Mainstreaming AYUSH: an ethical analysis

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Abstract

The National Rural Health Mission has stated as one of its key mandates the mainstreaming of the Ayurveda, Yoga, Naturopathy, Unani, Siddha and Homeopathy (AYUSH) systems in order to help solve the human resource shortage in Indian healthcare. This has been planned at the primary level by providing training to AYUSH practitioners on primary care and national health programmes; at the secondary level by establishing departments of AYUSH in the district and taluka level hospitals; and at the tertiary level by establishing AYUSH centres of excellence as referral centres, and research, development and supervision points. The practical challenges to be considered include a gross divergence in the basic philosophy of practice; disparities in approach to specific clinical conditions; differences in their normative approach in decision making; an unclear policy for cross referral and problems of cross practice that could potentially rise in this condition. Mainstreaming of AYUSH into the existing public health system can have certain ethical implications: not doing good by failing to concentrate on the community value judgments about AYUSH; doing harm by a confusing plurality in approach and unhealthy segregation of practices without healthy dialogue between practitioners of either system; not disclosing which type of practitioners (AYUSH or allopathy) the patient is seeing; lack of proper public accountability mechanisms at the primary care and grassroots levels; and, finally, lack of social justice. These ethical issues have to be considered while mainstreaming AYUSH.

Background

India is increasingly faced with a human resource crunch in healthcare. In 2004, there was one doctor per 1,676 population in India while the World Health Organization norm for good quality healthcare is a doctor to population ratio of 1:600 (1). This, combined with the fast increase in population, has contributed to large disparities in healthcare access. A similar dismal situation exists for other cadres of healthcare providers such as nurses, nursing assistants and pharmacists.

Several countries have tried to work around this health human resource crunch at the level of primary health care by creating a cadre of community health workers. The 'barefoot doctor' movement of China was a standing example of how rural farmers could be empowered to provide high quality preventive and curative care at the village level (2). Similar health worker-led movements in Brazil, Thailand and Iran are working well (3-5). India has its own grassroots healthcare in the form of auxiliary nurse midwives, multipurpose health workers and, more recently, Accredited Social Health Activists (ASHA).

One potentially feasible solution to this human resource shortage in India is to mainstream alternative medicine practitioners. There are several alternative systems of medicine such as Ayurveda, Siddha, Homeopathy, Unani, Naturopathy, and Yoga in India. As of 2003, there were close to 500,000 registered practitioners of the Indian systems of medicine and Homeopathy (1). There are formal schools of alternative medicine which have systematic curricula and rigorous training in these streams. The National Rural Health Mission (NRHM) of the Government of India, which attempts to improve healthcare access across the rural areas of the country, has adopted as one of its key mandates the mainstreaming of these systems known collectively as AYUSH (6). In an effort to understand the ethical issues in mainstreaming AYUSH, we reviewed the literature and visited some centres in Kanchipuram district of Tamil Nadu where AYUSH and Allopathic systems are functioning in an integrated manner. We did four case studies and some interviews with AYUSH practitioners in the integrated setting. In this paper we will discuss the process of mainstreaming of the AYUSH system, realistic challenges to the process, and its ethical implications as understood in the background of these case studies and interviews.

Mainstreaming of AYUSH under NRHM

The rationale behind the mainstreaming of AYUSH systems under the NRHM was to strengthen the public health system in the country at all levels, by engaging practitioners of alternate medicine, as they have a good presence, especially in the rural communities, as well as good acceptability from a cultural perspective in the rural areas (7). The key strategies that were identified by the Government of India towards the process of mainstreaming were (7):

1. Integration and mainstreaming of the Indian systems of medicine and Homeopathy into the existing public healthcare system and the national health programmes;
2. Encouragement and establishment of Indian systems of medicine specialty centres;
3. Facilitation and strengthening of quality control laboratories for the AYUSH system;
4. Strengthening drug standardisation research;
5. Advocacy for AYUSH; and
6. Establishing sectoral linkages for AYUSH.

