THE MEDICAL ETHICS OF PROFESSIONALISED ĀYURVEDA

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Abstract

In 1982, the Central Council for Indian Medicine (CCIM) issued guidelines on medical education and practice and a code of ethics for practitioners of Indian medicine, i.e. āyurveda, unani and siddha. These were at least partly based on the traditions of the respective medical systems and have been revised and adapted over the years. The ethical guidelines, however, followed standards set by the World Medical Association in the Declaration of Geneva of 1948 and the International Code of Ethics of 1949 and have not been updated since they were first issued. Rather than being a self-expression of the indigenous medical professions and their traditional values, the CCIM code of ethics aligned itself with international standards, thus ideologically placing the Indian systems of medicine on a par with biomedicine. This echoes developments in the early history of āyurvedic professionalisation, which was strongly influenced by the regulation and formalisation of medicine in Britain. In this article, I will trace the historical development of āyurvedic professional ethics, highlighting links with British health care regulations and international developments in the field of medical ethics.

In twenty first-century India, medical ethics form part of contemporary medical education and practice. Medical colleges and universities offer courses in medical ethics as part of their standard curriculum and there is a fair amount of documentation relating to modern case histories of clinical ethics. Public debate and most academic publications focus on the cutting-edge issues of the interdisciplinary field of bioethics rather than on the more traditional topics

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1 The article is based on material presented at the Dharam Hinduja Institute of Indic Research (DHIIR) workshop 2003, Faculty of Divinity, University of Cambridge, UK, and the DHIIR conference 2004, on 'Modern and Global Āyurveda', Cambridge.

2 See for example the online journals: Indian Journal of Medical Ethics, formerly Medical Ethics, and Issues in Medical Ethics, at http://www.issuesinmedicalethics.org and the Eubios Journal of Asian and International Bioethics at http://www.biol.tsukuba.ac.jp/~macer/EJAIB.html

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of its precursor, medical ethics. In contrast to the lively interest in current bioethical issues, the history of medical ethics in India is an under-researched area. Little work has been done so far to trace the historical developments that shaped the standards of professional conduct, etiquette and the code of ethics of the medical profession in India today.

Ayurvedic ethics take an interesting position within what little discussion there is on the history of medical ethics in India. The term ‘ayurvedic ethics’ is here used in contrast to the codified ethics of the formalised and institutionalised ayurvedic medical profession, i.e. ‘ayurvedic professional ethics’. This distinction parallels that between traditional ayurveda, i.e. the unregulated ayurvedic medical system as it is represented in the classical ayurvedic texts, and modern ayurveda, starting with the processes of professionalisation and institutionalisation in the late nineteenth and early twentieth centuries. In relation to traditional and modern ayurveda, ayurvedic ethics represent the ethical standards of traditional ayurveda. Values and morals embedded in the tradition and culture of ayurveda relate to the ideal conduct of the physicians but also comment more broadly on human relationships and the environment. While many of the ethical injunctions found in the ayurvedic texts are certainly expressions of the values of their times and cultural origin (as for example the directions to venerate brahmans and cows) and are as such perhaps not transferable into other times and cultures, others seem more universal and less restricted to time and place (as for example the ideal to earnestly endeavour for the relief of patients), ‘Ayurvedic professional ethics’, by contrast, denotes the far more limited area of the standardisation and regulation of ayurveda, and its normative definition as a profession. These codified ethics developed in parallel to the processes of the modernisation of ayurveda and thus first date to the period in which these processes were set in motion. They do not necessarily rely on traditional values expressed in the classical texts, though they may partly or fully adopt them.

Several of the few publications on Indian medical ethics present (or recommend) ayurvedic ethics as the basis of medical ethical stan-

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3 The latter is more narrowly defined as ‘an ethic of doctoring, devised by doctors to regulate their interactions with their patients, their peers and the public’. Baker [no date], p. 22.

