Ethical Issues in the Practice of Medicine

Historical

Medicine, according to Charaka, always existed and what we call its beginning is no more than a systematisation of available knowledge at some point of time. From its beginning in the remote past, the practice of medicine was permeated by a code of ethical conduct. In the Indian tradition, a young student was initiated into medical training only after careful assessment of his competence and suitability. The initiation ceremony was a grand ritual held in the presence of students and teachers when the preceptor would solemnly issue commands which the initiate was obliged to accept. The following extract from the commandments would give a flavour of the ethical dimensions of medical practice two thousand years ago in India.

“You should remain a celibate, speak truth, adhere to non-violence, abjure envy and, use substances that enhance intellectual power. You should sport a beard and moustache, avoid meat and, at all times, obey my commands except under threats of the King’s ire, death, unrighteous conduct (adharma) and calamities. You should look upon me as your master, follow the course that pleases me and live with me as my son, helper and servant. You should be vigilant, humble and careful and, at all times, maintain your presence of mind. You should move about with my permission; and whenever you move, even without permission on occasion, your purpose should be to collect things for me according to your ability. When you aspire to become a physician and seek professional success, wealth, fame and heaven hereafter, you should cherish the physician and seek professional success, wealth, fame and heaven hereafter, you should cherish the welfare of all living beings and especially that of cows and brahmans. You should strive by every means to get your patients well and never entertain evil thoughts about them even at the risk to your life. You should not, even in dream, covet other’s women or property and should remain modest in dress, appearance and conduct. You should shun liquor and keep away from sins and sinners. Your words should be pleasing, truthful, well-chosen, brief and matter-of-fact, you should never lose sight of place and time, the constant pursuit of knowledge and the improvement of equipment and skills.

You should decline to treat the enemies of the King, traitors, persons disapproved by the noble, and the wicked and loathsome in conduct who refuse to deny allegations against themselves. You should also decline to treat the moribund. You should not treat, or accept a reward offered by, women in the absence of their husbands or guardians. On visiting a patient’s home you should be properly dressed and accompanied by a person known to the family and whose entry is permitted. You should maintain a low profile but keep your memory sharp, and avoid unnecessary talk. You should concentrate your mind and senses solely on the patient, his well being and his bodily and other features. What you witness in the house should not be told outside; nor should you tell a patient about his shortened life span when the news may seriously hurt him or others. You should not parade your knowledge because pedantry — even on the part of experts — is always tedious.

Ayurveda is endless, so is its study. One should pursue it with unerring zeal because it deserves no less. Discarding jealousy, one should learn good conduct even from enemies because the entire world is the teacher for the wise just as it becomes the enemy for the unwise. The wise should welcome and act upon good counsel — even from an enemy — which vouchsafes gratification, long life, high repute, strength and popular esteem”.

Ayurveda of Charaka held sway in India from 600 BC to 800 AD to such an extent that P.C. Ray termed those centuries the “Ayurvedic period”. The term was chosen because Ayurveda encompassed not only medicine but also the beginnings of chemical, plant, animal and all that would merit the term biomedical sciences today. It is a reasonable assumption that ethical conduct in medical practice was largely upheld during the golden age as any lapse would have met with strong societal disapproval or would be punished by death penalty according to Kautilya’s Arthasastra. Kautilya not withstanding, there were fraudulent physicians who were graphically described and condemned by Charaka. But frauds then, as now, are impervious to ethics.

The Ayurvedic period of Ray was followed by a long period of 1000 years when the science and practice of Ayurveda became stagnant and the springs of originality dried up. What is important from the ethical point of view is that the surgical and other manual procedures which were highly prized at the time of the Buddha and recorded brilliantly in Sushruta’s classic disappeared from the main stream of Ayurveda when the stagnation began in the ninth century. They barely survived among castes who were regarded as untouchable. This was part of a vast national tragedy because not only surgery but all crafts which demanded the use and soiling of hands were downgraded and those who practised and refined
the crafts—surgeons, weavers, metal workers, potters, tillers and so on — were despised. This was perhaps the first and worst blow to the ethical practice of medicine in India, which cast a heavy shadow on not only our social history but also on our scientific creativity. Strangely, this phase of stagnation and social upheaval in India coincided more or less with the “dark age” in Europe when the practice of medicine was supposed to be based on the teachings of Hippocrates and Galen but was cruel and exploitative except where the Church ran charity institutions. Even as late as the fifteenth century when Ambrose Pare dominated European surgery, the commonest operations were amputations of the breast and limbs done without anaesthesia by ill trained or untrained physicians with horrific mortality. Medical treatment was not much better and invited the ridicule of Voltaire in a later period. Hahneman’s inspiration for the development of homeopathy came primarily from the dreadful complications of the chemical compounds used in medical practice. In fact medical doctors insisted on the exclusive right to treat diseases and rejected public scrutiny, leave aside control of medical practice in Britain as late as the eighteenth century. When the town council of Liverpool decided to appoint Duncan as a Health Officer to look after the newly created Department of Public Health for controlling cholera, the Medical Association protested vigorously on the ground that the treatment of cholera was solely their concern and the Municipality had no role in it! Public good was clearly subordinated to group interests with scant regard for ethics. The conclusion is inescapable that the high ethical ideals which had inspired the practice of medicine in the distant past had lost their hold on the minds of physicians thanks to the march of socio-economic events and the escalation of private greed.

