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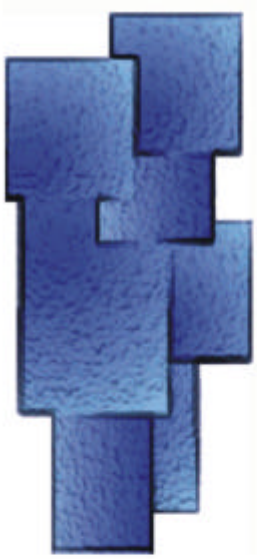

Health ethics in South-East Asia

Volume 1

Health ethics in six SEAR countries

Edited by Nimal Kasturiaratchi, Reidar Lie and Jens Seeberg

World Health Organization
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Introduction

Ethics has gained importance and urgency in the recent past due to a number of reasons. Rapid advances in science and technology, radical changes in macroeconomic planning and the introduction and promotion of market economies and globalization have all contributed to an increased attention being given to ethics, especially in health care. Within the health sector, questions are being asked about the possible threats to the accepted principles of equity and social justice in the delivery of care. In view of these developments, the Governing Bodies of WHO, both at global and regional levels, have recommended that health ethics should be promoted through a number of activities, including research and teaching.

In order to promote the teaching and practical application of medical ethics in clinical decision and health policy-making, an integrated research-cum-teaching project has been carried out in six countries in the WHO South-East Asia Region. These countries are: Bangladesh (two sites), India (two sites), Indonesia, Myanmar, Nepal and Sri Lanka. The project consists of four elements:

(1) A multi-centre baseline study on ethical values in teaching hospitals

(2) Establishment of a regional health ethics network

(3) Preparation of a teaching module in health ethics

(4) Promotion of health ethics through national workshops.

Country reports

The process of collecting situation analysis reports on the practice of ethics evolved when the Regional Teacher Training Centre at the Peradeniya Medical School, Sri Lanka embarked on developing a training programme in

health ethics in 1996. The first regional training workshop was conducted in Kandy, Sri Lanka, from 26 to 30 June 1996, with WHO assistance. Participants from Bangladesh, Bhutan, India, Indonesia, Nepal, Sri Lanka and Thailand presented situation analysis reports on the practice of health ethics in their respective countries.

This regional training workshop led to a series of activities in health ethics which were later undertaken in the South-East Asia Region (SEAR). As a follow-up to the workshop, WHO Regional Office initiated three major activities which included: a series of training programmes in health ethics conducted in Sri Lanka; a multicenter research study to take stock of the ethical values held by medical doctors in teaching hospitals, and an initiative taken to develop a South-East Asia Health Ethics Network (SEAHEN) which is epitomised by the publication of a Newsletter and designing of a web page (available at http://www.hf.uib.no/i/Filosofisk/seahen/default.html). Since the focus of the research programme was on teaching hospitals, the initial SEAHEN activities were limited to Bangladesh, India, Indonesia, Myanmar, Nepal and Sri Lanka.

It was decided that the country situation reports on health ethics in SEAHEN countries should be published along with the publication of research findings. This first volume in a series planned on "Health Ethics in South-East Asia", therefore, contains of situation reports only from the six SEAHEN countries involved in the research activities. While some of these reports are the revised versions of what was presented at the first training workshop on health ethics in June 1996, a few were prepared later at the request of the SEAHEN team.

The following sub-topics were agreed upon by the authors of these country situation reports in order to conform to a uniform format: history, organizational aspects, teaching, practice at the clinic, research ethics, contemporary national-level issues, and future prospects. While the way, authors have chosen to structure their individual country reports form variations over these themes, all these topics are covered in all reports, and some have been added if additional information was available.

The reports are indicative of the relative maturity of the precept and practice of health ethics in the SEAHEN countries. They show that in all these

countries, activities have been undertaken and methods designed to deal with ethical issues. Specific issues have been receiving both medical and social attention. Browsing through the material one can discern that the initiation of the teaching and practice of health ethics has evolved out of three factors: changes in socio-political scenario, influence of outside agencies, and the colonial legacy. A good example of the first factor is India where the general approach to uphold the rights of the people has been developed with the enactment of the Consumer Protection Act. Although several SEAHEN countries have consumer protection laws in place, it is only in India that the "health consumer" has also been included in the Act.

Agencies such as Christian missionary medical schools and the World Bank have also been influential in initiating directly or indirectly health ethics-related activities in some of the countries. Both in India and Indonesia, Christian medical schools have been conducting religion oriented health ethics courses. In recent times, the World Bank, with the introduction of the notion of "health reform" and "essential health care package" to recipient countries, has also been a significant player in this field.

In most of the SEAHEN countries the colonial legacy had also been an influencing factor as the legal systems and medical acts adopted by the newly-emerging nations which defined the responsibilities of their medical councils were inherited from the past. With the exception of Nepal, all the other participating countries were under the colonial rule for a significant period of time. Although most of these countries had their own traditional medical systems with longstanding ethical traditions, these systems had delegated a marginal position by the imposed Western medical ideology. Nepal, too later adopted a medical legislation which it borrowed from India, which had been inherited from the British.

Teaching of medical ethics in the SEAHEN countries is still in its infancy. In most countries medical ethics is taught in the department of forensic medicine emphasizing negligence and malpractice. Attempts are being made to have the teaching of ethics integrated into the various segments of medical school curricula and to train teachers in the concepts and teaching of ethics. It seems that the problems encountered by medical teachers are closely related to the medical technology available.

The most developed aspect of health ethics in the SEAHEN countries seem to be in the domain of research ethics. Most of the countries have functioning ethics review committees who evaluate the proposals for medical research for ethical implications.

Problems that have stimulated public discussion about their health ethics aspects reflect the socio-cultural realities of these countries. In this regard, the abortion issue in Sri Lanka and foeticide following ultrasonic scanning in India are the best examples. What is also seen to be an emerging issue is the rapidly developing role of the private sector in health care and the extent to which the private and public mix has taken place. In Nepal and Sri Lanka, there is a growing criticism of the tendency of government consultants to also practice in the private sector.

Another issue exercising the mind of doctors is the ethical dilemma resulting from rapid advances in medical technology – how much should they depend on life-support systems taking into account the cost involved in their procurement and use.

Ethical issues related to HIV/AIDS are also becoming important in countries such as India and Sri Lanka.

What also seems to be an issue in most of the SEAHEN countries is the confrontation liberal health care professionals have with their legal system. Although providing health care in an era of change, technological advances, new illnesses and the emerging private sectors evokes many matters of ethical concern, the perceived inability of the legal systems to adapt to modern situations seem to be a matter of additional concern for many.

This is the first publication on the situational analysis of ethics undertaken in countries in the WHO South-East Asia Region which are part of the SEAHEN project. One major limitation that most of the authors faced was the limited access they had to published material in the area of health ethics in their respective countries. Hence, while these articles would need to be revised and updated from time to time, they do form a significant first step towards understanding the status of health ethics and related activities at national level. It is hoped that this effort is sustained in the future.

Medical Ethics in Bangladesh

Professor M. Muzaherul Huq

Introduction

Ethics is the understanding of moral values. Medical ethics mean the moral principles, which should guide the members of the medical profession in the course of their practice of medicine and in their relationship with their patients and other members of the profession[1].

Medical etiquette is the mutual relationship between members of the medical profession. In other words, it is a sense of courtesy and respect which should govern the conduct of and relationship amongst the members of the medical profession[1].

In Bangladesh, medical doctors have traditionally enjoyed the highest respect among different professions. Advances in medical and health sciences and their being highlighted in the mass media, have made people so much conscious about their health and health rights.

Human rights activists and the Consumer Association of Bangladesh are also making people aware about their health rights. They are now concerned about the health care facilities available in clinics and hospitals and what they get from individual doctors. They are even questioning the cost of health care.

The expectations of people are increasing. Cases of negligence and malpractice on the part of physicians are being brought to courts with the result that professional organizations, such as the Bangladesh Medical Association and its members are becoming conscious of their code of conduct and ethical behaviour.

History and socio-cultural setting

The Geneva declaration of medical ethics was based on an ancient concept of ethics in the practice of medicine. This ancient concept of medical ethics was based on the early civilizations of Babylon, Egypt, India, Greece, Persia and China. Probably, the Babylonians were the first to codify the responsibilities of physicians. For the practice of medicine regulations were also found in ancient Egypt. In the Sushruta Samhita and Charika Samhita of ancient India, evidence of medical ethics is also available. The Hippocratic oath was formulated much later during the Greek-Roman period which brought about a transformation in the entire concept of medical ethics[2].

The World Medical Association, at its third General Assembly in Geneva in September 1948, adopted certain codes of ethics in the form of an oath to be taken by all members of the profession at the time of entering the medical profession. A year later, the Association adopted a code of ethics which is popularly known as the International Code of Medical Ethics. This dictates different duties of doctors considered from different angles. Bangladesh, as a member country of the Association, is a signatory to the codes[1].

Almost all existing medical and health laws and regulations in Bangladesh have been inherited from the British colonial rule in the Indian subcontinent. The Indian Medical Degree Act of 1916 is the principal statute to regulate the grant of titles implying qualifications in the Western medical science. The Act attempts to check the assumption and use of the medical title by unqualified persons. The same regulations were continued during the period Bangladesh was part of Pakistan. In 1971, Bangladesh emerged as an independent nation but it adopted the erstwhile legislation of Pakistan.

In Bangladesh, Government laws and regulations control medical practice. A code of conduct has been practised for hundreds of years which governs the way physicians are supposed to perform their professional work.

Organizations and agencies

The medical profession is governed by legislation and by a code of ethics and etiquette. Enforcement of the code is the responsibility of the Medical and Dental Council of Bangladesh.

The Bangladesh Medical Council was established in 1972. It was renamed as the Bangladesh Medical and Dental Council (BMDC) later. The BMDC is not an association or union for protecting professional interests, but was constituted under the Medical Council Act No. XXX of 1973 on October 2, 1973, and is responsible to protect the health and well-being of the people as a whole[3].

The BMDC is an autonomous body. Its president and members are either elected or are nominated by the Government. They include members of parliament and other high-placed people. The Council functions through different sub-committees and plays a vital role in setting standards for medical education and various courses and qualifications. The ultimate objective of the BMDC is to ensure standard medical practice in the country.

The Government enacted the Medical and Dental Council Act, 1980 (Act No. XVI of 1980) to establish a uniform minimum standard of basic and higher qualifications in medicine and dentistry and matters connected therewith[4].

The BMDC is empowered to look after public interest through maintaining proper medical and dental standards and medical and dental education in the country. It is responsible for maintaining a register of doctors who qualify from recognized institutions. In addition, it can take such disciplinary action as may be necessary for criminal conviction on serious professional misconduct by a doctor. It can also suspend or withdraw recognition of any institute and the qualifications conferred by it if its functioning is found to be substandard[4]. In order to promote medical education and the professional practice in medicine, the BMDC approves the medical curricula and courses developed by various institutes through the technical assistance of the Centre for Medical Education (CME), Bangladesh.

Inadequate manpower support - both technical and administrative, low productivity, inadequate resources, absence of any monitoring mechanism and follow-up action, lack of accountability, and lack of capacity in terms of enforcement of its own mandate are some of the weaknesses of the BMDC. The current legal instrument needs to be reinforced by articulating its policies, programmes and strategies which are consistent with the advances in medical technology and the emerging need for human resources development in national health services in order to confer validity to the BMDC's role.

Like the BMDC, the Nursing Council and the State Faculty of Medicine are responsible for overseeing the standard of practice and education of the nursing and paramedical personnel respectively.

In order to regulate the practice of pharmacy and matters connected therewith, the Government promulgated the Pharmacy Ordinance of 1976. For the development of human resources in the pharmacy discipline, the Pharmacy Council has been given elaborate terms of reference by the Ordinance. But the Council does not seem to be effective in terms of technology, enforcement of laws/rules, and maintaining interrelationship with teaching institutes to perform its functions relating to pharmacy education[7].

Apart from the BMDC, the Nursing Council, the Pharmacy Council and the State faculty, there is another organization known as the Bangladesh Medical Association (BMA). It is an elected body and is the largest organization and forum of the medical doctors' community. It functions nationally through an executive committee elected by its members. It has branches all over the country. The Association is more like a bargaining agent which protects doctors' interests. Apart from this role, it also advises the Government by making constructive suggestions in medical education and health care management. Though the Association has no power to take action against its members for negligence and malpractice, it does organize meetings and seminars to make them aware of patients' rights and medical ethics.

An association of medical educationists and teachers (National Association for Medical Education NAME) also organizes regular meetings and seminars on patients' rights, human health rights and different aspects of health ethics, including quality assurance.

Recently a group of health professionals has started working for the promotion and practice of health ethics. This group which has yet to form itself into a formal body, will pursue the general and specific objectives of promoting health ethics.

Formal teaching of medical ethics is imparted in all medical colleges and schools in Bangladesh at the undergraduate level as part of medical jurisprudence. Medical ethics are taught in the 3rd and 4th year of the MBBS course at the Department of Forensic Medicine through formal classroom lectures and group tutorials. There is a defined course and curriculum, which includes professional misconduct and other ethical issues relevant to medical practice in Bangladesh.

An exercise has been undertaken to integrate the teaching of ethics in all clinical teaching, with emphasis on attitudinal development. The Centre for Medical Education (CME) regularly organizes a 4-day intensive structured course on the teaching and practice of health ethics for teachers of medical colleges and allied sciences.

There is also an informal method of learning and practising other aspects of medical ethics and professional etiquette through discussion in the clinical classes.

At present, the teaching curriculum is being revised and behavioural science has been included in the 1st year course giving special emphasis to legal medicine and ethical aspects of medical practice.

