FROM THE THIRD GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE: CULTURAL DIVERSITY AND PERSON-CENTERED HEALTH CARE

Culture, Ethics and Medicine in South Asia

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Abstract

The criteria for health are not well defined, and they vary from culture to culture and from time to time. This paper discusses cultural influences on ethics in medical practice and research in South Asia, the poor cousin of the Western world. South Asian culture is a conglomeration of many religions like Hinduism, Islam, Buddhism and Christianity, and civilizations, which have been influenced in the later era by the Western medicine during the colonial period. The rich past heritage had had its own role. In recent years, South Asia has emerged as an important destination of translational research, for which it is crucial that ethical standards are maintained to prevent exploitation of the general population.

Keywords

Ancient, culture, ethics, India, medical

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Introduction

Cultural factors have influenced the definition of health and mental health. In ancient Greece Plato suggested, those who do not accept beliefs in Gods as laid down by the State be designated as deviant and mad and be isolated. He believed, a healthy State makes the 'psyches' of its citizens healthy. Bhagavd Gita created by Vyasa had a profound influence in Indian thinking since centuries. Gita is an ancient document on the affairs of the minds of men, their temperaments, behavior, frailties and strengths which guided ancient Indian physicians in their ethical practice. Ethics have also formed an important part of medical practice since the time of Hippocrates. Though the current concept of medical ethics has come from the Western medicine and is also applied in the modern medicine in other countries, role of local cultural influences can't be ignored. The cultural factors play an important role in acceptability of medical treatment, and have also implications in further development, research, and growth of medical science. In recent years, a lot of transnational collaborative research is taking place in poorer countries of South Asia. This has raised concerns about the protection of rights of the human subjects in biomedical research [1]. Hence it is important to review the ethical guidelines prevalent in South Asian countries in medical practice and understand the cultural influences, so as to protect the rights and prevent exploitation of the vulnerable patients of the poor countries. This paper discusses the influences of culture on medical ethics mainly from South Asian perspective.

What are ethics and their relevance to medicine?

Ethics have an important role to play in medical practice, where a doctor while treating a patient by different means, may have to perform different diagnostic or therapeutic procedures. Ethics basically refer to the principles of conduct that govern the behaviour of medical professionals, which includes moral duties, obligations and responsibilities towards the patients. The medical ethics differ from the clinical practice guidelines in form that they provide only some general guidance for the doctor in terms of medical practice and research, broadly referring to respect for autonomy, beneficence, non-malfeasance and

justice [2].The guidance is generally in form of what is good vs what is bad or what is right vs what is wrong.

Respecting people's autonomy means taking a person's consent before anything is done to him or her, after providing adequate information and ensuring that a person has understood the process. Autonomy also includes medical confidentiality, as the doctors have a general obligation to keep other people's secrets confidential, disclosed during the professional interactions. This is important because, without such assurance, patients are less likely to divulge the often highly private and sensitive information that is needed for their optimal care. Principles of beneficence and non-malfeasance refer to the traditional Hippocratic moral obligation of medicine to provide net medical benefit to patients with minimal harm. The medical professionals need to ensure that they provide the benefits they profess to be able to provide. The obligation to provide net benefit to patients also requires the professional to be clear about the risks and probable benefits associated with a particular treatment or procedure, when assessments of the expected benefits and possible harms are made. A low probability of great harm such as death or severe disability is of less moral importance in the context of non-malfeasance than is a high probability of such harm. Similarly, a high probability of great benefit such as cure of a life threatening disease is of more moral importance in the context of beneficence than is a low probability of such benefit. Justice, the fourth ethical principle, refers to the moral obligation to act on the basis of fair adjudication between competing claims. The obligations of justice include fair distribution of scarce resources, respect for people's rights and respect for morally acceptable laws [2].

