determines his choice. On the other hand an infant can neither be said to recognise personal individual good from personal social good nor can he perform voluntary action.

Again, there could be situations in which presumption of consent is reasonable in the case of an infant. The example of a child who needs blood transfusion of another child would be justified on the ground that presumed consent in such a case is not unreasonable, because the resultant good is at no or negligible cost to the donor child. Therefore, when an experiment involves no or negligible risk or pain or inconvenience to the child and the experiment promises considerable benefit to other children, one could presume that the child would consent for such an experiment. In other words, it could be presumed that the child would choose or *ought* to choose an action that will benefit others. It may be interpreted on the basis of various declarations such as U.S.

Guidelines on Human Experimentation and the Helsinki Declaration that "low risk" means "no realistic risk."[7]

Understanding 'Person'

Experimentation and research with human foetus raises issues radically different from experimentation with infants and other human beings. The discussions relating to experimentation with foetus presuppose a prior understanding of what is 'person'. In other words, the question is whether we recognise foetus as a person and accord him the moral values that we accord to adult humans and infants. It is therefore necessary at this stage that we clarify this issue before proceeding with the question of whether foetal research should be permitted as a public policy and whether such actions are morally permissible.

The *Belmont Report*[8] in Part B has laid down ethical principles on the basis of which experimentation with human beings for biomedical and behavioural research was permitted.

'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*. In the Kantian sense, persons, not things are of unconditional worth, persons are ends in themselves. Respect is an attitude to persons, not to things. One of the psychological characteristics (philosophically significant) of person is self-consciousness. 'Person' is one who is

conscious of his own identity through time. As Kant puts it, "that which is conscious of the numerical identity of itself at different times is in so far a person".[9] For Leibniz, person is synonymous with 'self' as "the consciousness or the reflective inward feeling of what it is: thus it is rendered liable to reward and punishment".[10] Both rationalist and empiricist definitions of 'personhood' are characterised by "self-awareness" or rationality. For instance, for Locke, "a thinking intelligent being, that has reason and reflection can consider itself as itself, the same thinking thing, in different times and places; which it does only by that consciousness which is inseparable from thinking and seems to me essential to it."[11]

Historically the definition of person is not identical with human beings. For instance, slaves in Ancient Greece had no legal rights and hence were not treated as persons (that is, not ends in-themselves). Aristotle while justifying 'slavery' called them "living instruments for the conduct of life". Person is any being having legal rights and duties. But not every human being is in this sense a person. For example, children, infants and idiots have no rights and hence are they persons? Again not every legal person is a human being, for example, corporations, associations, etc.

In the context of bio-ethics, not all humans are equal (apparent from divergent capacities) example, competent adults, mentally retarded adults, children, infants, foetuses, etc. Even common sense and law (judiciary) recognises these differences in spite of the 'principle' that "all men are equal". 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.

Competent rational adults have unquestionable moral obligations. But what about infants and mentally retarded as well as foetuses? If the categorisation is based on metaphysical commitments or doctrines, there will be divergent views. One should use the secular reflection, that is treat X as a person if and only if he is a rational being. Rationality is claimed if there is evidence for it. In brief, as John Harris puts it, "a person will thus be any individual capable of valuing its own life. Such a being will, at the very least, be able to conceive of itself as an independent centre of consciousness, existing over time with nature that it is capable of envisaging and wishing to experience."[12]

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 uses of 'person' not in the strict sense, but in the social sense. The various senses of persons is as follows:

P_1 - Persons as moral agents.

P_2 - Persons to whom full rights are accorded - infants.

P_3 - Neonates, who are not yet as strong and secure as infants.

P_4 - Those who were P_1 (moral agents) but are no longer so, and can interact minimally, for example people with Alzheimer's disease in advanced stage.

P_5 -Retarded or those who will never be P_1 (moral agents).

P_6 - Severely or permanently comatose, that is, those who cannot interact minimally.

P_7 - Dead Bodies.

There is a difference between persons who are moral agents and persons to whom rights of moral agents are *ascribed.* One can blame or hold responsible P_1 (moral agents), as they have rights and duties. One cannot, however, blame infants. They are bearer of rights and not duties. P_1 have rights as part of morality itself. But rights of persons to whom the moral agents' rights are ascribed are created by particular communities. There is also a distinction between humans with moral standing who play a social role and those that do not.

The purpose of this discussion is not to exhaust the various senses in which the term 'Person' is used. It is pertinent to note the various attitudes towards humans, higher animals, lower animals, plants and other inanimate entities. Ethically, it is universally accepted that humans are persons and treated as such. P_2- P_6 are also humans although they are not rational at that point of time. They were or will be fully self-conscious, rational and with minimal moral awareness. Most cultures treat all such cases as 'persons'.

Moral Status Of Embryo And Foetus

Traditionally the question regarding moral status of embryo (for that matter even foetus) depended upon two prior questions, namely, when does life begin? and when does life begin to matter? To the orthodox moral theologians, it is indisputable fact that not only life begins at the time of conception, but the moral status of the person is linked up with the first moment of life. The scientific claim that life begins at the time of conception and that there is continuous process of development leading to maturity, is taken as an axiom by the 'pro-life' moral philosophers. Reacting to those who would claim that there is life even in ova and sperm, the 'pro-life' activists would argue that a new *individual* begins at the time of conception.

That the above argument is 'absolutist'[13] is obvious from the fact that there are situations in which embryo is not treated with the status of the individual. For instance, conception in the fallopian tube or when fertilisation does not result in an embryo but in a tumour as in case of hydalidiform mole are cases wherein the resultant embryo is not invested with all rights and protections that we extend to 'persons' believed to be formed at the time of fertilisation. Again, the fertilised egg is a cell mass which divides into two major components, the embryoblast and the trophoblast - embryoblast becomes the foetus and the trophoblast becomes the extraembryonic membranes, the placenta and the umbilical cord. Geneticists have pointed out that trophoblastic derivatives are alive, are human, and have the same genetic composition as the foetus - but discarded at the time of birth. Besides, the fertilised egg is not a new individual,

as it is often split resulting into twins which may occur even two weeks after fertilisation.

One of the most quoted arguments on behalf of 'embryo as person' is *potentiality argument* Major criticism against potentiality argument is that just because something (x) will become a person (P_x) is not a good reason for treating the same as if it is P_x. Surely, I would not like myself to be treated as a dead person because I will finally die one day. That the fertilised egg is a potential new human being has to be supported by other premises, namely, that certain other things would happen (like implantation) and certain other things would not happen (like spontaneous abortion). If such additional premises are accepted, then even sperm and ova are to be treated as potential new human beings.

Two conclusions may be derived from the above discussion. First, life is a continuum and that individual emerges gradually. And second, it is not important when life begins, but when life begins to morally matter. The answer to the second query is largely determined by the socio-cultural value system mitigated by certain universal values that we profess as humans.

