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The Benefits & Burdens of Importing Bioethical Principles' Approach

DeenDayal B. Reddy, B.Sc. (India), MS, MA, PhD (USA)

Professor & HOD of Bioethics, Apollo Institute of Medical Sciences & Research, AIMSR, Jubilee Hills, Hyderabad

Email: deen.reddy@gmail.com

Abstract

A teachable point of this paper is that we cannot hurriedly pedal our way through the portals of the Internet and get enlightened about bioethics. Just like any other subject in medicine, bioethics needs to be studied seriously and taught systematically. In view of the growing demand for western ethics, in India, this paper will focus primarily on the benefits and burdens of importing bioethics, under four sections. Section I, considers the reasons for relying on western ethical principles and paradigms. Section II, highlights the pros and cons of such reliance. Section III, offers credible reasons why India's ethical heritage has *not* stepped up to the plate and produced a meaningful treatise on medical ethics. Section IV, suggests how we may expand the reach and repertoire of the bioethical principles. A two-fold theme runs through the sections: (a) There exists an internal vacuum where the indigenous methods of moral enquiry have become sterile; (b) This vacuum can be filled by a systematic study of bioethics—besides importing the Four Principles' Approach (FPA). As with any import, FPA comes with its share of burdens and benefits. The burdens include reducing the principles as conscious-raising ceremonials or as *contradictio in adjecto.* The benefits include extending the reach and repertoire of the principles. To wit: The bioethical principle of *beneficence* encompasses a fiduciary duty towards moral strangers besides family or friends; the principle of *nonmaleficence* includes offences against fellow human beings other than cows or trees; *justice* supports both fair-play and natural rights; and respect for *autonomy* is attuned to the inherent moral worth than the material worth of a human person. Perhaps the ultimate benefit, of studying bioethics systematically, is that it helps us to ascertain whether the ethical thought inherited under the aegis of history, recent or remote, is as ineffectual as ancient surgery or as precious as ancient sculpture. If it is the former, we should be wrong to take it seriously; if the latter, to lose it would impoverish us.

Keywords: Bioethical Principles; Four Principles' Approach; Autonomy; Beneficence; Justice; Nonmaleficence; Indian Ethics; Swarājy-ka-āadar; Daya, Upakaar; Nyāya; Ahimsa

Introduction

INDIA imports iPhones, aircrafts, earthmoving heavy machinery, space-age technology, PET scans and even fancy cars—all the time. It makes perfect sense to buy these—from the outside, when one does not have the raw materials or the wherewithal, to build them—on the inside. But, of all things, import bioethics! That too, into a country which articulated the notion of nonmaleficence or ahimsa way before Hippocrates did? Now, that does not seem to make good sense. To imply that India lacks internal resources to nurture bioethical principles would be outrightly unfair if not pejorative. Then again to pine after ethical paradigms from distant societies could be viewed as a tacit admission that the foreign methods of moral enquiry are of superior quality and indigenous methods are of inferior quality. While the merits of such admission remain unsettled and at times unsettling, prudence requires that we should, at least, read the fine print before using the product; analyse the reasons why indigenous products and methods were bypassed; and, above all, not be silent on such matters of ethical import.

The purpose of this paper, therefore, is to seek out and suggest plausible explanations to the following four enquiries. I: Why is India importing or relying on western bioethical principles and paradigms? II: What are the advantages and disadvantages of such reliance? III: Why India's ethical heritage has *not* stepped up to the plate and produced a matching thesis on medical ethics? And IV: How may we expand the reach and repertoire of the bioethical principles, which are in vogue, in India? I shall attempt to respond to these four enquiries in the order they are written.