Historical perspective

History of medical ethics in the modern medicine can be traced back to the time of Hippocrates, the famous Greek physician of 5th century BC, on whose teachings the Hippocrates Oath is based. It states "…Except for the prudent correction of an imminent danger, I will neither treat any patient nor carry out any research on any human being without the valid informed consent of the subject or the appropriate legal protector thereof, understanding that research must have as its purpose the furtherance of the health of that individual. Into whatever patient setting I enter, I will go for the benefit of the sick and will abstain from every voluntary act of mischief or corruption and further from the seduction of any patient…". The Hippocratic tradition, however, is not the only option for resolving medical ethical dilemmas. Some other frequently referred to texts on the subject include the Declaration of Geneva, the Principles of Ethics of the American Medical Association, or the national guidelines of the country of practice [3].

Historically, need for medical ethics was felt following the shocking behaviour of the German medical practitioners post Second World War in conducting experiments on human subjects without their consent and exposing them to grave risk of death or permanent disability. Thereafter, concerns were raised internationally over regulating medical research. Nuremberg Code, the first international statement on the ethics of medical research using human subjects was formulated in 1947. The Code highlighted the essentiality of voluntary consent. Subsequently, the Universal Declaration of Hunan Rights, which was adopted by the General Assembly of the United Nations in 1948, expressed concern about rights of human beings being subjected to involuntary maltreatment. Based on the preliminary efforts of the Council for International Organisations of Medical Sciences (CIOMS) in 1964 at Helsinki, the World Medical Association formulated general principles and specific guidelines on use of human subjects in medical research, known as the Helsinki Declaration, which has been revised from time to time. The most recent revision was adopted by the 56th World Medical Association Assembly in Seoul in October 2008.

Medical Ethics in South Asia: Role of cultural factors

Culture can be broadly defined as a common heritage or set of beliefs, norms and values, and refers to the shared attributes of the particular group. Since cultural values affect the medical beliefs, health seeking behavior, acceptability of a particular treatment, cultural factors are also likely to influence medical ethics. The modern medical ethics mainly refer to the modern medical practice, or more specifically the Western medical model. Even in the Western culture, the traditional Hippocratic model or the modern ethical principles may not be fully compliant with major Western religious systems like Judaism, Catholicism or Protestantism or the Western secular philosophical options like Kantianism, utilitarianism or libertarianism, and a conflict is possible between ethics and cultural values [3]. Here, we will refer to influences of the traditional cultures of the South Asia, which includes ancient Indian system of medicine, Hinduism, Buddhism and Islam.

Medical ethics in India are embedded in its ancient and diverse medical and cultural traditions. India is a multicultural, multilingual and multiethnic society. Variations in the traditional health related beliefs may thus be seen across different parts of the country, which also follow a number of medical systems (Ayurveda, Siddha, Unani, Homeopathy, etc.) embedded under the Indian Systems of Medicine [4]. Indian history and the ancient treatise on Indian medicine provide a framework for understanding Indian medicine and for understanding ethical action within medicine. The ancient medical texts of India, especially the *Charak Samhita* [5] have wide

references to medical ethics. The Indian understanding of the importance of progeny, especially male progeny, provides a framework for understanding Indian views on conception, pregnancy, abortion, and sex selection. A Hindu, who sees death as a transition to a new and potentially better life is likely to have difficulty communicating with a secular Western physician for whom death is the end of all that is [6].

The value systems in India have been influenced by all the prevalent religions, predominantly by Hinduism, the major religion (82.64% of the population), contributing to the philosophy and ethics of the people of' the country[7]. Closely allied to Hinduism are Jainism and Buddhism. Ayurveda (the ancient science of life), the ancient system of medicine in India, lays down the principles of management in health and disease. It also has a code of conduct for the physician. Charaka, a famous Indian physician of the ancient period, has described the objective of medicine as two fold; preservation of good health and combating disease [5]. Charaka Samhita prescribes an elaborate code of conduct. The medical profession has to be motivated by compassion for living beings. Charaka's humanistic ideal becomes evident in his advice to the physicians, that "He who practices not for money nor for caprice but out of compassion for living beings, is the best among all physicians". Charaka also advises the physician to take into confidence the close relatives, the elders in the community and even the State officials, before undertaking procedures which might end in death of the patient. The physician is to proceed with the treatment only then.