Even if it is granted that foetus is a person, one may have to decide what status we attribute to "non viable foetus" which is one that is incapable of extra-uterine survival? In experimental situation, viable foetus is treated as a child, and hence may be discussed in the context of presumed consent. The issue takes a new dimension when

the "nonviable foetus" is said to be either *in utero* or *ex utero*. Again, the status of "nonviable foetus" *in utero* be distinguished on basis of whether the foetus is alive or dead, there is a plan for abortion or not. Similarly, the "nonviable foetus" *ex utero* be distinguished on the basis of whether the foetus is such due to spontaneous abortion or induced abortion, and whether the foetus is alive or dead. The above distinctions are not unnecessary 'hair-splitting' exercise, but necessary for deciding in favour or against a public policy regarding experimentation with foetus.

The questions of experimentation with foetus will depend upon how we treat the foetus. In other words, what is our attitude towards foetus, namely whether we treat foetus as "disposable maternal tissue"; "potential human life" or "person". If the nonviable foetus is viewed as "disposable maternal tissue" then experimentation of all sorts cannot be stopped or controlled on moral grounds. If "nonviable foetus" is treated as "protectable humanity" or "person" with rights, then decisions regarding the non viable foetus will be similar to that of infants and children. However, such decisions regarding nonviable foetus will take into account the maternal health. The differences in attitude towards "nonviable foetuses" is a clear indication of cultural differences in the value systems of specific communities.

It needs to be emphasised at this stage, that although there is a distinction between experimentation with children and foetuses, there is continuity between the justification of experimentation with infants/children and foetuses. If one takes the position that all experimentation with terminally ill children is immoral as it constitutes

abuse, and regards nonviable foetuses as persons, all experimentation with living foetuses would be deemed immoral. On the other hand, if one justifies at least some experimentation with children, then the same justification could be extended to experimentation with foetuses.

There are, therefore, three possible positions one could adopt in the case of experimentation with foetuses. Firstly, the nonviable foetus must be protected but be valued less than viable foetus or new-born. Secondly, the foetus is a fellow human and be treated as such and in the case of experimentation, the same should be treated as a child. The nonviable foetuses in this position are comparable to an unconscious patient, 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 foetuses being a fellow human being, be treated in the same way as one treats a child. In brief, the 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. McCormick adopts the third position which may be treated as moderate one. He consequently analyses all categories of foetuses discussed above. [14]

McCormick points out that in the case of foetus *in utero* where no abortion is planned, experimentation is morally justifiable as in the case of experimentation with

children provided appropriate proxy consent is obtained. He however questions the necessity of such experimentation as absolutely necessary. In the case of foetus *in utero* where abortion is planned, McCormick questions the morality of deriving any benefits from the results of an immoral action. In other words, if all planned abortions are immoral, the question of whether the foetus is living or dead is immaterial and any moral legitimation of accrued benefits from such immoral actions would undermine the moral sensitivity of the community.

In the case of foetus *ex utero* as a result of spontaneous abortion, to experiment with the foetus (whether living or dead) with proxy consent is morally justifiable, provided there is no pain for the foetus if it is living. In the case of induced abortion, if the same was morally legitimate, experimentation is morally justifiable if proxy consent is obtained. McCormick however points out that in case induced abortion is morally illegitimate, and the foetus is living, one may question the moral legitimacy of proxy consent.

McCormick however notes that the moral sensitivity while deciding the above issues will depend upon the cultural pragmatism of the community and its moral orthodoxy. Western industrialised societies value medical technology, evaluate moral actions in terms of cost-benefit calculations, value youth, pleasure, health etc., marginalise senility, retardation, defectiveness, etc. In brief, there is strong faith in effective and quick intervention to preserve what is seen as good and elimination of what is seen as

unwanted. McCormick goes to the extent of saying that such cultures translate morality into efficiency.

Finally, the question regarding legitimacy of foetal experimentation becomes complex in the context of *in vitro* experimentation. In the case of *in vitro* fertilisation, the reproductive process takes place outside the human body and consequently the question of right of the mother/woman become meaningless. There is, in other words, no violation of privacy, integrity of woman's body etc. in the case of *in vitro* fertilisation. More importantly, in the case of *in vitro* fetilisation, the spare embryos[15] (after the successful implantation of one fertilised egg) are available for experimentation or the same 'condemned' to destruction. There is a prior question that has to be settled at this stage before deciding whether experimentation in the case of spare embryos is morally legitimate.

Engelhardt while arguing that foetuses are not persons in strict sense - they are the biological products of persons - claims that there are no sustainable moral arguments against non-therapeutic experimentation with foetuses. Foetuses will become strict persons only sometime after birth. In the early gestation period, foetuses have minimal mental life, argues Engelhardt, and hence they do not appear to suffer like other normal adult mammals.[16] If Engelhardt's position is accepted, then there is no moral restriction on conducting experimentation with spare embryos, provided proxy consent is obtained. And such a proxy consent is more of the nature of legal requirement than based on moral considerations.

Recent literature on this issue takes a different form of argumentation. This is particularly so when the slippery slope[17] argument is employed to argue against non-therapeutic experimentation with human embryo. The American legislations[18] controlling federal funding for experimentation with spare embryos has tried to lay down clear guidelines regarding human embryo research.. And the subsequent *Human Embryo Research Penal* in its report articulated what is legally permissible (sic. morally) and what is not in terms of research with spare embryos. The philosophical presuppositions of the guidelines are based upon our understanding of what constitutes pain and suffering, what is the scope and limitation of consent, and what type of ownership right do individuals claim vis-à-vis the embryos, particularly spare embryos.

The understanding that embryos are not persons in strict sense does not necessarily lead to the conclusion that nothing is wrong with killing an embryo or experimenting with it in whatsoever manner. Pain and suffering are a major criterion for deciding whether experimentation with embryo should be permitted, as human sensitivity is against inflicting pain on any sentient being (even when such animals are used for food and other human purposes). Of course, at another level one may question the moral justification of killing animals for human consumption.

It was commonly accepted that embryo is not capable of feeling pain during the first few weeks of life as for almost eighteen weeks central nervous system has not been

formed. The *Human Embryo Research Panel* considered additional embryonic stages, namely 14 days (appearance of primitive streak), 18 days (beginning of neural tube development) 22 days (onset of foetal heartbeat), and suggested on the one hand that serious moral consideration should be given to the embryo, and on the other that it does not have the same moral status as infants and children. The panel has identified various factors (such as genetic uniqueness, potential for full development, sentience, brain activity, degree of cognitive development, human form, capacity for survival outside mother's womb, degree of relational presence to mother and others,) that could be used to assess the moral status of embryo. The report had argued that no single factor can be used to justify moral status of the embryo. But the increased presence of the above mentioned qualities enhance the moral status of embryo/foetus. The process culminates at birth when substantial development has taken place and the foetus is capable of independent existence outside the womb of the mother.