Ethics in medical practice

The BMDC maintains disciplinary control over medical practitioners with regard to misconduct, malpractice, negligence as well as behaviour in their medical practice. However, much information is not available on this particular aspect. There are very few complaints made to the BMDC against doctors for the violation of the ethical code or malpractice. People here rather go directly to the court. On some occasions complaints have been lodged with the employing authority or the Government to redress such issues.

There has hardly been any disciplinary or penal action initiated by any professional body, including the BMDC. As the BMDC is considered to be a body dominated by medical professionals, people are reluctant to lodge complaints against doctors with the BMDC. According to the BMDC, they hardly receive any complaint of negligence or unethical practice. In addition, the BMDC also admits its poor functioning and lack of monitoring and supervision mechanisms.

Medical ethics in research

The Bangladesh Medical Research Council (BMRC) was established in 1972 as a semi-autonomous body under the Ministry of Health and Family Welfare. The BMRC is the national focal point for health research. It has an Ethical Review Committee, of which the main function is to review research protocols for their ethical aspects before approval[8].

Ethical committees also exist in different institutes to give ethical clearance and to oversee the ethical aspect of any research where human subjects are involved.

Legal perspectives

The medical practice in Bangladesh is governed by legislation and medical laws, which are enforced by the Ministry of Health and Family Welfare. Hospitals, clinics and diagnostic centres are also governed by government regulations. Physicians perform their professional work in conformity with these regulations. But enforcement of these acts or laws does not seem to happen very often.

Teaching of ethics

The main problem in the teaching of ethics is that teachers have little knowledge about medical ethics, etiquette and code of conduct. Also, medical students do not have much interest in learning about medical ethics

as they consider other subjects to be more important for qualifying the examination. Moreover, professional conduct and etiquette are learnt by observation rather than through the reading of books. The students rarely find a role model among their teachers for ethical practice. Practice of right conduct by senior doctors influence the behaviour and attitude of junior doctors. Penalization in case of misconduct can enforce the code of conduct.

The teaching environment and methods are also not favourable for the teaching of ethics. Whatever little teaching is provided is imparted during pre-clinical teaching sessions when the students have not been exposed to patients. Integrated teaching of ethics in clinical years can be a better setting. A structured curriculum for the teaching of ethics needs to be prepared for health professionals, including medical students and doctors.

Health policy reform and other contemporary issues

Malpractice and misconduct by medical practitioners are the most common problems of public concern in Bangladesh. The standard of public health service is gradually deteriorating and private doctors have commercialized the profession. Self-advertisement, overcharging, indiscriminate use of drugs, unnecessary surgical operations, recruitment agents to get more patients and providing false and fabricated medical certificates are major ethical problems.

Bangladesh is yet to adopt a health policy though a population policy and a population council are in place. Recently, task forces have been formed to formulate a health policy. This is in line with the national objective of poverty alleviation through improvement of nutrition and the health status of the people, with particular attention to mothers and children. The main aim of the policy would be fair and equitable distribution of available resources to the needy and deprived population that lives in urban slums and rural areas. An Essential Health Care Package Services (ESP) will be provided to the poor and all women and children in the country. Another aspect of the health policy would be equitable distribution of health care facilities, incorporating an affordable cost-recovery mechanism, to cover the entire country.

The basic doctors will be equipped with the knowledge and skill of ESP delivery. A skill-mixed human resource development plan will be implemented to make the health care services more effective and optimally functional. A quality control mechanism, with proper monitoring and supervision, will be established at all levels of health care services.

Looking towards the future

In order to develop awareness about ethical values among students, more importance should be given to the teaching of medical ethics. More emphasis should be given to the development of students ' attitude in the course curriculum of medical ethics so that they can gain and imbibe knowledge about ethical practice.

It should be the responsibility of all professional organizations to uphold the principle of medical ethics and professional conduct. The BMDC, the Nursing Council, the Pharmacy Council and the State Medical Faculty should be strengthened to enable them to monitor health education and health services so that people can receive optimum care from doctors and government health services. Health planners, policy-makers and implementers should give priority to ethical issues in medical and allied education as well as medical practice. They should provide technical support to medical institutes so that they can develop and implement an integrated curriculum for the teaching of ethics.

Medical schools should develop a structured course of teaching of ethics in collaboration with the involving Centre for Medical Education (CME). This courses should be implemented with a view to bringing about behavioural change among students about ethical issues and their relevance in education and practice. The CME, with the technical expertise at its disposal, can also promote research and innovations in issues related to medical ethics. It can also help update medical laws and health regulations of the country through a needs analysis and a review of the existing laws in the country. The changed perceptions of the society on ethical issues strengthen the need for a revision of the existing laws.

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Ethics Perspectives from India

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History and socio-cultural setting

India presents a unique case of socio-economic, ethnic, religious and cultural diversity. Its population of over 930 million makes it the second most populous country in the world after China. This accounts for about 15 per cent of the world's population with only 2.4 per cent of the total land area. Nearly 75 per cent of the people live in villages. The density of the population varies from state to state and from urban to rural areas.

The Constitution of India envisages the establishment of a social order based on equality, secularism, freedom, justice and the dignity of the individual. It aims at the elimination of poverty, ignorance and ill-health and directs the State to promote a healthy living and enhances the standard of living of the people. The Republic of India has a federal structure which consists of 25 states and seven Union Territories (UTs). Constitutionally, health is the responsibility of the states/UTs. However, subjects such as population control, family planning, medical education, and drug control are concurrent subjects, i.e. under both the Central and state governments. The formulation of national health policy and the overall coordination of state health departments is overseen by the Central government.

India recently celebrated its 50th year of Independence. Impressive strides have been made in the fields of agriculture, food production,

infrastructure development, transport, science and technology, commerce and industry as well as in health, education and social welfare. However, the burgeoning population, with the annual growth rate of 2.11 per cent, and the unplanned increase in urban population have nullified the benefits of the progress made in various fields.

Historical perspective

Historically, India had a rich public health system as evidenced from the relics of the Indus Valley civilization which demonstrate the existence of a holistic approach towards health and disease. The philosophy of Ayurveda, which was predominant between 800 B.C. and 600 A.D., subsequently gave way to other co-existing systems of medicine such as Siddha, Unani system, Tibbi, homeopathy, and the latest, allopathy. The public health system in the country declined through the ages because of successive foreign invasions, introduction of alien cultures, and degradation of environment due to population growth. With the establishment of the British rule and the introduction of the practice of Western medicine in India, the traditional holistic approach went into disuse and was replaced by disease-doctor-drug-orientation in the health system.

At the time India achieved independence in 1947, the health situation in the country was dismal. Following the implementation of the recommendations of the Bhore Committee, India witnessed a phenomenal growth in the health infrastructure as well as health manpower. During the successive Five-Year Plans, several initiatives were taken by the Government to tackle health problems. Chief among them were the formulation of a National Health Policy (1983), commitment to the goal of Health for All by the Year 2000 through the primary health care approach, and the launch of several national health programmes and other intervention measures. The key achievements in health since independence are summarized in Table 1.

*Table 1**. Achievements in health in India at a glance (1948 and now).***

➢ Decline in birth rate from 39.9 to 28.3 per 1000 population
➢ Decline in death rate from 27.4 to 9.0 per 1000 population
➢ Reduction in infant mortality rate from 134 to 74 per 1000 population
➢ Increase in life expectancy among males from 32.5 years to 62.8 years and among females from 31.6 years to 64.2 years.

While the National Family Welfare Programme aimed at controlling the population, the National Child Survival and Safe Motherhood (CSSM) programme provided maternal and child health (MCH) services. Since 1996, these two programmes have been merged into the Reproductive and Child Health services, with the additional component of the management of reproductive tract and sexually transmitted infections. Other national programmes are: the control of malaria, filariasis, guineaworm infestation, Kala azar, leprosy, tuberculosis, cancer, iodine deficiency disorders, and blindness. Special attention is being given to the promotion of mental health, prevention of cardio-vascular diseases, and tackling injuries besides trauma care.

Health infrastructure and health manpower development

India has one of the largest health care infrastructures in the world. It consists of a network of tertiary care hospitals at the state/national levels, district hospitals and dispensaries at the district level, a chain of community health centres at the block level, and primary health centres and sub-centres at the grassroot level.

The Union Ministry of Health and Family Welfare is headed by a Cabinet minister, assisted by a minister of state. The Central Council of Health

and Family Welfare is the highest advisory body to recommend broad guidelines for health policy matters. The Ministry of Health and Family Welfare (MOHFW) has three departments: the Department of Health, the Department of Family Welfare, and the Department of Indian System of Medicine. The Department of Health is headed by a Secretary to the Government of India, and has a technical wing under the Directorate-General of Health Services.

At the state level a ministry of health, headed by a minister, looks after health and family welfare matters. All the states have directorates of health while some states also have separate directorates of medical education.

Each state is divided into districts, which is the principal unit of administration in India. In each district, there is a district hospital and a district health officer (designated as chief medical officer or district medical officer) who is in overall charge of district health administration. A district is divided into sub-districts *(talukas),* each having a community health centre or an upgraded primary health centre. Primary health centres are the basic unit of primary health care catering to a population of 20 000 to 30 000. These primary health centres provide universally comprehensive health care services to the community, at a cost that people can afford. Their services include preventive (vaccination and public health training), promotive (healthy lifestyle practices), and curative (medical-surgical) services. Under the primary health centre there are sub-centres which cover a population of 3 000-5 000. The *Panchayat Raj* system, which means local self-government, is becoming an increasingly important unit of administration and has tremendous scope of promoting health interventions through community action. Table 2 depicts the health infrastructure in the country.

Along with the increase in the health infrastructure, India also witnessed an unprecedented growth in the production of health manpower, especially medical manpower as shown in Table 3.

*Table 2.. **Health Infrastructure in India.***

	1951	Current level
Hospitals	2,694	13,692
Dispensaries	5,306	28,321
Beds	117,178	596,203
Beds per 100 000 pop.	32	70
Community health centres (80 000-120 000 pop.)	-	2,424
Primary Health Centres (20 000-30 000 pop.)	-	21,854
Sub-centres (3 000-5000 pop.)	-	132,730

*Table 3. **Growth of health manpower in India***

	1951	Current level
Medical colleges	17	162
Annual turn-out of doctors	1,400	17,000
Doctors	61,840	489,189
Dental surgeons	3,290	11,300
Nurses	16,550	559,896

It can be observed that there is an over-production of doctors while nursing and other health personnel are not being produced in sufficient numbers. The distribution of doctors is also irrational. Most of the doctors are concentrated in hospitals located in urban areas and metropolitan cities while villages, hilly and tribal areas and urban slums lack their presence. The tendency among doctors for over-specialization and the emergence of high technology have not only resulted in increased cost of health, but have also

undermined the humanistic aspect of medicine. The health care delivery system and the medical education system are not working in a complementary manner.

The role of professional councils

The Government of India has set up several regulatory bodies for monitoring the standard of professional education and for maintaining a code of ethics in the country. These are: the Medical Council of India (MCI), the Nursing Council of India, the Dental Council of India and the Pharmaceutical Council of India. In addition to the MCI, each state has its own state medical councils.

The MCI is the apex body. It is involved in the recognition of medical colleges for the grant of undergraduate and postgraduate medical degrees. It conducts inspections at regular intervals to ensure that minimum standards of education are maintained. The MCI also prescribes the curriculum for the MBBS degree course. All medical graduates have to register themselves either with the MCI or with a state medical council before they can practice medicine in the country. A countrywide register of all physicians so registered is maintained. The Council has formulated a code of medical ethics to be followed by all registered medical practitioners.

Code of medical ethics

The Medical Council of India requires that every new graduate should be given a copy of the code at the time of registration, and should agree to abide by it. The code declares, "I pledge to consecrate my life to the service of humanity. I will not use my medical knowledge contrary to the laws of humanity. I will maintain the utmost respect for human life from the time of conception." This is a 12-page document that covers the character and responsibility of the physician; advertising by the physician; professional services rendered; duties of the physicians to their patients and the profession at large, to each other and to the public.

In all medical schools, the students on graduation have to take a pledge to the Hippocratic oath. At the All India Institute of Medical Sciences, New Delhi, the following oath, composed by Charak, a famous physician in ancient India, has to be taken: "Not for self, not for the fulfilment of any worldly material, desire or gain, but solely for the good of suffering humanity, I will treat my patient and excel all."

The Medical Council of India can take disciplinary action in case the code of ethics so prescribed is not adhered to. The punishment awarded depends upon the level of misconduct. It may be as harsh as removal, altogether or for a specified period, from the register the name of the registered practitioner who has been convicted. A list of various types of punishable misconduct has also been given in the book "Code of Medical Ethics".

At present there is no system of quality assurance such as re-registration, compulsory continuing of medical education, and medical audit, though such a need has been increasingly felt. It is expected that with the promulgation of the Consumer Protection Act (1986), the MCI will take action against erring physicians.

Most of the major disciplines in medicine also have their respective academies or associations. Membership of these associations is given on the recommendation of their members. However, these academies or associations do not have any legal power to take action against physicians for misconduct or unethical practices.

Teaching of medical ethics

It is widely accepted that the teaching of medical ethics should be an integral part of undergraduate and postgraduate medical curricula. In the past, this was done on a one-to-one basis. Students learned by following their teachers as role models. With the introduction of larger numbers of medical students in a class, the above approach needed to be replaced by classroom didactic teaching. The goals of classroom teaching were mainly cognitive; students were expected to identify, analyse and debate on ethical issues.

