Medical Ethics in India

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1. Medicine and Ethics

Medicine has the prime aim of preserving and restoring physical health. Health actually is a state of well-being as Daniel Callahan defines. It refers to a state of "adequate" physical, mental, spiritual and psycho-social well-being and not merely absence of disease. Christian response to sickness is not merely *curing* the disease, but *´healing´* the person.[1] Healing is in fact *wholing* or restoring the integrity of the person as much as possible.[2] As Victor Frankl says, the radical cause of sickness is the loss of meaning in life and hence sickness cannot be handled effectively unless that meaning is restored.[3] He says in his celebrated book *Man´s Search for Meaning,* "an incurably psychotic individual may lose his usefulness but yet retain the dignity of a human being."[4] Similarly Mowrer has drawn attention to the importance of handling moral guilt, and not merely psychic guilt feelings in the treatment of illness.[5] Thus, even the psychosomatic approach to healing is incomplete. Health and illness have a still deeper dimension involving the spiritual area of the human personality. This noble thought would make it clear that physical curing will not alone make a person healthy.

Human suffering has a deeper meaning. Medicine cannot reduce suffering. A physically healthy person may still suffer. Medicine caters to physical health and alleviates

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1 B. M. Ashley and K.D.O´Rourke, Health Care Ethics (St.Loius, Miss. The Catholic Hospital Association, 1978) 33-39.

2 See P. Ramsey, The Patient as Person (New York: Yale University Press, 1980); B. Häring, Manipulation (Slough, England: St.Paul Publications, 1973) 98-102.

3 Victor E. Frankl, The Doctor and the Soul: An Introduction to Logotherapy, Published by Alfred A.Knopf (New York: 1955); Will to Meaning, (London: Souvenir Press, 1971).

4 Victor E. Frankl, Man´s Search for Meaning: An Introduction to Logotherapy, trans. By Ilse Lasch (Allahabad: St.Paul Press, 6th Print 2000): 119.

5 See O.H.Mowrer, The Crisis in Psychiatry and Religion, (New York: Van Norstand Reinhold, 1961).

physical pain. Correspondingly, medical profession has two fundamental guiding principles: (i) first do no harm and (ii) do good. When the dual principles of non-maleficence (do no harm) and beneficence (do good) come in conflict, the former has the precedence. Physicians should not harm the patients in the first place. Physical harm is tolerated only when the harm is the only means towards curing a physical illness.

Ethics refers to what is right and what is wrong. Civil law criminalizes or decriminalizes an act, but it does not say whether the act is morally right or wrong. At the legal level, medical ethics may refer to faithfulness to a law that is in place to regulate a medical practice. At the ethical level, medical ethics refers to the very question of rightness or wrongness of a practice itself. Medical ethics thus has a dual role of checking legal as well as moral aspects of the medical practices. Physicians may not be committing a crime by conducting abortions in India today. Till the enactment of the Medical Termination of Pregnancy Act in 1971, abortion was considered immoral and punishable crime in India. Though the civil law legalized and decriminalized the immoral act of abortion under the pretext of medical reasons,[6] many Hindus were disturbed by the use of elective abortion as birth control.[7] Legalization has not changed the immoral act of abortion into a moral act. Unfortunately, people are prone to learn morality from the civil law.

2. Teaching Ethics in Medical Profession

The application of ethics in medical practice originated from the ancient civilization and even today all medical practitioners must take the Hippocratic oath. There are many codes of conduct and laws in place to regulate the medical profession in India, however complaints

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[6] Jyotsna Agnihotri Gupta comments on the MTPA 1971: "The legislation provided recourse to abortion under broad health (physical and mental) grounds, on eugenic indications, under juridical conditions (such as incest or rape, and for social reasons such as mental or social injury to the mother). The law did not express population control as its objective explicitly. However, provisions of the law were liberal enough for those who wished to avail themselves of it to do so." Jyotsna A. Gupta, "Practices in India," in: *Der Umgang mit vorgeburtlichem Leben in anderen Kulturen.* Tagungsdokumentation, Jahrestagung des Nationalen Ethikrates 2003, 63-76 (Berlin: Nationaler Ethikrat, 2004), 64.

[7] William A. Young, *The World´s Religions and Contemporary Issues* (NJ: Prentice Hall, 1995), 128. M. A. Warrenn, *Gendercide: The Implications of Sex Selection* (Totowa, NJ.: Rowman & Allanheld, 1985), 16, curiously attributes abortions in India to Hinduism´s silence in this matter.

against the unethical practices of physicians are increasing largely due to the increasing public awareness. Physicians should not only possess knowledge and skills in medicine, but must also be of good character. They should primarily commit themselves to the welfare of patients and gain the trust of patients. An aggressive and self-interested person is not suitable to the medical profession. Physicians are supposed to practice their profession within the ethical guidelines and refrain from unethical practices.

Medical practice without ethics will be dangerous and adverse to the very purpose of medicine. Unethical practices can not only harm the patients, but also bring disgrace to the medical profession. Someone raised an apparently logical question, "When society at large is corrupt and unethical, how can you expect doctors to remain honest?"[8] Medical practice is a noble profession and doctors should not cheat the patients. There should be complete sincerity from the part of doctors in reciprocity to the trust of patients on doctors.