Feasibility analyses have shown that opening new exclusive AYUSH hospitals under the NRHM would not be sustainable (8). Therefore the NRHM planned to integrate AYUSH treatment systems, facilities and faculties into the existing healthcare system. AYUSH practitioners were to be appointed in the existing primary health centres, community health centres or block primary health centres. A National Commission on Macroeconomics and Health background paper has described integration of Indian systems of medicine into mainstream medical practice at three phases. In the first phase, all AYUSH doctors are to be trained in providing primary healthcare and in emergency obstetric and neonatal care. In the second phase, all district and municipal level hospitals providing secondary level care should have exclusive departments of AYUSH medicine providing specialised care. The third phase envisages tertiary level centres of excellence of AYUSH medicine providing specialised care, training and supervision. These centres should also be engaged in standardisation, quality control and research (8). The NRHM also emphasised that AYUSH practitioners should be involved in all national health programmes such as the Reproductive Child Health programme, Revised National Tuberculosis Control Programme, and other communicable disease control programmes for malaria, filaria, etc. It further specified that AYUSH doctors would be trained in primary healthcare and all national disease control programmes (7). This mandate for mainstreaming AYUSH implies the coming together of varied paradigms of practice.

Practical challenges

There are some practical challenges in the mainstreaming of AYUSH into the existing healthcare system.

First, the broad philosophical orientation of each system of medicine is distinct. Table 1 describes the various systems of medicine and their philosophical bases. For example, while the allopathic system addresses symptoms and treatment of causes of illnesses based on a biomedical model understood with the help of epidemiological investigations, the Ayurveda system largely operates on a holistic approach to illness (9) that balances the three *doshas* namely *vata, pitta* and *kapha* and places health in the larger context of social, economic, environmental, and psychological situations. This diversity in approach is very important to keep in mind while integrating the systems. While this difference pertains to only one of the AYUSH specialties, it is important to note that AYUSH itself comprises five very different specialties, thus leading to greater diversity. Philosophically divergent practices forced together without a common ground can mean chaos unless the systems are ready to evolve, gaining from their mutual strengths.

Notwithstanding these macro-level differences, there are also distinctions in the approach to specific illnesses. One such difference is explained in Case Study 1. Differences in approach in various areas of healthcare such as for chronic kidney disease, cancers, diabetes, etc., are well known. Such differences in approach for specific illnesses and hence the plurality of practice that arises in such integrated centres have to be kept in mind during the integration.

Case Study 1*: A 17-year-old boy came to the primary care clinic with complaints of nocturnal emission of semen. The elders at home had told him that the emissions would make him feel tired and drained out. He was frightened by this new occurrence and wanted to know if it was a disease. In such a situation, the modern medical practitioner is trained to inform this boy that what he is going through is a physiological phenomenon and there is no illness. The modern medical practitioner believes that once the boy's fear and ignorance are removed, the psychological feeling of tiredness and weakness will not occur. On the other hand, an alternative system of medicine, namely Siddha, views this as an imbalance in the naadi (pulse) and suggests medicines for the same (10).*

At least in the current form in which it is practised, the Ayurveda and Siddha systems largely derive their knowledge base from traditional wisdom, not supported by a body of evidence as understood by the allopathy practitioner. Though Ayurveda texts do describe several levels of evidence, they do not exactly match what allopathy considers as good quality evidence, namely randomised controlled trials (9). While the question of over-reliance on randomised controlled trials for evidence is the matter of a separate debate, it is important to address