Situation in medical colleges

However, if we look at the prevalent situation in India, the teaching of ethics as a formal part of the curriculum is largely absent. The MCI has been charged with the responsibility of setting minimum standards for medical education. It has not prescribed a separate curriculum in medical ethics. However, the curriculum for forensic medicine includes one or two formal lectures on some of the ethical issues.

At the All India Institute of Medical Sciences, New Delhi, for example, ethics is taught and assessed as part of the forensic medicine curriculum. The Kasturba Medical College, Manipal, has a series of sessions touching upon ethical issues, and several other medical colleges similarly have six to eight sessions on the subject. The Christian Medical College, Vellore, has been a leader in this area and uses case studies during internship to inculcate ethical thinking in future doctors. Well-known lawyers and experts in medical ethics attend these sessions.

The St. John's Medical College in Bangalore has, however, set an example that should be followed by the MCI and every medical school in the country and elsewhere. Since the establishment of the college in 1963, St. John's has paid particular attention to the teaching of this subject. The college is unique among medical institutions in having a department of medical ethics. This department has four faculty members, headed by a professor. Their teaching programme for medical ethics extends as a continuum throughout the undergraduate training period and is reinforced during both internship and residency by clinical case-oriented sessions. Since 1992 this pioneering medical college has also conducted monthly 'clinico-ethical' conferences which are held during the weekly hospital meetings. For each of the monthly session, a case with ethical issues is selected from the wards and presented by interns and residents. A senior clinical faculty member of the concerned discipline then discusses the case with participation by the audience. Thus, in each such session, students, interns, residents and clinical faculty get an opportunity to participate in the discussion. Topics such as truth and confidentiality, life support, transplantation, respect for life, drug promotion and prescription and patient-doctor relationship are discussed.

The St. John's Medical College has evaluated its teaching of ethics. A questionnaire was distributed to: (I) the College's their own early interns who did not have any exposure to the ethics course; (ii) to interns from the Jawahar Lal Nehru Institute of Postgraduate Medical Education and Research (JIPMER), Pondicherry, where there is no formal teaching of ethics, and (iii) to interns who had the advantage of an ethics course. The latter group achieved the highest scores while the responses of the two 'control' groups were essentially similar. The need for a formal course in ethics thus seems clear from the St. John's experience.

The Consortium Initiatives

The consortium of medical institutions comprising the All India Institute of Medical Sciences, New Delhi; the Christian Medical College (CMC), Vellore, JIPMER, Pondicherry; and the Institute of Medical Sciences – Banaras Hindu University (IMS-BHU), Varanasi, formulated inquiry-driven strategies in 1989 for innovations in medical education with financial support from WHO. A number of instruments were used for identifying curricular deficiencies during the inquiry. These included questionnaires eliciting the faculty's and the students' perceptions of the curriculum and the expectations of patients and the community at large from doctors and medical services.

One of the important findings of this inquiry was that the ethical, moral and humanistic aspects of disease were neither taught nor assessed. The consortium proposed modification of the existing undergraduate curriculum based on the results of the inquiry. It was proposed to have a formal course in medical ethics. The course content and teaching-learning methodology have been finalized (Annex I). It has been largely drawn from the course being followed at the St. John's Medical College, Bangalore. It has been stressed that this course should be taught preferably by case examples, case discussions and role models rather than as lectures. The course is to be administered to the final year MBBS students by a group of faculty drawn from a number of departments. Assessment of the course should be an integral part of the assessment of clinical subjects, either in the form of short case or viva voce or an objective structured clinical examination (OSCE). However, it has yet to be introduced by most of the medical colleges in the country.

Ethics in clinical practice and legal perspectives

In India, it is not always possible to follow the four principles, i.e. beneficence, non-maleficence, patient autonomy and justice in making ethical judgements. This is because the rapid growth in population has put a tremendous pressure on the resources needed to meet the basic needs of the people such as food, housing, education and health. It is not surprising, therefore, that in bio-ethical decisions, sanctity of life is deemed to be less important than the quality of life. This kind of judgement poses many ethical dilemmas for the people, which, in practice, are resolved in the context of cultural traditions interacting with socioeconomic considerations. There is also a tremendous amount of age-old faith, trust and respect in the Indian culture towards physicians. The doctor is often viewed as a demi-god and his decisions are taken as gospel truth without any doubt or misgivings. This imposes immense responsibility on the physician to maintain an ethical, correct and honest approach in his dealings with his patients.

There is an unequal distribution of health services between the poor and the rich, the rural and the urban populations and between men and women. Disparities also exist between tribal and non-tribal people, and between the lower and the upper castes. The existence of such inequalities is a stark reality in India, which has led to considerable social, political and ethical dilemmas. Changes have been observed in people's lifestyles, family dynamics and health-seeking behaviour in recent years due to the introduction of a free-market economy and globalization. From the traditional joint family system, the nuclear family system is now fast emerging. In the former, decision-making was vested in the eldest member of the family, which is not the case with the nuclear family structure. Some of the major issues confronting the Indian society are highlighted below.

Poor vs. rich

In India, free health care services are provided by Government hospitals and dispensaries while private practitioners and specialists and private hospitals provide health services for a fee. The services provided by the latter are of better quality which are easily comparable to the services available in

developed countries. However, these services are beyond the reach of the poor because of the high costs involved. Government hospitals do provide health services of reasonably good quality but they are over-crowded, have long waiting lists, and often lack cleanliness and courtesy. Sick patients at times are refused admission in government hospitals due to lack of beds. Many a time doctors in these hospitals have to rely on the second or third line of therapy, as the best may not be affordable by the patient The physicians thus constantly face the ethical dilemma in the choice of treatment and in the choice of the patient who should receive the available treatment. The limited number of beds and equipment in the intensive care unit, thus necessitating the doctor to select from among the many patients who may require these services, exemplify this situation. It is to the credit of doctors that in most cases they try to choose patients according to the medical needs. Many of them prefer to use the limited resources for those who have treatable disorders and a reasonable chance of full recovery without any handicap. On occasions, patients suffering from disorders where normal mental functions cannot be assured and who require very expensive treatment are often given only restricted or palliative treatment. This may appear unethical although there seems to be no other choice.

Rural vs. urban

It is paradoxical that although 79 per cent of the Indian population lives in rural areas, only 20 per cent of the health budget is allocated for rural use. Although the government has been making efforts and has developed a vast network of rural health services, disparities still persist between urban and rural areas. Many of the primary health centres and sub-centres remain without doctors or medicines. This explains the differences in health indicators between urban and rural areas.

Bio-ethics and religion

India is a secular country with the predominant religion being Hinduism. Islam, Christianity, Jainism, Sikhism and Buddhism are other religions followed by a significant proportion of the population. The philosophies of these

religions are quite different. Many Hindus blame or credit every misfortune to destiny and God, while often it is not so with Christians. Many Hindus interpret many of the diseases to be due to the curse of gods and goddesses. This usually leads the patients to refuse treatment in the belief that treatment would further annoy the relevant god or goddess. It thus becomes difficult for doctors to force treatment in such instances, which again leads to an ethical dilemma.

Status of women and ethical implications

Women in India have traditionally a lower status in society. The Indian Constitution, however, strongly asserts the rights of women as equal to men's. In practice, however, women are at a disadvantage for all demographic and health indicators. Literacy, a basic requirement for socio-economic development, is considerably lower in females. Discrimination against the female child begins even before she is born. The female foetus may be aborted when its sex has been documented by prenatal diagnosis. Young girls have poorer nutritional status than boys. Unlike most other countries, there is a higher male/female sex ratio in all age groups in India. In the Indian society in general, especially in the lower and lower middle socioeconomic communities, it is the fathers, brothers, husbands or sons who often make the decisions for women. Steps are being taken to enact suitable legislation to aid women's causes and to protect women's rights.

Medical termination of pregnancy

Medical termination of pregnancy (MTP) has been permitted under the law since 1971 "provided the continuance of the pregnancy would involve a risk to the life of the pregnant woman or a grave injury to her physical or mental health", or "there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped". The Medical Termination of Pregnancy Act explains that pregnancy caused by rape, or failure of contraception by a married couple, would fall within the purview of the first indication as the anguish caused by

these situations is presumed to constitute "grave injury to the mental health of the pregnant woman".

Medical termination of pregnancy can be performed up to 20 weeks of gestation. For gestation up to 12 weeks, any medical practitioner can make the decision for MTP. When the length of gestation is over 12 weeks, two or more medical practitioners are required to conclude an opinion regarding the indications for the termination of pregnancy. In spite of this legislation, illegal abortions are performed by untrained people as well as by trained people for wrong indications. Some debate has recently been generated about the indications for MTP in the third trimester. A number of cases are being diagnosed on ultrasonographic examination to have 'lethal malformations' in the third trimester. Families would like to have abortion but the law does not permit MTP to be carried out beyond 20 weeks of gestation.

Prenatal diagnosis of sex and female foeticide

Since the passage of the MTP Act, an important ethical problem that has emerged in India is the prenatal diagnosis of sex for social reasons and abortion of the foetus if it is determined to be female. Advances in reproductive technology in the past decade have allowed the determination of foetal sex from the chorionic villus samples taken at 9 to 12 weeks of pregnancy; amniotic cells withdrawn at 14 to 18 weeks of pregnancy; or ultrasonography examination at 16 to 18 weeks of pregnancy. In India, social pressures force couples to have a male child. With the norm of small families becoming a necessity, couples want to determine the sex of the unborn baby. A lot of debate has been generated but there is no consensus that prenatal diagnosis of sex for social reasons is unethical. Most people do appreciate that sex determination and female foeticide are ethically wrong. However, cultural, economic and social realities have overridden moral objections and, for these reasons, prenatal diagnosis of sex was widely practised during the 1980s. The government took cognizance of this practice and the state of Maharashtra was the first to enact a law in 1988 to regulate prenatal diagnostic tests in order to prevent their misuse for prenatal sex determination leading to female foeticide. The Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act, 1994, has been passed by the Indian

Parliament. This Act provides for: (a) prohibition of the misuse of prenatal diagnostic techniques for the determination of the sex of the foetus leading to female foeticide; (b) prohibition of the advertising of prenatal diagnostic techniques to determine sex; (c) permission and regulation of the use of prenatal diagnostic techniques to detect specific genetic abnormality or disorders; (d) permitting the use of such techniques only under certain conditions by registered institutions; and (e) punishment for the violation of the provisions of the proposed legislation. The Bill provides that genetic counselling centres and genetics laboratories and clinics be registered with the appropriate authority; they should have trained manpower and specified equipment and should maintain records of each woman or man undergoing any tests. It lays down specific conditions under which prenatal diagnostic tests are permitted, e.g. chromosomal abnormalities, genetic metabolic disease and congenital anomalies. It forbids relatives or husbands of pregnant woman to encourage the use of prenatal diagnostic techniques for sex determination. The Bill lays down stiff penalties. It is well-meaning and demonstrates the interest of the government in the welfare of women and tries to curb one of the most unethical practices gaining popularity due to socio-cultural reasons.

Donation of human organs for purposes of transplantation

Recent technological advances have made it possible to transplant human tissues and organs such as cornea, ear-drum, kidney, heart, lung, liver, pancreas, skin and bone marrow. In the absence of a law regulating the donation of organs, large-scale trading in human organs was started some years ago by a number of unscrupulous physicians. In fact, India became an international market centre for kidney transplants from live donors.

In July 1994, the Transplantation of the Human Organs Act was passed. The Act provides for the regulation of removal, storage and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in human organs and for matters connected therewith. Under this Act, brain stem death has been defined as the stage at which all functions of the brain stem have permanently and irreversibly ceased and are so certified.

All brain stem functions can be tested by a skilled person at the bedside of the patient without using sophisticated or expensive equipment. The Act provides for the people who are competent to certify brain stem death and for persons authorized to give permission for the removal of human organs from the body of brain-dead patients for therapeutic purposes. It also entails that only hospitals registered under this Act shall conduct or associate themselves with the removal, storage or transplantation of any human organ. Stiff penalties have been laid down under this law. The organ transplant Act does not come in the way of legitimate therapeutic procedures. It insists that live donation should be made to near relatives only (husband and wife, father and mother, son and daughter, brother and sister). At the same time the Act has a provision allowing that in case of dire necessity, in genuine instances, a live donation can be made to a person other than a relative. Cadaveric organs can be used for anybody who is in need and not necessarily a near relative. This Act has been able to regulate the unethical large-scale trading in human organs in the country.

Consumer Protection Act

Until recently, if any dispute regarding negligence on the part of physicians or hospitals was raised in a court of law, it was filed either under the law of torts or under the Indian Penal Code. The introduction of the Consumer Protection Act in 1986 opened up the possibility of easy, inexpensive and quick redressal for misconduct or negligence by medical professionals.

The Consumer Protection Act was enacted in response to the public opinion generated by consumer movement in India. The Act aimed to protect the rights of consumers through settlement of disputes by consumer tribunals at the district, state and national levels. Unlike law courts, no cost is involved in filing cases in consumer tribunals. The complainant can make out a case and argue it without engaging an attorney. A complaint under this Act is decided in three to four months, while it usually takes years in the civil or criminal courts.

The Act defines the consumer "as any person who buys goods or hires services for a consideration". This definition is broad enough to encompass a

patient as a consumer who obtains professional services from a physician for a fee (consideration). As a result, consumer tribunals started receiving complaints of negligence from patients against physicians and hospitals and stiff compensation was awarded in several instances.

However, the Consumer Protection Act led to a major controversy and debate in the country. Consumer activists argued that doctors generally conducted themselves without any sense of fear of liability for negligence and maltreatment. Cases of gross callousness, malpractice and neglect had not been dealt with properly for want of an easy mechanism of redress. The Medical Council of India, established as a watchdog agency, had failed to take any action against the wrongdoers.