Teaching Ethics in medical institutes is of paramount importance to make the student aware of the moral nature of the art and science of medicine and ethical issues involved in it.[9] Unfortunately not only medical students but also doctors lack awareness of the medical code of ethics.[10] Hence, medical ethics should be a distinct and compulsory discipline in medical curriculum in order to make physicians be aware of the ethical aspects of medicine. Lack of knowledge can lead to unethical practices.

3. The Ancient Indian Medicine and Medical Ethics

Ancient civilizations had their own medicinal systems, however the ancient Ayurvedic Indian medicine is considered to be the most organized system in its ideas and its curative measures. The Siddha System of Medicine (Traditional Tamil System of medicine), which has been prevalent in the ancient Tamil land, is the foremost and the oldest documented

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[8] Sunil K. Pandya, "History of Medical Ethics in India," *Eubios Journal of Asian and International Bioethics* 10 (2000) 40-44, 44.

[9] S. Chattopadhyay, "Teaching ethics in an unethical setting: "doing nothing" is neither good nor right," Indian Journal of Medical Ethics 6 (2009) 93–98.

[10] A. S. Brogen, B. Rajkumari, J. Laishram, A. Joy. "Knowledge and attitudes of doctors on medical ethics in a teaching hospital, Manipur," Indian Journal of Medical Ethics 6 (2009) 194–197.

medical system in the world. The word *Siddha* means established truth. The Siddha System of Medicine origin goes back to B.C 10,000 to B.C 4,000.[11] A major portion of the siddha medicines uses herbs and green leaved medicines.[12]

A more rational and systematic system of Indian medicine known as Ayurveda (the Science of Life) existed beginning from 600 BCE.[13] The Ayurvedic practitioner was called *vaidya*, meaning a person of profound knowledge.[14] The *vaidyas* had to have a license from the state in order to take up medical practice and monetary punishments were imposed for the incorrect treatment of patients.[15] Suśruta Samhita describes the internal and external character of medical practitioners, who were expected to be honest, humble, temperate, generous, and hard-working.[16] The great physician of ancient India and the father of Indian (Āyurvedic) medicine, Caraka, emphasized that the pregnant woman in her delicate situation should be treated like a vessel brimful of oil and should never be agitated, even if any mishap took place.[17]

The most influential surgeon of the early centuries of the common era, Suśruta, also known as the "father of surgery" recognized that a spontaneous abortion (miscarriage) was

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[11] S. Ottilingam, T. Murthy, V. Raghavan, Mental Health: Concepts and Treatment in the Siddha (Tamil) System of Medicine, Asean Journal of Psychiatry 16/2 (July - December 2015).

[12] S. S. Shukla and S. Saraf, Fundamental aspect and basic concept of siddha medicines. Systematic Reviews in Pharmacy 2 (2011) 48-54.

[13] G. Mazars, "Indian medicine across the centuries. A Concise Introduction to Indian Medicine (La médecine indienne)," T.K. Gopalan, translator. Ch. 1. (Delhi: Motilal Banarsidass Publishers Private Limited, 2006) 1-24. (Wujastyk D, Zysk KG, editors. Indian Medical Tradition; Vol. VIII). B. V. Subbarayappa, "A perspective," In: Subbarayappa BV, editor (Medicine and Life Sciences in India. New Delhi: Centre for Studies in Civilizations, 2001) 1-38; K. Lochan, "Appendix 3, Historiography of early Indian medicine," Medicines of Early India: With Appendix on a Rare Ancient Text (Varanasi: Chaukhambha Sanskrit Bhawa, 2003) 155-65.

[14] B. G. Gopinath, "Foundational ideas of Ayurveda," In: B. V. Subbarayappa, editor, Medicine and Life Sciences in India (New Delhi: Centre for Studies in Civilizations, 2001) 59-107.

[15] K. Lochan, "Practise of medicine," Medicines of Early India: With Appendix on a Rare Ancient Text. Ch. 5. (Varanasi: Chaukhambha Sanskrit Bhawan; 2003) 104-20.

[16] Y. N. Nuraliev, "Doctor's ethics in ancient east written classics and in the works of middle age medical scientists," In: W. H. Abdi, M. S. Asimov, A. K. Bag, M. M. Khairullayev, S.R. Mikulinsky, S. K. Mukherjee, et al., editors. Interaction between Indian and Central Asian Science and Technology in Medieval Times. Medicine, Technology, Arts and Crafts, Architecture and Music. Vol. II. (New Delhi: Indian National Science Academy, 1990) 11-8.