Section I: An important reason why the Indian medical enterprise is relying on western bioethical models is that the top regulatory bodies have endorsed them. The recent guidelines[(1)] from Medical Council of India (MCI) and Indian Council on Medical Research (ICMR)—replete with *western* ethical nomenclature—have recommended the inclusion of bioethics in medical degree (MBBS) programmes.[(2)] In response, a few progressive medical colleges have produced bioethics syllabi fashioned, to a large extent, after western models. There is even the talk about making bioethics a compulsory subject at all medical colleges in India.[(3)]

Secondly, there appears to be an internal vacuum in Indian ethics where the traditional methods of moral enquiry appear to have become sterile. This is evidenced by the absence of a formalised instruction in ethics[(4)] at a vast majority of Indian medical schools; and a growing demand for westernized ethics, *especially*, the Four Principles' Approach (FPA),[(5)] which comprises of (1) Respect for Autonomy; (2) Nonmaleficence; (3) Beneficence; and (4) Justice. In the common Indian parlance, they are: (1) Swarājy-ka-āadar; (2) Ahimsa; (3) Daya or Upakaar and (4) Nyāya, respectively. Judging by their citations in published articles and references at many Indian ethics websites,[(6)] one could infer that FPA has taken a firm hold in the hearts and minds of many Indians. Moreover, its reputation as a reliable quadpod

supporting the crucible of American bioethics appears to have valorized the notion that if it works in the US; then, it might do the trick in India as well.

Section II: The Four Principles' Approach (FPA) is advantageous not because it is a highfaluting idea 'made in America' but because it offers a simple ethical framework within which to analyse and address the increasingly complex issues such as human organ transplantation, and the allocation of scarce resources. Additionally, FPA enables us to draw parameters of moral relations between strangers, and facilitate a method of decision-making that people with different cultural backgrounds would consider morally acceptable.[7] Perhaps the stellar feature of the FPA, as the editor, Raanan Gillon, of the primer on "Principles of Health Care Ethics," explains[8] that it offers a world, burdened with *multi*-cultural, *multi*-religious, *multi*-philosophical views, a *trans*cultural, *trans*religious, *trans*philosophical paradigm for ethical analysis. By such universality, FPA is able to promote a greater measure of clarity, comprehensiveness, practicability, explanatory power and justificatory power to a world steeped in nothing firmer than professional codes, moral slogans, and shibboleths. Lastly, since FPA has been subjected to continuous refinements and updates over the past 50 years, its appeal continues to gain ground both in India and throughout the world.

However, the authors of FPA Tom Beauchamp and James Childress[9] and their ardent critics[10] all caution that, FPA is neither the alpha nor omega of bioethics; and if imported *as is*, the principles may end up as 'ceremonials,' perhaps 'conscious-raising' but seldom clarifying the moral issues in a given situation. The critics also point out that the principles, when not specified, are too vague to adjudicate conflicts—with no clear priority rankings, they are often susceptible to multiple analyses. To wit: As the saying "A for Apple" could turn out to be an oxymoron in a place where apples do not grow, so also the slogan 'a' for autonomy might end up as *contradictio in adjecto* in a society which is responsive to communal decisions rather than autonomic ones. The judicial concept[11] of autonomy—*thoroughgoing self-determination*—is patently different from that of the ethical (Kantian) conception of autonomy: which rests on *moral self-regulation*. Since absolute autonomy is antithetical to any organized society, the ideation of Kant that requires moral self-regulation through a structure of reason, where just restraints suffer no loss of freedom, appears as an acceptable idea to many. Considering that a vast majority of Indians is sensitive and responsive to family consensus and *corporate* decisions, one could appreciate why most would gravitate towards the contextual notion of autonomy more than the American-made self-determination. To appraise such nuances, we are advised to *specify* the principles so that the ensuing deliberations might remain in context. Short cuts, in lieu of a serious study, will not only impoverish our understanding but also disserve those who depend on our expertise.