Islam, the other dominant religion in many South Asian countries, also had its own influences on medical ethics, which were inspired by a dual set of sources. The first was scriptural and historical, embodying the Islamic message, revealed to the Prophet Muhammad and recorded in the Qur'an. The second set of sources consisted of combination of influences resulting from the Muslim conquest and expansion from the seventh to the eleventh centuries into domains, whose cultural and scientific heritage were selectively appropriated by Muslims, and were then refined and further developed. The elements in the early moral environment refer to healing within the larger world-view of the Qur'an, which were later modified in terms of intellectual and cultural adaptation. These subsequently integrated the new values and practices that were not directly derived from the Qur'an, Prophetic practice or Arab. The traditional notion of *adab*, another related concept from Islam, refers to the integration of human learning and knowing of the right and appropriate human conduct into a conception of criteria for excellence. While the traditional Hippocratic medicine lacked any full theory of justice or the duty of physicians to treat those in need, Islam has, with its sister traditions, Judaism and Christianity, historically provided a special commitment to treat the poor [3,8].

Buddhism, the third major religion of the South Asia, follows the virtue based system, as also the other religious systems, which is in contrast to the Western medical ethical systems in its emphasis on equal treatment. There is also a relative lack of interest in the Western notions like privacy and confidentiality. Veracity is always a duty for people in general and medical personnel in particular. Falsehoods and deception cannot be morally justified simply on the grounds that we think it is good for another. Buddhism also prohibits killing. The doctrine of *Kamma* holds that joys and sorrows are the result of one's own past actions. *Kamma* must run its course or will be manifest in a future life. Compassion goes beyond justice to self-giving and self-denial. It is central to the path to the attainment of highest human fulfilment [9].

Thus the principles of duty, justice, equality and do good, as professed in major religions and cultures of the South Asian countries have an important influence on the practice of medical ethics here.

Medical Ethics in the modern medicine as practiced currently in South Asia

The professional medical associations and the national research bodies of many countries of South Asia have generally made their ethical guidelines, based mostly on the Western model. The countries as members of the United Nations Organization are signatories of the Declaration of Geneva, International Code of Medical Ethics, and Declaration of Helsinki. In India, there is an exclusive journal on Medical Ethics by the name Indian Journal of Medical Ethics, which is being published in India since 1993.

As an example, the Medical Council of India, the professional licensing medical body of the Government of India and the Indian Council of Medical Research, Union Government's advisory council on medical research have framed their own code of ethics on medical practice and research respectively. [10,11] In additional, various other professional societies of different medical or surgical specialties have also framed their own ethical guidelines for medical practice and research. This section briefly discusses about the ethical guidelines generally followed in India.

All medical institutions in India now have to adhere to the research guidelines as issued by the Indian Council of Medical Research and have also to constitute an Institute Ethics Committee as per the guidelines suggested by the Council.

The Medical Council of India gave its latest regulations on the professional conduct, etiquette and ethics in 2002, called Code of Ethics Regulations, 2002 [10]. The code is very elaborate. It has 8 chapters, referring to duties and responsibilities of the physician in general, duties of physicians to their patients, duties of physician in consultation, responsibilities of physicians to each other, duties of physician to the public and to the paramedical

profession, misconduct, punishment and disciplinary action. Each chapter has further sections and subsections giving details of the guidelines. Some of the salient features are further detailed in the following paragraph.