Taking into account the various embryonic stages mentioned above, the report of panel had suggested embryo before 14 days has no moral status except that it has the biological uniqueness. In the next stages (14 days when primitive streak sets in and 18 days when neural tube development begins), the embryo possesses the quality of respectability and consequently has enough qualities not to permit arbitrary research.

There have been criticisms to the panel's recommendations as such minute differentiations may not necessarily raise the moral status of embryo or foetus. The recommendations are both vague and difficult to apply. Besides, the recommendations

seem to be concerned more with the instrumental concern of permitting or not permitting research, rather than intrinsic concern for human subjects.

The question regarding who has the moral right to determine the fate of embryo fertilised in vitro and the nonviable foetus needs to be analysed on the basis of the distinctions made above. In the normal circumstances, abortion against the will of the mother does not arise, as it is morally unacceptable that there is outside interference with the mother's body. In such cases if the mother decides to abort the foetus, what should be the fate of such aborted foetus? Is mother's consent required to conduct experiment with such aborted foetus? The answer to this, in the first instance will depend upon the moral nature of abortion. If abortion itself was immoral, then the mother has no more right to determine what should happen to the aborted foetus. Secondly, if the abortion was 'morally legitimate' (for instance to save the life of mother etc.) then the question has to split into two parts: whether the foetus is alive or dead. If the foetus is nonviable and there is definite need for morally legitimate experimentation, seeking consent from the mother is not necessary. If we are not morally bound to preserve the life of such foetuses then seeking consent from anyone does not arise. But in the case of aborted foetus which is alive and the mother desires that it should live, the foetus should be treated as a premature birth, and taken care and subsequently restored to the mother.

The issue regarding consent in case of nonviable foetuses, the expressed concerns are not moral. They are legal concerns that arise within the scope of property rights. The

mother claims the right to foetus by virtue of the foetus growing in the womb of the mother. Although in many legal cases such property rights have been upheld, it is both rationally and morally not justifiable. There may be situations in which something growing in the body of mother may not necessarily belong to the mother (e.g. viruses). Again, the mother may be restricted and harangued in order to prevent harm being done to foetus.

One can argue in similar manner the case of embryo *in vitro*, the only difference being that in this case there is no mother. No woman has a right that the egg she has donated be implanted. She has only a, perhaps contractual right that it be implanted in her if she wants it. In brief if the experimentation envisaged is morally justifiable as the same is for the benefit of mankind, then "there is no moral virtue in killing or allowing embryos to die when they could rather be used to benefit us all and there is less virtue in allowing human cadavers to go to waste, when we could, with, say, transplantation order or the like, save very many lives."[19]

The moral reasoning involved in the objections against experimentation with embryo seem to vary from situation to situation. So long as there is no justification for treating embryo as a sort of creature that is morally entitled for the same status as that of persons , (by way of concern, respect and protection) there is no moral objection to prevent experiments that would benefit mankind without risks and pain to other persons. Mary Warnock[20] while admitting that there must be some law to prohibit commercial exploitation of embryos, argues that the 'slippery slope' argument in its

most general form must be resisted , or else there would be no progress and advancement of knowledge.

Abortion And Consent

The discussion regarding consent in the case of abortion requires that we understand the basic moral issue involved in the abortion debate. A brief review of the most orthodox position will suffice to show that the moral concern in the case of abortion is same as in the case of embryo and foetus. In the abortion debate, greater emphasis on the right of mother will be recognised by all in view of the relationship between the mother and the foetus.

The Roman Catholic Church, theologically more articulate Christian group, teaches that human life is a sacred gift over which we have 'stewardship' but not complete dominion. Therefore, all are morally bound to sustain and protect life from conception to natural death. It is deemed a moral imperative that any health care system should assure care for all in terms of dignity of the human person and the good of society.[21] The Church recognises all health care concerns as based upon fundamental belief regarding the dignity of the human person and the value of human life. Life is recognised as a precious gift from God, and this gift is to be protected, sustained with respect at every stage from conception to natural death. Each human being is person, and this personhood gives special dignity and basic rights to the individual.

All major religions believe in human dignity and human rights and provide a theological justification for the same. There are also other individuals who profess no specific religion but have strong convictions and defend human dignity. These beliefs therefore, at one level may be integrated into a religious worldview. It is not an exclusively religious teaching nor one that cannot be deeply held without faith or religious commitment. Almost all national constitutions recognise protection of life, liberty, and the pursuit of happiness as universal truths.

Catholic Church recognition that each person has a *right to life*, to bodily integrity and to the means necessary to sustain and develop life and health becomes the theological basis for opposing direct abortion. The Church at the same time emphasises right to health care, preventive and curative, as a responsibility of the individual person and of society. And since human life is a *continuum* from conception to natural death, health care includes education, research, care of the disadvantaged or disabled and care of the elderly.

One must appreciate Catholic Church's position when it (she) points out that abortion, in general terms is recognised as a matter of *free choice for a woman* and not a medical treatment. Studies show that most abortions are performed for personal reasons and not in consideration of the medical condition of the mother. Consequently, abortion is seen as an elective procedure that has social or ideological reasons, and not as a therapeutic procedure for some specific pathology. In developed societies the

major force behind legalisation of abortion has been the argument of free-choice for a woman. In India, it has been the socio-economic concern for population growth.

Catholic Church's arguments against euthanasia and assisted suicide are similar to its moral opposition to abortion. Instead of looking at these issues as moral predicaments, the Church argues that developments in science and technology that cure 'incurable' diseases, that prolong life of terminally ill and dying, must be seen as avenues and part of our moral responsibility to sustain life. Catholic moral teaching emphasises that it is not permitted to destroy or directly terminate human life. Moral theologians, however, have developed principles to guide patients, physicians, paramedics and families to understand that it is morally permissible to discontinue life-sustaining technologies when death is imminent or when the treatment is useless, so long as care of the patient is continued. There are two theological beliefs that justify such a position. One, moral theologians recognise that human suffering has salvific[22] character. Secondly, death is seen as transition from one life to another and never as an end in itself.

In some industrialised countries such as United States of America, England, Sweden, etc., where abortion and euthanasia are often treated as matters of privacy or individual choice beyond the reach of public moral accountability, the Catholic Church's opposition is logical and consistent. It maintains that abortion and euthanasia are morally objectionable behaviours, destructive of human life, offensive to God and dangerous to the well-being of society. It also opposes all forms of health care systems that finance a social policy and strategy that condones abortion.