[17] G. Pandeya (ed.), The Caraka Saṃhitā of Agniveśa (Varanasi: Kashi Sanskrit Series 194, 1969) p. 825, vr.22.

understandably unavoidable, but induced abortions were severely punishable. The Suśruta Saṃhitā, makes a distinction within miscarriage (pātanam – causing the fall of the foetus) describing in "flow" terms in early pregnancy and in "falling or dropping" terms in later pregnancy. It has a section called "The Foetus Astray" (mūḍhgarbha) under which there is a chapter titled "Cikitsāsthāna" which deals with the eventuality of aborting the foetus. The chapter begins with the text that "there is nothing as difficult as the delivery of a foetus astray in the womb, for here….the job must be done ´by feel´… by one hand, without injury to mother or foetus (if possible)."[18] It continues, "if the foetus is alive, one should attempt to remove it from the womb of the mother (alive)."[19] The physician was advised to save both live child and mother with great care and with the chanting of mantras. If the foetus is already dead (*mṛte garbhe*), then it may be removed by cutting (and dismembering, if necessary; *sūtra* 9).[20] Surgery is forbidden when the foetus cannot be safely delivered, "For if (the foetus) be cut one would harm both mother and her offspring. In an irredeemable situation, it is best to cause the miscarriage of the foetus, for no means must be neglected which can prevent the loss of the mother."[21] Only in extreme cases of a medical problem, where the mothers' life was in danger and when the life of the mother had to be weighed against that of the foetus, an induced abortion or removal of the foetus was permitted.[22] For this reason, the king had to be informed to avoid subsequent charges of homicide.[23]

The ancient Indian medical ethics not only upheld a high moral character in the practice of medicine, but also believed in the absolute moral value of every human life. Abortion was permissible only as a last resort to save the life of the mother. Suśruta tolerated the destruction of dead or poorly positioned foetuses for the sake of saving the endangered

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[18] Quoted in: Julius J. Lipner, "The Classical Hindu View on Abortion and the Moral Status of the Unborn," in: Harold G. Coward, Julius J. Lipner and Katherine K. Young, (eds.) Hindu Ethics: Purity, Abortion, and Euthanasia, 41-70 (Delhi: Sri Satguru Publications, 1991), 49.

[19] Lipner, "The Classical Hindu View on Abortion…," 49.

[20] Lipner, "The Classical Hindu View on Abortion…," 49.

[21] Lipner, "The Classical Hindu View on Abortion…," 50, *sūtra* 10-11.

[22] Suśruta, *The Suśruta Saṃhitā*, 2.8.9, in K.K. Bhishagratna (trans.), Op.cit., 2, 58-60. See H. Willer Laale, "Embryology and Abortion in Indian Antiquity: A Brief Survey," *Indian Journal of History of Science* Vol. 31, No. 3 (1996) 233-258, 246, 257.

[23] Katherine K. Young, "Medical Ethics through the Life Cycle in Hindu India," in: Robert B. Baker and Laurence B. McCullough, (eds.) *The Cambridge World History of Medical Ethics* (Cambridge, New York, et. al: Cambridge University Press, 2009), 101-112, 103.

mothers. He performed caesarean operations to save the unborn living children in cases of difficult labour. He removed surgically the living unborn child from the womb of a dead mother.[24] Throughout his work, the lives of both mother and the unborn in the womb are highly respected and are given supreme protection. Suśruta seems to have applied the principle of double effect long before the Western ethics. Unfortunately, the modern Western medicine of "allopathy" has pushed Ayurveda and other forms of indigenous medicines to the periphery of medical practice. Ethical deliberations by an authority like Suśruta should be treated with due consideration in medical practice in India. Unfortunately, Indian doctors, educated in Western science, are ignorant of the medical ethics of native culture.

4. The Advent of Western Medicine in India[25]

In the 16th century, the Portuguese introduced Western medicine into India for the first time but catered chiefly to their army. In 1600, the first fleet of ships of the East India Company brought medical officers and Western medicine to India. In 1822, the Native Medical Institution was established in Calcutta to provide medical training to Indians. European texts in anatomy, medicine, and surgery were translated into the local languages for the benefit of students.[26] In 1826, classes on Unani medicine were held at the Calcutta madrasa, while the Sanskrit college conducted classes in Ayurvedic medicine. In 1826, to offer Indians the opportunity to learn and practice Western medicine, an Indian medical school was started in Southern Bombay, which however did not run beyond 6 years.

In the 1830s, the anglicists overturned several cultural educational policies started by the natives. The termination of official patronage to indigenous systems of medicine brought closure to the two leading oriental institutions in Calcutta. Gradually the classes held at the madrasa and the Sanskrit College were discontinued in 1835, but in their place a new medical college was established in 1835 to train Indian students "in strict accordance with the mode

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[24] Young, "Medical Ethics through the Life Cycle in Hindu India," 103. Laale, "Embryology and Abortion in Indian Antiquity," 246, 257. See also P. Ray, H. Gupta and M. Roy, *Suśruta Saṃhitā: A Scientific Synopsis,* (New Delhi: Indian National Science Academy, 1980), 22.

[25] For this whole section see, Supe A. Anshu, Evolution of medical education in India: The impact of colonialism. Journal of Postgraduate Medcine 62 (2016) 255-259, 255.