A physician is expected to uphold the dignity and honour of his profession. The principal objective of the medical profession is to render service to humanity with full respect for the dignity of profession and man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion. The Code gives some standard guidance on maintenance of medical records, prescribing medications by generic names, guidance regarding referring to other doctors and display of fees. A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency. Physicians are expected to behave like good citizens and should disseminate advice on public health issues. They have an important role to play in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. The physician shall not aid or abet torture nor shall he be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights. A physician can conduct clinical drug trials or other research involving patients or volunteers as per the guidelines of the Indian Council of Medical Research (ICMR), provided ethical considerations are borne in mind. Violation of existing ICMR guidelines in this regard shall constitute misconduct. Consent taken from the patient for trial of drug or therapy which is not as per the guidelines shall also be construed as misconduct. Any complaints with regard to professional misconduct can be brought before the appropriate Medical Council for disciplinary action [10].

A number of researchers have also studied ethical practices in South Asia. In one of recent analysis of original research publications from Sri Lanka, spanning over 1985-2005, Sumathipala et al [12] found that only about one third of the publications had mentioned having taken approval of the Ethics Research Committee and procurement of informed consent. However, the authors noticed a positive trend in local postgraduate research and in local medical journals.

Kuwait Declaration on Patient Safety, 2004

Ethics in medical practice have also been a focus of discussion in the Muslim world. Kuwait declaration on patient safety of 2004 was a step in this direction. The meeting was attended by experts and health professionals from many Islamic countries including Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Pakistan, Saudi Arabia, Sudan, Tunisia, United Arab Emirates and Yemen on the initiative of the WHO Regional Office for the Eastern Mediterranean in 2004. The meeting deliberated on the health situation in developing countries and countries in economic transition with specific focus on the Eastern Mediterranean Region., The poor state of infrastructure and equipment, unreliable supply and quality of drugs, lack of or poor pre-qualification of medical supply factories, inadequate application of good manufacturing practice, shortcomings in waste management and infection control were some of the important areas of discussion. These are also relevant to various South Asian countries. Issue of patient safety especially how best to prevent harm occurring to patients through learning from errors and incidents, and advocating the culture of learning from mistakes was an important agenda. The declaration is a call upon the regional scientific community and civil society to join the efforts of WHO and ministries of health to attain the better care that all are striving to achieve.

Goals of declaration included developing integrated national patient safety programmes with clear targets in all countries of the Region to ensure the safety of patient care at all levels, facilitating a culture of safety through better reporting and information systems which assists the systematic monitoring, analysis and improvement of patient outcomes. There was also emphasis on consumer involvement in improving health care safety. Improving communication between patients and physicians, enhancing and supporting the research activities for patient safety and developing centres of excellence at national levels, and facilitating coordination of national efforts to improve patient safety through effective networking and collaboration with regional and international centres involved in patient safety were some other goals. Proposed strategies for patient safety included establishing continuous training programmes on patient safety for different categories of health care providers, and developing, updating and disseminating universal protocols and guidelines on evidence-based practices to health care team providers for different aspects of patient safety. Capacity building activities need to be undertaken by increasing resources allocated to patient safety programmes. Similarly, there is a need to ensure high level commitment for patient safety and patients rights through enactment of legislation, development and enforcement of regulations and allocation of financial and human resources, and so on [13].

Specific needs of the countries of South Asia

A number of issues like informed consent, patient rights, confidentiality, conflict of interests, unnecessary investigations, treatment and hospitalization and unethical advertising need special discussion.

In South Asian countries, traditionally, the patient and the general population often reposes great trust on the

treating doctor. The patient often comes with the notion that the doctor knows the best and expects the doctor to make a decision about the treatment. A paternalistic view had been the norm over a long period, though the trends are changing now, and this is starting being questioned now [7]. Trust based on goodness of the doctor is slowly giving way to the concept that making the decision is the patient's right. Introduction of the consumer rights movements, increasing costs of medical treatment, increasing privatization of medicine, introduction of medical insurance have brought the change[1]. Similarly, with the introduction of the West sponsored multinational drug trials in the South Asian countries, the issue of informed consent has become more important, as many times an untried drug may be brought for trial here. Concerns about this have been raised in the lay press as well as the medical journals. In informed consent, how much is actually understood by the patient has also been a focus of study. In a study on informed consent from Bangladesh, Lynoe & Hyder [13] examined participants' understanding of iron supplementation in a community-based study. Although consent had been obtained after detailed explanation of the study, many participants did not understand that they were free to decline to participate, or they could choose to leave the study, and about half believed that the participation was part of routine health care. This raises important question about the use of doctrine of informed consent in research.