Section III: These four principles are not new to India; they have been around for eons, since the Vedic times. Hence, the question: Why has India's ethical heritage[12] *not* stepped up to the plate and produced a meaningful treatise on medical ethics? I do not know all the answers. But, to the modesty of my understanding, I shall share a few plausible ones (A) **Diverse demography**: While the four principles may be teased out from the Vedic moral particularity, which evolved around 1500–500 BCE;[13] the religious order that supported it was oblivious of their application to the modern diversity. The nearly 400 million (33%) non-devotees of Vedic culture living in India, (Buddhists, Christians, Sikhs, Muslims, and Dalitbahujans),[14] would call into question the validity of *varnashramadharma* or caste/station/duties. Prof. Arti Dhand affirms that the Vedic tradition's preoccupation, with "particulars of a person's embodied existence"[15] (caste, creed, and gender) in lieu of the *potentialities* proper to her specific nature (conceptual thought and the capacity to choose), hampered its efforts at articulating a trans-religious morality with philosophical exactitude. Since the demography of medical students affirmatively includes India's religious plurality, one can appreciate why a moral fiat based on *varnashramadharma*, may be unconvincing to those who were systematically excluded or ostracized by the same moral code, for years on end. (B) **Sloganizing vs. Ethicizing**: Since the times of *Caraka* and *Sushrutha samhitas* (the magnum opus of Ayurveda) subsequent discourse on the evolving field of bioethics appears to be in a state of moratorium. Yet, the sayings of the great *Caraka* are often sloganized[16] as—moral shibboleths—another platitude to *do some good* rather than a correlative *duty to act* in a certain way. It is doubtful if people will ever sacrifice everything for others just by heeding to *Caraka's* advice: 'thou shalt endeavour for the relief of patients with all thy heart and soul' OR stop telling intentional lies just by heeding to the oft repeated *Gandhian* slogan: *satyamé-vijayathé*—truth shall prevail. If slogans have any merit, it is in their uncanny ability to keep the moral injunctions in logic-tight compartments thus foil them from challenging the other. Even after long years of some centuries, the sloganized morality continues to make efficient lubricant for moral evasiveness. (C) **Scholastic disengagement**: While western scholars, both religious and secular, are deeply engaged in contextualising and refining ancient ethical texts and searching for a common ground to resolve contemporary bioethical disputes; the Hindu philosophers are "still isolated in intellectual *asrams.*"[17] Indologist Cromwell Crawford offers three strong reasons: Firstly, doing bioethics assumes a prior interest in ethics, which, judged by the number of Indian publications in this field does not enjoy priority status. When ethics is discussed it is pervasively through Western categories and modalities. Secondly, the

phenomenal growth of bioethics experienced in the West has not arisen in India to the same degree. The third reason is that the majority of philosophers in the Hindu area have not developed corresponding expertise in the facts, relationships and the concepts of the medical world.[18]

Western experience suggests that it is possible to vacate intellectual enclaves of inept slogans and settle on a common ground of trans-religious (universalisable) principles. As the history of the Four Principles suggests, it is possible to refine them by the force of reason and wean them from the weight of erstwhile traditions. I am sure, my esteemed readers would agree to the following weaning criteria: First, we must acknowledge that there exists a gap between the principles we have at hand and the problems that have simply gotten out of hand. Next, bridge the gap with universalisable values culled from within the tradition and from competing traditions. Lastly, as Micah Lott suggests, we must encourage rational competition across traditions.

The adherents of the tradition in crisis must first learn the second tradition [such as the Four Principles' Approach] as a 'second first language;' and must come to understand it conceptually *on its own terms*, rather than simply from the perspective of their original tradition. Having come to "speak" the language of two traditions, adherents of a tradition in crisis might discover that the rival tradition provides the conceptual resources lacking in their own tradition to solve…, the problems of their own tradition which had led to an epistemological crisis, and also explains why those problems were unsolvable. This process of abandoning one tradition in favor of another constitutes the way in which there may be rationality across traditions…. Rational competition between traditions takes place on the basis of the ability of one tradition to solve both its own problems and the problems of rival traditions by the rival's own standards.[19] *Parenthesis mine*.

Lott's assertions appear to explain why the hitherto trusted methods of moral enquiry have become sterile. He pinpoints at the root of moral inertia and suggests a way out: First, we must appreciate the strengths and weaknesses of our moral tradition so that we may understand *how and why we got into this mess in the first place*. Second, as we get proficient at 'speaking the language' of rival tradition, and understand its terms and limitations, the new language compels us to 'abandon' those values that are narrow and sectarian and congregate around values that are broader and secular. Experience informs us that when discrete traditions liaise together they tend to create an effect greater than the sum of the effects each is able to exert independently.