In the United States of America, the Catholic Church[23] is particularly agitated at the Clinton administration's proposal under which abortion is not limited in any way but is provided as a matter of choice. In other words, abortion is available for any reason, at any time during pregnancy without any limitations or qualifications and paid for by public funds. The choice of abortion need not be justified for therapeutic consideration. It may be purely for social reasons or personal convenience. Catholic Church considers abortion morally wrong committed both by the woman who obtains an abortion and by those who provide the service whether physicians or paramedics.

The American Catholic Church is particularly agitated that the new policy may recognise abortion as another optional service rendered by the hospitals and health care program. Such an action will institutionalise abortion as a matter of choice, easily available, socially acceptable and free from any moral considerations.

In a pluralistic society, theological considerations may not have universal acceptance and the rational consideration why abortion is morally acceptable needs to be reanalysed. As discussed earlier, central to the debate is the issue regarding personhood and the right of woman to determine its own life. The debate regarding 'what is a person' seems to be such that it is endless and futile as it will not lead to any solution. The problem is seen as insoluble in the context of abortion wherein the fertilised egg develops into a human being in a continuum of life change. The argument of potential persons is pointed out as fraught with difficulties as Jane English[24] had

argued. She has pointed out that if we assume foetus is not a person, then abortion is nevertheless not permissible in the later months of pregnancy. And if we assume foetus is a person, then abortion is nevertheless permissible in the early months of pregnancy. Hence, abortion controversy does not depend upon the status of foetus as person or non-person. English has further argued that the concept of person is so vague, that attempts to use the concept to solve the abortion controversy is clarifying *obscurum per obscurius*. J. J. Thomson[25] provides an elaborate argument that justifies abortion on the ground that women have right to control her own body. The Argument: "If a person, A, is dependent for her/his very survival upon the use of another person's, B's, body but B has no responsibility to preserve the life of A, then B violates no rights of A by severing their connection, even if this results in the death of A," ...(and)... "the principle gives B the right to be freed from A but not the right to kill A." (However), "the death of A is, ... not a wrongful death if A is totally dependent upon B for survival or the only way in which B can be freed from A entails the death of A."[26] The logic of the above argument is that abortion is permissible because the connection between woman and foetus cannot be severed without killing the foetus. It has been argued that the objective of abortion is termination of pregnancy and not termination of development of the foetus. If the former can be accomplished without the other, it is ideal. However, if it is not possible, then the moral burden is not on the mother who merely asserts her right over her own body.

The above argument seems to be inadequate as most of those who argue for justifiability of abortion claim that the woman has right not only to terminate

pregnancy, but also to terminate the further development of foetus. In other words, even if medical technology were to develop techniques that will allow *ex utero* development of foetus, the mother has a right to decide whether the foetus extracted from her body should be allowed to grow to its full potential.

In all the above arguments, the central premise is the right of woman to control one's own body. And this right has been upheld by most of the legislations thus far enacted. And most of those who argue for the permissibility of abortion on the basis of the principle of right to control one's body seem to accept the extraction from one's body, but not death as the justification. But the question is whether foetus is to be treated as a tumour or fat tissue that can be discarded at any time. The general feeling that an expression of one's right if it harms or goes against that of another, is regarded as morally unjustifiable, re-establishes the primacy of the question of moral status of foetus. In other words, should foetus be treated as person or non-person?

The principle of right to control one's own body is not a simple right. It is a complex of rights that emphasises autonomy, non-interference and self-determination. These complex of rights justify condemnation of all forms of exploitation of one person by another. Similarly, it justifies non-interference with one's body against one's will and protects the right to determine for oneself what one desires to do with one's body, how to use it. In the present context, it justifies the right to control one's reproductive system such as when to have children, or use means to prevent conception. But such a complex of rights cannot justify killing of one's children as this would involve

interference in the rights of another person. In the case of abortion, the issue is whether this complex of rights that allows control of one's body and the reproductive system extends beyond conception. If this right is extended past conception then the right to control one's reproductive system would also mean that the mother can ensure that the foetus does not develop further (*in utero* or *ex utero*).

David S. Levin argues that the controversy regarding abortion lies in the vagueness or hopelessly impreciseness of the concept and that we must recognise that "foetuses are potential persons, neither fully persons nor utterly non-persons."[27] If the question of when the foetus becomes a person (choosing a point and deciding that all foetuses after this stage are to be treated as persons) is to be decided on the basis of stages of development, then there is likelihood of a arbitrary decision of a stage. For example, suppose a point is decided on the basis of independent survival of the foetus outside mother's womb, the point will change from time to time depending on the development of biomedicine and its capacity of death with immature foetuses.

The whole issue seems to be dependent upon the primacy of metaphysics and such a 'fixation' may not contribute to the resolution of the problem. Instead, one may inquire into two crucial questions which are interdependent: what is the value of potential persons and what are reproductive *rights* and *responsibilities*. The understanding that each person has right to control his/her own body has been defined in terms of rights of autonomy, non-interference and self-determination. Implicit to this complex of rights is the right to control one's reproductive system. It is under this

principle that societies recognise woman's right to decide and control when one has children or even take various precautions to prevent conception. Coupled with this right is the moral responsibility to promote the well-being of the offspring. It is accepted that the *responsibility* does not begin with birth, but at the time of conception, as it is crucial for the health of the offspring that the mother behaves responsibly so that no harm is done to the foetus during the crucial period of development.

There is however another moral responsibility linked with the unique reproductive function endowed to woman. Simultaneous with right of autonomy, non-interference and self-determination is the *moral responsibility to control one's reproductive system*. This responsibility ensures that woman does not indulge in reproductive processes without moral determination and due care for the potential persons that result from her actions.

Potential persons are as valuable as persons depending upon our decision to allow it (embryo or foetus) to develop into a full person. For example, killing a foetus that a couple wants is same as homicide. On the other hand, we do not seem to attach same value to foetuses that do not meet the above requirement. Besides, naturally aborted foetuses are not treated in the same manner as we treat infants or children who die due to diseases. It is obvious that personhood in strict sense is defined in terms of rationality and consciousness. But personhood in derived sense ('social sense')

depends upon our person attitudes. Potential persons that embryos and foetuses are, seem to provoke different attitudes under different circumstances.

From the above analysis it may be concluded that potential persons as in the case of foetuses be treated as persons and be accorded due rights. The same would apply to embryos and fertilised eggs, except in the case of spare embryos in *in vitro* fertilisation. The question of consent to abortion ought to be linked up with the moral right and responsibility of the woman. It may be recalled that it is in rare cases (when there is life threat to the mother and there is no possibility of saving the foetus) that abortion is morally justifiable. Although the mother has the moral right to make decisions regarding her reproductive functions, the mother who has abdicated its responsibility regarding the reproductive functions has no moral right to consent for abortion. Reproductive function ought not be treated as individual, private and non-moral activity of a woman.