[26] see Anshu, Evolution of medical education in India, 256; S. Chatterjee, R. Ray, D. K. Chakraborty, Medical college bengal-a pioneer over the eras. Indian Journal of Surgery 75 (2013) 385-90.

adopted in Europe through the medium of the English language," ushering in a new beginning to medical education in India. In the same year, another medical school was established in Madras to "afford better means of instruction in Medicine and Surgery to the Indo-British and native youths, entering the medical branch of the service in the presidency." The Grant Medical College, now known as the Sir JJ Hospital, in Bombay was started in 1845 with an aim to "impart the benefits of medical instruction to the Natives of Western India through a systematic system."[27]

In 1840, the Portuguese started the Medicine and Pharmacy Licentiates, now known as Goa Medical College. University-affiliated medical education became the norm in the 1850s, after the opening of the first three Indian universities in Madras, Bombay, and Calcutta. The Mutiny of 1857 led to the dissolution of the East India Company and the British government was established in India. Madras Medical College was the first in India to open its doors to women students in 1875. Even so, in 1877, among the 8000 medical practitioners, only 450 were trained in Western medicine. The rest were practitioners of indigenous Ayurvedic or Siddha systems of medicine. [28]

An anonymous article in the June 1928 issue of The Journal of Ayurveda or the Hindu System of Medicine argued, "Medical Education in India should be so devised that it should take into account not only the present-day medical education but also medical knowledge of the past… While Ayurveda cannot move on in [an] old groove, Allopathy should not be accepted in toto for India. While we should absorb the pathology of the 'seed of disease' from Allopathy, we must give the 'pathology of the soil' in disease to modern medicine. The two angles are at present different but should be harmonized."[29] Physicians, siddhas and vaidyas were upright persons and held a high standard of morality and of good character. They dedicated their whole life to the welfare of the people.

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[27] see Anshu, Evolution of medical education in India, 256-257.
[28] See Anshu, Evolution of medical education in India, 258-257.
[29] Quoted in: Supe A. Anshu, Evolution of medical education in India, 258; Anonymous. Scientific vs. practical medicine. JAHSM 4 (1928) 444.

5. Emerging Modern Medical Ethics in India

In 1992, eight doctors known for their eminence in ethical practice and concern for the public health system established a panel on the platform of Forum for Medical Ethics (FME) in Mumbai. They published the first newsletter, entitled Medical Ethics, in August 1993. From January 1996, it was brought out as Issues in Medical Ethics. Later, with the permission of the Registrar of Newspapers, it is published an as Indian Journal of Medical Ethics from January 2004. Its current editor Amar Jesani expresses the concerns of the Forum for Medical Ethics Society (FMES): "How can we practise ethically?" and "How can we contribute to a health system in India that makes it possible for all to practise ethically?"[30]

Since 2005 the FMES has organized 6 National Bioethics Conferences in various cities of India in collaboration with medical institutes and social welfare groups. In December 2018, the Forum for Medical Ethics Society and the Sama Resource Group for Women and Health in collaboration with other welfare agencies will organize the 14th World Congress of Bioethics of the International Association of Bioethics in Delhi. The theme of this international conference is "Health for all in an unequal world: obligations of global bioethics."[31] The FMES has representatives from many parts of India, from many religions, from fields of medicine and humanities. It has many former and present officials of Indian Council of Medical Research as its members. The FMES, in which I am a member, is deeply committed to medical ethics in India and has a strong voice in the study, critique and strong influence on various issues in medical ethics in India.

Though there seems to be a great interest and responsibility in the minds of medical experts, philosophers and theologians of the West on the ethics of abortion, in vitro fertilization, stem cell research, etc., however, in India, these issues lie below the surface of the public mind or have to come out of the closet yet.[32] It is surprising that the members of

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[30] A. Jesani, Editorial. In the 25th year of bioethics publishing: new challenges of the post-truth era. Indian Journal of Medical Ethics 2/1 (Jan-Mar 2017) 3-5.

[31] Jesani, Editorial. In the 25th year of bioethics publishing, 4.

[32] Lipner, 1989, 61, note 1. The first footnote of his article illustrates his own experience further, "In preparation for a visit to two well-known universities in India, shortly after completing this chapter, I offered the present topic (among others) to the relevant departments for possible seminars/public lectures. I was not too surprised to discover that, in both cases, this particular topic was politely

scientific community, (Hindu) philosophers, theologians of modern India have not been very vocal about their view on abortion. Modern scientific knowledge on human embryology would help the scientific community voice their opinions at least from a medical point of view. There may be a few[33] doing this, but it has not been much heard on a national platform or in the world of literatures on medico-ethical issues. In 1998, there was but one institution in India, St. John´s Medical College, Bangalore, which offered a structured course on medical ethics throughout the undergraduate curriculum.[34] In the last decade, however, there is a greater awareness and awakening of bioethics in India. There are a few bioethics committees and institutes set up in medical colleges, educational institutions and Universities. There are as many as 58 units of the UNESCO Chair in Bioethics in many medical and other research centres. The Catholic as well as Protestant theological centres and seminaries offer courses on biomedical ethics primarily to educate their pastors. This is not enough. Medical ethics should be taught at every school, college and university of India to pave a way for the new generation to get right information on medical issues and ethics involved in them.