Section IV: The preceding observations are critical to carrying our argument forward in response to the final question: How may we expand the reach and repertoire of the bioethical principles? Stated differently, how may we eschew those values that are narrow and sectarian and congregate around transcultural values that are broad and secular? First, we will begin with the Indian expressions that closely define **respect for autonomy**: Swarājy-ka-āadar or Swatantrata ka-āadar. Properly understood, it refers to the right to make decisions about one's own life and body without coercion from others. In health care decisions, our respect for the autonomy of the patient would imply that the patient has the capacity to act intentionally with understanding and without controlling influences that would mitigate against a voluntary and a free choice. This principle also serves as the backbone of an 'informed consent' in clinical research and in physician/patient interaction regarding health care. In its *narrow* conception, respect for autonomy is often linked, as noted elsewhere, to the rugged self-determination, material worth, and—as India's past would no doubt attest—to the acquired properties of caste, status, wealth, and even gender. If unopposed, respect and dignity will continue to be accorded to those who have the wherewithal to purchase, possess, or dine at the Ritz. It is no accident that the lion's share of healthcare resources is beholden to the demands of the upper richest quintile,[20] which is able to express its preferences and act on them. I am persuaded that a systematic study of bioethics holds out the possibility of accepting the *broader* conception of respect for autonomy, based on inherent properties of rational capacity and moral choice, thus enabling the less-fortunate to lay claim to what is morally owed to them, let alone dinning at the Ritz.

Next, the principle of **Nonmaleficence** (Ahimsa): There is little ambiguity that both *ahimsa* and nonmaleficence denote the same meaning. However, based on what is being said and written about ahimsa, its connotation appears to evoke a watered-down version of non-injury. For instance, killing of animals and trees is given more "press" than abortion on demand. Rarely does one find the notion of ahimsa associated with rules prohibiting infliction of harm against the disenfranchised fellow (women, children, menial labourers) human beings, such as: do not cause pain (including mental anguish), or do not deprive others of their freedom of opportunities and pleasure. There are others which fall squarely within the purview of *ahimsa*, such as: do not deceive, do not break promise, do not neglect duty, and do not steal. Virtually all are self-evidently injurious, especially to others. Expectedly, most of the above were factored in the 2015 Corruption Perception Index by Transparency International (TI) of 168 countries, which assigned India a 76th spot, straddling between the least and most corrupt nations in the world.[21] When all cases of *himsa* are not regarded as violations of ahimsa, it will perpetuate a diluted version if not negligent behaviour. By maximising the purview of ahimsa, I believe we can minimise its dilution and realise our *paramadharma*, (supreme obligation) which includes the welfare of humans, animals, flora and fauna.

Thirdly, the principle of **Beneficence**: The meaning of beneficence may be traced to the words karuna or

daya.[22] These words connote 'mercy' or 'compassion' more than beneficence as a positive obligation *per se*. Such connotation of 'mercy' in some measure continues to fan the flames of paternalism, for it is not uncommon to see patients literally and figuratively prostrate in deference to that which the physician orders. The ideation of daya appears to advocate a relationship based on the "priestly"[23] model where the physician acts as a *vicar* articulating and implementing that which he considers to be in the patients' best interest. The ancient *Samhita* which records the Physician Oath of Initiation, proposed by the great *Caraka*, defines the notion of daya with some grandiosity: "Day and night, however you may be engaged, you shall strive for the relief of the patient with all your heart and soul. You shall not desert or injure your patient even for the sake of your life or living." Yet in the same context it clearly enjoins a physician from treating those who are *not* quite *on a par*.