4 Both examples are from the Carakasaṁhitā, Vīmānasthāna, 8.13.
standards in India, both for biomedicine and for āyurveda. But they rarely mention the history and the contents of ethical codes officially adopted by the medical associations of the Indian government. Various interpretations of āyurvedic ethics are juxtaposed with ethical standards that were adopted as a result of a conscious division between 'Western medicine' and indigenous systems of medicine in the nineteenth and twentieth centuries. An ideal—or what seems to be felt a superior standard—is contrasted with the reality of medical legislation and government-regulated codes of ethics. The stance is nationalistic: in contrast to the official codes of ethics that are based on Western thought and concepts, the ethical standards of medical practice recorded in the classical āyurvedic texts ascribed to Caraka, Suśruta and Vāgbhaṭa reflect an exclusively Indian view of medical ethics, evoking a glorious past free from foreign influence and interior decline. Particularly the passage in Caraka’s Vimānasthāna 8.13–14, which has been dubbed ‘Caraka’s Oath’, is cited as the āyurvedic code of medical ethics and is compared with the Hippocratic Oath. Both oaths are put on a par with modern declarations and codes such as the 1948 Declaration of Geneva and the 1949 International Code of Medical Ethics, issued by the World Medical Association. In the case of the Hippocratic Oath, such a comparison is justified, as the oath was widely used by European and North American medical societies and institutions up to the mid-twentieth century. The Declaration of Geneva was expressly drafted to update the contents of the Hippocratic Oath, and different versions of the Hippocratic Oath are still used by some medical institutions in the USA and in the UK today. Thus, the precepts of the Hippocratic Oath form part of the modern conceptions of medical ethics, though in a modified form.

6 It needs to be asked though if an official code is more meaningful to actual practice than inofficial rules of conduct and etiquette.
8 See http://chrononet.hypermart.net/hippocratic/main.htm for an example of an altered Hippocratic Oath. Please note that all websites quoted in this article were consulted in the period between June 2003 to February 2004. If the quoted URLs are no longer valid, they may be retrieved with the ‘Waybackmachine’ at the Internet Archive at http://www.archive.org/
There is no evidence for a parallel development in the case of Caraka’s Oath. To begin with, this passage in Caraka’s text is, strictly speaking, not an oath. The chapter of which it is part is an exposition on the correct methods of study, teaching and discussion. The immediate setting of the passage is the solemn initiation of the pupil into āyurvedic studies. The teachers are to give instructions to their pupils on the correct conduct during their apprenticeship as well as their future practice. The pupils are expected to agree with and follow these guidelines. If they fail to act accordingly, the teacher is not to teach them. The passage ends with the words: ‘Thus, the rule for teaching has been announced’ (‘iṭy adhyāpanavidhir uktam’ Vimānasthāna 8.13). Though the passage is evocative of an oath, it is actually intended as a guideline for the teachers as to how to commence their teachings and what moral grounds to base them on.

More importantly, however, it must be stressed that the passage in Caraka’s text is by no means the only or the most important passage on ethical standards for medical practice in āyurvedic texts. On the other hand, Caraka’s Oath, as it will hereafter be referred to, does summarise many ethical injunctions also found elsewhere in āyurvedic texts and therefore is to a certain extent representative of āyurvedic ethics, though not a comprehensive summary of them. The main problem is to establish whether it (or other ethical injunctions laid down in the āyurvedic texts) ever had any significance for actual practice or whether standards of conduct for physicians would have rather been dictated by regional law and etiquette, religious grouping or caste. In the case of the Hippocratic Oath, for example, it has been established by Edelstein that its ethical precepts express Pythagorean values, and therefore would not have actually been representative of the mainstream ethical opinion or the standard medical practice of its times. Nevertheless, it became highly influential in later times and, as mentioned above, physicians in Europe and in other parts of the world have pledged their commitment to the tenets of the Hippocratic Oath over the last two millennia. Again, there is no evidence that Caraka’s Oath ever received similar recognition since the Carakasamhitā was compiled. The question thus arises, why ethical precepts laid down in the āyurvedic texts should be considered authoritative for modern practice, if it is

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9 Edelstein 1987b.
not even certain that they represent the standards of ancient āyurvedic practice?