Table 1: Various systems of medicine and their philosophical basis

System of medicine	Cause of disease	Approach to cure
Ayurveda	The body is made up of *pancha bhootas* (earth, air, water, fire and ether) and the imbalance between the three *doshas – vata, pitta and kapha* – leads to disease.	Re-establishing a holistic equilibrium between the three *doshas*.
Yoga and naturopathy	Five *kosas* or sheaths envelop the soul of the person. Disturbances in these *kosas* lead to disease.	The eight limbs of yoga – *Yama, Niiyama, Asana, Pranayama, Pratyahara, Dharna, Dhyana, and Samadhi* – are various techniques combined with diet modifications with natural foods, which cure illnesses by affecting the various *kosas*.
Unani	Disease is caused by imbalance between four humours phlegm, blood, yellow bile and black bile.	The three-fold approach is elimination of cause, normalisation of humours and of tissues and organs.
Siddha	Disease is caused by imbalances between *vatam, pittam* and *kapham*	*Pathya and Apathya –a* list of do's and don't s including diet, lifestyle and medicines –is prescribed for cure.
Homeopathy	The body is ruled by a spiritual vital force. Disturbance in this vital force is the main cause of disease.	*Similia similibus curentur* – substances which produce symptoms similar to the disease –are used in diluted amounts as a cure for the disease.
Allopathy	Diseases are caused by changes at the level of the organ involved, its structure or function.	Drugs containing molecules which counteract the effects of the disease at the cellular level can cure the disease.

the difference in normative evidence-based versus empirical approaches between the modern medical practitioner and the AYUSH practitioner.

Yet another significant challenge in the mainstreaming process that is currently advocated is that of cross referral of patients. The National Commission on Macroeconomics and Health background paper on integrative medicine does highlight some important illnesses where the AYUSH system seems to have better remedies compared to allopathy. This is a tentative and prescriptive list, but the area of understanding of each other's strengths and weaknesses is still nebulous and needs to be worked on for effective mainstreaming (8). One example where Ayurvedic treatment has a better remedy for an ailment compared to allopathy is the Ksharasutra therapy for anorectal anomalies. In allopathy, the treatment is surgical, with a chance of recurrence. The Ksharasutra treatment which comprises an alkaline medicated thread acts as an effective alternative treatment. Vaidya in one of his elegant expositions on this topic has addressed the important ethical issues in integration of practices. He points out the importance of cross referral, discussions between the Ayurvedic (interpreted here to represent all practitioners of AYUSH) and allopathy practitioners about patients and arrival at a common ground (11).

Legally, cross practice has been prohibited by the Supreme Court of India, where there is a clear direction that non allopathic practitioners may not practise allopathic medicine. This is also clear in the Code of Medical Ethics of the Medical Council of India clause 1.1.3, where it is stated:"A person obtaining qualification in any other system of Medicine is not allowed to practice Modern system of Medicine in any form."(12) The Common Review Missions of the NRHM have shown that AYUSH practitioners are practising Allopathic medicine in several states, including Uttar Pradesh, Chattisgarh and Bihar (13). Given that there is clear law prohibiting cross practice, its implications on mainstreaming have to be assessed.

Ethical perspective in mainstreaming of AYUSH

In healthcare, ethical principlism has been described with great erudition by scholars (14). Several frameworks have been described to assess the ethical veracity of public health interventions(15). Applying the outlines of any of these frameworks to the process of mainstreaming of AYUSH would yield a detailed ethical analysis. But it would be an inappropriate exercise as it would not be relevant to the specific contextual issues unique to this situation. Therefore, we propose to analyse the ethical issues in the process of integration of AYUSH into mainstream medicine under the following broad titles:

- Doing good,
- Doing no harm,
- Truth telling,
- Informed choice
- Mutual respect and trust
- Public accountability, and
- Social justice.

Doing good

While discussing the concept of 'doing good', it is important to clearly define 'good' with standards and criteria. It is also important to define the person / persons whose 'good' is being discussed. Some of the 'good's which are being considered in mainstreaming of the AYUSH system into the modern medical system are:

- Better access to good quality medical care in rural areas,
- Management of common minor ailments with traditional remedies, and
- Revitalisation and development of traditional systems of medicine

The above mentioned goods are accrued to the community at large. Apart from being beneficial to the individuals in the community, the fact that the community becomes empowered by its wealth of indigenous knowledge and wisdom also acts as a shared good for the community which cannot be attributed to individuals, but is a collective good (16).