No persons, who are hated by the king or who are haters of the king or who are hated by the public or who are haters of the public, shall receive treatment. Similarly, those who are extremely abnormal, wicked, and of miserable character and conduct…, those who are on the point of death, and similarly women who are unattended by their husbands or guardians shall not receive treatment.[24]

My point in quoting the above is not to berate *Caraka* or his devotees but to point out that the conception of daya or beneficence, as a *positive duty "*upakaar*"* has not been explicated, especially as regards moral strangers, with ethical clarity. Of course, there are countless instances, in *Caraka Samhita* itself, of extreme generosity and beneficence, yet virtually all were conditioned by *jātidharma* or caste-specific duties.[25] If a society were to accord beneficence only to the familial or to the familiar, the plight of moral strangers will continue to suffer. Considering India's population of a whopping 1.2 billion it is more likely that an ER doctor meets moral strangers (indigent patients) than friends. Here, the rule of reciprocity may not hold its sway but the fiduciary duty does; simply because the patient needs a lifesaving medicine which the doctor *can* prescribe or has access to it. As the definition of daya gets infused with the idea of 'upakaar' (positive and fiduciary duty), it is more likely to hold its control when decisions are made whether or not to build the next hospital in the rural areas where two-thirds of the population resides.[26]

Lastly, the principle of **Justice.** The Indian words that correspond closer to justice is nyāya or dharma-nîti. Both connote 'fairness.' Still, when justice is invoked to mean equal or *natural* rights I could not find its equivalence in the ancient Indian texts.[27] Based on the Aristotelian definition, justice consists in treating equals equally and unequals unequally in proportion to their unequality; "injustice" is said to result when *equal rights* are violated and or when similar cases are not treated in a similar fashion. Fairness on the other hand has been often used with regard to an ability to judge without reference to one's feelings or interests; such as judging the criteria used to grant admissions into medical schools. In any case, the notion of desert is crucial to both justice and fairness. While the original ideation of *dharma-niti* stood in step with Stagarite's definition, it gradually regressed, as the caste system took a firm hold, into a "double entendre": Overtly as *sadharnadharma* common-fairness and covertly as *varnadharma* caste-fairness. According to W.D. O'Flaherty, when push came to shove, the latter superseded the former.[28] To the extent of my research, the linkage of *nyāya* to *natural rights* was not given legitimacy until the Indian Constitution adopted the Fundamental Rights on January 26th 1950, which upholds the natural rights of all citizens to life, liberty, and freedom of religion, assembly, and movement.[29] While a considerable progress has been made in the sphere of fundamental rights, mind-boggling disparities continue to exist among the *haves* and the *have-nots*. Lack of universal health coverage continues to entice the private sector in exploiting the situation. As Sunil Pandya notes, "medical care is bought and sold like any other commodity not infrequently to the highest bidder."[30] All such instances of injustice give us more reasons why we should continue our efforts to educate and free *sadhanadharma* from the grip of its antecedent anchorage.

Concluding Remarks

Why are Indian medical colleges importing bioethical principles? I believe we offered compelling reasons for their reliance on the familiar but highly evolved Four Principles' Approach (FPA). Perhaps the primary reason is to satiate a pressing need for a transcultural, trans-creedal and universalisable bioethics, suitable to the diverse religious and cultural backgrounds of Indian medical students. The experts[31] we consulted recommend that we study the principles, refine them and test them against our moral sense so that the principles we finally assent to may be continually forged by the force of reason and reflection. The upshot of it is: we are able to appreciate that *beneficence* refers to a fiduciary duty to help a moral stranger besides friends or family; *nonmaleficence* includes offences against fellow human beings besides cows or trees; *justice* supports both fair-play and natural rights; and respect for *autonomy* is accorded because of the inherent moral worth of a human being but not because of material worth or social status. Perhaps the ultimate benefit of studying the bioethical principles, systematically, is that it helps us to ascertain whether the ethical thought inherited under the aegis of history, recent or remote, is as ineffectual as ancient surgery or as precious as ancient sculptures. If it is the former, we should be wrong to take it seriously; if the latter, then to lose it would impoverish us.

To be sure, we are not advocating for a conversion from tradition but for the convergence of an insight, that compels us to avoid the fundamental mistakes of the past and offers clarity in a world entrenched in nothing firmer

than professional codes and subjective judgments. Looking forward we can hope that out of each ethical investigations emerges criticisms and arguments by which disputes can be resolved and agreements reached. When that happens, the matter under dispute becomes a settled matter, and the pursuit of truth pushes the edges of enquiry on to matters still disputable.

