Abstract

This paper is the first of two that set out to explore issues that arise at the interface between globalised systems of biomedicine and bioethics on the one hand and non-western traditions of medicine, healing and ethics on the other. At this interface, fundamental questions of relativism and context are in evidence. Here we offer a preliminary overview of these questions in relation to medical education in Sri Lanka and attempts by local scholars to develop curricula that incorporate indigenous traditions in ways that are both appropriate and realistic. In the paper, we argue for approaches that go beyond simply accumulating and juxtaposing knowledge of different traditions. The strategy we advocate takes the experience of the medical student as the starting point for pedagogical enquiry into different ethical traditions with an emphasis placed on their translation, evaluation and comparison. The promise of such an approach is a bioethics that makes beneficence, respect for life, honesty, truthfulness, dignity and respect central.
but, through on-going dialogue, connects these values to the local moralities that inform all cultures of healing and care.

**Keywords**

Medical Ethics, Cultural Relativism, Sri Lanka, Buddhism, Ayurveda
Introduction

Medical ethics has a long and distinguished genealogy. Its origins are typically linked with the Greek physician Hippocrates in the fourth century BC who, through the oath that he is reputed to have devised, committed generations of doctors to a profession built on beneficent practice. Needless to say, swearing by Apollo, Asclepius, Hygieia and Panacea and all the other gods and goddesses of the Greek classical pantheon is no longer de rigueur. However, the durability and transposability of this touchstone of human concern and the commitments to health, healing and human well being that physicians are required to foreswear have proved remarkable. In many parts of the world the Hippocratic oath continues to provide a kind of charter that broadly indicates what physicians should expect as proper conduct for their profession (Jonsen 1999). It is also invoked as the guiding principle of more recent refinements of codes of medical ethics. A seismic event in this regard was the atrocities committed in the name of medical science under the Third Reich. Recognition of the appalling nature of the activities of Nazi scientists resulted in an international inquisition and the Nuremberg Code (1947), a set of principles that would enable subsequent generations of scientists to judge for themselves, and in the work of others, just what constituted morally acceptable treatment of human subjects. This code in turn was led to the Declaration of Helsinki 1964 (World Medical Association) and its subsequent revisions (1975, 1983, 1989, 1996 and 2000). It has continued to be endorsed by such globally influential organizations as the Council for International Organizations of Medical Sciences and the World Health Organization. Following the events, which led to the formulation of the Nuremberg Code, the beneficence of doctors was increasingly complemented by a second pillar, the moral agency of the patient, encapsulated in the notion of autonomy. It
was not enough that doctors were simply exhorted to do good but in the analytical bioethics which has largely superseded medical ethics, patients should be empowered to place their own checks on medical power through the use of informed consent procedures (Volpe 1998).

Given that western biomedicine is now practised on a global scale, it is not surprising that this tradition of medical ethics and its subsequent evolution into bioethics is similarly ubiquitous when it comes to regulating practitioners and protecting users. Indeed, the brief history outlined above has taken on canonical status and finds its ways into the normative teaching of medical students the world over, both as a paradigm for professional practice as well as the source of broad guidance for how to proceed in particular cases.