Ethics in the Practice of Medicine: New Beginning

Medical practice and medical research can be independent of each other but, like two parallel strings, they intertwine too often and come apart again. Medical research which does not benefit medical practice sooner or later hardly deserves its name and a medical practitioner whose practice does not keep in step with clinical and epidemiological research may lose not only his re-certification but even his indemnity insurance! In fact, the practice of modern medicine based on research did not begin until after Renaissance in Europe when Vesalius published his marvellous book on the “Fabric of the Human Body” Come nineteenth and early twentieth centuries, four great winds in Europe changed the direction of modern medicine. These were public health measures, anesthesia, antisepsis and advances in chemistry and physics which altered the practice of medicine so thoroughly that it was never the same again. During those eventful years, ethical discussions were few because every physician was guided by his honour, by his concern for peer approval and above all, by his conscience. One might say, it was the period of ethical innocence, if not indifference, for the medical profession. It was unthinkable for the profession to imagine that physicians could be cruel or even sadistic to patients under any circumstances. This comfortable myth was shattered when the notorious experiments of the Nazi doctors became known though the Nuremberg trials after World War II. A shocked world learnt that prisoners had been put into low pressure tanks to determine how long they would tolerate hypoxia; they were forced to remain naked outdoors in freezing weather for 9-14 hours to see the efficiency of rewarming techniques; they were infected with malarial parasites to test the efficacy of antimalarial drugs; similar experiments were done with typhus, various poisons and so on in a sickening series of ghastly experiments. The Nuremberg code which emerged from the trial was primarily applicable to clinical research and its connections to the practice of medicine in hospitals were not believed to be a matter of concern in hospital practice. This second myth was shattered in 1966 when Beecher of the Harvard Medical School described no less than 22 studies from contemporary literature which could by no stretch of imagination be justified from the ethical stand point. Hospitalised patients were injected with plutonium without their knowledge to determine the toxicity of the metal; live cancer cells were injected into elderly and debilitated patients to assess the rate of rejection; a needle was introduced into the left atrium during bronchoscopy to measure the pressure directly with a metal; live cancer cells were injected into elderly and debilitated patients to assess the rate of rejection; a needle was introduced into the left atrium during bronchoscopy to measure the pressure directly with

Ethical Issues in the wake of Technological Progress

The ethical issues which so dominate the practice of medicine as well as medical research today began to grow in importance in the post World War II period. On even cursory examination it would be obvious that most of the ethical issues arose from the introduction of new technologies. Medical technology may be classified under instruments, devices and biotech products. Examples from each group would make it clear that few technologies are without ethical dimensions.

Physicians and Technology

Take instruments. For making a diagnosis analytical (e.g. autoanalysers), electrophysiological (e.g. ECG),
Imaging (CT, MRI, radionuclide, ultrasound) and optical (various fibreoptic scopes) instruments are routinely used and no modern hospital could be without them. Unfortunately medical instruments become invariably more expensive with every new generation in sharp contrast to computers. As a result, public hospitals which serve the majority of people in India find themselves without many modern instruments or are able to meet no more than a part of the great demand. Under these circumstances, how does a doctor prioritise patients? This is a painful choice which confronts hundreds of our physicians everyday. Instruments raise other ethical issues as well. It is common knowledge that diagnostic laboratories are set up as commercial establishments by businessmen who offer a commission to the doctor who refers patients to them. The situation is worse when the physician has a financial interest in the laboratory and the conflict of interest becomes glaring.

Moving on to another area of instrumentation, one needs to look at life support and monitoring instruments in the intensive care unit (ICU). The per diem cost of maintaining a patient in the ICU is high and the availability of beds can often be a problem even in large hospitals. How does one prioritise admissions to the ICU? If a patient on a ventilator is maintained by drugs, i.v. alimentation etc., and no EEG is available, when does one turn off the support systems especially when severely ill patients are knocking at the door for admission? On the other hand, how does one deal with the complaint of patients that they were needlessly kept in the ICU for “observation” when it could have been done at a fraction of the cost in the ward? Issues of prioritisation, conflict of interest, cut practice and corporate profiteering turn up again and again when one looks at the advent of newer medical instrumentation. The worst example of unethical practice in the use of instrumentation is ultrasound in foetal examination. This puts all other examples in the shade.

The next large area of medical technology covers devices which may be disposables or implants. There are literally thousands of disposables ranging from syringes to dialysers and modern medical practice is hardly possible without them. Among the ethical questions one faces with disposables, re-use is an example. The manufacturer stipulates that the devices are for one-time use but the agent of the company as well as the physician’s experience may support their re-use especially for poor patients when a disposable catheter may cost Rs. 5,00,000. In regard to implants, how ethical is it to use pacemakers removed from cadavers abroad and sent to India for charitable use in poor patients? These are happening all over India and no one seems to even detect an ethical issue in such practices.