The main counter-arguments of the medical profession, voiced by the Indian Medical Association, included: (i) the physician-patient relationship cannot be equated with a trader-consumer relationship; (ii) the cost of health care will rise due to an increased tendency to file claims, thus increasing malpractice insurance premiums; (iii) the consumer forums, comprised of non-professionals, cannot evaluate the complex decisions made by physicians; (iv) physicians would be reluctant to work in critical care areas for fear of litigation; and (v) frivolous charges may be brought against medical professionals because of the simplified procedure available under the Act.

The Supreme Court of India upheld the contention that the Act should apply to medical professionals. It has also been clarified that physicians working in government hospitals come under its ambit in case these hospitals have any paying beds.

It is now certain that the medical profession in India will be under stricter legal scrutiny in relation to negligence and misconduct in the future. This perception is already changing the way physicians practise medicine, at least in the private sector.

Neonatal and perinatal services and ethical issues

The perinatal period poses a large number of ethical dilemmas. In the neonatal period the common ethical dilemmas pertain to: (a) whether to

resuscitate a very immature neonate; (b) how to manage a neonate with severe asphyxial encephalopathy; (c) whether to provide life support to neonates with genetic disorders like Down's syndrome or potentially fatal congenital malformations; (d) for how long to support a neonate with irreversible neurological disorders causing brain stem death; and (e) how to allocate meagre resources to such neonates with competing indications.

Quality-of-life considerations weigh heavily on the minds of families as well as health care providers. The decision whether to provide care also includes the consideration of resource limitations, medical prognosis, family make-up, religious convictions, and a family's economic constraints.

Neonatologists and paediatricians in India face the dilemma of how much aggressive care should be given to very immature infants. Given the high mortality and morbidity rates and the availability of limited resources, it is extremely difficult for physicians to justify vigorous attempts to sustain or prolong life in such infants. Many physicians are reluctant to commit meagre resources to infants with perceived poor outcome. Added to this may be the difficulty or the inability of the family to pay for these interventions in private hospitals.

Decision-making by physicians is thus difficult. Many paediatricians have suggested the following principles for use as guidelines.

- Sound ethical decisions be based only on correct medical facts.
- It should be known with a fair degree of confidence whether the intended therapy in a particular patient is likely to be rewarding or futile.
- The burdens (suffering, death, disability) and benefits of the proposed intervention to the child, family and society should be carefully weighed.
- A team-approach should be followed by taking into confidence all the medical and nursing experts for the identification of various options and for making a reasonable and right opinion.
- The issue should be discussed with the parents to seek their opinion through a process of informed consent.
- The final decision should be recorded in the case file with full justification and endorsement by the parent/s.

Ethical issues and AIDS

Since the first documented evidence of HIV infection in Chennai in 1986, cases with seropositivity and clinical AIDS have been on the rise in the country. Although the government is giving top priority to the control of HIV infection, it is estimated that India will emerge with the largest number of AIDS patients in the next decade.

Ethically, a physician's primary obligation is to treat the sick without discrimination and, thus, he/she may not ethically refuse to treat a patient solely because the patient is seropositive for HIV. However, in practice, many doctors are refusing to provide treatment to AIDS patients, and many private hospitals and nursing homes have been known to discharge patients who test positive for HIV. Many doctors have the unfounded fear of contracting HIV if they treat such patients.

Other issues emerging with regard to ethics and AIDS are:

(1) The requirement of informed consent for the HIV testing of blood of a given individual. Experts argue that when patients get admitted voluntarily to hospitals or clinics for investigation and treatment of disease, specific informed consent for HIV testing is not necessary provided strict confidentiality is maintained. In practice, however, informed consent is essential.

(2) Obligation on the part of the patient in being truthful in disclosing the details of his/her personal history to the treating physician. Such an attitude will help health professionals in preventing the spread of the HIV infection to the community and to themselves.

Suicide and euthanasia

Under the Indian law, attempt to commit suicide is a criminal offence and is punishable by imprisonment or fine. On the other hand, under the current

laws of the country, euthanasia amounts to homicide by the physician and suicide by the patient. There are many who support the legalization of euthanasia. Many bills proposing this action have been introduced in the Indian Parliament but these have not been accepted. Another bill termed as the "Physician Immunity Bill" was introduced in the Maharashtra State Legislative Council (Upper House). The bill sought to empower persons to give advance directives regarding their treatment if and when they are diagnosed as having a terminal illness. However, in its present form, the bill can become an instrument of death by providing full scope for misuse and abuse in the hands of unscrupulous persons. It must be admitted that passive euthanasia is being practised in India without it being legalized. If a patient is terminally ill with an incurable disease and cannot be saved, the doctors, motivated by compassion, do not always resort to heroic measures just to prolong a vegetative existence. However, most Indians agree that human life, being of infinite value, should be undoubtedly promoted, protected and preserved.

Assisted reproductive technologies and ethics

With the advances in technologies, assisted reproductive technology facilities are being made available at some of the specialized hospitals and clinics in India. It is anticipated that a mushrooming of such services will occur over the next decade. These services are going to pose ethical dilemmas on the questions of surrogate mothers, artificial insemination, sperm banks, etc.

The Delhi Legislative Assembly enacted the Delhi Artificial Insemination (Human) Act, 1995 to legalize donation of semen and ovum. Banks for the storage, sale, donation and supply of semen have been recognized with provisions for their compulsory registration. The Act provides for strict testing of the semen against HIV infection, and prohibits the segregation of the X-and Y-bearing sperms. It also provides for confidentiality about the identity of donors and recipients. Written consent of both husband and wife is necessary. Strict punishments have been built into the provisions of the Act for non-compliance. The Act, however, fails to resolve many legal and ethical issues that may arise.

Ethical issues and disabled persons

A large number of patients with locomotive, visual, hearing and speech disabilities exist in India, although precise data on the prevalence of various disabilities are lacking. Care of the disabled leads to a severe drain on the already meagre resources. A survey was conducted (Verma et al.) to ascertain the views of 1212 respondents, who were common people, on the hereditary handicaps and related ethical issues. An analysis of the data shows that on most issues people held similar ethical viewpoints. Most subjects expressed support for prenatal diagnosis, abortion of an abnormal foetus and carrier-testing..

Facilities for the rehabilitation of persons with disabilities are grossly inadequate in India. Hence the care and rehabilitation of the disabled is a source of ethical dilemma both for professionals and parents. The question uppermost in the mind of physicians is whether to use available resources for healthy individuals or for handicapped persons. The Government of India is keenly aware of the problems and has formulated a number of welfare measures. One of the important measures aims at providing financial assistance up to 90 per cent of the cost to voluntary organizations for setting up educational and rehabilitation training institutions for the disabled. The Government has also passed the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. Under this Act, disabilities include blindness, low vision, cure of leprosy, hearing impairment, loco motor disability, mental retardation and mental illness. Guidelines have been laid down for the evaluation and assessment of various disabilities, persons competent to certify the above, and the concessions/facilities which may be offered to the disabled persons, including reservation of jobs for them.

Bio-ethical issues and mental retardation

Until recently in India, the mentally retarded were considered under the Lunacy Act of 1912 whereby all persons with mental retardation were categorized as mentally ill. In 1986, the Mental Health Act was passed which excludes the condition of mental retardation from the definition of mental illness. The Act, however, includes no enforcement mechanism and thus leaves a legal vacuum.

Most parents of the mentally retarded children are worried about their children's future after their own death. The Ministry of Welfare, Government of India, has drafted a bill to constitute a 'national trust' for the welfare of persons with mental retardation and cerebral palsy. The trust envisages to arrange for and provide care and rehabilitation to persons with mental retardation; to set up homes and service institutions to provide support to organizations, families, parent associations and voluntary organizations, and to receive monies and properties from the parents for the maintenance of their children. The bill, however, awaits legislative approval.

Bioethical issues and mental health

Ethical issues are involved in declaring a person mentally ill and consequences arising therefrom. The Government has enacted legislation clearly defining various issues. The Indian Lunacy Act of 1912 and its modifications and the National Mental Health Act of 1987 deal with the reception, care and discharge of mentally ill persons and the establishment of treatment facilities for them. According to the Act, the medical officer should examine mentally ill persons not more than seven days before the presentation of the petition. A reception order expires in 30 days unless the mentally ill person is admitted to the place mentioned therein. The court determines whether the alleged mentally ill person is of unsound mind and is incapable of managing himself/herself. The court can then appoint a guardian for this person or a manager of his/her estate, as the case may be.

According to the Act, no person shall establish or maintain a psychiatric hospital or nursing home without a valid license. A valid license is granted by a licensing authority on receipt of an application if on inquiry it is established that such a hospital or nursing home is necessary and the applicant can provide the minimum facilities for admission, treatment and care of mentally ill persons. Involuntary care ensures treatment even for non-consenting patients.

Criminal responsibility is assigned only when a man is considered sane. If a mentally ill person attempts to commit suicide and does any act towards the commission of such an offence, he can be punished with simple

imprisonment for a term up to one year or with fine or both. A mentally ill person is not considered to have committed an offence if the person at the time of committing it, by reason of mental illness, did not know what he was doing or that what he was doing was either wrong or contrary to law.

Ethics and research

A considerable amount of medical research is being carried out on human subjects in India. The research concerned with the clinical, epidemiological and sociological aspects of health and disease and includes drug trials involving large numbers of volunteers and patients.

The Indian Council of Medical Research (ICMR) is the national body that monitors, supports and provides financial aid for a large number of research projects. In addition, the Department of Biotechnology (DBT), the Department of Science and Technology (DST), the Council for Scientific and Industrial Research (CSIR) and the Departments of Science and Technology in the states are other funding agencies. Pharmaceutical companies are also financing large numbers of drug trials.

The ICMR constituted a Central Ethics Committee of the Council. The Committee issued a policy statement in 1980 on ethical considerations involved in research on human subjects. The Committee appreciated that research involving human subjects was essential if progress was to be maintained and better medical and therapeutic modalities discovered for the benefit of mankind. However, it felt that strict guidelines needed to be enforced. The guidelines formulated to protect volunteers and patients participating in clinical research are as follows:

- The rights and welfare of human subjects on whom experiments carried out should be adequately protected.
- The risks to an individual are outweighed by potential benefits to him or to society or by the importance of the knowledge to be gained.
- Informed consent should be obtained from the individual by methods that are appropriate and adequate.

- The clinical investigation on human subjects should be carried out by an investigator who has the requisite background and competence to carry out such research; and
- The investigator should have a framework for obtaining advice, support and assistance from his peers before embarking on a particular clinical research programme.

Institutional ethical committee

The ICMR has also recommended that all medical colleges and research centres involved in clinical research be required to form institutional ethics committees. The ethics committee should consist of 5 to 7 members with different backgrounds such as an experienced clinician (who may have been carrying out clinical research and clinical evaluation in the past), an expert on drugs and one or two non-medical persons who could provide guidance to the committee in the matter of ethics and law. Wherever possible, a lawyer or a judge should be a member of the institutional ethics committee. The ethics committee at any institute or college can also have members from other institutions.

The ethics committee should meet at least once in three months and review every proposal for research on human subjects to assess, among other considerations, whether:

- voluntary consent of the individual is being obtained;
- the experiments are so designed that they would yield meaningful results that could not be obtained by other methods;
- the animal experiments carried out support the need for clinical experimentation;
- the experiments would be conducted in a manner to avoid all unnecessary physical and mental suffering and injury;
- the experiments have been planned in a manner so that the degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiments;

- proper preparations have been made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death;
- safeguards have been taken to see that the experimentation would be conducted only by scientifically qualified persons who possess the requisite competence, experience and qualities to carry out the research;
- it had been made perfectly clear to the subject or patient that he would be at liberty to bring the experiment to an end at any time he desires to do so;
- the scientist in charge of the research project is prepared to terminate the experiment at any stage if he has probable cause to believe in the exercise of good faith, skill and careful judgement required of him, that a continuation of the experiment was likely to result in injury, disability or death to the experimental subject.

Though the ICMR suggests that all medical colleges and research centres should have ethics committees, in practice, institutional ethics committees have been constituted only by a few selected institutions. The All India Institute of Medical Sciences in New Delhi has an ethics committee which reviews all research proposals involving human subjects from an ethical point of view. Informed consent from volunteers and patients is a prerequisite. Investigators are expected to give six-monthly progress reports on the projects cleared from the ethical angle.

Drug trials

It is mandatory under the law to obtain permission from the Drug Controller of India before clinical evaluation of any new drug is undertaken. It is also necessary to formulate a research proposal and obtain clearance from the relevant institute's ethics committee after obtaining permission from the Drug Controller. These procedures have to be followed irrespective of the fact whether the drug has been developed in India or abroad, or whether clinical trials have been carried out outside India. There is, however, no requirement for clearance to be obtained from the Drug Controller for conducting trials of products already used widely in the traditional systems of medicine in the country.

Ethics and human genome studies

India provides an ideal setting for human genome and diversity studies. It has an enormous population comprising 4 635 castes, 3 000 communities and 28 000 endogamous groups. Consanguineous marriages are common, extended families live in one locality and have large numbers of children. Not unexpectedly, foreign scientists and multinationals eye on these vast natural and human resources in India. Poverty and illiteracy, the heavy burden of genetic disease due to lack of rehabilitative services, and the intense struggle for survival make the people prone to exploitation. For meagre rewards, they may agree to part with their resources and their blood.