This question echoes the larger discussion on what constitutes āyurvedic medicine, from which textual and other sources to derive authoritative definitions of āyurvedic theory and how to interpret and to evaluate these. There are two dimensions to this: Which sources to choose, and whether to fully or only partly accept their tenets.\(^{10}\) These issues have been at the forefront of debates on the modernisation of āyurveda since the nineteenth century—and until now, no unilateral understanding has been established. There is, however, some agreement on the significance of the classical āyurvedic texts for āyurvedic practice. This is reflected in the guidelines of the Central Council for Indian Medicine (CCIM), according to which the reading of the classical texts forms part of the curriculum in modern āyurvedic colleges and universities.\(^{11}\)

Thus, presuming that āyurvedic education and practice at least partly rely on the ancient texts, it would seem that the ethical standards expounded in the classical texts should form part of guidelines on professional conduct for practitioners of āyurveda today. However, the code of ethics that has actually been adopted by the CCIM does not rely on Caraka or any of the other āyurvedic authorities. The Indian Medical Council (IMC) website, with an emphatic affirmation of its adherence to international biomedical standards, establishes its link with biomedical history by including the Hippocratic Oath and the Declaration of Geneva in its documentation.\(^{12}\) The CCIM website,\(^{13}\) by contrast, does not even mention Caraka’s Oath or any other passages from āyurvedic texts on ethical standards for medical practice in its section on medical ethics. It is arguable that the CCIM, as representative of not only āyurveda, but also of other systems of medicine such as unani and homeopathy, could not officially adopt ‘purely’ āyurvedic ethical codes. However, the Central Council for

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\(^{10}\) The idea of giving preference to one part of the texts over the other refers to the ongoing discussions on inconsistencies in the āyurvedic texts, pointing to the merging of different schools of thought. See on these issues, for example, Chatto-padhyaya 1977, and Zysk 2000.

\(^{11}\) The official CCIM curriculum for example comprises examinations on the Carakasamhitā and the Āstāṅgasamgraha. See: http://www.ccimindia.org/Curriculum āyurveda1.htm

\(^{12}\) http://mciindia.org/know/rules/ethics.htm

\(^{13}\) http://www.ccimindia.org/regulations_5.htm
Homeopathy offers an alternative: While adopting the CCIM code of ethics, it also incorporates the Hahnemanian pledge, thus keeping a distinct identity while simultaneously acknowledging its affiliation to the CCIM and the Indian Systems of Medicine.14

Menon and Haberman provide a place for Caraka’s Oath in the wider context and history of medical ethics by arguing that it reveals significant parallels between the medical ethics of India and those of the Western world, suggesting a diffusion of ideas, probably from India to the West.15 If this were so, Caraka’s Oath would have come full circle from India and back in the shape of the modern code of ethics as adopted by the medical associations of India. In the more recent and somewhat less speculative history of āyurvedic professional ethics, the ‘lineage’ of the CCIM code of ethics can be traced directly to Western codes of ethics, most notably to the international codes of the World Medical Association. This is particularly clear in the case of the CCIM’s declaration, i.e. its version of the physician’s oath. As will be shown below, the CCIM declaration follows the wording of the declaration of the Indian Medical Association (with minor differences), which in its turn copies the Declaration of Geneva, first issued by the World Medical Association in 1948.

Oaths, declarations and codes of ethics

Codes of ethics have long been regarded as the classic expression of directives on the professional duties of physicians and other persons involved in health care. Oaths, pledges and declarations formalise the principles and rules of conduct for the medical profession more concisely and are used to publicly pledge the new physician to uphold the recognised responsibilities of the medical profession. Codes, on the other hand, elaborate on the directives of oaths and generally provide more comprehensive standards to guide the practising physician.16 Each form of ethical statement in a code or an oath implies a moral imperative, either to be accepted by the physician personally or to be enforced by a medical organisation upon its members.

16 Konold 1982, p. 162.
At the same time, such statements are never complete or fully authoritative, but form part of an ongoing dialogue between the expert group—the physicians—and the larger community. The expert group depends on the community for the recognition of its expertise and the grant of professional authority. Professional norms can therefore not be mere expressions of the expert group’s interests, but must fulfill standards that relate to the needs of the larger community, adhere to the laws of the respective country and follow current political trends.