Issue of confidentiality of the information shared by the patient during the therapeutic interaction is another important concern. Patients are frequently accompanied by family members, who would often be present while clinical history is taken and examination is conducted. The patients often may not object to the family members being told about the medical details. Many times, the information shared may be of sensitive nature, where it may not be in interest of the patient to share the information. Sometimes in cases of serious or life threatening illnesses like malignancy, the family members may desire the information about diagnosis not to be disclosed to the patient [14,15].

Conflict of interest is another issue needing attention. Sometimes, there may be an inherent interest on the part of the doctor recommending a particular treatment or ordering for an investigation or hospitalization. Kickback practice for referrals to diagnostic centers or to the big hospitals for advanced treatment or unethical promotional favours by the pharmaceuticals for prescriptions is not uncommon. These issues have been a focus of discussion in recent years [16].

Pharmaceutical companies may try to induce doctors in different ways. Iinducements can range from seemingly small gifts such as pens and writing pads with drugs' names inscribed to gifts and free meals, financial support for travel, lodging and dinners to all expenses paid participation in seminars, symposia and medical conferences, and lavish trips and entertainments [16]. The Medical Council of India has taken some initiative to curtail this practice [10]. The drug firms also generally don't follow the WHO's ethical criteria for drug promotion. In a recent direction, the Government of India asked the pharmaceutical companies to self-regulate rather than have a legislation to tackle the menace [17]. Recently, the Organisation of Pharmaceutical Producers of India (OPPI), an association mainly of multinationals which is estimated to account for 70% of the drug market in India, came out with some regulations to check the practice. But the move is questionable, since more than a quarter of the members of the OPPI are subsidiaries of companies that have been penalised in the US for illegally promoting various drugs through inducements for doctors [18].

A desire to have a male child in India as well as some other South Asian countries has led to rampant practice of pre natal determination of sex and then resorting to medical termination of pregnancy if the foetus is female. Female infanticide is also not uncommon. This has led to disturbing the male/female sex ratio in the population, not a healthy trend. The Government of India has even brought a law by the name the Pre-Natal Diagnostic Techniques Act and Rules in 1994 to regulate this practice.

There has been a massive increase in recent years in recommendations of unnecessary investigations like imaging of different body parts, ultrsonography, endoscopies or cardiac procedures or other surgeries in the absence of proper indication or in the name of safe practice, which is probably a fallout of mushrooming of private sector in medicine and opening of corporate chains of hospitals. This has increased the cost of medical care many fold, and has been a matter of serious concern in term of medical ethics [19].

Advertisements of deceptive nature with false claims of success with some treatments are also not uncommon. In fact, many times such misleading advertisements are given by unqualified quacks or lay practitioners.

Though there have been many initiatives by different organizations including the Medical Council of India, professional associations, human rights groups and media, and there is some improvement in maintenance of ethical standards in medicine, still much is to be achieved.

Doctors also have their own limitations. In the state owned hospitals, they are often over worked. They are often criticised because they are the most visible and senior members of the health professions and therefore hold a major responsibility for the failings of the system. State-funded health services throughout the world are imperfect, over pressured and under-resourced. In spite of the best intentions, they sometimes damage and dehumanise the people that move through them [19]. Many patients may perceive that the health professionals are more interested in sickness than in them and more interested in biological faults than the people who experience them.

Conclusion

The modern medical practice in various South Asian countries though predominantly follows a Western model cultural factors have an important influence on the application of the accepted ethical standards in medical practice and research. The traditional system of medicine, socio religious factors and overworked medical profession sometimes act as impediments.

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