Most scientists and doctors lack training in ethical principles and have poor financial resources and support and inadequate facilities for molecular studies. They are open to exploitation by scientists from Western countries to provide/share blood samples of subjects with rare/interesting diseases to map out new genes for scientific discoveries or with an eye on patenting the genes or products for their diagnostic or therapeutic value. The government and the public have shown considerable concern at the clandestine transfer of samples of 'natural' products and blood samples to foreign laboratories, and have introduced measures to curb these activities. There is a need to develop a balanced policy to allow the advancement of science without exploitation and within a framework of good ethical practices.

Other issues

Broad guiding principles have been laid down by the ICMR for obtaining informed consent. However, institutional ethics committees go over the informed consent forms developed for each project. They ensure that the patients and volunteers are informed of the potential benefits and side-effects or hazards of the new treatment or drug.

It is recommended that research should be avoided on prisoners, medical students and laboratory personnel, as it is difficult to obtain voluntary informed consent from these groups. With regard to clinical research on children, the mentally ill and the mentally deficient individuals, the guiding

principle should be that any experiment to be carried out should aim to provide treatment or should add to new information about the condition or disease from which the patient is suffering. Informed consent must to be obtained from parents or guardians of children and mentally deficient patients.

The ICMR is in the process of revising the guidelines issued in 1980. Apart from the ICMR, other funding agencies do not have clear-cut and written instructions or an established procedure for doing ethical review of projects being funded by them. In recent years, the Department of Biotechnology (DBT) has constituted an ethics committee to review projects on gene therapy.

Problems of applying teaching in practice

Implementation of any new innovation is generally met with resistance. The same is true of the introduction of modules developed for teaching ethics to medical students.

Much legislation (as stated in the section on Ethics in clinical practice) has been introduced to curb unethical practices. Although the MCI is empowered to take punitive action, it is embroiled in a lot of red-tapism and politics. It is also difficult for the various government agencies to keep a strict watch that the legislation is not flouted.

A lot depends on physicians 'will. If he/she is determined to follow ethical practices, there is less use for legislation and government control. Hence, the most important need would be to inculcate the philosophy of ethical practices into the minds of medical students. In India, this process has yet to take off and there is a need to sensitize the medical faculties in this regard.

Looking towards the future

With rapid improvements in the health care delivery system, the scenario in India is changing. It is expected that the incidence of infectious diseases will come down while cases of trauma, cancer, cardiovascular diseases and

neurological and genetic disorders will rise. Advances in technology will make artificial reproductive technologies, carrier screening, molecular diagnosis of genetic disorders, pre-implantation diagnosis and gene therapy more widely available to the public. All these developments are going to raise newer and different kinds of ethical issues and dilemmas. This will perhaps necessitate more detailed and stringent legislation and guidelines. A continuous dialogue among physicians, regulatory bodies and governmental agencies is essential to prevent the use of unethical practices in medical and health fields.

Indian Literature on Ethics

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Ethics in Medical Education and Medical Practice: Indonesia

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Introduction

I would like to mention some facts about the development of medical education and medical ethics in Indonesia. During the mid-1950s we saw the flowering of medical education in one of Indonesia's medical schools, the Medical School of the University of Indonesia, through co-operation with the University of California, Los Angeles, USA.

During the 1960s clinical medicine made momentous and important advances in the United States as a result of investments made in basic biomedical research. Problems of research ethics and medical ethics started to evolve and slowly the training and practice of medicine in Indonesia were faced with the same problems. In those years solutions to the ethical dilemmas were left to the discretion and judgement of the individual practitioner.

The Indonesian Medical Association felt that a systematic and concerted effort was urgently needed to address the issue of the rising number of cases of alleged malpractice by its members, and initiated discussion in the early 1970s. Establishment of an ethical review committee was timely, since the number of reports on professional misconduct by Indonesian medical practitioners started to pile up with an ever-increasing pace. This committee, named Majelis Kehornatan Etik Kedokteran, or Ethical Review Committee, did a tremendous job. The burden was shared with regional committees, and a

working mechanism developed slowly until the present state was achieved: charges are first dealt with at regional level while the central committee acts as a committee of appeal.

The Ethical Review Committee has no legal authority to decide on charges or litigation which are of non-ethical nature. A statutory body, the Majelis Disiplin Tenaga Kesehatan or the Health Manpower Disciplinary Court, which is outside the medical association, has been established recently. This court handles disciplinary and administrative matters. Legal matters are handled in the court of law. Thus, we now have three bodies dealing separately with cases of ethical, disciplinary (mostly administrative) and legal nature.

The education and training of physicians was lagging behind the demand for preparedness at graduation for handling ethical dilemmas in medical practice. It was not until 1993 that 12 out of 200 credit units were assigned for teaching the humanities – including medical ethics – in the medical curriculum. The Consortium of Health Sciences, an agency within the Ministry of Education and Culture, is entrusted with the task of developing, in close cooperation with the deans of all medical schools, the specific contents of the medical undergraduate curriculum, including a course in medical ethics.

Current situation

Ethics in medical education

Table 1 below provides a complete list of the names of medical schools and cities where the main campus is located, with designation of ownership (state or private) and the number of students enrolled in the academic year 1995-96.

Table 1. ***Medical Schools in Indonesia and Number of Students***
(Academic year 1995-96)

No.	University	City	State(s)/ Private (P)	No. of students
1.	Airlangga University	Surabaya	S	1176
2.	Andalas University	Pedang	S	953
3.	Brawijaya University	Malang	S	812
4.	Diponegoro University	Semarang	S	1257
5.	Gadjah Mada University	Yogyakarta	S	1228
6.	Hasanuddin University	Ujung Pandang	S	1474
7.	University of Indonesia	Jakarta	S	1030
8.	Lambung Mangkurat University	Banjar Baru	S	225
9.	Padjadjaran University	Bandung	S	1259
10.	Sam Ratulangi University	Manado	S	853
11.	Sebelas Maret University	Solo	S	1271
12.	Sumatra Utara University	Medan	S	1395
13.	Syiah Kuala University	Banda Aceh	S	502
14.	Udayana University	Denpasar	S	713
15.	Achmad Yani University	Bandung	P	259
16.	Atma Jaya Catholic University	Jakarta	P	1085
17.	Hang Tuah University	Surabaya	P	756
18.	Islam Sultan Agung University	Semarang	P	1409
19.	Islam Sumatra Utara University	Medan	P	1395
20.	Kristen Indonesian University	Jakarta	P	1659
21	Kristen Krida Wacana University	Jakarta	P	550
22.	Kristen Maranatha University	Bandung	P	861
23.	Methodist Indonesia University	Medan	P	746
24.	Muhammadiyah University	Yogyakarta	P	340

No.	University	City	State(s)/ Private (P)	No. of students
25.	Muslim Indonesia Universisty	Ujung Pandang	P	193
26.	Tarumangara University	Jakarta	P	860
27.	Trisakti University	Jakarta	P	1425
28.	Veteran UPN	Jakarta	P	252
29.	Wijaya Kusuma University	Surabaya	P	925
30.	Yarsi University	Jakarta	P	1605

All medial schools are required to apply the second revised Core Curriculum for Medical Schools (Kurikulum Inti Pendidikan Dokter Indonesia 2, KIPDI-2), 1994. Two main additions have been made to the basic philosophy of the Second Curriculum, namely: (1) that the curriculum is oriented towards the advances in medical sciences and technology and not only to the needs of the community; and (2) that a certain number of credit units be allowed to the teaching of humanities in medicine, consisting of medical ethics, medical history, medical law, the philosophy of science, and the philosophy of medicine.

The main problem in implementing teaching in the humanities is the scarcity of scholars with a solid background of formal education, e.g. in medical ethics.

- Only one university, Atma Jaya Catholic University, has a Centre for Ethics at the university level, established in 1992. This Centre, with its small number of scholars, functions as the core upon which the teaching of medical ethics relies. By having a centre like this one, the development of a scholar's career is sustained and guaranteed.
- Other universities would like to see all scholars in medical ethics belong to one national group of professionals, emphasizing the exchange of experience and views being vitally important for the development of scholarship in this particular field.

- A smaller number of universities prefer to maintain the current situation whereby all faculty members interested in the teaching of medical humanities are identified and their existence recognized.
- Only one university accepts the idea of having an autonomous department of medical humanities within the medical school.

The actual contents of the curriculum on the basic principles of medical ethics and on the understanding of the Indonesian Code of Medical Ethics are similar. Anything else than these, while covering a broad field of ethics and law, may differ from one school to another. This broad field of includes topics such as ethical decision-making, assisted reproduction, surrogate motherhood, genetic engineering, termination of pregnancy, sterilization in men and women, euthanasia, brain stem death, organ procurement and organ transplantation, prolongation of life, persistent vegetative state, withholding treatment or withdrawing treatment from the terminally ill, truth-telling, promise-keeping, infamous professional conduct, informed consent, dichotomy, and the right of the individual for autonomy, self-determination, confidentiality and privacy. A few topics in medical law are also found in the list. These include: medical malpractice, the expert witness, informed consent, medical licence to practice, medical certificate, medical prescription, and tort law.

The methods used in teaching medical ethics are formal lectures, discussion of relevant aspects incorporated in actual clinical cases, formative assessment of progress, and summative examination. Knowledge of the basis of medical ethics is acquired through formal classroom lectures, mostly during the early years. Discussions on specific topics and training in ethical decision-making are part of clinical teaching activities.

The core resources used vary widely in number and in the range of topics from one medical school to the other. "Western" philosophical thinking dominates the pursuit of scholarship in medical ethics. Christian and Muslim ethics are referred to infrequently and only as comparisons to pure philosophical ethics.

Ethics in medical research

The first national workshop on ethics in medical research was held in Jakarta in 1986. This workshop led to the publication of ethical guidelines for medical research in Indonesia. Every medical school was encouraged to set up a committee on ethics in medical research. After more than ten years, only three medical schools have established permanent committees which are functioning properly. The 1993 International Ethical Guidelines for Biomedical Research Involving Human Subjects is constantly used for resource and consultation, even by medical schools with non-permanent ad hoc committees.

The Committee on Ethics in Medical Research of the University of Indonesia School of Medicine issues on an average number three letters of ethical clearance weekly. This 12-member committee is a permanent body which ensures that every research proposal submitted has provisions regarding the protection of human subjects involved in a study.

Ethics in medical practice

The ethical conduct of physicians is measured against the Indonesian Code of Medical Ethics. Charges of ethical misconduct are handled by the regional and Central Ethical Review committees. During the 24 month period from January 1994 to December 1995, the total number of charges brought against physicians over the whole country was 21. The charges ranged from gender insensitivity to improperly performed operations, prescribing the wrong medicine, fraudulent medical certification, breach of duty, and excessive use of expensive medical technology. Four out of the 21 cases were taken to the court of law on charges of malpractice.

The current number of medical practitioners in Indonesia is 31 396. This number includes 6,876 medical specialists in 24 different specialties (Source: The Indonesian Medical Association, 1996). The licence to practise medicine is issued, suspended or revoked by the Minister of Health. A medical council does not exist in Indonesia.

The Consortium of Health Sciences

The Consortium of Health Sciences was established in the early 1970s as one of the 11 consortia within the Ministry of Education and Culture. There is a consortium for every subject of science, technology or art (e.g. the Consortium of Mathematics and Natural Sciences, the Consortium of Agriculture, the Consortium of Economics, the Consortium of Law, the Consortium of Philosophy, etc.). One of the activities of a consortium is to advise the Director-General of Higher Education in matters of curriculum development of the respective subject of science, technology or art.

The Consortium of Health Sciences develops the curriculum of medicine, dentistry, nursing, and public health. The curriculum of undergraduate medicine is a good example which is the result of many months of hard work by the deans of all medical schools. The deans meet for three to four days twice a year in Jakarta in the premises of the Consortium; this gathering is a forum for sharing ideas and developing plans. This "college of deans" has proved to be very productive. Every participant is involved in the making and development of plans, and decisions are taken by this "college". By so doing, it is hoped that not many problems will arise at the operational level since every dean has contributed to the achievement of a consensual agreement while developing plans.

In cooperating with the deans of medical schools, a relationship based on trust has been evolved. The "college" of deans, together with the Consortium, developed the first core curriculum of undergraduate medical education or the KIPDI-I in 1983. The second curriculum was published in 1994. It has quite a different philosophical foundation than the first curriculum. The main difference is the shift in priorities – from orientation on health care delivery and community needs to a combined orientation on advanced medical science and technology and community needs. Medical humanities is assigned 12 credit units out of a total of 200.

While developing the curricula of medical specialities, the Consortium cooperates with medical colleges and societies. There is a functional working relationship between the Consortium and the colleges. This has also proved to be very effective, not only in developing curricula but also in developing

criteria for the accreditation of centres and programmes, and mechanisms for on-site visits. In 1978, the Consortium started developing, together with the respective colleges, the curricula of 16 medical specialities. The number has now grown to 24.

The Consortium works closely with other government agencies such as the National Planning Bureau for Development (BAPPENAS), the Ministry of Health, the Ministry for the Utilization of Human Resources, and the Armed Forces.

A plea for improvements

Need for general education [(1)]

It is felt that a longstanding crisis is creeping upon us. It is a condition caused by neglect and erosion of general education, including ethics in medicine, that lasted at least for two decades. While stirring no alarm, the situation merits urgent and serious concern. In many universities around the country, great apprehension is felt over the threats to academic freedom and academic standards.

There is a feeling of the seeming failure of the younger generation to respect academic freedom and academic standards or appreciate what this loss could mean. There is also lamentations over the danger to scholarship posed by the attempted subjugation of all learning to the dictates of bureaucratic and political powers.