But there is another angle that needs to be assessed. This is the issue of value placed by the community on different systems of care. In the Case Study 2 discussed below, with the rapid medicalisation and commodification of health that is rampant in the rural area from where the boy hailed, the value placed on a modern medical practitioner and her pills, injections and medicines, is much more than that placed on traditional medicines. Therefore it is important to bring local value judgments into consideration before making integration efforts.

Case Study 2: *A 10-year-old boy from a village had developed a cough, cold and fever since that morning. The father, who is a marginal farmer, took the boy to see the doctor in the nearest primary health centre. A Siddha doctor was running the outpatient clinic that evening. When the anxious father came to know that the treatment is going to be given by 'traditional doctor', he refused treatment and took the child to a private practitioner more than 10 km away from the village, in the nearest town. Not only was he unhappy about not getting the kind of care he wanted in the health facility near his home, he also had to spend money out of pocket to get the care he valued from a private practitioner.*

While discussing the practical challenges in the process of mainstreaming in the paragraph titled "Practical Challenges", some basic differences in approach, differences in normative processes and understanding of health and cure between the allopathic medical system and AYUSH were brought up. Some of these differences if not addressed appropriately could lead to significant harms to the community. For example, the 17-year-old boy who was presented in Case Study 1, who had the nocturnal emission of semen, was seen on the day of his index visit by an allopathy practitioner, who explained to him that nocturnal emission of semen is a normal process and indicate only that he is normally producing semen and allayed his immediate anxieties and scheduled a revisit for further counselling. During his second visit he happened to see the Siddha practitioner, who gave him a prescription of medications for imbalance in his *naadi*. The mere plurality in approach

confused this young man, and made him go to an unqualified practitioner for some other easy 'non-confusing' remedy. Any system of medicine largely works based on trust and faith, and this plurality in approach robs the system of that faith. This discussion is not a judgment on which system's approach to the treatment of this boy is correct. Rather it is a critique of the effect of plurality in approach on trustingconsumers of healthcare. The other area where significant harm could occur is in the context of cross referral of patients between the AYUSH and the allopathy systems. As yet, allopathy and the AYUSH system have not arrived at an understanding of their mutual strengths and weaknesses (8). There is no documented protocol for cross referencing. Case Study 3 is an example that explains this point.

Case Study 3: *A 28-year-old woman came to the primary care clinic with history of swelling of her legs. She was seen by the Siddha practitioner in the primary health centre and was started on some herbal remedies for reducing the swelling of her feet. She came for a revisit during which the swelling had reduced but she had developed a skin rash. The AYUSH practitioner continued the same medicine for some more days and added a balm for local application on the rash. About a month later she came back to the primary health centre with an emergency condition of breathlessness and severe chest pain. Her blood pressure was recorded and noted to be 180/100 mmHg (very high!). The allopathy practitioner assessed her this time and found her to have high levels of proteins and blood in the urine. More detailed evaluation revealed that she was suffering from a condition called Systemic Lupus Erythematosus.*

In Case Study 3, could a respectful cross referral and discussion of the patient between the two practitioners have led to an earlier diagnosis? Could it have salvaged her kidney, which is now irreparably damaged? These are valid questions to be addressed. Another situation is explained in Case Study 4.

Case Study 4: *A 23-year-old lady, who was a known asthmatic on various medications from the allopathic system for several years but all in vain, came to the allopathic practitioner, who gave her an inhaler medicine and steroid tablets to lessen the airway inflammation. The lady's marriage was fixed within the next six months and her mother wanted something to be done to cure her of the disease before the marriage. Fortunately the Siddha medicine practitioner happened to hear the conversation and offered to give the lady a trial of his treatment. The Siddha medicine worked very well for her.*

Should the lady in Case Study 4 have been referred much earlier for a trial of Siddha medicines? These case descriptions are not to bring out the inherent difference in approach of the AYUSH and allopathy systems, but to question which patients should be referred and when. This same quandary has been described by Vaidya in a previous paper on integration of systems of medicine (11).