Euthanasia and Consent

Since the approval of "living will" bill by California Legislature (USA) in 1976, there have been many similar legislations in various countries that allow euthanasia under very unique conditions. A brief study of the California legislation, namely Natural Death Act (NDA) is presented as a paradigm case of 'living will legislations'.

The main features of NDA and other similar legislations are: (i) The execution of a document or 'living will' directing or withdrawal of extraordinary life sustainers when

the individual is in a terminal condition. (ii) Definition of 'terminal illness' as that which will end in natural death whether life sustainers are used or not. (3) The verification of the prognosis by one or more physicians. (iv) Provisions for protecting compliance of the physicians, paramedic staff, etc. against criminal and civil liabilities.

What are the presuppositions of any such legislation? First, the legislation seeks to maintain self-determination of the patient to seek medical care. In other words, it asserts that medical profession is the servant of the patient. Physicians have no right to treat the patient unasked. In fact there is no need to assert this point, as it is implicit to medical ethics, that a patient seeks medical help. He does not surrender or abdicate his life to attending physician. The most unfortunate historical precedent was set when the Quinlans (Karen Ann Quinlan, New Jersey 1976) were forced to go to court to subtract their daughter from unnecessary artificial life sustainers.

The second presupposition of NDA is that it will free physicians, paramedical staff and health facilities from civil and criminal prosecution when they refuse to give unnecessary treatment demanded by patients or guardians of patients. The assumption is that the relations of patients demand excessive treatment, or demand to be overtreated and that the physicians cannot withdraw from giving such treatment. Actually, in normal medical practice, a physician can withdraw from treatment on conscience grounds. Again, studies of hospital functioning have pointed out that in most cases families do not demand excessive treatment. The closeness of family members to the patient have resulted into according them the status of *co-physicians*

in deciding the line of treatment. Further, they are treated as *co-patients* as they 'suffer' with the patient.

The implications and consequences of such legislations may lead to threatening consequences. For instance, 'refusal to be treated' by any or all physicians is a fundamental right and has been codified. In the absence of a will or a document, the physicians may assume that the patient can be treated in any manner. Further, it is almost impossible for individuals to anticipate the future possible events to make such a will and the absence of such a 'living will' may leave the patient in a medico-moral limbo. This would be particularly so in the case of accident victims. The instate patients will be left entirely to the mercy of legal system and their fate will be decided by impersonal State. The most important consequence of such living wills is that the rigidity of legal system will enter into the delicate physician-patient relationship, particularly when the patient is in his or her last stage of life.

In spite of the above warnings, there is moral predicament regarding terminally and chronically ill patients demanding euthanasia. There are a number of physicians who are willing to help such patients in this regard. Again there are patients who wish to end the 'indignity' of life and demand that they be not treated anymore, but the physicians refuse to stop treatment. It is in such situations that a legislation seems to be necessary as without it patients seem to be unable to subtract themselves from the physicians or the health care system. Further, it seems that without such a legislation the physicians cannot render the type of treatment the patients seek and is appropriate

under the conditions. The type of legal interventions *in force* seems to be based upon the presupposition that physicians overtreat the patients (or refuse to treat properly) and patients demand to be overtreated or demand euthanasia under least strain. The presuppositions seem to be based upon a hermeneutic of suspicion between the patient and the physician and attempts are made to protect the patient against the physician and the physicians against the patient. The need of the legislation is felt to protect both the patient and the physician from the impersonal health care system. Such a health care establishment has rules and regulations governing the activities of bureaucrats, physicians, paramedics, insurance agents, etc. each of whom play their role swiftly and efficiently in a given system. Since patients come in contact with physicians and paramedics, they (patients) carry the impression that physicians and paramedics are solely responsible for the treatment of the patients. It is the impersonal and sometimes inhuman world of huge health care system entangled in complex rules and regulations, that the Quinlans were fighting to subtract their daughter.

It may be noted that in a survey conducted by *American Medical Association* [28] ninety four and half percent physicians surveyed stated that they normally adhere to terminally ill patient's expressed wishes, when approaching death. In another survey, hospital authorities admitted that normally they do not use extraordinary and costly treatment and such treatment is rare in case of terminally ill.

On the basis of the above analysis one may conclude that living will legislation is at best redundant and at worst creates conflict in the hitherto unique physician-patient

relationship. It tends to legitimise that what is bad in the health care system, as a living will to subtract oneself from being overtreated (patient) or being compelled to overtreat (physician) grants the possibility that in the absence of such living wills, the patient will be overtreated and the physician will be compelled to overtreat. The conflict of interest between administrators, pharmaceutical companies, insurance agents etc. on one side and physicians and patients on the other in the health care system, seems to be the sole *raison d'être* of such living will legislations.

An individual makes his decision how he will live while dying based upon his *meaning* of life and death. A Christian (more particularly Roman Catholic) whose meaning of life is based upon his faith does not recognise any difference between purpose of living and purpose of dying. For such individuals living and dying is nothing but various stages of unification with his creator, God. All Semitic religions have the same metaphysical and religious beliefs of after life and therefore they seek death as an end of life. Similarly most religions have some form of eschatology or belief in after life. Catholic tradition taking into account the biomedical changes recognised the need for being treated as per the needs of the patient. The terms "ordinary" and "extraordinary" means of preserving life came to be accepted in the discourse of moral philosophy. The decision to discontinue "extraordinary" means of preservation of life is in harmony with the religious belief of the patient or his guardians in higher spiritual values to which other values are subordinated. For such individuals, any form of legislation that desires that one state the type of death one desires, is only a reinforcement of a mistaken belief that physicians have mastery over patients.

Legislations such as living will tend to exclude family from the responsibility of intervening on behalf of the patient. Most often there is an element of suspicion on the part of legislators that members of family tend to overtreat the patient, or that they have 'ulterior' motive for sustaining or not sustaining life of the patient. Instead, legislations tend to give physicians and State the right to implement or decide the course of action. It may be noted that family members and relations of the patient tend to know better the wishes of the patient. The living will legislations have remained silent on this count and by and large the role of relations have remained undetermined.

Since prolonging life is not always in an individual's best interests, in the absence of a written directive, proxy decision to refuse treatment is morally justifiable. The justification is on the basis of principle of autonomy as relations or guardians represent the best possible judges of what the patient would have desired. Further the principle of beneficence justifies such proxy consent as any reasonable and prudent man would see that the prolongation of life under the circumstances would do more harm and suffering than good to the patient. There are however some grey areas in the proxy consent, such as in the case when the costs are taken into account while deciding the termination of extraordinary treatment. This is particularly so in health care system in which costs are debited to the family members or relations. It is paradoxical that insurance system in some health care programmes at one level was seen as responsible for the overtreatment of patients, and at another level is seen as a blessing while deciding (in case of proxy consent) when to stop extraordinary treatment.