When the Central Council for Indian Medicine, the representative body of āyurvedic practitioners, was set up in 1971 under the Indian Medicine Central Council Act of 1970, its main objectives were to prescribe minimum standards of education for the Indian systems of medicine (āyurveda, siddha, unani); to advise the central government in matters relating to the recognition (inclusion/withdrawal) of medical qualification; to maintain an up-to-date central register on Indian medicine; and to prescribe the standards of professional conduct, etiquette and code of ethics to be observed by the practitioners of Indian medicine.

The guidelines were issued in 1982 as the ‘Practitioners of Indian Medicine (Standards of Professional Conduct, Etiquette and Code of Ethics) Regulations, 1982’. The document ends with a declaration—the modern equivalent of the physician’s oath—that is to be signed by the practitioner-to-be and forwarded along with the rest of his or her application form for registration.

Persons applying for registration with State Medical Council or Board/ Central Council of Indian Medicine shall forward along with his application form the following declaration duly signed by him, namely:

1. I solemnly pledge myself to consecrate my life to the service of humanity.
2. Even under threat, I shall not use my knowledge contrary to the laws of humanity.
3. I shall maintain the utmost respect for human life from the time of conception.
4. I shall not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

18 See http://indianmedicine.nic.in/html/edu/aemain.htm
5. I shall practise my profession with conscience and dignity.
6. The health of my patient shall be my first consideration.
7. I shall respect the secrets which are confided in me.
8. I shall give to my teachers the respect and gratitude which is their due.
9. I shall maintain by all means in my power, the honour and noble tradition of medical profession.
10. I shall treat my colleagues as my brothers.
11. I shall maintain the standards of professional conduct and etiquette and observe the code of ethics, laid down in these regulations.
12. I make this declaration solemnly, freely and upon my honour and agree to abide by the same.\textsuperscript{19}

The CCIM declaration is predated by the declaration of the Indian Medical Council (IMC). The latter was established in 1934 under the Indian Medical Council Act, 1933, with the main function of establishing uniform standards of higher qualifications in medicine and recognition of medical qualifications in India and abroad. As the number of medical colleges had increased steadily during the years after Independence, it was felt that the provisions of the Indian Medical Council Act were not adequate to meet with the challenges posed by the very fast development and the progress of medical education in the country. As a result, in 1956, the old Act was repealed and a new one was enacted, which was further modified in 1964, 1993 and 2001. In 2002, the Indian Medical Council issued the following declaration as part of its code of ethics (first issued in 1956).

At the time of registration, each applicant shall be given a copy of the following declaration by the Registrar concerned, and shall read and agree to abide by the same:

1. I solemnly pledge myself to consecrate my life to the service of humanity.
2. Even under threat, I will not use my medical knowledge contrary to the laws of humanity.
3. I will maintain the utmost respect for human life from the time of conception.
4. I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
5. I will practise my profession with conscience and dignity.
6. The health of my patient will be my first consideration.

\textsuperscript{19} Note: The numbering was done by the author, DB.
7. I will respect the secrets which are confided in me.
8. I will give to my teachers the respect and gratitude which is their due.
9. I will maintain by all means in my power, the honour and noble traditions of medical profession.
10. I will treat my colleagues with all respect and dignity.
11. I shall abide by the code of ethics as enunciated in the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002.
12. I make these promises solemnly, freely and upon my honour.\textsuperscript{20}

A comparison between the CCIM and IMC declarations shows them to be nearly identical. They differ in point two, in that ayurvedic practitioners (and those of other Indian systems of medicine) pledge not to use their knowledge contrary to the laws of humanity while the IMC declaration qualifies this knowledge as medical knowledge. This could mean that the CCIM wished to point out that practitioners of Indian systems of medicine have more to offer than merely medical knowledge. That, however, is not necessarily so, as the text in question, which is derived from the ‘Indian Systems of Medicine and Homeopathy’ (ISM&H, renamed AYUSH in 2003) website,\textsuperscript{21} had several orthographical and grammatical mistakes.\textsuperscript{22} It is therefore not unlikely that this is simply an inadvertent omission.