Truth telling

During an informal interview with an AYUSH practitioner in a primary health centre, he said:

> Sometimes I give 'paracetamol' injections (to treat fever) to the patients who come to the clinic. The patients think I am the 'MBBS' doctor and expect me to give the injection. How can I refuse it? They don't understand that I am an 'AYUSH' doctor.

This made us realise the importance of truth telling in the practice of primary care. Though the law is clear that non allopathic practitioners cannot practice allopathic medicine, it is important to note that situations such as those described above can happen when AYUSH practitioners practice side by side with allopathic practitioners. Given the public's right to know who is treating them, whether an allopath or an AYUSH practitioner, and the public's right to chose where to get treatment from, this process of 'posing' as a specialist in another type of medicine is not only illegal but also acts to undermine the autonomy and rights of the public and its trust in the practitioner. On the other hand, if the public is clearly told who is treating them by clear segregation of the consultation rooms with appropriate name boards, it enhances the right of the patient to choose and fosters trust and faith.

Informed choice

There is a lot of emphasis on the process of informed consent for treatment in allopathic medical practice. There is an equally important need for provision of information in case of integration of allopathic practice with AYUSH. In the case studies 3 and 4, the choice of type of treatment should be left to the patient, after adequate information is given. The fact that certain illnesses respond well to certain systems of medicine needs to be identified and discussed with patients. The need for the allopathic practitioner to be open minded to AYUSH treatment has to be emphasised at this point. In order that the patient be provided the appropriate choice and be allowed to make the decision, both the allopathic practitioner and the AYUSH practitioner should know about each other's practice. They should be able to evolve a system of joint consultations for the benefit of the patient to facilitate informed choice.

Mutual respect and trust

The need for mutual respect between the allopathic and AYUSH practitioners is paramount. Unless they respect each other's system of practice and work as a team, there is a likelihood of the system becoming competitive and counterproductive. Mutual respect will also encourage cross referrals, as noted in case studies 3 and 4, and will benefit the patient. A trust deficit about AYUSH is another common phenomenon observed today among allopathic practitioners. There is also a trust deficit about AYUSH among the public. A trusting environment in the integrated practice with healthy interactions can foster public trust and enable the seamless integration of the systems.

Public accountability

Accountability of the system to the public is an essential component of the health system as it ensures community acceptance, involvement and participation. The NRHM has

incorporated several mechanisms for community accountability. Some of these are community monitoring of the programme; village health, water and sanitation committees which make the detailed village level health plan; and patient welfare societies (*rogi kalyan samitis*) at the level of the primary, secondary and tertiary care facilities which will govern the functioning of the facilities (7). Such accountability mechanisms are now largely restricted to the allopathic system. The document on mainstreaming of AYUSH does mention the establishment of patient welfare societies for AYUSH hospitals at the district and tertiary care levels (6). But there is no mention of accountability at the level of integrated care at the primary and secondary levels. Though there is a clear mention of training the ASHA in AYUSH, the village health plan does not emphasise AYUSH. AYUSH should also be made a part of the village health plan. Unless it is integrated at the grassroots level, there is no scope for proper public accountability of the AYUSH practitioner. For better evolution of the public accountability mechanism, there is also a need for active advocacy about AYUSH at the village level and health worker level. Unless patients know what they are getting, how can we expect them to question it?

Social justice

Justice is a difficult concept to understand in the context of public health. Several philosophers have defined justice in different ways. But one popular way of understanding justice in the public health context is by asking the following questions (17):

- Will this act benefit some people more than others in a biased way?
- Will this act harm some people more than others in a biased way?
- Will the balance between benefits and harms be distributed in a similar manner among all people?
- Who will decide whether there is justice and how will they decide that?

It has to be acknowledged here that there are several other aspects of justice which need to be addressed, but this is a simplified version of what justice is. Applying the process of mainstreaming AYUSH into the modern medical practice through these questions, we can arrive at some normative decisions on the justice of this process.