In most living will legislations no attempt is made to include liability clauses in case the will is not implemented. There is no penalty for the violations that may occur and which will be against the expressed wishes of the patient. The absence of penalty clauses seem to give rise to the suspicion that living will legislations are meant to protect physicians from civil and criminal liability. The objective is not to protect the patient but the physician. As McCormick argues, "it is not clear why the legislation is written in the first place, for a medal, an armband, or even a written document without legal force would suffice to inform a physician of the patient's general philosophy of living or dying."[29]

Organ Transplantation And Consent

Organ transplantation has given hope when formerly death was inevitable. But the replacement of vital organs highlights major moral and philosophical problems in medicine concerning the role of physicians and nurses, patient autonomy, and respect for the dying and the dead. These include the morality of excising organs from a healthy donor, and related problems regarding an individual's consent to have organs removed for the benefit of others. These problems are not restricted to live organ donation: cadaveric organ removal raises problems over the definition of death, and raises further questions of fundamental moral and philosophical concern over procurement and distribution of organs. Guiding decisions in these areas is a mass of empirical knowledge, scientific theory, and philosophical beliefs concerning what it

means to say that someone is dead or alive, or whether given persons are competent to make a decision, or whether other considerations should override a competent decision.

Living donors present a problem for the 'do no harm' imperative in medicine as they are said to be harmed by the loss of the relevant organ. This applies only to irreplaceable organs (blood for instance is self-replenishing and can be collected without harm to the donor). There are risks involved in the donation of solid organs, such as kidneys, but the general consensus is that, if the risk is not too great, an individual who freely wants to donate an organ should not be prevented from doing so.

One objection to live donation of non-generating organs involves an appeal to the principle of totality. This principle acknowledges that a diseased limb or organ should be amputated or excised for the good of the body as a whole, but it forbids the removal of healthy organs as it would threaten the functional integrity of the body as a whole. On these grounds, so it would seem, the principle rules against live kidney donation. The principle of totality also underpins several cultural objections to post-mortem excision of organs, as in the case of traditional Japanese beliefs.

Objections based on the principle of totality should not be taken too seriously. Their weakness is revealed once the arbitrariness of the concept of totality is exposed. Human beings do not exist in a strictly biological sense apart from other humans. A

'total' human being is essentially social and to a certain extent totality implies a degree of dependence upon other humans. Thus when an individual is removed from a social environment, psychological, and possibly physiological, dysfunction can be predicted. Since man is a social being, it can be argued that the principle of totality must include a capacity to co-operate with others, respond to their needs, and receive help. Rationality and morality are also part of this totality. This implies an awareness of imperatives to come to the help of other human beings, and possibly experience some risk, falling short of self-destruction. Given that self-destruction is not an inevitable consequence of kidney donation, it would appear that the risk entailed and modest dysfunction are compatible with the principle of totality, especially when threats to social and psychological totality are apparent, such as the potential loss of a caring and loved relative. If there is no coercion, it is widely agreed that organ donation is one of the finest gestures of fraternity of which human beings are capable.

There are limits on imperatives to help others. It is important to recognise the distinction between moral and legal duties. Live organ donation is justified by the humanitarian desire to benefit others, but this does not justify obligatory harvesting or undue pressure to donate.

The ethical dilemmas of live donation continue to generate controversy. Arguments in favour stress the altruistic aspects of live donation while opponents refer to the emotional pressure on family donors. Further questions have been raised with regard to the very nature of voluntary donation, which requires two conditions: freedom from

coercion and a competent volunteer who is aware of the risks and possible consequences. Given the kind of atmosphere in which live donation is required, it is not always easy to determine whether the decision is free from psychological pressure, or to assess adequately the volunteer's perception of risks involved. It is not unusual for families to perceive one member as less valuable than another. It is not unusual to exert pressure on the least valuable member to donate a kidney to a more valuable member. On the other hand the burden of psychological pressure may be placed on the potential recipient, and many who have received organs from family members , have suffered considerable anxiety, including feelings of guilt and a sense of failure, if the graft from a close relative is rejected. One justification for the risks involved in live organ donation from relatives or spouse is that benefits might accrue to the donor which could bear the risk.

Live organ donation from minors and incompetent adults is clearly a highly controversial topic, for it is not always obvious that the voluntary principle has been maintained. This is not guaranteed by the legal advice of linking potential benefits with consent. Similar controversies arise over the practice of extracting bone-marrow from retarded siblings or minors. When this is done it is justified on the grounds that the risk to the non-consenting 'donor' is minimal. But it still breaches the principle that prohibits invasion of another person's body without consent. The defence of this practice, that the child or retarded sibling would not object if it understood, is a presumption which scarcely provides a satisfactory basis for ethical conduct in a highly sensitive area.

The problem of live organ donation may never be fully resolved so long as the suspicion of coercion and deceit or fraud looms largely over medical practice. Cadaver donors are seen both as alternative to live organ donation and solution to the ethical dilemma faced in the organ transplantation. But the present issue takes an altogether different ethical dimension while determining death of a person. This is particularly so when the medical fraternity have accepted brain death as de facto death, for the procurement of organs.

First and foremost, in the interests of both scientific accuracy and ethical propriety it is essential to separate the questions relating to the need to obtain organs for transplantation from questions related to the conceptual and factual aspects of determining death. Under these circumstances physicians can be subjected to conflicting moral demands when the organs of one patient can be used to save the life of another. To avoid potential conflicts between the attending physician and the needs of the transplant team, practices have been consolidated which ensure that the donor's physician should have no role in the transplantation procedure itself. This separation principle (questions regarding need for transplantation of organs and determination of death) was recognised in the earliest formulations of the definition of brain death.

'Brain death' is defined in various ways even in medical practice. The definitions of brain death range from 'brainstem death' to ' whole-brain death'. There are medical practitioners who define 'whole-brain death' in terms of 'neocortical death'. There are

other definitions of 'brain-death' that do not refer to brain at all. They only refer to consciousness or mental activity. There are various relativistic definitions of brain death and they seem to largely depend upon the societal concerns or cultural values. There seems to be lack of clarity regarding what constitutes 'brain death' because of the absence of a universal medical criteria determining brain death.

Philosophically analysed, brain death could mean various things on different occasions. For instance, (1) it could mean breakdown of functions of the brain. It could also mean (2) irreversible breakdown of the functions as in the case of renal failure. It could also mean (3) death of whole human being due to complete and irreversible breakdown of brain function. Critics have pointed out that the transition from (1) to (3) is unwarranted, and the above definitions will lead to a dualism of human being and human person.