6. Right Understanding of Biosciences and Humanities for Medical Ethics

The most fundamental good of human life is the bodily life itself, without which an earthly life is not possible. It is in and through the physical body that a person can exist and act. That is why, the most fundamental human right of human beings is the inviolable right to bodily life. No science and not even any faith should go against the inviolable right to life. The biological understanding of "when does an individual human begin and end?" is essential in order to apply the principle of inviolable right to life. Philosophy has to rely on biology and ontology in order to make authentic conclusions regarding human life. What is necessary and what is desirable: making people better or making better people? Should we do what we can?

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singled out for exclusion on "cultural" grounds. It so happened that soon after my return from India I was to visit a university in Canada and one in the United States. I made the same proposal; in both instances, this topic was singled out for presentation."

[33] For example, Prof. Dr. Inderbir Singh and Prof. Dr. G. P. Pal have jointly written a book on *Human Embryology* (Delhi: Macmillian Publishers India, 1976, ninth edition, 2012). Jagannadha Rao, Bangalore, Lalji Singh, Hyderabad.

[34] Sunil K. Pandya, "History of Medical Ethics in India," *Eubios Journal of Asian and International Bioethics* 10 (2000): 40-44.

Can we alter the human nature?[35] The demarcation between therapy and enhancement is important. Therapy is necessary, but enhancement endangers human dignity and alters human nature.

In dealing with issues in medical practice, we need a consistent ethic. Application principles in isolation can contradict with each other and may not ensure a proper decision. The biomedical ethics has focused on four philosophical principles: (i) autonomy, (ii) beneficence, (iii) non-maleficence, and (iv) justice.[36] Such principles should be applied in complementarity. People have tendency to use the moral principles in isolation leading to conflicts and inconsistent conclusions. For example, some argue that women have *autonomy* to decide the fate of the foetus in their womb, whereas they neglect the *autonomy* of the growing foetus. The principle of autonomy makes sense only when it respects the intrinsic dignity and inviolable right to life of everyone. The foundation of all principles is the principle of human dignity, which can be an umbrella principle to deal with all human conditions. In order to construct a consistent ethic for medical ethics, we need a sound anthropology of "what is human and what is not human?"

Biological facts establish that an individual human life begins at conception. Philosophy substantiates that human life has dignity and inviolable right to life till the natural death. Practical philosophy can combine the biological facts and philosophical moral truths. Theology asserts that human life is a gift and not a right. Natural law and sexual morality states that a rightful marriage is possible only between a man and a woman and only heterosexual marriages can naturally help continue the human race. Fertilization technologies in procreation would challenge the very aspect of natural conception. Surrogacy and single parenting would deprive the right of children to natural parents.[37] Selfishness of a single parent generation should not take away the rights of future generations. People who suffer the

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[35] Jürgen Habermas, Die Zunkunft der menschlichen Natur. Auf dem Weg zu einer liberalen Eugenik? (Frankfurt a. M.: Suhrkamp Verlag, 2001).

[36] Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics (Oxford: Oxford University Press, 7th edition, 2012)

[37] Karan Johar has become a single father of twins - a baby boy and girl - who were born through surrogacy. Can he give them a mother? Retrieved from http://www.india.com/news/agencies/karan-johar-welcomes-twins-via-surrogacy-1893809/. Accessed on 5 March 2017.

problem infertility and other marital problems need pastoral as well as psychological support. Medical ethics cannot be merely a set of principles to make decisions, but it must offer pastoral and humane solutions.

The philosophy of personhood by John Locke, Peter Singer, Michael Tooley, Tristram Engelhardt and others that makes a distinction between humans and persons has done a huge damage to the understanding of human beings. The American pragmatist Tristram Engelhardt, among others, thinks that "not all humans are persons. Fetuses, infants, the profoundly mentally retarded and the hopelessly comatose provide examples of human non-persons. Such entities are members of the human species… but they do not have standing in the moral community… only persons have [that] status."[38] Similarly, the Australian Philosopher Peter Singer says, "person is often used as if it meant the same as human being. Yet the terms are not equivalent; there could be a person who is not a member of our species. There could also be members of our species who are not persons."[39] They deny moral value, dignity and protection to the preborn.

The fact is that humans grow as humans and never unto humans or persons. The qualities of rationality, autonomy, consciousness, self-awareness and morality that differentiate humans from other animals and render them a unique value to humans is present all the time in humans, sometimes dormant, sometimes injured and may at times be in coma. There cannot be grades of intrinsic value within the members of any natural species. A truly intrinsic value cannot be merely a name given to a class of individuals that share certain qualities. Intrinsic dignity is the value that pertains to a thing by virtue of its being the kind of thing that it is, that is why, the intrinsic dignity of a demented member and a philosopher is the same,[40] because both are humans.

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[38] Tristam Engelhardt, "Some Persons are Humans, some Humans are Persons, and the World is What we Persons Make it," *Philosophical Medical Ethics* (Boston: Reidel, 1977): 183-194, 138-139.

[39] Peter Singer, *Practical Ethics,* Second ed. (New York: Cambridge University Press, 1993), 91-92. Singer says, "the life of a fetus is of no greater value than the life of a nonhuman animal at a similar level of rationality, self-consciousness, awareness, capacity to feel, etc., and that since no fetus is a person no fetus has the same claim to life as a person." Ibid., 169.