A real difference in content occurs in point ten: while the CCIM announces that practitioners should treat each other as brothers, the IMC declaration, more politically correct due to its recent update in 2002, lets colleagues treat each other with all respect and dignity. The original IMC declaration of 1956 uses the phrase ‘My colleagues will be my brothers’.\textsuperscript{23} This stems directly from the Declaration of Geneva,\textsuperscript{24} which was adopted by the General Assembly of the WMA.

\textsuperscript{20} See http://mciindia.org/know/rules/ethics.htm
\textsuperscript{21} The website is at http://indianmedicine.nic.in
\textsuperscript{22} One of the mistakes shared by both texts on their respective websites was in point seven—the original text read in both: ‘I will respect the secrets which are confined in me’. This points to one copying from the other.
\textsuperscript{23} It is an example of the state of research on medical ethics in India that the various authors who have written about the code of ethics and its declaration differ on its date: it is, rightly, 1956, according to Jaggi 1982, and 1908); 1959, according to Mehta and Taraporevala 1963, p. 95; and 1970, according to Desai 1995, pp. 1473–4.
\textsuperscript{24} The declaration can be found at http://www.wma.net/e/policy/c8.htm, where it is appended to the International Code of Ethics, as adopted by the World Medical Association (WMA) in 1949. Note also the obviously Christian wording in the
at Geneva, Switzerland, in 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, in 1968; the 35th World Medical Assembly, Venice, Italy, in 1983; and the 46th WMA General Assembly Stockholm, Sweden, in 1994. The following declaration is quoted from the 1948 version with some additions in brackets to point out amendments.

Physician’s Oath
At the time of being admitted as a member of the medical profession:

1. I solemnly pledge myself to consecrate my life to the service of humanity;
2. I will give to my teachers the respect and gratitude which is their due;
3. I will practice my profession with conscience and dignity; the health of my patient will be my first consideration;
4. I will respect the secrets which are confided in me, even after the patient has died;
5. I will maintain by all the means in my power, the honour and the noble traditions of the medical profession; my colleagues will be my brothers [in the amended version of 1994: my colleagues will be my brothers and sisters];
6. I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient [amended in 1994 to: I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient];
7. I will maintain the utmost respect for human life from the time of conception, even under threat, I will not use my medical knowledge contrary to the laws of humanity;
8. I make these promises solemnly, freely and upon my honour.

The declaration of the IMC (and thus of the CCIM) is basically the same as the Declaration of Geneva of 1948, merely the order has been changed. Thus, point two of the Geneva declaration can be found as point eight of the IMC declaration and three is five and six. Point four, with the addition of ‘even after the patient has died’, is seven. Point five matches nine and ten. While the amended 2002 version of the IMC instructs physicians to treat colleagues with dignity and

International Code of Ethics: ‘A physician shall behave towards his colleagues as he would have them behave towards them’. See the ‘Sermon on the Mount’, Matthew, 7.7.
respect, the original 1956 version of the IMC followed the wording of the Geneva declaration of 1948, declaring ‘my colleagues will be my brothers’. Point six (in its 1948 version) is four, and seven equals three and two. The change of order from the Geneva declaration to the IMC declaration could denote a difference in emphasis on what the IMC deemed to be most important. And the difference in point four of the Geneva declaration to point seven of the IMC declaration would suggest that the IMC does not require posthumous confidentiality. However, both the omission in point ten and the general sequence could simply be due to indifferent editing.

In summary, the CCIM code of ethics ultimately reiterates the international standards of the Geneva declaration, though it is more likely that its authors used the IMC declaration as their blueprint (particularly as the sequences of the two codes concur). There was obviously no attempt made to formulate a more specifically āyurvedic declaration or to update its contents in other ways. The reasons for such complete reliance on standards set by others are complex and are as much embedded in the history of the formalisation of medicine outside of India as within. Looking at early documents of āyurvedic professional ethics, it emerges that, in their decision to follow international standards, the CCIM simply built on the foundations of what had been established in the early days of professionalised āyurveda.