Much ink has been spilled in trying to clarify the status of ethicists in relation to biomedicine in the West: is bioethics an integrated and essential complement to biomedical research and practice or a parasitic meta-discipline that physicians could easily do without? It is not our intention in this paper to engage with the extensive debates that underpin such positions but to pose a set of different but related questions. These concern what happens when this tradition is set down in contexts that are manifestly different in social and cultural terms from those in which these traditions have developed; specifically, that is, in contexts outside the Euro-American anglophone orbit. Moreover, given that such contexts are not devoid of traditions of ideas which also address fundamental questions regarding the human condition and what constitutes appropriate conduct in the face of suffering and its relief, we consider what place, if any, local traditions might have within the broader scheme of biomedical ethics outlined above? The context in which we set out to explore these questions is that of contemporary Sri Lanka. On the one hand, Sri Lanka is a country with a long and established tradition of western biomedical practice and teaching (Uragoda 1987). On the other
hand, the Island has a rich mosaic of religious traditions (Buddhism, Hinduism, Christianity and Islam) and ethnic groups (predominantly Sinhalese and Tamil). Considering the relationship between a western-inspired tradition of medical ethics and the form and consequences of its implementation is, we believe, pertinent for at least three reasons. First, it comes as part of a growing recognition that, when it comes to medical ethics, the hegemony of the western tradition may not be entirely sustainable. Recognition by physicians and biomedical researchers that they necessarily practice in socially and culturally diverse settings is a fact of life for which the tools provided by a conventional reading of biomedical ethics may be ill-equipped to deal (Turner 2003). Second, there is a growing recognition that the traditional relationship between ethics and medicine is inadequate to cope with the issues raised by the burgeoning possibilities for medical intervention. Developments in biomedicine and biotechnology mean that doctors can no longer play the role of humble servants in the face of malfunctioning nature but become capable of a range of interventions that extend beyond what was hitherto thought to be naturally ordained. Progress in genetics, pharmacology, organ transplantation, pre-natal testing and the technology of life support, to name but a few, all serve to muddy the distinction between doing good and doing harm. Medical practice can no longer operate in a comfortable world of paternalistic beneficence but must negotiate the growing incursions of technology, business, research and the market in medical practice. To assist in the decisions that have arisen as a consequence, medical doctors and researchers have increasingly drawn on that field of specialization referred to as bioethics. Third, at the point where social and cultural diversity intersects with the proliferation of biotechnology and the increasing sophistication of biomedicine, there is a growing expectation that science and society are engaged in a kind of coproduction (Jasanoff 2004). The implication of society in scientific practice and
progress is apparent in the growing expectation that there will be moni-
toring, surveillance, public consultation and participation in decision
making, and explicit attempts to anticipate and manage risk in relation to
 technological and therapeutic advance (Nowotny et al 2001). Increasing-
ly, the expectation of sensitivity towards different cultures and traditions
is being added to this list. In short, we are seeing something of a para-
digm shift. Whereas the last century was characterised by an increasing
medicalisation of society and the growth of medical power and autho-
 rity, the present one is showing a turn to the socialization of medicine
and attempts to render it both appropriate and accountable to its diverse
public. Just as these aspirations are being voiced in relation to medical
practice, they are also heard in relation to the ethical superstructures that
govern them.

However, rethinking aspects of western medical ethics as they are
delivered in the context of contemporary medical education in Sri Lanka
is not to produce an ethics rethought, that is, one reconstructed root and
branch (cf Nowotny et al 2001). This would be a massive and, ultimately,
impossible task. Our ambitions in this paper are both modest and rea-
listic. What we offer are the fruits of a conversation that has taken place
over several years between a social scientist, a medical microbiologist, a
Buddhist philosopher and a UK-based anthropologist. In this conversa-
tion, questions of cultural difference, relativism and the teaching of me-
dical ethics have been brought together for critical examination.¹

Cultural Difference, Relativism and Bioethics

The questions we seek to answer have a resonance in the context of
biomedicine for the simple reason that medicine is socially permeable in
a way that other aspects of science are not (Pickstone 2006). There is a
fundamental connection between the most advanced therapies available
to physicians on the one hand and the elementary and mundane forms of pain and suffering on the other. This is not a connection that is easily overlooked by physicians or their patients and one which renders it vital to ask the question of how ‘local moral worlds’, to use Kleinman’s phrase, are factored into the use and advancement of biomedicine (Kleinman 1995). However, whilst the question is a familiar one, it is often broached in rhetorical fashion only and is rarely engaged with in any analytical depth within the western tradition, let alone from outside it. Part of the reason for this somewhat selective focus is that proper analytical engagement requires an awareness of context, which in turn requires a shift away from abstract moral reasoning and into what is often feared as the ticket of cultural relativism and the mire of ethical nihilism that lies beneath (Macklin 1998).

Some years ago, the anthropologist Clifford Geertz attempted to characterize this negative and fearful response (Geertz 1984). In so doing, he identified a widespread and pervasive anti-relativism emanating from those immersed in the master narratives of science, medicine, law and philosophy. From these quarters there is often a deep suspicion when culture is invoked for this inevitably implies a variability of human action and endeavor that is difficult to encompass within overarching moral paradigms. Geertz contrasted this view with his own ‘anti anti-relativist stance’ in which he advocated the ever-present possibility of nuance in human action and interaction. Our own ‘anti anti-relativist’ stance is similar in that we are not advocating an each-to-his-own anarchy of beliefs and values but a dialogue around the facts of cultural difference. Let us illustrate this with reference to a paradox that is evident in the ‘making’ of doctors in Sri Lanka:

1. The tradition of biomedicine is firmly established in Sri Lanka. The Colombo Medical School opened in 1870 and is the second oldest in
Asia (Uragoda 1987). Until the mid-1950s the School was partly staffed by teachers from the UK and only became entirely run by local doctors after the mid-1950s. There is still a widespread expectation that clinical post-graduate medical training will take place abroad and typically in the UK. Despite recent changes in immigration laws in the UK and Europe, which have resulted in some relocation of training in the Asia-Pacific region, Sri Lankan doctors tend to travel north rather than south. In short, there is still a strongly Europeanised medicine taught and practiced in Sri Lanka.