It appears that universities are being expected to assume a prophetic role in regard to the teaching of values for the solution of human problems. Education, as a basic value and for the larger purposes of the human community, is one of the major tasks of "general education". Its neglect or mismanagement will be deleterious both to the university community and the society as a whole. The *raison d'être* of general education is not just the defence of academic freedom, nor can the survival of the latter be assumed simply by giving renewed attention to the former. What should be a matter of concern to the scholar is illustrative of a larger problem. If he cannot cope with the challenges even in respect of his own basic needs and functions, how can he fulfill his responsibility as an educator to the community?

There is also a weakness among academics in the postgraduate and professional schools, who expect instant recognition of their own highest values, without appreciating the educational processes needed to justify and sustain them. It has always been easier to find fault with general education than to do anything about it, to dismiss it as simplistic, and then to complain about the products of undergraduate education when it failed to produce honest people who would appreciate the finer things in life, and not only one's own brand of scholarship.

The prime responsibility and function of general education, in its simplest term, can be described as "acquiring an understanding of the society and the place of the individual in it, including its contact with history and the nature of other cultures. It should be a broad learning experience and should provide opportunities to survey the cultural heritage of mankind, to understand man and society". The term "general education" conveys the impression of something that is inherently diffuse; it consists, among others, of "the humanities" and "liberal education".

We need not question the sincerity of intention in order to demonstrate how empty is the gesture being made to liberal education. It can no longer be assumed that the basic elements of humanistic education are there for the taking or that general education is something for which one only needs to make a place. After years of neglect, the problem for general education is not how to make an allowance for it, but how to make a provision for it.

The role of humanities in medical education [(2)]

There have been major changes in the influence of the humanities on medical education. At present, a majority of medical schools in the world offer some form of instruction in the humanities. It varies from full-fledged departments, found only in a few medical schools, to the innumerable number of "problems" that have their home in other departments or in the dean's office. There are, in addition, several schools that have institutes that are freestanding but are closely attached to their schools of medicine.

The word "programme" needs to be understood. In medical schools, any faculty or student effort, regardless of its size, whose existence is officially

recognized, may be called a "programme". Thus, a programme may consist of an unfounded idea for teaching, research or service which claims the attention of a faculty member and which has the dean's approval, even if nothing is being done as part of the programme. Since designating something as a "programme" implies that the school recognizes its importance, it is assumed that the "programmes" will acquire funding, and will grow and perform their function. For that reason, a "programme" may also be well-funded, fully staffed and turn out to be extremely productive.

This programme of the teaching of medical ethics came into being in Indonesia, albeit slowly and sporadically, in the late 1980s. Why this development occurred is not entirely clear, but it was perhaps initiated primarily by students. Students were no longer content to be taught what their faculty believed to be important. It was important to the students that their classes be "relevant" to the problems of poverty, inequity and other major societal problems. These issues were perceived by some students to be widespread in the society with which they were frequently disillusioned. Medical faculty members, eager to avoid the strife that at one time embroiled universities, were quick to plan a curriculum involving the choice of "relevant" studies. Further, informal classes were planned and taught by invited faculty members in subjects that stressed the humane aspects of medicine and medicine's commitments to the poor, the underprivileged, the neglected and the downtrodden. The concern that medicine be more humanistic also persisted, as did some other courses that were begun at the time to teach the humanities. Most of the innovative educational ventures did not survive. The revolt against "science and technology" which had wide support among students in the seventies, did not have a set of alternative concepts to put in place that would be effective in the care of the sick. Such effective alternatives are just beginning to come along, aided by the currently widespread teaching of the humanities in medical schools. It is also important to be aware that many programmes included in the rubric "humanities" are primarily, if not exclusively, concerned with the teaching of ethics.

Ideally, physicians should define their diagnostic and therapeutic goals in terms of the everyday life and function of individual patients. Unfortunately, that ideal is seldom met because of the difficulty of holding impersonal technical imperatives in check, and because physicians seem to be trained to

focus on diseases almost to the exclusion of how sick persons actually live their lives in families and communities. In part, the problem arises because physicians are trained from their first days in medical school to disregard the knowledge they bring with them of everyday life and human function as irrelevant to medicine. Another obstacle is that physicians are not trained to include in their decision-making the kind of "soft" and often subjective information that is relevant to the everyday life and function of a sick person. Correction of these flaws in education would do much to help change physicians' priorities in patient care.

Superior training in the science of medicine is the hallmark of modern education. Unfortunately, neither the need for depersonalizing the physician's knowledge, nor the method of teaching the ability to apply the generalities of science to individual patients have made much headway in medical schools. There is reason to believe that training in the humanities might lead to the achievement of these goals.

Recommendations

(1) To initiate a national debate to make the political commitment to establish a Medical Council in Indonesia as a statutory body. Efforts to have this Council were started in 1985 with the combined initiative of the Indonesian Medical Association and the Consortium of Health Sciences. The purpose of having a medical council is to regulate medical education as well as improve medical and health services. In view of the sensitive nature of the issue, caution and tact would be necessary.

(2) To initiate discussion among universities in Member Countries about defining the meaning and exploring the possibility of the use of "general education" in higher education.

(3) The role of the WHO Regional Office for South-East Asia should include advocacy and technical collaboration as well as providing a forum to improve the commitment of Member governments to solve ethical issues in medical education and medical practice.

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Issues of Ethics in Health Care: A Myanmar Perspective

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Historical aspect

Myanmar Naing-ghan (Burma), before its annexation by the British, was a sovereign country ruled by Myanmar kings. The word "Myanmar" represents all the ethnic races - Kachins, Kayahs, Karens, Chins, Mons, Bamars, Rakhines, Shans and others residing in the country.

During the British administration, doctors employed in Myanmar were drawn from the Indian Medical Service. In 1907, the Burma Government Medical School was formally started with the introduction of a four-year medical course known as L.M.P (Licentiate of Medical Practitioner). Forensic medicine was included in the third year of the course.

A medical department at the University College of the University of Rangon was formed in 1923 and a degree course for the Bachelor of Medicine and Bachelor of Surgery (M.B.B.S.) was introduced the same year. Medical ethics was taught by the department of forensic medicine in the final Part 1 MBBS class.

Organizations and agencies

After the enactment of the Burma Medical Act, 1957, the Burma Medical Council was formed in 1959. The Burma Medical Act laid down some

guidelines to regulate medical practice. The main functions of the Council were:

(a) Registration of qualified medical doctors;

(b) Supervision of medical education in medical colleges, and

(c) Disciplinary action against doctors who were found guilty of serious professional misconduct.

The Council published a booklet titled "Simple Code of Medical Ethics" for the newly-qualified medical doctors.

However, the Council could only perform its role fully up to 1978 after which, due to the policy of the government, re-election of its members was not possible. It became a regulatory body, which has no mechanism to help doctors resolve ethical issues. This organization needs to be strengthened.

The Council has no subcommittees to look after the educational and ethical aspects or professional misconduct. The registration and disciplinary functions were taken over by the Sama Registration Board (Medical Registration Board) with the Director-General of the Department of Health as its Chairman.

The Myanmar Medical Association is the only professional organization of doctors in Myanmar. It is in no way connected with the Myanmar Medical Council and is active in the continuing medical education programmes and primary health care services. Sadly, it has no subcommittee to handle ethical issues for Myanmar doctors.

Teaching

Medical ethics is included in the curriculum of forensic medicine for medical students in the final Part I MBBS class. The departmental objectives of all the four medical institutes in Myanmar are the same, which are:

After the course of instruction the student should:

(1) be able to state the noble aim of the medical profession;

(2) be able to state and describe the Declaration of Geneva (the Hippocratic oath) and thereby understand the fundamental ethical responsibilities of doctors to the patient and to each other;

(3) describe the relevant sections of the Burma Medical Act, 1957, and other laws relating to medical registration;

(4) be able to define Infamous Conduct 'and describe at least six main types that are common in Myanmar;

(5) be aware of the disciplinary action that can be taken by the Myanmar Medical Council for professional misconduct and especially of the conditions where a doctor can be de-registered;

(6) describe at least 10 main codes of medical ethics and

(7) know the fundamental ethical principles in the conduct of biomedical research involving human subjects.

Only three hours of lecture time is devoted to the subject as other medico-legal topics demand more attention. Assessment of the knowledge of medical ethics at the moment is only aimed at its recall and nothing more.

A more comprehensive five-hour lecture is now being devoted to the recently started course of Doctor of Medical Science (Dr. Med. Sc.).

Clinical practice

With the change in health policy where private hospitals and polyclinics are playing a substantial role in health care delivery, there have been reports of negligence, unethical conduct and overcharging. The Department of Health Sciences is aware of the situation and is now incorporating ethical considerations into the postgraduate training programmes.

Research

Research proposals involving human subjects such as clinical drug/vaccine trials, clinical studies on patients, use of radioisotope and epidemiological and behavioural studies involving sensitive issues are required to be submitted to the Ethical Review Committee before their commencement.

The mechanism for facilitating the ethical review of research in the country is such that the research proposal must be submitted to the Scientific Protocol Review Committee before putting it up for consideration by the Institutional Ethical Committee. For new drugs or vaccines, clinical trials or any other protocols have to be submitted to the Institutional Ethical Committee, followed by their submission to the National Ethical Committee.

There are two levels of ethical review committees in Myanmar, particularly for purposes of medical research. The National Ethical Committee on clinical research is chaired by the Deputy Attorney General with the Director-General and Deputy Director-General of the Department of Medical Research as secretary and joint secretary respectively. Its members include the Director-General of the Department of Health, the Director of National Archives department, the Director of the office of the Attorney General and one woman writer. The Institutional Ethical Committee is headed by the Director-General of the Department of Medical Research, with a research scientist from the medical institute acting as secretary. Its membership consists of one non-medical woman from outside, the Director and head of the division of the Institute for related subject, and another set of a director and head of the division of an unrelated subject. Both the committees have the right to approve or disapprove or to modify a proposal if necessary. Approval is granted if the results of experimentation can be considered beneficial to the society, if the proposal is in line with the ethics, the investigator himself is a subject, and he follows the guidelines of the Helsinki Declaration. If the Institutional Committee on Medical Ethics decides that the ethical clearance needs the approval of the National Ethical Committee, the proposal is forwarded to the latter for further consideration.

Problems associated with teaching and practice of medical ethics

The focus of medical education in the past has been mainly on the understanding of disease processes and their diagnosis and management. However, the medical student is also encouraged to respect patients 'rights in all respects and to be aware of the moral and ethical responsibilities involved in patient care. However, attitudes are developed and acquired through personal contact and experience. Attitudinal aspects and ethics cannot be adequately assessed in the context of the existing examination system.

Professional conduct and ethical responsibilities are acquired by observing peers and upholding good conduct. The medical profession as a whole should encourage undergraduate trainees to observe such a code of conduct and introduce it on a day-to-day basis. Although these qualities are fostered, the onus of acquiring them falls on the individual, his environment and the society he lives in.

Health policy reform and other contemporary issues

Health care (medical care) has been given free of charge to all the citizens in Myanmar for a long time. There were a few medical practitioners who worked as full-time general practitioners, while in-service doctors worked as general practitioners in their off hours.

In 1989, the State Law and Order Restoration Council introduced a market economy, and the National Health Policy encourages the involvement of the private sector in health care delivery. Since then there has been an enormous growth in the number of private hospitals, clinics (polyclinics) and diagnostic centres, but a proper regulatory mechanism is not in place. It is the financiers and health care providers who manipulate prices and regulate its quantity and quality. No wonder therefore that many ethical issues are bound to arise from these existing conditions.

Looking into the future

The people of Myanmar are traditionally courteous, nurturing deep respect towards their elders, teachers and healers. These sentiments are also reciprocated. However, current societal issues and cultural mores tend to influence this relationship. The ethics of conduct of the medical profession may be adversely affected by the "life getting into the fast lane".

The medical profession should try its utmost to uphold its tradition despite modern influences. The ethics of practice should be maintained despite efforts of entrepreneurs of the market-oriented economy who cater for a consumer society.

Efforts are required so that the medical profession has good conduct and ethical practices imbued in them. The presence of a disciplinary body that will enforce the code of conduct is important. The Myanmar Medical Association should assist the regulatory body. Only then a general environment where the medical profession is ethical can prevail.

Medical Ethics in the Nepalese Context

Dr Ramesh K. Adhikari

Historical aspects

The history of modern medical practice in Nepal is relatively short. Prior to 1951, Nepal was under an autocratic regime, which kept a strict control over the introduction of modern education and health facilities into the country. The development of health facilities depended on the wishes of the ruling class, not on the identified needs of the people. There were very few health institutions and the number of qualified doctors was around 20 in 1951, which year marked the onset of democracy in Nepal.

The association of medical doctors came into existence ahead of a medical council. In fact, it was the Nepal Medical Association which, in the twelfth year of its existence, first demanded the establishment of a medical council to regulate the medical practice. The Nepal Medical Association, during its first national conference in 1963, unanimously passed a resolution demanding the creation of the Nepal Medical Council. Subsequently, the Nepal Medical Council Act was enacted in 1964. Though the Act was passed in 1964, it took another two years before the provisions of the Act were implemented.

The Medical Council Act laid down some guidelines regulating the medical practice in Nepal. Prior to the enactment of the Act, medical practice was a matter of law and order and was regulated by the provisions of the National Civil Code *(Muluki Ain).* The earliest legislation in relation to medical practice can be traced to the publication of *"Ilaj garne ko"* (on treatment) in *Muluki Ain* (Law of the land) in 1853. Since the establishment of the Nepal Medical Council, it has been made mandatory that the doctors wishing to work in Nepal should register themselves with the council and sign an oath to follow the code of ethics developed by it. By signing this oath, the registering

doctors commit themselves to follow the code of ethics developed by the Nepal Medical Council.