The early days of āyurvedic professional ethics

As medicine was increasingly formalised and regulated in the UK, Europe and the USA, the British took care that their colonial medical establishment in India followed suit. Along with the establishment of new educational institutions and hospitals, this brought forth a new type of textual documentation for medical practice in India—reports, acts, laws and decrees on the formal practice of medicine. From these, we can learn much about the beginnings of āyurvedic professional ethics. The aim was to establish Indian medical education and practice as conforming to international standards, thus giving Indian medical practitioners international recognition and enabling them to practise worldwide. This was also the context of āyurvedic professionalisation and would have played a role in the early history of its professional ethics.
Paul Brass has argued in *The Politics of Ayurvedic Education* that biomedical practitioners had fewer difficulties than their ayurvedic colleagues in establishing their occupation as a profession, as they could present more or less uniform structures by appealing to international standards.25 Following the pattern of professionalisation set by medical associations in the USA and the UK, the biomedical interest group was able to interpose itself between the politicians and the medical profession as an effective restraint upon political interference in the establishment of educational and professional standards. According to Brass, the movement for ayurvedic professionalism followed a different course, as the ayurvedic interest groups failed to agree among themselves upon their professional standards. Instead, they ‘entered the political arena directly in an effort to win political support for government imposition of professional standards’.26 While the ayurvedic interest groups were struggling to present ayurveda as equal to biomedicine, establishing a framework for policy and administrative procedures seems to have presented less of a problem, as the standards set down by the biomedical interest group were simply copied.

The earliest instance of ethics specific to the professional group of ayurvedic practitioners (which included also siddha and unani practitioners) can be traced back to 1938 to the establishment of the first official governing body of Indian systems of medicine, the ‘Board of Ayurvedic and Unani Tibbi Systems of Medicine’.27 The Board’s function was to regulate the qualifications and to provide for the registration of practitioners of the Indian systems of medicine. The first register for practitioners of indigenous systems of medicine was established as a result of the decision of the IMC not to register indigenous practitioners, due to the fact that international recognition of Indian medical degrees by the General Medical Council in London depended on a very clear distinction between Western doctors and the rest.28 While the motivation for separate registration was based on a negative judgement on the indigenous systems of medicine and

26 Brass 1972, p. 364.
27 Established under the Bombay Medical Practitioners’ Act, 1938. Bombay Act No. XXVI of 1938. ‘The Board of Indian Systems of Medicine, Bombay’ is also referred to as ‘The Board of Ayurvedic and Unani Tibbi Systems of Medicine’. [*Unani Tibb’ means unani or ‘Islamic’ medicine; eds.]*
thus perhaps suggested diminished prospects for international recognition, it also at least theoretically opened greater possibilities towards autonomy and self-definition of the indigenous medical groups.

The Bombay Medical Practitioners’ Act gives only a glimpse of directives on physicians’ professional conduct. The significant passage in the Act reads as follows:

Section 16(3): The Board may direct that the name of any practitioner who has been convicted of a cognizable offence as defined in the Code of Criminal Procedure, 1898, which discloses such defect of moral character as is, in the opinion of the Board, sufficient to make him unfit to practice [sic] his profession or who, after due inquiry, has been found guilty of conduct which is in the opinion of the Board infamous in any professional respect, shall be removed from the Register. The Board may, on sufficient cause being shown, also direct that the name of the practitioner so removed shall be re-entered in the Register.

This passage is an elaboration of point nine of the Bombay Medical Act of 1912 (Bombay Act No. VI of 1912), with which the first register for Indian medical practitioners was established. The main difference is that the 1912 Act does not include mention of a ‘defect of moral character . . . sufficient to make him unfit to practice his profession’. In its turn, the passage of the Bombay Medical Act of 1912 has very similar wording to a parallel passage in the British Medical Act of 1858. The latter reads as follows:

If any registered medical practitioner shall be convicted in England or Ireland of any felony or misdemeanour, or in Scotland of any crime or offence, or shall after due enquiry be judged by the General Council to have been guilty of infamous conduct in any professional respect, the General Council may, if they see fit, direct the Registrar to erase the name of such medical practitioner from the Register.29

The crucial statement in the 1938 Act (as in the other two Acts) is that the name of any practitioner, who ‘has been found guilty of conduct which is in the opinion of the Board infamous in any professional respect’ would be removed from the Register. Persons, whose names were thus removed from the Register were no longer ‘legally qualified’ or ‘duly qualified’ medical practitioners, i.e. they could not hold an ‘appointment as a Physician, Surgeon or other medical officer