As we become adept at the exceptions, syntax, and usage of FPA, we may never have to import anything except refine and *internalise* the original principles. That process extends beyond these pages: For the letter and spirit of FPA cannot be impressed from outside if it is not accepted from the inside. Acceptance includes a firm commitment to formalise the study of ethics by qualified ethicians and a combined effort, by the professionals and public, to set policies and see their effects percolate down to the grass roots. We know that re-injection of ethics into medical schools in the form of slogans or platitudes will end up as irrelevant as they were in the past. I am persuaded that we can and therefore ought to correct the folly of yesteryears with the amplified ideas already present in *ahimsa*, *upakaar*, *nyāya*, and *swarājy-ka-āadar*, which, of course, define our *paramadharma*. Anything less would seem to be unethical!

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5. For the purposes of this paper, I relied extensively, albeit not exclusively, on the internationally renowned text book, by Tom L. Beauchamp and James F. Childress: Principles of Biomedical Ethics, 7th ed. (2013).
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9. Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, 7th ed. (2013): 15-25.
10. D. K. Clouser; B. Gert. "*A Critique of Principlism*." Journal of Medicine and Philosophy 15 (1990): 232.
11. It is peculiarly an American concept (famously noted by SCOTUS Justice Cardozo (1870-1938), a by-product of its politics, culture and legislation. Insofar as it lifts the external barriers to exercise the power of free choice—that all rational beings antecedently possess—it is of immeasurable worth; but if it is pursued down the path of anarchic liberty, so that any emancipated adult may exercise her free choice to 'act' as she pleases, then it's of little worth.
12. When one thinks of India, one often thinks of Hinduism and *vice versa*. Hinduism's dominance and its presence since three millennia make its study both attractive and imperative to further our understanding of the question. Though over the years Hinduism splintered into more subdivisions than Christianity, Judaism, and Islam combined, it continues to exert its matriarchal influence and enjoy more attention and homage than any other native traditions.
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14. Dalitbahujans = Untouchables. Rechristened by Mahatma Gandhi as Harijans = Children of God. Dalitbahujans are about 16%, according to Navsarajan (Human Rights Organisation). When combined with Muslims, Christians, Sikhs, Buddhists, it is around 33%. Source: http://navsarjan.org/navsarjan/dalits/whoaredalits (accessed on 24 Jan2016).
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17. By extension medical students who, at 18 years, enter medical colleges with no background in logic + humanities.
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22. Cromwell Crawford, in his treatment of beneficence in Hindu Bioethics prefers the word *daya*; while Robert Florida used *karuna* for beneficence in his exposition of Lotus Sutra and Healthcare Ethics.
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24. Priyavrat Sharma, ed. Caraka Samhitha, 3 vols. (Varanasi/Delhi: Chaukamba Orientalia, 1981) 62-63.
25. Arti Dhand: Journal of Religious Ethics 30.3 (2002): 347-372.
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27. My commentary on Hindu moral particularity is not to be conceived as a key that unlocks sacred insights but rather as a discursive method by which we may unpack imbedded values that may be universalized. The contribution I hope to make is to communicate its fundamental insights in language and examples that have currency today, thus making them more accessible to the contemporary reader. After many readings of Hindu texts, much remained that I could not assimilate to our purpose and much remained obscure. Therefore, I will dwell on those ideas that I could expound clearly, defend as true, and put together into a coherent moral train of thought. For additional information readers are advised to refer to: Dumont, Louis. Homo Hierarchicus: The Caste System and Its Implications.

28. Wendy Doniger O'Flaherty, The Concept of Duty in Southeast Asia (New Delhi): Vikas Publishing (1978) 96-97.
29. The Nehru Report" (after Motilal) declared that the "first concern of Indians was to secure the Fundamental Rights that have been denied to them."
30. Unscrupulous clinicians-and there are plenty-have been quick to…. refer every patient with a headache or a backache for such scans, often without a detailed clinical examination (Pandya 40-44).
31. They also warn that FPA is not to be understood as the 'be all and end all' of medical ethics but as provisional principles upon which to build an ethical framework.