[40] Daniel P. Sulmasy, Dignity and the Human as a Natural Kind, in: Health and Human Flourishing. Religion, Medicine and Moral Anthropology, Carol R. Taylor and Roberto Dell`oro, editors (Washington, D. C.: Georgetown University Press, 2007) 71-87, 82-83.

Do I become a non-person or a non-human in coma? No. If I were not a person from the beginning and all through the stages of physical development, then when do I become a person? In fact, all humans are persons. The concept of personhood distinguishing humans and persons is illusory. In other words, person is a surplus word to understand humans. The identity of a particular human being is same all the time from conception to natural death. This understanding is vital in order to respond to the biomedical problems adequately.[41]

7. A Scary Affair of Commercialization of Organs and Biomaterials

Kakodkar and others report the prevalence of unrelated liver donations including two deaths.[42] A field study found that 96% of participants (over 300) sold their kidneys to pay off debts. About 86% of participants have reported deterioration in their health status. A total of 79% would not recommend that others sell a kidney. Goyal and team say that "In developing countries like India, potential donors need to be protected from being exploited. At a minimum, this might involve educating them about the likely outcomes of selling a kidney."[43] Lawrence Cohen, who interviewed the donors in southern India, reports that, "there were no follow-up care after the operation nor were there efforts to prevent infection in the donor."[44] Cohen noted that most of the donors were women whose family was in debt. Chengappa reports that some poor donors have cited the reasons of meeting the expenses of the marriage of a sister or of constructing a house. He notes further that there are many instances in which young women are forced by their husbands to sell their kidneys.[45] The donors from the economically poor strata of the society heed a deaf to all explanations given by the doctors and transplant, authorization committees about the surgery. They simply say only what they

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41 For an elaborate discussion on the concept of personhood, see J. Charles Davis, The Ethics of Human Embryonic Stem Cell Research: Proposals for a Legal Framework for India (New Delhi: Atlantic Publishers and Distributors (P) Ltd. 2014) 73-87; also 48-78 for Species-Continuity-Identity-Potentiality (SCIP) arguments in defense of absolute moral status.

42 R. Kokodkar, A. Soin, S. Nundy, Liver Transplantation in India: Its evolution, problems and the way forward, in: National Medical Journal of India 20 (2007) 53-56.

43 Cited in: Sunil Shroff, Legal and Ethical Aspects of Organ Donation and Transplantation in India, in: Indian Journal of Urology 25 (2009) 348-355, 352.

44 L. R. Lawrence, Where it Hurts: Indian Material for an Ethics of Organ Transplantation, in: Daedalus 128 (1999) 135-165. Cited in: Sunil Shroff as above.

45 Raj Chengappa, The Organs Bazaar, in: India Today (July 31, 1990) 65.

were instructed to say for petty financial gains. Indian state is actually commercializing biomaterials with parent rights enabling donating citizens to choose between morality and survival.

Organ commerce makes human body parts a commodity and erodes moral and social values. This cannot be an acceptable alternative to overcome the scarcity of organs in an ethical society. An ethical society is built on social values through democratic institutions, which cannot alter certain values for convenience. The aspect of marketing and trading reduces everything to a status of commodity. Human bodies and their labours cannot be sold or bought. Organ sale or purchase goes against the nature and integrity of human beings. Every human being has an inherent dignity that cannot be violated even for one´s own sake. Francis Delmonico et.al. state,

> The Fundamental truths of our society, of life and liberty, are values that should not have a monetary price. These values are degraded when a poor person feels compelled to risk death for the sole purpose of obtaining monetary payment for a body part. Physicians, whose primary responsibility is to provide care, should not support this practice. Furthermore, our society places limits on individual autonomy when it comes to protection from harm. We do not endorse as public policy the sale of the human body through prostitution of any sort, despite the purported benefits of such a sale for both the buyer and the seller.[46]

At the same time, Delmonico et.al. suggest ethical incentives for organ donations and oppose any monetary payment. In my opinion, even ethical incentives can give a wrong signal and bad impression. It is a controversial issue to tackle the matter as who would meet the expenses of a poor donor. It is precisely the point that the poor should not be brought in the case of organ donation because the context forces the matter of money in the process. Cantarovitch suggests that organ transplantation can be dealt with under social contract and

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[46] Cited in Sunil Shorff, 354. See F. L. Delmonico, R. Arnold, N. Scheper-Hughes, L. A. Kahn, S. J. Youngner, Ethical Incentives – Not Payment for Organ Donation, in: New England Journal of Medicine 346 (2002) 20022005. C. T. Patel proposes a similar argument: "Kidney donation is a good act. It is a gift of life. The financial incentive to promote such an act is moral and justified." See Live Related Donation: A Viewpoint, in: Transplant Proceedings 20 (1988) 1068-70. Some authors say that "it is better to buy than to let die." See K. C. Reddy, C. M. Thiagrajan, D. Shunmugasundaram, et. al., Unconventional Renal Transplantation in India: To buy or Let die, in: Transplant Proceedings 22 (1990) 910-11.

social trust under national and international laws ensuring the rights of donors and recipients.[47] The social contract is a risky matter and rewarded donation is misleading and ethically controversial. Treatments such as transplantation and stem cell therapies seem to be an affair of the rich. Can the country adopt a fair allocation of such costly treatments for all? India has scarce health resources for primary care, vaccinations child health, etc.