Some empirical studies have shown that the elderly, women and persons with long term illnesses mostly access AYUSH compared to men and younger individuals (18). The most common reason cited for using AYUSH by these groups is the fact that AYUSH is less expensive than allopathy, especially in the public health system, because of its reduced reliance on expensive laboratory investigations, which the allopathy practitioner gets done from private laboratories to support her/his treatment process. When the reason for making a choice of one system compared to the other is not purely based on the merits and demerits of the system per se, but on the affordability, justice cannot be said to exist.

Taking ethical steps forward

While integrating AYUSH and mainstreaming it into the healthcare system in India, some of the important measures that need to be considered are:

At the institutional level:

1. Clear role definitions of AYUSH practitioners and allopathy practitioners in their treatment of patients, in their mutual interactions, and in community accountability mechanisms is important. This should include the process of proper identification of allopathy and AYUSH practitioners by patients, understanding of the limits and restrictions of each other's practice boundaries, and establishment of specific accountability mechanisms for each system.
2. Establishment of protocols for interactions and referrals between the allopathy system and AYUSH, stemming from a proper discussion and understanding of their mutual strengths and weaknesses.
3. Ongoing standardisation and quality control of AYUSH treatments and procedures.
4. Building a strong traditional knowledge database and a strong evidence database for AYUSH remedies by high quality research.
5. Building an ethos of trust and mutual respect between AYUSH and allopathy practitioners.

At the community level:

1. Obtaining community acceptance by accountability, transparency, necessity, and justification.
2. Active advocacy about AYUSH and integration of AYUSH and allopathy in the community.
3. Providing ample opportunities for patients to make a fully informed decision about the type of care they want.

In summary, paying proper attention to the ethical perspectives in integration of AYUSH into mainstream medical practice is very important for taking correct public health decisions. It is understood that this cannot be an overnight process. Protocols and regulations can be a starting step. This has to be supplemented by active research, development, standardisation and advocacy at the policy and the grassroots level.

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Patients' rights in India: an ethical perspective

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Abstract

Patient autonomy is affected by a number of factors, including severity of illness, socio-economic status and dependence. Many patients find that they are not treated with due consideration and compassion, and also have no control over their own care.

In this article, we consider whether the Code of Ethics Regulations of the Medical Council of India protects patients' rights, by comparing the code with the charter of patients' rights of the Consumer Guidance Society of India. We then look at other developments in protecting patients' rights and the need for further work in this area.

Introduction

The low doctor-population ratio in India puts a tremendous strain on the available medical facilities and restricts the time available for doctors to interact with patients. There are thus valid reasons why doctors do not explain in detail to the patient, the diagnosis, the treatment planned, or expected prognosis. However, not providing such information to patients is a clear violation of their rights.

The Universal Declaration of Human Rights (1) grants us the right to life, liberty and security of person (1: Article 3). Additionally, we as human beings also have the right to a standard of living adequate for the health and well being of oneself and one's family, including food, clothing, housing and medical care" and the right to support during the period of illness, disability, unemployment etc (1: Art. 25). The Declaration recognises "the inherent dignity" (1: Art. 1) and the "equal and unalienable rights of all members of the human family" (Preamble). In general terms, this implies that all humans, irrespective of gender, age, education, state of health or economic condition enjoy these rights. It is on the basis of these undeniable human rights that the rights of patients are based. The World Health Organization (WHO) defines patients' rights as those owed to the patient as a human being, by physicians and by the state (2). Patients' rights vary in different countries and are influenced by the patients' status, family, society and country-related factors.

The patient's right to have a say in his/her own treatment depends upon the model of physician-patient relationship. There are four models of physician-patient relations which define the rights that patients enjoy and the extent to which they do so (3). In the paternalistic model, the physician adopts the role of a decision maker and decides what would be good for the patient. In the informative model, the physician acts as an information source, and decision making is in the hands of the patient. The interpretive model has shared decision making; the physician helps the patient to interpret complex