2. In learning to practise western allopathic medicine, Sri Lankan doctors also acquire the ethics that goes with this tradition.

3. The population that comes under their medical care is one that, whilst culturally heterogeneous, is South Asian in outlook, values and ethos. Particularly in rural areas, this ethos is likely to be manifest in distinctive ideas about fate, suffering, death, responsibility for others and theories about the body and how it works, to name but a few.

4. Doctors themselves are also increasingly likely to be drawn from out of such contexts and into medical education. This is particularly so, as access to medical training has been widened beyond an English-speaking urban bourgeoisie. These students may well experience something of a re-orientation during their medical education in which values with which they grew up, and which may be at odds with the normative medical ethics they imbibe, are gently expunged. The result is that Sri Lankan doctors and students trained in Western medicine are either unaware of the ethical ideas in indigenous medical, and cultural systems, or have experienced their
devaluation in the face of western biomedical authority (see Arseculeratne 1980, unpublished ms).

5. This schism is likely to have been reinforced by a firm polarization of education into the Humanities and the Sciences from the secondary school level onward. In Sri Lanka, this has resulted in an exaggerated form of what C.P. Snow described in his 1959 Rede Lecture as the ‘Two Culture’ problem. Put simply, there is a lack of awareness of indigenous literatures, cultures and histories on the part of those who follow the science route.

6. There is an important upshot of these paradoxes when it comes to medical practice. Sri Lankan medical practitioners who have been inculcated into the ethical frameworks of western biomedicine might be inclined to overlook local social and cultural sensibilities. Blindness to these local nuances is likely to have serious consequences when it comes to effective medical practice given that understanding and communicating with patients is integral to the therapeutic process. In the doctor-patient relationship, there may be tensions arising from an encounter in which there is at best an ethical parallelism or at worst a complete discontinuity (cf Francis 1993 who makes a similar point in relation to the Indian context). In short, doctors may be acting ‘ethically’ within the western canon, but, in so doing, this may restrict the possibilities for them to respond in ways that are culturally appropriate (Simpson 2004).

It is this sequence of observations, and particularly the final point, that leads us to the conclusion that it is important to consider where something like an ‘indigenous bioethics’ fits within the delivery of medical education in Sri Lanka. However, such an assertion raises two other
crucial questions. First, what do we mean by an indigenous bioethics and second, how might this be incorporated into medical education?

What do we mean by ‘indigenous bioethics’?

In Oct 2005 the 33rd session of UNESCO adopted by acclamation the Universal Declaration on Bioethics and Human Rights. This short document sets out to provide a set of ‘universal principles’ in relation to bioethics and nothing less than ‘a foundation for humanity’s response to the ever-increasing dilemmas and controversies that science and technology present for humankind and the environment’. Article 12 of the Declaration on Bioethics and Human Rights refers to ‘respect for diversity and pluralism’ and states: ‘the importance of cultural diversity and pluralism should be given due regard. However, such considerations should not be invoked to infringe upon human dignity, human rights and fundamental freedoms, nor upon the principles set out in this declaration, nor to limit their scope’. The Declaration, as with many of its predecessors, attempts to square a very familiar circle, that is, to make claims which have universal validity whilst acknowledging that, where religion, culture and moral values are concerned there are competing and sometimes contradictory authorities in play which necessarily have to be acknowledged and encompassed. Yet, raw facts of culture as evident in feelings, emotions, perceptions and attitudes are not easily subordinated and, as in the biblical story of the tower of Babel, a project that holds the promise of higher unity begins to be founded on the fact of human cultural diversity.