29 Smith 1993, p. 57.
in any Āyurvedic or Unani dispensary, hospital, infirmary or lying-in hospital supported by or receiving a grant from the Provincial Government and treating patients according to the Indian systems of medicine or in any public establishment, body or institution dealing with such systems of medicine’.\textsuperscript{30} Considering this, one might \textit{prima facie} expect to find a formal statement defining the nature of ‘infamous conduct’ that would guide the decision-making processes of the Board (or of the respective Medical Councils) and provide informative guidelines for practitioners. In nineteenth-century Britain, however, official guidelines on correct professional conduct were sparse. Though the earliest publications on medical ethics as the ethics of a profession were written in Britain, and the very term ‘medical ethics’ was first introduced by Sir Thomas Percival in his famous publication of 1803, these were not officially adopted by the British Medical Association or its regulatory body, the General Medical Council, established in 1858 under the British Medical Act.\textsuperscript{31}

\textit{Medical ethics in Britain}

The British Medical Association (BMA) understands the promotion of standards of good professional practice and the contribution to the discussion of ethical issues to be two of its major functions. Its forerunner, the ‘Provincial Medical and Surgical Association’, established in 1832, asserted its objective to be ‘the maintenance of the honour and respectability of medicine by defining those elements which ought ever to characterise a liberal profession’.\textsuperscript{32} The Association appointed committees in 1849 and in 1853, to draw up a short code of medical ethics—but they failed to do so. In 1856, the Association changed its name to its current one—the BMA—and commissioned yet another committee in 1858 to draft a code of ethics, which again failed. Thus, the issue of an official code was left to rest and although a Central Ethical Committee was set up in 1902, it ‘wisely rejected a request to draw up an ethical code’.\textsuperscript{33} In 1927 the BMA council again advised against the preparation of an ethical code. A turning

\textsuperscript{30} Bombay Medical Practitioners’ Act, 1938, 19 (3).

\textsuperscript{31} This is a marked difference to developments in the USA, where Percival’s code was used as the basis for the Code of Ethics adopted by the American Medical Association following their establishment in 1847.

\textsuperscript{32} Sommerville 1993, p. xxv.

\textsuperscript{33} Sommerville 1993, p. xxv.
point came in 1949 when it finally produced a publication on proper (and improper) professional conduct that had long been demanded by medical practitioners. A small pamphlet, entitled ‘Ethics and Members of the Medical Profession’ was to give guidance to members of the medical professions, mainly on the subject of their relationships with each other and members of other professions. While giving only very basic information, the booklet refers to the code of professional conduct that was then under preparation by the World Medical Association.\footnote{BMA 1949, p. 7.} The first BMA handbook of medical ethics was published as late as 1980. It has since undergone several revisions.

The General Medical Council (GMC), on the other hand, for a long time flatly refuted its responsibility to give any guidelines whatsoever on professional conduct. Practitioners could obtain some information on what the GMC considered bad practice by reading reports of earlier disciplinary cases. This information was, however, not comprehensive, particularly as the GMC in the first years did not give out information to the press. Considerable numbers of practitioners would not have been aware of the GMC’s views regarding particular types of conduct. The first definition of ‘infamous conduct’ dates back to 1883:

\begin{quote}
That the Council record on its Minutes, for the information of those whom it may concern, that charges of gross misconduct in the employment of unqualified assistants, and charges of dishonest collusion with unqualified practitioners in respect of the signing of medical certificates required for the purposes of any law or lawful contract, are, if brought before the Council, regarded by the Council as charges of infamous conduct under the Medical Act.\footnote{Smith 1993, p. 60.}
\end{quote}

By the turn of the century, this first definition was elaborated to a formal ‘warning notice’, which was issued to all newly registered medical practitioners. Between 1920 and 1958 warning notices were published as part of the Medical Register. They were substituted by ‘Notes by the Disciplinary Committee’ until 1963, when these in turn were replaced by the separate publication of ‘Blue Pamphlets’. Warning notices contained very brief advice on questions of certification, employment of unqualified assistants, sale of poisons, association with
unqualified persons, advertising and canvassing. This was only useful
to a certain extent, as the GMC 'maintained a strict policy of not
elaborating upon or explaining the matters contained in the Warning
Notice, because its judicial function is perceived as being inconsis-
tent with an advisory role'.