However, the Nepal Medical Council is a regulatory body with inadequate infrastructure to instruct and educate the doctors and to supervise their work. Similarly, it has no mechanism to help doctors to resolve the ethical dilemmas they may face in their day-to-day practice.

The training of doctors in Nepal was started only in 1978 with the initiation of the MBBS classes at the Institute of Medicine. Prior to that, the Nepalese doctors were trained in India, some other neighbouring countries and in the medical schools of the former Soviet Union. Therefore, the learning experience regarding ethics is varied among different Nepalese doctors. However, most of the doctors who qualified from India, Bangladesh and Pakistan had to sign an oath developed by the medical councils in those countries before getting themselves registered with them.

Organizations involved in regulating medical practice

Nepal Medical Council

The Nepal Medical Council is a statutory body established by an Act of Parliament. It consists of 21 members with a chairman nominated by the Ministry of Health and a vice-chairman elected by the registered medical practitioners. The day-to-day work of the Council is supervised by a registrar who is appointed by the Health Ministry. The responsibilities of the Council are:

(1) to maintain a register of all qualified doctors practising in the country;

(2) to regulate medical education in the country through regular monitoring of the activities and facilities of medical schools;

(3) to ensure that medical practitioners practise medicine ethically according to the guidelines laid down by the Council;

(4) to censure unethical practice and to disqualify doctors from medical practice if found to be indulging in unethical behaviour;

(5) to grant recognition to medical schools conducting training courses according to the Council rules;

(6) to de-recognize medical courses conducted in contravention of the rules stipulated by the Council, and

(7) to maintain a register of specialist doctors.

In addition to the chairman and the vice-chairman, eight members are elected from among the registered doctors, nine members are nominated by the Ministry of Health (four are specialist doctors and four are other doctors, while one member is a non-medical eminent person from the society) and one member is nominated by the Nepal Medical Association. The Dean of the Institute of Medicine and the President of the Nepal Medical Association are ex officio members of the Council.

The Council meets every month and considers various issues besides considering the applications for registration. The Council has various Subcommittees and the Ethics Sub-committee plays an active and important role in dealing with ethical issues in medical practice. The other important subcommittees of the Council are the education and registration subcommittees. The education subcommittee is responsible for granting recognition to medical schools. It regularly inspects the physical infrastructure and teaching/learning activities in the medical schools. It also advises the Council with specific recommendations for changes in the medical curriculum, which are communicated to the respective medical schools. The Chairman of the Council is an ex officio member of the faculty boards of the medical schools and this facilitates the adoption of such recommendations. The registration subcommittee is responsible for scrutinizing the individual applications for registration. The Council offers registration only to those whose applications have been cleared by this subcommittee.

Role of Nepal Medical Council within the health care system

During the 30 years of its existence, the Nepal Medical Council was rather inactive for the first 20 years. It could not even enforce the mandatory provision of registration with the Council before a doctor could start working in Nepal. However, in the last 10 years, things have improved. It is mandatory

that every doctor wishing to work in Nepal should register himself/herself with the Council. No hospital in the government sector will accept an application for job from a doctor who has not been registered. There may, however, be some hospitals in the private sector who may hire doctors who have not been registered with the Council but the NMC is regularly notifying all concerned that it is illegal to do so. The Nepal Medical Council has an important and crucial role to play in the field of medical education. It constantly reminds policy-makers that the establishment of a medical school without fulfilling certain essential prerequisites would be detrimental to the medical practice in the country. The role played by the NMC in deterring unscrupulous entrepreneurs in the field of medical education has earned it great support from among the intellectuals in the country.

Nepal Medical Association

The Nepal Medical Association (NMA) is the largest professional organization of doctors in Nepal. Out of around 2000 doctors registered with the Nepal Medical Council, more than three-fourths are members of the NMA. The members of the Association elect an executive committee consisting of 15 members. The NMA constituted a subcommittee on "Medical ethics and human rights" in 1993. The subcommittee has been entrusted with the task of identifying the ways to resolve the ethical dilemmas faced by the members of the Association.

In 1995, the NMA organized a workshop on "Torture and medical professionals". One of the sessions during that workshop was devoted to the issue of medical ethics. The participants in the workshop made positive suggestions regarding the measures to be taken to monitor ethical practice in medicine. The workshop also made suggestions on the teaching of ethics in medical schools.

Similarly, another meeting jointly organized by the NMA and the NMC to discuss medical education in Nepal also considered the issue of ethics in medical practice. The workshop considered the ethical issues. Medical practitioners in Nepal seem to be most concerned about the malpractice indulged in by some of its members in order to attract patients. Informal discussions among doctors usually bring out their worries regarding false

claims made about qualifications, undue advertisements and false statements made to suit different political groups. Some of these are

- False claims to titles
- Too large a sign board to attract patients
- Inappropriate advertisement of cures and self-advertisement
- Giving statements in the media harmful to the profession or colleagues
- Providing false certificates of illness or health for a fee
- Breaking confidentiality regarding a person's health status
- Conducting abortions in violation of legal provisions
- Blatant cheating of patients
- Certificate of health or illness to suit a particular group or party
- Advising a particular treatment to a patient who cannot afford it
- Giving information regarding infectious illness in a patient to family members or of an incurable illness to the patient

The workshop identified that most of these issues were related to questions of simple honesty and should be dealt with by the law and order authorities. A lot of work needed to be done to create awareness among medical practitioners about other ethical issues of concern. Some of the areas that needed discussion were identified as follows:

- Consent and refusal of treatment
- Confidentiality and medical records
- Treatment of children and young people
- Caring for the dying
- Cessation of treatment, non-resuscitation
- Treatment and prescribing
- Relations between doctors
- Inter-professional relations

- Research
- Rationing and allocation of health care resources
- The issue of abortion in reproductive health

This workshop also endorsed the recommendations forwarded to it by the NMA and called upon the medical schools to strengthen the teaching and learning of ethics in medical schools.

Subsequent to this workshop, the Nepal Medical Association organized its biannual Eighteenth All Nepal Medical Conference in 1997 with the main theme as "Ethical Issues in Medical Practice". The conference programme included two orations related to ethics and one panel discussion. The journal published on the occasion of the conference contained six articles devoted to the subject of medical ethics.

The NMA oration on the occasion was delivered by Prof. Robert Lee of the University of Calgary, Alberta, Canada, of which the title was "Ethical principles of medical practice in developing and developed countries". Another oration was delivered by Dr. G.S.L. Das, one of the seniormost physicians in Nepal. He talked about the difficulties of ethical practice in Nepal over the last four decades. Subsequent to these orations, one afternoon session was devoted to the panel discussion. The panel discussion was coordinated by Dr W.J. Pigott, WHO Representative in Nepal. The speakers in the two orations and the immediate past president and the current president of the Nepal Medical Association acted as panelists.

The panel discussion started with a brief introduction to the topic by the coordinator, followed by responses to the question "What do you believe are the most significant ethical issues in medical practice in Nepal today? " The following issues were identified as significant both by the panelists and the participants:

- Sense of responsibility: This issue is concerned with the quality and ethical standards in medical practice.
- Resource allocation: This appears to be unequal, with basic inadequacies in some places while high technology was being installed in other places. There was a conflict between the

expectations and the reality and also between the responsibility to individuals and the responsibility to the community. This issue had to do with equity and included access to medical education.

- The medical profession was losing its shine. It appeared to be becoming unpopular. There was much criticism of medical professionals in the society, and one of its consequences had been the consumer courts in India taking medical care under their jurisdiction.
- Doctors' attitude towards patients: arrogance and a lack of sympathy.
- Doctors working for their own benefit and not for patients' welfare.
- Lack of awareness of ethical issues among medical professionals. (The NMA needed to formulate a code for its members.)
- Need to educate young doctors.
- Need to implement medical audit in practice.
- Relationship of the cultural practices with ethical behaviour should be highlighted.
- Relationship of the political and social environment with the ethical behaviour in medical practice needed to be considered.

The discussions generated much interest among the participants and the meeting recommended that such discussions should be regularly arranged by the Association. WHO was requested to facilitate such meetings. Dr. Pigott, WHO Representative in Nepal, assured the NMA that the Organization will be happy to facilitate such meetings. However, no subsequent meeting has taken place after the event.

The Nepal Medical Association and the Nepal Medical Council play complementary roles in promoting ethical medical practice. The Council has a regulatory role given to it by law, while the Association has the responsibility of educating its members and preparing them for ethical medical practice as stipulated by the NMC.

Teaching of medical ethics

The MBBS programme at the Institute of Medicine is the oldest medical course in Nepal and, so far, 12 batches have graduated. There are two more medical schools in Nepal; however, their courses are only two years old. The description of the teaching of medical ethics in Nepal, therefore, mainly reflects the teaching practices at the Institute of Medicine.

Medical ethics is taught as a part of the course in medical jurisprudence. The objectives in relation to medical ethics are stated as follows:

At the end of the course, the students will be able to:

- enumerate the duties and the right of medical practitioners;
- define the Hippocratic oath and the Geneva Declaration; and
- define malpractice and medical negligence.

The curriculum in another medical school (BPKIHS) also has made medical ethics a part of the curriculum in forensic medicine. The relevant curricular segment reads as follows:

At the end of the course, the students should be able to:

- describe the code and law of medical ethics, unethical practices, dichotomy, consumer protection, etc.;
- describe the duties of a medial practitioner towards his patients and the society; and
- define consent, vicarious liability, malpractice, and contributory negligence.

The curriculum at the new medical school is more comprehensive; however, it is yet to be implemented. The inadequacy of teaching of medical ethics within these content areas has been recognized and the Medical Association has recommended revision of the curriculum. The Medical Council has approved the recommendations of the Association and these recommendations have been forwarded to the faculty board of the Institute of Medicine and other medical schools.

Ethics in clinical practice

The NMC Code of Ethics guides medical practitioners regarding behaviour in their clinical practice. The Code of Ethics is divided into different sections. Each section deals with a specific issue. The issues dealt with in the code are: general principles; duties of physicians to their patients; duties of physicians to the profession; duties of a physician to another physician; duties of physicians in consultation, and disciplinary action.

The section on general principles guides doctors on the appropriate behaviour and their responsibility, on advertisement, on terms of payment of professional services, on open shop and on legal restrictions. One example of the guideline relates to the issue of commission or gifts. This section cautions doctors against accepting or offering any gift or commission in consideration of or in return for referring, recommending or procuring of any patient for medical, surgical or other treatment.

The section on duties of physicians to their patients discusses physicians' obligations to the patients, issue of patients' secrecy etc. It further advises doctors regarding their responsibility of explaining the prognosis of the disease to the patients correctly without exaggerating or minimizing the true nature of the disease.

The section on duties of the physician to the profession discusses the responsibilities of the physicians to uphold the honour of the profession, to safeguard the standards of profession, and to bring the unethical behaviour of any of the members of the profession to the notice of the Medical Council. If any abuse by a physician of any of the privileges afforded to him or restriction of professional duty or serious breach of medical ethics is brought to the notice of the Council, the Council will form a professional conduct committee to look into the matter and, depending on the nature of the misconduct, the committee will recommend a suitable course of action.

In the history of the Nepal Medical Council, there has been only one case of cancellation of registration and that also was due to the submission of false certificates of qualifications. There are occasional complaints against medical practitioners but in none of the cases was a significant conviction

recommended. With the increasing awareness among the people, the newspapers are full of stories of professional misconduct of medical practitioners, but most of these stories relate to unqualified practitioners and are beyond the scope of any action by the Medical Council.

Research ethics

Research in health is relatively new in Nepal. In fact, modern research in health started when the Nepal Health Survey was conducted in 1966. Most of the research studies in Nepal have been descriptive in nature. It is only recently that research, with experimental design involving human subjects is also being conducted. These developments prompted the government to establish a Medical Research Council in the country.

Initially a committee named as the Nepal Medical Research Council (NMRC) was established in 1982 within the Ministry of Health under the chairmanship of the Health Secretary. This was to be the national focal point on health services research. The NMRC later formed an Ethical Review Board which was entrusted with the task of reviewing research proposals from an ethical point of view.

Subsequently, the Nepal Health Research Council (NHRC), an autonomous body established by an Act of Parliament in 1991, has been made responsible for granting permission to research proposals. The NHRC is responsible for looking into the ethical aspects of research. The guidelines laid by the Council for International Organizations of Medical Sciences (CIOMS) are used by the NHRC as reference documents for considering the ethical issues in any research activity.

The NHRC executive committee has a standing Technical Review Committee which scrutinizes all applications for research. In many cases a research proposal is approved by this committee itself, but if there are any ethical issues which need further consideration, the proposal is referred to the Ethics Subcommittee. The Ethics Subcommittee regulates the ethical aspects of any research proposal submitted to it for approval. All research activities related to health have to be approved by the NHRC.

Problems associated with teaching and practice of medical ethics

Problems associated with teaching

Ethical practice is imitated rather than learned by reading in the books. The right conduct is learnt best by observing it, following it, being appreciated for it, and being penalized for the wrong conduct.

The pressure of medical curricula in most of the medical schools does not allow the students to devote much time to the issue of medical ethics. The students are busy learning the subjects that are considered important for examination and apparently medical ethics does not figure in that category. Moreover, the subject of medical ethics is difficult to assess through the usual assessment tools currently in use in medical schools.

Practice of medical ethics

The moral values prevalent in the society determine the ethical practice in any profession. If the general social environment demands aggressiveness, cunning and shortcuts for survival, medical practitioners cannot be expected to be very much different, whatever may be the guidelines of the national medical council. The only hope of promoting ethical behaviour among doctors is to create a society where the entire professional group is ethical. However, a strong regulatory body with adequate physical and manpower infrastructure can enforce the code of conduct approved by the council. Similarly, demonstration of the practice of right conduct by senior professionals and teachers in medical schools can influence the behaviour of young doctors.