Bioethics as a kind of Babel manifests in a number of ways. First, there are the voices of those who point out that there are differences in the philosophical underpinnings of different traditions. Attention is drawn to legitimate ethical perspectives originating outside the western
tradition. Edmund Pellagrino, a noted professor of medical ethics, for example, suggests that:

Western values, however, may be strongly at odds with worldviews held by billions of other human beings. Those billions ... may be drawn more strongly by the spiritual and qualitative dimensions of life. Their ethical systems may be less dialectical, logical, or linguisti
c in character, less analytical, more synthetic, or more sensitive to family or community consensus than to individual autonomy, more virtue-based than principle based. (Pellegrino 1992)

A similarly philosophically inspired reflection is offered by Hall who, as a teacher of medical ethics and the history and philosophy of science at the University of Malaya, found western philosophy ‘excruci
catingly narrow and unsubtle’ when it comes to teaching ethics:

It seems to be founded on shifting epistemological stands as one school of thought comes into vogue after another. It is narcissisti
cally concerned only with Man and reflects Nature not at all. It is a procedure of intellec tion rather than of realisation. It is often insuffi
ciently appreciative of Man’s social nature.

Transition from intellec tion to action has always been a central con
cern in Eastern/Asian ethics ... The task of translating ethical prin ciples into good living has never become peripheral to its philosophy, so that the dilemma which seems to confront Western Moral Philo
sophy today – how ‘oughts’ can be felt as practical imperatives – has not been experienced in Eastern/Asian moral discourse. (Hall 1987)
Broadsides have also come from sociologists eager to point out that bioethics as practised in many parts of the western world is often disem-bedded from the social contexts in which it is most vigorously applied. One of the most trenchant critiques is provided by Fox and Swazey:

Mainstream American bioethics is ethnocentric, individualistic, secular and has atomistic presuppositions vs ‘holistic’ understand-ings of ‘medical morality’ found in various communities around the world. (Fox & Swazey 1984)

Critics from within the western tradition have been complemented by critiques from without. For example, Sakamoto wishes to take the position beyond philosophy in his attempt to root differences in essen-tialised notions of culture and identity:

Bioethics in the East Asian region might be fundamentally different from the Western pattern in its cultural, ethnological and also philo-sophical basis, reflecting present day multi-cultural post-modernism. (Sakamoto 1999)

The recent introduction of the European idea of human rights cau-sed moral, ethical and political conflicts among Asian societies ... Generally speaking, Asians hold a holistic way of thinking instead of the European individualistic way. Therefore Asian people put a higher value on the holistic happiness and welfare of the total gro-up or community to which they belong rather than their individual interests ... Western philosophy introduced ‘personal identity’ which remains invariant through all possible changes as a human being. This idea of invariance is somewhat foreign to the traditional Asian ethos. This is one of the most significant differences between
Asian and Western ways of understanding Nature and human being. (Sakamoto 1999)

None of Buddhism, Confucianism, or Taoism etc., have a concept of individual human rights, but rather the weight of consideration given to the whole, the family, neighbourhood, community, society etc., is heavy. (Sakamoto 2002)

In the attempt to bring Western bioethical presuppositions to bear in local contexts, it is apparent that there are places where things do not quite seem to fit. From Pakistan, for example, questions are raised about the ideas of personhood which lie at the core of ethical reasoning:

Thus bioethics practices such as autonomy, full disclosure of terminal diagnosis, advance care planning or informed consent in both clinical and research setting(s) may be in conflict with religious or cultural practices. (Aasim Ahmad, 2007, see also Moazam 2000)

Similarly, divergent ideas of death and personhood, have led to conflicts over the reception of bioethical ‘norms’:

... up until 1997, Japan resisted the idea that brain death represents the end of a person’s life, the usual explanation for this unusual standpoint – which effectively ruled out heart transplantation in Japan for almost three decades – has been that many Japanese believe that a dead person’s body may be inhabited by a soul even after death, and do not like the thought of a family member’s dead body being ‘invaded’ for the removal of organs or tissues. (Takebe, 2000; also see Lock 2002);
Such critiques tend to highlight the philosophical underpinnings of the western tradition and contrast these with a philosophical ‘other’ which is variously labeled as ‘Asian’, ‘African’ or simply ‘indigenous’ and which tends to be all that the former is not. To summarise, the emerging contrast goes something as follows: a western-originated bioethics exhibits a morality preoccupied with the individual, is built on abstract and analytical principles and tends towards rules and rights. By contrast the philosophical ‘other’ is taken to be holistic, somehow closer to the people who make up society and focused on the morality of actions and results. Furthermore, implicit in the above quotes, it would seem that the philosophy of the ‘other’ is complemented by assumptions about a sociality of the ‘other’. The philosophies in question place explicit emphasis on individuals who are caught in webs of relationality (families, kindred and communities) rather than as reified individuals. It would seem that this orientation renders autonomy and agency an uncomfortable apparel to wear, whereas paternalisms of one kind or another, presumed to be so actively resisted in the west, are comfortable and consistent with the wider local ethos. However, there is a danger in these formulations. Built as they are on simple and seductive binaries, it is all too easy to conclude that Westerners prize their autonomy above all else and Asians are collectivists who like nothing better than to submerge their identities in marriage, family, and community.