The poor are exploited for short-term financial gains. The editorial of Lancet state that "the success of transplantation as a life-saving treatment does not require nor justify victimizing the world´s poor people as the source of organs for the rich."[48] The World Health Organization (WHO) concludes: "The human body and its parts cannot be the subject of commercial transactions. Accordingly, giving or receiving payment… for organs should be prohibited."[49] Hence, any financial incentive for organs can never be ethically justified, and it would distort the very concept of donation. John Paul II said, "any procedure which tends to commercialize human organs or to consider them as items of exchange or trade must be considered morally unacceptable, because to use the body as an ´object´ is to violate the dignity of the human person."[50] Paid donations would spoil the spirit of altruism. It is not a true charity.

The commercialization of human organs prompted India to enact laws on an urgent basis. The Transplantation of the Human Organ (THO) Act 1994,[51] which came into force on February 4, 1994, strictly prohibits trade in human organs. The THO Act has neither stopped the organ commerce nor increased the number of cadaveric donors. It had some loopholes in the management of the transplantations and thus the government of India had to enact a couple

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47 Cantarovitch, Persons and Their Bodies: Rights, Responsibilities, and the Sale of Organs, in: Philosophy and Medicine (2002) 1-32.

48 Editorial, in: The Lancet 372/9632 (5 July 2008) 5-6.

49 Available at [http://www.who.int/ethics/topics/transplantation_guiding_principles/en/index1.html].

50 John Paul II, Special Address to the XVII World Congress of the Transplantation Society. August 27 – September 1, 2000, in: Transplantation Proceedings 33 (2001) 31-32, 31.

51 The Ministry of Law, Justice and Company Affairs, Government of India, The Transplantation of Human Organs Act 1994 (July 8, 1994). Available from: [http://india.gov.in/allimpfrms/allacts/2606.pdf]. Cited on 05.06.2012.

of amendments in the form of Rules.[52] The THO Act allows "near relatives"[53] as potential donors and recipients as primary option. It needs only a genetic test or a legal proof. In addition, the Act allows organ donation to an unrelated person for reasons of affection, attachment, or for any other special reasons specified by the donor. This needs a special approval by the government authorized committee that the motive of donation is purely out of altruism or affection towards the recipient. This clause is subject to misinterpretation and misuse. In fact, the word "affection" has been used in many cases to give legal protection against the commercial dealings behind the scene.[54] Though the main thrust of the Act is against the commercial dealings in human organs, such practices have not been completely ruled out irrespective of careful scrutinises.

7. A Major Investment of Indian Government in Biotechnology

The Indian government has committed itself to a major investment in promoting scientific research and development in the field of Biotechnology (BT). Stem cell research is one of the major areas of biotechnological research in India. In fact, India is ahead of most countries in human embryonic stem cell (hESC) research, and it has created enormous infrastructure for this research. However, India has not enacted a specific legislation with regard to this research, except "National Guidelines for Stem Cell Research and Therapy,"[55] jointly published by the Department of Biotechnology (DBT) and the Indian Council of Medical Research (ICMR) of the Department of Health Research in 2013. India permits

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[52] Government of India, Gazette, The Transplantation of Human Organs Rules, 1995, G.S.R. 51(E) - In exercise of the powers conferred by sub-section (1) of Section 24 of the Transplantation of Human Organs Act. 1994 (42 of 1994). Amended vide GSR 571(E), dt.31-7-2008. Available from [http://www.medindia.net/ indian_ health_act/the-transplantation-of-human-organs-rules-1995].

[53] Near relatives, according to the THO Act 1.2.i, means spouse, son, daughter, father, mother, brother or sister. The Gazette has included grandparents to the list of near relatives.

[54] M. K. Mani, Making An Ass of the Law. Letter from Chennai, in: National Medical Journal of India 10 (1997) 242-243.

[55] Department of Biotechnology and Indian Council of Medical Research (DBT-ICMR), *National Guidelines for Stem Cell Research and Therapy*, (New Delhi: ICMR, November 2013). Hereafter: DBT-ICMR Guidelines 2013. Available at *http://icmr.nic.in/guidelines/NGSCR%202013.pdf*

extraction of stem cells from embryos up to 14 days. The guidelines do not discuss the ethical aspect of destroying embryos for research.

Due to lack of public awareness, this is taken as an unquestioned permission for using spare embryos for research. As Bharadwaj states, "the favourable cultural environment is a reflection of the fact that the embryo is not accorded the kind of significance it is in Europe, Australia, the United States and other countries."[56] The promotion of hESC research in India has more to it than what meets the eye. It is located in the economy sector rather than in the health sector. The government and private companies see great business potential in this research. The lack of legal framework makes the research liberal, permissible and almost free for all.