Although it is not part of the present study to analyse the various definitions of death and the medical criteria laid down for deciding the same, it is enough to point out that there is methodological confusion regarding the concept of purely medical confirmation of death.[30] There is one more serious objection which seems to be at the centre of all definitions of 'brain death'. The critics of brain death claim that the reasons provided for the claim of irreversibility of loss of brain-functions or destruction of brain, are unwarranted. There are reported cases in biomedicine where individuals in a state of coma for a long period of time have regained consciousness (sic brain functions).

Philosophers have rightly pointed out that matters of moral concern should inform medical criteria for death and organ removal. Respect for the body of the deceased is a feature of all religious and secular belief systems. The body represents the past memory of the departed person, and wanton mutilation is unacceptable. To lose respect for the body of a dead human being is indicative of disrespect for that person, the next of kin, and ultimately for all human beings in general. Although respect for the deceased reveals cultural variations, violation of the body's integrity for therapeutic purposes, such as transplantation, is rarely prohibited.

Routine Procurement And Presumed Consent

Laws based upon presumed consent empower physicians and coroners to remove organs and tissues from a deceased patient without prior consent. In the USA many states have enacted laws authorising the removal of corneas and pituitary glands on a presumed-consent basis, but do not extend this to the removal of solid organs, such as hearts, livers and kidneys. In Austria, Czechoslovakia, Denmark, France, Belgium, Israel, Poland and Switzerland, solid organs can be procured on a presumed-consent basis.

There are strong utilitarian arguments in favour of routine procurement. It would save time and lives, increase the supply of organs, reduce costs, avoid awkward and very often painful requests of distressed relatives, and eliminate the effort of carrying donor cards. The major ethical problem concerning routine procurement is not over the

mutilation of the corpse, as most religious and secular moral systems acknowledge that organs can be removed under appropriate conditions. The question is primarily whether organs should be removed without express consent. There are, however, precedents as in the case of most Western countries, post-mortems are conducted for law-enforcement purposes without seeking consent of next of kin. This practice does not appear to greatly offend society in general. If organs can be removed for autopsies as a matter of public interest, then why not for the purpose of transplantation? Critics usually appeal to loss of autonomy and the opportunity to exercise generosity. If organ donation is one of the supreme gifts that one individual can bestow on another, it is argued, then society cannot afford to lose such altruistic practices, the benefits of which spread further than the demand for more transplantable organs. Routine procurement policy could be implemented by contracting our arrangements for those with religious and moral objections, and thus incorporate an element of consent , so that an individual who has not expressed a wish to the contrary may be presumed to have consented to donation. It is argued that some countries have at its disposal sufficient information on the beneficial aspects of organ transplantation. Under such circumstances it can be presumed that the individuals would have made their objections known in their lifetime. Criticisms against such routine procurement and presumed consent comes from some theologians who see such a method as coercive and against civil rights of the minorities.

It may be impossible to reach a clear-cut decision in favour of either policies based on the doctrine of presumed consent or those based on express consent.[31] There are two

levels of the argument which need to be distinguished. At one level we find practical arguments based on the need for organs and the beneficial consequences of maximising the harvest. The decision here between taking and giving would simply turn on which side a most convincing argument for the strategy is presented that would lead to the maximisation of supply. Thus, if the overriding objective is a policy to maximise the number of organs under most efficient methods then a policy of presumed consent with contracting-out provisions would be most innocuous strategy, provided that there are safeguards to minimise distress caused to relatives. Yet on another level there are conflicts which may only be resolved by a general shift in the moral climate. For it is impossible to weigh up and assess arguments which counter the interests of the dead and the living. Those who resist proposals for the routine salvaging of organs, express concern for matters such as the integrity of the corpse (emphasising its symbolic role), the emotional feelings of the relatives, and a wide range of notions of respect for the being that was. Opponents who dismiss these objections as signs of emotional immaturity have not even begun to address the moral issues, which lie at the heart of most of the world's cultures.

NOTES

[1] H. T. Engelhardt, *The Foundation of Bioethics*, N. Y.: Oxford University Press, 1986, p.263

[2] Ibid. p. 262.

[3] Engelhardt refers to indentured servitude'of both, which is due to minors receiving parental support while not seeking emancipation.

[4] H.T. Engelhardt ,(1986),p.287.

[5] Quoted in Richard A. McCormick, *How Brave A New World- Dilemmas in Bioethics*, N.Y., Double Day & Co.,1981, p. 59.

[6] Ibid. p. 61.

[7] *Encyclopedia of Bioethics (EB)*, Vol.4, (Appendix), p.1774 and p.1770.

[8] *The Belmont Report* of the National Commission for Protection of Human Subjects of Biomedical and Behavioural Research of U. S. A. lays down *Ethical Principles and Guidelines for the Protection of Human Subjects of Research* which are common to all forms of human experimentation whether it is with adults, children, infants, foetuses and embryo.

[9] Quoted in Arthur C. Danto, "Persons" in Paul Edwards (ed.), *The Encyclopedia Of Philosophy*, N.Y., The Macmillan Company & The Free Press, 1967,Vol.6, p.111.

[10] Ibid.

[11] Ibid.

[12] John Harris, "*In Vitro* Fertilisation:The Ethical Issues I", *The Philosophical Quarterly*, Vol. 33, No. 132, 1983, p. 225.

[13] "Absolutist" arguments are those that tend to argue to all or none without taking into consideration the context/situation, which may radically change the status of embryo.

[14] Richard A. McCormick, (1981), pp. 77-84.

[15] *Spare* embryo generally refers to fertilised eggs in *in vitro* fertilisation procedure when multiple eggs are fertilised and only one or two used for implantation. The remaining fertilised eggs are deemed to be *spare*. In more specific terms it may also refer to deliberately produced embryos (in the fertility clinic) either for perfecting fertilisation techniques or for other therapeutic reasons.

[16] Cf. H. T. Engelhardt, (1986), pp. 236-237.

[17] 'Slippery slope' argument holds that an action should not be permitted (or is deemed illegitimate) because it will lead to a consequence which is deemed harmful or morally wrong. J. S. Freeman has recognized three types of slope arguments - "logical" slope argument, "empirical" slope argument and "full" slope argument. ("Arguing Along the Slippery Slope of Human Embryo Research", *The Journal Of Medicine And Philosophy (JMP)*, Vol. 21, No. 1, 1996, pp. 61 - 80.) The argument has also been presented as *the principle of dangerous precedent* and in this form it argues that one should not do even "right action for fear you or your equally timid successors, should not have the courage to do right in some future case, which ex hypothesis is essentially different, but superficially resembles the present one. Every public action which is not customary, either is wrong, or, if it is right, is a dangerous precedent." (F. M. Cornford, *The Microcosmosgraphia Academica*, Cambridge, 1908 quoted in John Harris (1983), p. 236.)