Warning notices in India

The GMC's warning notices were imported to India, where they
were republished verbatim in the Provincial Medical Registers. Thus,
for example, the Madras Medical Register of 1936 (a register for
allopathic practitioners) begins:

The following 'Warning Notice' which appears in the British Medical
Register is reproduced for the information of medical practitioners reg-
istered in Madras, as the Madras Medical Council have resolved that
'the Resolutions and Decisions of the General Medical Council of the
United Kingdom upon forms of professional misconduct should be
adopted by the Madras Medical Council subject to the laws in force
in India'.

If we reread point 16(3) of the Bombay Medical Practitioners' Act,
1938, we see that the Board's decisions are to be based on the
Board's opinion: The pattern set is that of the GMC's procedure of
deciding each case ad hoc. In the case of ayurvedic regulation, how-
ever, a different course may have been followed. Mehta and Terapo-
revala in Medical Law and Ethics in India quote the 'Code for
Practitioners of Ayurvedic and Unani Systems of Medicine', as adopted
by the former Board of Ayurvedic and Unani Tibbi Systems of
Medicine, Bombay, under the Bombay Medical Practitioners' Act,
1938. However, Mehta and Teraporevala do not provide a proper
reference: the code is not part of the Bombay Medical Practitioners'
Act, 1938. The origin of this code is therefore not clear. Nor has it
been established when—if at all—it was published by the Board of
Ayurvedic and Unani Tibbi Systems of Medicine, Bombay. If, how-
ever, the Code had been published shortly after the establishment
of the Board, it would predate the otherwise first medical code of

36 Smith 1993, p. 64.
ethics of India, adopted by the Indian Medical Council in 1956. It would also predate any official British Medical Code of Ethics. This could mean that the Board of Indian Systems of Medicine, while functioning within a framework of British legislation, was not following the British attitude towards codified professional ethics. The particulars of this, however, remain yet to be ascertained.

Conclusion

India was still a British colony at the time of the establishment of its first medical register. It is therefore not surprising that India followed the British model of setting professional standards. The general aim was to establish Indian medical education and practice as conforming to international standards, thus giving Indian practitioners of medicine international recognition and enabling them to practise worldwide. It is important to remember that the early Indian codes represent not only early days in the professionalisation of Indian medicine, but also of medicine worldwide—they are the result of the beginnings of international discussions on ethical and educational standards for medical practice. The decisions that were made in the early years of āyurvedic formalisation, however, formed the foundation for later policy and set the pattern for the CCIM’s decision of 1982, when it adopted its code of ethics. Since then, āyurvedic professional ethics have remained static.

Āyurveda has excited a certain amount of international interest in recent years as a complementary or alternative form of healing. It is, however, still far from being recognised as a discipline equal to biomedicine, both in India and globally. While being recognised internationally is thus an aim yet to be attained, the regulatory bodies of āyurveda (as of other Indian systems of medicine) could consider whether the unquestioning following of the much invoked, but often only loosely defined, ‘international standards’ has actually met with success, i.e. boosted the āyurvedic profession. Such a boost might be achieved by a more active participation on the part of the āyurvedic communities in international discussions on medical ethics. This would of course involve discussions within the āyurvedic communities themselves on what exactly an ‘āyurvedic perspective’ entails. The formulation of an ethical code can be seen as part of the self-definition of a profession. Rather than following biomedical definitions,
a code closer to the roots of āyurveda (i.e. based on ethical standards from the classical and later āyurvedic texts and perhaps on what is known from other indigenous medical traditions), could be devised and—following the example of the Homeopaths—added to the international code.

The complex history of āyurveda and particularly the developments in the twentieth century prior to and following Indian Independence in 1947, when discussions on āyurveda were brought into the realm of politics, make a consensus among the various āyurveda interest groups seem a very difficult goal to achieve. However, the fact that discussions are ongoing, shows that there is continued interest in the issue of what constitutes āyurveda.

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