The third and emerging area of technology is biotechnology which, it is claimed, will dominate the practice of medicine in the current century. Here again, a diagnostic kit based on recombinant DNA technology gives a powerful tool to the physician and leaves him to grapple with a host of questions, such as, should all patients listed for procedures be tested for HIV? What about testing the doctors? Should the results be disclosed? So on it goes. These questions will multiply in one form or another when we come to therapeutics and vaccines based on biotechnology, stem cell research, assisted reproduction, xenografts and so on.

**Physicians and Industry**

Technology reaches the physician through industry which does its own R&D, scaling up etc., and make large investments. Though the consumer of drugs, devices and other products of industry is the patient, the physician is an indispensable intermediary and could almost be regarded as an intermediate consumer because the patient would be guided in his choice of products by the physician. It is known all over the world that industry spends a fortune on promotional activities among physicians and prestigious journals such as *JAMA* and *BMJ* have had campaigns on the ethics of this practice. The public regards a physician as a fiduciary, thanks to his domain knowledge, trustworthiness, high standards of conduct, objectivity and his ability to stay clear of conflict of interest. What does such a physician who advises a hospital on purchase do if the supplier of a scanner being considered for purchase by the hospital offers to fly him to visit the manufacturing and training centre of the firm in Europe or the US for three days with all expenses paid? What should be the physician’s attitude to gifts offered by industry? How does one ensure that the interests of industry along with those of the patient? What should be a mechanism to scrutinise the practice of industrial gifts and ensure that they do not influence physician’s decisions?

Industry involves areas other than the manufacturing of drugs, instruments and devices. Physicians must deal with insurance companies, hospital corporations, commercial laboratories and a host of other industries. Ethical issues arise in each of these encounters. Suppose the insurance company receives a bill for services, some of which may not have been provided? What about physicians receiving kickbacks from laboratories and scanning centres? Industry sponsors a discussion for half a day in a luxury hotel on a particular disease for which the company produces drugs and invites physicians with air travel, hotel accommodation, a decent honorarium and cultural programme thrown in. Should they accept the invitation?

A practising physician may have occasions to take part in research sponsored by industry. The criteria which are accepted the world over for the participation of physicians are that the integrity of research and the
The practice of medicine in a teaching hospital would raise altogether different issues. A medical student is unprepared and untrained to look at the rising tide of clinical trials scientifically and get involved without violating the ethical code of the profession. The ultimate victims of unethical practices in medicine will be the people who may be unaware of their rights, unable to give informed consent and too poor to seek remedies. But their collective anger can and will give powerful jolts to the society as several attacks on hospitals have already shown.

CONCLUSIONS

The vast population, their rising expectations and the unprecedented interaction between medicine, technology and industry have made it imperative that effective mechanisms are put in place to uphold ethical conduct in medical practice. This has become more urgent, thanks to the rapid advances in technology which reach India almost at the same time as the countries of their origin and raise new ethical issues which we would not have encountered or studied. Besides, we are constantly witnessing new developments—medical tourism, corporate medicine, holistic medicine and a host of others—whose regulatory and ethical dimensions are far from clear. The existing bodies such as the MCI, State Medical Councils etc., were set up for very different purposes.
long ago and have neither the competence nor the moral authority to uphold ethical standards in the practice of medicine. Unfortunately our professional associations have failed to develop effective and elaborate mechanisms to ensure the ethical conduct of members as the BMA and AMA have done to their credit in the UK and USA. The need for a body to uphold ethics in the practice of medicine has never been more acute than at present. It is not only most desirable but essential that a Council for Medical Ethics is set up in India on the lines of the Press Council of India by an Act of Parliament to serve as an ethical watchdog of the medical profession for the benefit of the public. The medical profession must have full freedom to practise medicine, conduct research, teach and publish their research findings without hindrance from authority, individuals or organised bodies. But this claim to autonomy is legitimate only so long as ethical conduct is ensured in the practice of medicine including investigative medicine. When the ethical norms are breached by unprofessional conduct, the regulatory function should not be left to the Government, which would be a case of remedy being worse than the disease. The Press Council of India is an admirable model for medicine to ensure that practice and research involving human subjects adhere to the highest standards of ethical conduct. The medical profession should, according to me, welcome this prospect as the proposed Council for Medical Ethics would be an effective form of peer view. While the PCI Chairman is a retired judge of the Supreme Court nominated by the Chief Justice, 20 out of 28 members of the Council represent the Press. The medical profession would, therefore, play a central role in regulating itself. The Council should be empowered to deliberate on all complaints of unethical conduct of medical doctors and institutions and warn, admonish, censure, and order punishments, and its decisions should not be questionable in a court of law. Unless we take a bold step now, we shall be guilty of building a grand medical mansion on ethical sands, which would fall when the rains come and winds blow.

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