[18] The National Institutes of Health Revitalisation Act of 1993.

[19] John Harris, (1983), p. 232.

[20] Cf. Mary Warnock, "*In vitro* Fertilisation: The Ethical Issues (II)", *The Philosophical Quarterly*, Vol. 33, No. 132,1983, p. 248.

[21] For a most faithful position of Roman Catholic Church please refer to C. H. Peschke, *Christian Ethics*, Vol. II, Bangalore, Theological Publications in India, 1981.

[22] Moral theologians have always glorified suffering of a type as part of their attempt to solve the problem of evil.

[23] Cf. James T. McHugh, "Health Care Reform and Abortion: A Catholic Moral Perspective", *JMP*, Vol. 19, No. 5, 1994, pp. 491-500.

[24] Jane English, "Abortion and the Concept of a Person", *Canadian Journal of Philosophy*, 5, 1975, pp. 233-243.

[25] J. J. Thomson, "A Defence of Abortion", *Philosophy and Public Affairs*, 1, 1971-72, pp. 47-66.

[26] Thomson's argument as summarised by David S. Levin, "Abortion, Personhood, and Vagueness", *The Journal of Value Inquiry*, Vol. 19, No.3,1985, p. 202.

[27] David S. Levin, (1985), p. 204.

[28] American Medical Association, *News*, 1977, quoted in Richard A. McCormick, (1981) p. 411.

[29] Richard A. McCormick, (1981) p. 409.

[30] For a detailed analysis of various definitions of 'brain death' refer to Joseph Seifert, "Is 'Brain Death' Actually Death", The Monist, Vol. 76, No. 2, 1993, pp. 175-202.

[31] In USA there is a system of *required request* whereby hospitals are under obligation to request relatives of dying patients to consider organ donation after the death of the patient in question. The *required request* presupposes dissemination of information regarding impending death, counselling of relatives of patients, etc. While implementing required request it was argued that the supply of donor organs will increase without sacrificing the principle of voluntarism. There has not been substantial increase of donor organs in spite of such a system. England, and many other countries have opted for education on donation of organs and donor-card system.

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

consititutes 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 Āyurveda, (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 *Dharmaśāstras* 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 purusharthas 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."[2]

Concept of health in Āyurveda is explainable (like *prakṛti* in Sāṁkhhya 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 (*kaumārabhṛtyatantra*), toxicology (*agadatantra*), geriatrics (*rasāyanatantra*), rejuvination (*vājikaraṇatantra*), 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 (*mahābhūtas*) 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 *(saṃskāra).* 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 *moksa.*

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 *dharmśāstras* do not deal with the ethics of medical practitioners *(vaidyadharma). Āpastamba Dharmasūtra* briefly refers only to the duties of a king *(rājadharma). Yājñavalkyasmrti* has chapters only on *rājadharma* and *yatidharma.* Even Kautilya's *Arthaśāstra* 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."[3]

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 (*prakṛtistha*). 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.[4]

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 a 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 Āyurveda 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 Āyurveda 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 *riṣṭa-lakṣaṇa* 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 *riṣṭa*-symptoms.

If Āyurveda 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 Āyurveda to vigorously pursue in this direction when faced with the challenge of failure. Āyurveda 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 *Dharmaśāstras* 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 Āyurveda science of medicine.

Caraka lays down a clear code of conduct for the Āyurveda 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 started[6]. 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*).[7] Fasting to death (*sallekhanā* or *samādhimaraṇa*) 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, *prāyopaveśana* (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 (*ahiṁsā)* 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.[8]

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 grand daughter 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.[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.

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.' [12]

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 (c) 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."[14]

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".[15]

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[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.[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[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

[1] Carakasaṁhitā Sūtrasthāna ,1-1, quoted in S.E. Bhelkey, "A Moral Predicament of an Āyurvedic Physician", unpublished paper presented at the Seminar on *Bioethics: Indian Perspectives*, (Department of Philosophy, Goa University, 26-28, Nov. 1997), Proceedings,p.37.

[2] Srinivasa Rao, "Ethical and Other Allied Ideas in Āyurveda", unpublished paper presented at the Seminar on *Bioethics: Indian Perspectives*, (Department of Philosophy, Goa University, 26-28, Nov. 1997), Proceedings, p. 13.

[3] Srinivasa Rao, (1997), pp. 18-19.

[4] Carakasaṁhitā Indriyasthāna, 12.62-64, quoted in Pradeep Gokhale , "Ethics and Bioethics of Life and Death in the Ancient Indian Context (Some Observations and Comments)", unpublished paper presented at the Seminar on *Bioethics: Indian Perspectives*, (Department of Philosophy, Goa University, 26-28, Nov. 1997), Proceedings,p.30.

[5] See *The Cultural Heritage of India*, Vol. VI, Calcutta, 1986, p. 174.

[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.

[7] cf. Katherine K. Young, "Euthanasia", in Harold G. Coward, Julius J. Lipner and Katherine K. Young, *Hindu Ethics*, N.Y., State University of New York Press, 1989, p. 74.

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

[9] Prakash N. Desai, "Medical Ethics in India", *The Journal Of Medicine And Philosophy (JMP)*, Vol. 13, No. 3, 1988, p. 252.

[10] Studies such as that of Prakash N. Desai (*op. cit.)* inadequately portray medical ethics in India as uniquely Indian based upon *Dharmaśāstras* 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 smṛti 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.

[11] D. P. Chattopadhyaya, *Science and Society in Ancient India*, Calcutta, Research India Publications, 1977.

[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)

[13] C. K. Parikh, *Parikh's Text Book Of Medical Jurisprudence And Toxicology*,Bombay,Medical Publications,1981, p.611.

[14] Ibid.

[15] Ibid.

[16] Medical Council of India, Code of Medical Ethics in *A Review Of Medical Ethics And An Update*, Indian Medical Association Publication, 1990,p.60.

[17] R. Srinivasamurthy, Somnath Chatterji, T. G. Sriram, Vardhini Parvatha, Mamatha Shetty, and K. S. Raghavan, "Informed Consent for drug trial: a systematic study", *NIMHANS Journal*, Vol. 6, 1988, pp. 145-149.

[18] T. T. Thomas v. Elisa, AIR, 52, Cited in C. M. Francis, "Medical Ethics in India: ancient and modern", *Medical Ethics*, Vol. 4, Oct.-Dec., 1996, p116.

[19] cf. B. N. Colabawalla, "Understanding voluntary euthanasia: a personal pespective", *Medical Ethics*,Vol.4.,No.1,Jan.-Mar,1996, p.11.

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'.

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-àvis 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 reflective

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-àvis 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'*.

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. In 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 Āyurveda 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 Āyurveda 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 Āyurveda 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 Āyurveda. 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.

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