Looking towards the future

Professional organizations of doctors will be required more and more to educate and help their members in different aspects of medical ethics. In some countries of the South-East Asia Region, doctors' services for a fee have been considered a consumer commodity and patients have been given the right to go

to the court for the redressal of their grievances. Therefore, doctors will have to be conscious about the right and the wrong while dealing with their patients. The medical curricula that the doctors were taught in their medical schools had not prepared them to face problems which could have different answers. When there are more than one solution to a problem, how does one choose the right solution? What happens if the solution chosen by a doctor is considered inappropriate by the patient or his relatives or the society?

All these issues should motivate the Nepal Medical Association to develop mechanisms to help its members in this regard. It has been suggested that the NMA's activities in this area should be:

- Raising the issue of medical ethics and malpractice in regular meetings of its members;
- Collecting its members' points of view by means of a questionnaire on different ethical issues, and reviewing international practices on different ethical issues;
- Reaching a consensus on what should be done in a particular issue, and
- Responding to questions from its members who are facing an ethical dilemma.

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Status of the Teaching and Practice of Medical Ethics in Sri Lanka

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History

The interest in medical ethics in Sri Lanka was confined mostly to universities. Two notable personalities in this regard were the late Professor S. R. Kottegoda and Professor Valentine Basnayake, who initiated interest at the Colombo and Peradeniya Medical Faculties, respectively. Their contributions were mainly oriented towards ethics in medical research. However, the Sri Lanka Medical Council, which had been established under the Ceylon Medical Ordinance, had been exercising the legal authority to deregister medical practitioners found guilty of malpractice. However, instances of actual deregistrations were rare. The Sri Lanka Medical Association (SLMA), on the other hand, has been instrumental in developing a general awareness among its members. The SLMA also has a subcommittee to look into ethical issues relating to the professional practice of medicine, research and health policy.

Organizations

Apart from the Sri Lanka Medical Association and the Sri Lanka Medical Council, there are other organizations which directly or indirectly deal with ethics in medical practice. These organizations are: the medical schools ethics committees, the Postgraduate Institute of Medicine, Ministry ŝ Health ŝ Health Systems Research Programme, the National Institute of Health Sciences and Natural Resources, and the Energy and Science Authority of Sri Lanka, which

is a donor agency for research and policy formulations. Most of these organizations, except the Ministry of Health, have their own research and ethical committees. In addition, there is much interest in the ethical aspects of medical profession among politicians and the general public. The subject also receives attention in the mass media.

Teaching

Almost all medical schools in Sri Lanka teach some aspects of medical ethics to their undergraduate students. The content of the curricula varies from professional misconduct to much wider and complex ethical issues, which are relevant to Sri Lanka. The most comprehensive training in ethics for undergraduates, at present, is delivered by the Colombo Medical Faculty. Given below is a description of the activities undertaken at each faculty (excluding the University of Jaffna) with regard to ethics teaching.

Faculty of Medicine, University of Peradeniya

The Peradeniya medical school still follows a traditional curriculum and therefore the teaching of medical ethics takes place at the Department of Forensic Medicine. In addition, ethical issues relating to resource allocation and health policy are covered within the curriculum for Community Medicine. During the clinical clerkships in the 3rd, 4th & 5th years of studies, medical students are exposed to aspects of clinically relevant topics in medical ethics by the clinical teachers. In the new curriculum, which is still in formative phases, introduction to the Humanities and Medical Ethics has been envisaged in the first year.

Faculty of Medicine, University of Colombo

Following a one-day workshop held in September 1990, the Faculty of Medicine decided to expand the educational activities on ethics. The Department of Psychological Medicine started a formal teaching programme on ethics. A lecturer was recruited to be trained in the field of medical ethics, which was introduced in 1994. During the third year about six lectures are

given, and in the fourth year seminars and small group discussions with a total duration of approximately 6 hours are conducted. The students are evaluated on this section along with the rest of the evaluations done in psychological medicine.

The Department of Pharmacology conducts a 2-hour tutorial entitled 'Ethical considerations in pharmacology and experimentation" during the third year of the curriculum. This has been done over the past five years. Students are given two or three cases (of ethical dilemmas) illustrating different ethical principles. Examples of some of these dilemmas are given below:

(1) A lecturer wants to carry out an experiment (testing a drug) on his/her students. What ethical issues come up?

(2) A school girl is coming to you requesting a prescription for contraceptives. As the regular doctor of the family of this girl and as a family friend of her parents, what will you do?

(3) You are the medical officer in an Obstetric Unit where a baby is found to have gonococcal ophthalmia neonatorum. What ethical issues come up in dealing with the baby and the mother?

The department of forensic medicine conducts one or two lectures in the field of professional ethics. This activity has been conducted for over 30 years. Apart from the above, the clinical departments (medicine, surgery, obstetrics & gynaecology, paediatrics and psychological medicine), the department of community medicine and other departments also discuss aspects of medical ethics in their programmes. Ethical issues are always discussed in all the clinical appointments in relation to patients. These aspects are covered by the clinicians.

Since 1996, the Faculty of Medicine, University of Colombo, has started a new curriculum. The aim of the new curriculum is to produce a doctor who can address the health problem in the individual and in the community with competence, compassion and care. Compassion and care are inextricably linked with high standards of professional behaviour, moral values and ethics. Some of the institutional objectives of the new curriculum are as follows:

(1) To develop and maintain personal characteristics and attitudes for a career as a health professional;

(2) To develop into a self-directed learner with the capacity to recognize the need for self-evaluation; and

(3) To work harmoniously with others as a leader/member of a health care delivery team.

Most of these objectives cover different aspects of medical ethics. In the new curriculum a behavioural stream has been introduced and it spans the entire five years of the medical course. In the behavioural stream, interpersonal relationships and ethics are covered extensively. The educational settings in which instructions are given include small group discussions, lectures, seminars and debates.

Faculty of Medicine, University of Ruhuna

It has been the practice to give one or two lectures on medical ethics to students at the time of entry to the academic course. This was usually done along with the English course. After the second-year MBBS examination the students are given an introductory clinical course before they go to the wards. Since 1995 this introductory course has been expanded to form a short course on medical ethics. The Ethics Committee of the Faculty has enlarged this programme further and has drafted a course on medical ethics in September 1995.

The course conducted in 1995 constituted seven lectures and one seminar. The documents entitled "Core knowledge and abilities" and "Course in medical ethics" give details of these courses.

Apart from the above-mentioned activities several other departments conduct activities on ethics (e.g. lectures in forensic medicine). The clinical departments cover ethical dimensions when discussing patients in the wards.

Faculty of Medicine, University of Kelaniya

During the introductory course for the new entrants to the Faculty, two to four lectures are given to introduce the subject. Throughout the curriculum the subject of ethics is discussed by different departments. The Department of Forensic Medicine conducts lectures on professional ethics. During ward work ethical aspects of patient care are discussed wherever relevant.

Faculty of Medicine & Medical Sciences, University of Sri Jayewardenepura

When new students join, aspects of medical ethics are introduced to them during the initial induction sessions. This institution is now in the process of identifying the clinical appointments and the contents of the curriculum for forensic medicine. The academic staff is well aware of the importance of having inputs in the area of medical ethics. In future, when programmes are planned this subject is expected to be incorporated.

Practice of clinical ethics

Not much information has been generated with regard to this particular aspect of medical ethics. However, in general, patient autonomy, beneficence, non-maleficent and issues relating to justice are of concern to many clinicians. Paternalism is however still a factor to reckon with. Additionally, there have been a few instances where doctors have been subjected to indictments. In most of these cases what has been at issue was professional misconduct. Even at present there are several court cases awaiting judgements.

Role models and actual ethics learning in the continuing education programme are yet to be evolved systematically. The boards of study of the postgraduate institutes of medicine have, however, shown interest in incorporating ethical considerations into their training programmes.

The trade union actions launched by the Government Medical Officers' Association has sparked considerable interest in the politico-social circles with regard to the ethical behaviour of medical officers.

Research ethics

The Faculties of Medicine were probably the first institutions to start a formal ethical review of their research in Sri Lanka. The Faculty of Medicine, University of Colombo, during the deanship of Professor S. R. Kottegoda (in the late 1970's) established an Ethical Review Committee. This committee has been functioning ever since. The main function of this committee is to review the research submissions about their ethical aspects. From time to time, the committee, which has about 12 to 15 members, has also organized workshops to update young researchers about ethics in research. The members include faculty staff, clinicians from the Colombo group of hospitals, members of the nursing profession and lay public. They meet about eight to ten times a year. The committee has designed an application form. Investigators are required to send in as much information as possible along with the completed application form. Depending on the nature of the submission, the Committee decides to discuss it among themselves or to seek referee opinion. The decision of the Ethical Review Committee is communicated to the Faculty Board. After approval by the Faculty Board, the Dean informs the investigators.

Since 1994, the committee has been reviewing submissions made by investigators from other institutions and non-governmental organizations as well. A fee of Rs. 250 is charged from investigators who are not attached to the Faculty of Medicine. About 35 to 40 submissions are reviewed annually.

Depending on the nature of the submission some protocols are given ethical clearance without any modification. However most protocols undergo minor or intermediate scale modifications. At times, some of the submissions are found to have a poor methodology. In such instances the investigators are asked to seek specialist advice. The guidelines of the CIOMS and the Royal College of Physicians (UK) are used in such deliberations.

University of Ruhuna

An Ethics Committee was established here in 1984. The functions of the committee are to review all research undertaken by members of the faculty and students and to plan and conduct the programme of teaching medical ethics. This committee consists of about 10 members and uses the CIOMS documents as guidelines. The format of application for ethical clearance and consent form is similar to those of the Faculty of Medicine, Colombo.

University of Kelaniya

An Ethics Committee has been established to review the research conducted in the faculty.

University of Sri Jayewardenepura

An Ethics Committee has been established with membership drawn from the faculty, extended faculty and lay people. It has been functioning for about two years. The research conducted by faculty members is reviewed by the committee.

University of Peradeniya

The Research and Higher Degrees Committee was started in 1969 and ethical review was added as a subject in 1979. This committee, which has 12 members, reviews about 15 - 20 proposals a year. It also assists the Ministry of Health's Health Systems Research Programme by reviewing their proposals for ethical clearance. It is the only functioning ethics review committee at the University of Peradeniya.

Apart from the medical schools mentioned above, the Medical Research Institute, the National Institute of Health Sciences at Kalutara, the Sri Lanka Medical Association, the Sri Lanka Association for the Advancement of Science and several other institutions have ethical review committees.

The Natural Resources, Energy and Science Authority (NARESA) set up a committee to draft a national code of ethics in scientific research in 1991 - 1992. A group of experts developed draft guidelines. The Sri Lanka Medical Association has also been involved in the field of ethics. There is an expert committee on ethics. Drafts on "Patient Charter" and on "Ethical Guidelines for Medicinal Drugs" are being discussed.

Contemporary ethical issues relevant to Sri Lanka

In our view, the following ethical issues have evoked much discussion in Sri Lanka.

(1) Ethical issues relating to abortion and menstrual regulation

(2) Ethical issues relating to HIV/AIDS

(3) Issues associated with trade unionism among doctors

(4) Issues associated with patients' rights

(5) Issues associated with social justice and allocation of health care resources both at micro and macro levels

(6) Private practice by state-employed doctors

(7) Groupism with regard to proposal reviewing, funding and published research

(8) Medical paternalism.

Problems associated with teaching of medical ethics

The issues brought to light under this section cannot be considered in isolation. Standards of medical practice, facilities available for doctors, doctor/patient ratio, time spent per patient and economic considerations are factors which invite attention in dealing with ethical aspects of medical profession.

With regard to teaching in medical schools, students sometimes tend to think that ethics is an "all talk, no action" area. As for its practice, students are

keen observers of what is happening in the hospitals, wards, and the outside world. Whatever the theoretical (or classroom) inputs may be, they will also be judging for themselves what they see. Their practice of ethics will be significantly influenced by what they see. It is with regard to this larger domain that the above-mentioned factors will have the most significant effect.

Furthermore, there are a few specific problems that can be identified as factors hindering ethics education within the medical education system in Sri Lanka. In our view these are:

(1) Lack of trained medical teachers to teach medical ethics;

(2) Lack of curricula time and flexibility to incorporate modules;

(3) Lack of teacher motivation to emphasize ethical aspects during teaching;

(4) Lack of interest by students due to insufficient application of evaluation methods; and

(5) Lack of interest among clinicians.

Looking towards the future

All the faculties of medicine have realized the importance of the teaching of medical ethics. Most faculties have taken some steps depending on the resources available with them. In raising awareness about medical ethics, we feel Sri Lanka has done well. Most of the researchers are now aware that ethics is an important component of research and that they should seek approval for their proposals.

Presently, there is also a media blitz on the medical profession about their poor professional ethics. It might not be correct to generalize and paint everyone in the profession with the same brush. However, we feel that the medical profession has a serious challenge to face and the time has now come for it to dig deep, reflect and find answers to these criticisms. Regulation by outside agencies (or the state) would lead to unpleasant consequences.

There is now a considerable amount of interest among various organizations in the health sector regarding medical ethics. The Colombo Medical Faculty, the Sri Lanka Medical Association and the Peradeniya Medical Education Unit have undertaken many training programmes. There is a high level of political interest in ethical issues relating to health policy. More and more ethics committees are being established in medical schools and other organizations and, in some, guidelines for the evaluation of research have been developed. Meanwhile there is much interest in the media and among the general public in the ethics programme which has received support from the World Health Organization and NORAD.