The DBT-ICMR Guidelines protect the scientific community from public criticism and legal harassment. The rule seems to be: "Anything that is not illegal is legal." The scientists cannot be penalized because these are guidelines and not laws. The "lack of formal regulation makes it easy for Indian scientists, unlike their Western peers, to forge ahead relatively unencumbered" and "unlike in the Euro-American context, there is no consensus on the moral status of the human embryo. Different philosophical, religious and ideological persuasions define and debate life in an eclectic and open-ended way."[57] And as Bharadwaj comments: "India is seen as a ´maverick´ location devoid of high, exacting standards of ethical and moral governance as well as rigorous research and innovation."[58] India has a great stake in hESC research because of the booming IVF technology that creates surplus embryos. The debate on the morality of using embryos for research is very much missing. There is seldom any discussion on the moral worth and the human dignity of embryos. Some scientists and clinicians justify the destruction of embryos even in the name of sacrifice and informed consent.

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[56] Aditya Bharadwaj and Peter Glasner, Local Cells, Global Science: The Rise of embryonic stem cell research in India (London: Routledge, 2009), 3. See also Aditya Bharadwaj, "Cultures of embryonic stem cell research in India," in: W. Bender, C. Hauskeller and A. Manzei (eds.), *Crossing Borders: Cultural, Religious and Political Differences Concerning Stem Cell Research* (Münster: Agenda Verlag. 2005).

[57] Bharadwaj and Glasner, *Local Cells, Global Science*. 62.

[58] Bharadwaj and Glasner, *Local Cells, Global Science*. 16.

8. Social Problems affecting Medical Issues

Many factors, such as, illiteracy, poverty, family decision making and manipulation make the issue of informed consent very complex. The rationality of informed consent is high-jacked by emotional and social needs. India is a multi-lingual country with numerous dialects. As Bhatta says, "Official consent forms, therefore, need to be translated into multiple languages and dialects, particularly in rural areas where literacy rates are very low. This makes the context in which translated documents are accessed and signed extremely problematic."[59] Multiple languages in addition to illiteracy are major hurdles in India to get proper informed consent.

In India patients look at their doctors as next to gods. The knowledge and expertise of doctors and physicians are seen "undisputed and normative,"[60] and patients are generally seen as "ignorant and incapable of understanding information provided by the doctors, who regarded the patients´ knowledge as misconceived or pre-formed."[61] This has been "the traditional cultural acceptance of the moral authority of physicians."[62]

Family also plays a role in informed consent. Especially, among the Hindus, the in-laws play a decisive role in decision making. The principles of confidentiality and privacy are at risk here. All this goes to say that informed consent in India is a complex issue, can be discriminative and easy to obtain for the reasons mentioned earlier. Informed consent has become almost a necessary ritual, a formality, rather than a responsibility. Informed consent thus becomes a mockery.

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[59] Bharadwaj and Glasner, *Local Cells, Global Science*. 108. See Z.A. Bhutta, "Beyond informed consent," *Bulletin of the World Health Organisation*, 82/10 (2004): 774 (771-78)

[60] Bharadwaj and Glasner, *Local Cells, Global Science*. 108.

[61] Bharadwaj and Glasner, *Local Cells, Global Science*. Quoted from G. Fochsen, K. Deshpande and A. Thorson, "Power imbalance and consumerism in the doctor-patient relationship: health care providers´ experiences of patient encounters in a rural district of India," *Qualitative Health Research,* 16/9 (2006): (1236-51).

[62] Bharadwaj and Glasner, *Local Cells, Global Science*, 108.

9. Future Prospects

The Catholic Bishops Conference of India might probably be the only one that has not instituted a national center for Bioethics in India, which could facilitate seminars, research, dialogue, social action and political lobbying in matters of biomedical issues. It is a high time to start national center, for example, Center for Bioethics and Human Digntiy.

Indian Catholics should involve in public protests and political lobbying in fighting against medical practices that are unethical per se. Indian Catholic moral theologians can take initiative in this direction. Writing short articles on medical issues and pointing out unethical medical practices in the dailies are helpful to spread awareness among the people.

We must make every effort to influence the legislative processes with moral truths, and we should never get tired of fighting against laws that are unethical per se. It is high time that we at least join in hands with secular and interreligious voices who have similar agenda in medical ethics.

We should not restrict ourselves to teaching of medical ethics in centres of priestly formation, but should make our voice heard in the outside world of society and politics. Medical ethics should be introduced in schools and colleges. Ethical committees should be established in every hospital.

Catholic pastors should be well informed about the moral teachings of the Church and the law of the land, if they want to guide the faithful well. Pastors must be precise, distinct and clear while guiding the faith. There is always room for critique and disagreement, but they should not confuse the people with ones´ own confused position.

It is important that we integrate philosophical anthropology particularly of the Indian classical philosophy that values human life highly into medical ethics. There is a lot of scope for Indian Moral Theology to incorporate Indian philosophy and cultural values that uphold moral value of human life.

Medicine may not promise cure for all illnesses, particularly to terminally ill patients. In such situations, palliative care should be given. Palliative care is gradually gaining momentum in India.