Embracing such stereotypes, however, can prove as unhelpful as proceeding in ways that are blind to culture and context. There can be a tendency to ‘read off’ from the outward signs of ethnicity, religion or culture how people will think and, indeed, feel. Thus, Chinese people will do ‘this’, Moslems think ‘that’ and secular westerners will do the ‘other’. Ultimately, Bioethics falls prey to a kind of ‘balkanisation’ (Baker 2003) in which each group has its ethics, and the quest for solutions to real and particular problems become obscured by the aspirations of
different collectivities for distinction and identity.

For example, the Thai social scientist Deepadung implies a kind of bioethical apartheid:

Metaphysical and epistemological foundations are noticeably different (between East and West) and attempts to integrate the two systems would encounter un-resolvable difficulties. (Deepadung 1992)

This never-the-twain-shall-meet approach taken to its logical conclusion would result in a carnival of fundamentalisms, each seeking to align its particular ethical, religious and cultural orientations in response to biomedical advance. Not only would such efforts run against the grain of global movements of people, information and ideas, it would also make the Babel of bioethics an obstructive reality.

What then are the alternatives? On a somewhat more optimistic note, An-Naim, a Sudanese law professor, points out that comparability of traditions and their reconciliation is not only possible and desirable but absolutely essential:

Culture matters to globalisation, to economic and social rights, and to civil and political rights because the very idea of rights is a cultural construct ... We have to take culture seriously, so that what we say at these meetings and what we do as human rights activists has resonance, relevance and efficacy in producing changes in our respective societies. What I have seen, among both activists and scholars, is a reticence to engage the cultural issue because of fear of opening the door to relativism. In the final analysis, there is no alternative to reconciling elements of our respective cultures with human rights norms. (An-Na’im 2005)
In other words, to pursue the Babel analogy a little further, humanity might have been left with different languages but we at least have the possibility of their translation from one to another and the benefit of the trans-cultural dialogues that ensue. It is an obvious fact that cultures are different; they are comprised of diverse histories, ecologies, polities, religions and are subject to complex and ongoing admixture. The challenge for the comparative bioethicist, like all translators, is to engage the imagination, artistry and compassion that all acts of translation require. In other words, it is not enough to merely to make the observation that there are speakers of different languages but to recognise the need to develop those skilled in their translation.

An indigenous bioethics?

Before going on to discuss the implications of this observation in the context of Sri Lankan medical education we highlight the places where Sri Lankans might typically look for an ‘indigenous bioethics’. In other words, what are the points of translational engagement?

The main sources of guidance for medical practitioners would be drawn from the Island’s own traditions, noting that this is located within a wider Indian literature describing the ethics of traditional forms of medicine such as Ayurveda. The oldest of these texts is the Atreya Anushashana followed by the Charaka Samhita (600BC) and the Susrutha Samhita of about the same time (Francis 1993). These texts all made specific recommendations regarding the ethical behaviour of medical personnel, including such areas as: beneficence towards the patient and his or her family; the giving of health and relief of suffering; obtaining consent before giving treatment; maintaining confidentiality; avoiding pursuit of material benefits; having proper deportment, attire, and behaviour; being restrained in one’s desires; avoiding misconduct. In
these ancient treatises, the virtues to which physicians should aspire are clearly comparable to the Hippocratic Corpus, yet reflect particular cultural orientations such as the awareness of the patient’s wider family “listen to and act suitably even to others: if it be for the benefit of the patient” and the recognition and concern that relief of suffering is not restricted to humans (You shall pray for the well being of all creatures day and night; you shall endeavour to relieve their suffering with all your heart and soul).

The first book of Ayurvedic medicine to be compiled in Sri Lanka was the Sarartha Sangarava attributed to King Buddhadasa (362-409 AC). Subsequently, other works dealing with medical practice appeared such as the Bhesajja Manjusa and the Vaidyacintamani Bhesajja Sangarava written by Buddhist monks in between the 13th and 15th centuries (Uragoda 1987). Indeed, Buddhist monks played a significant role in the development of traditional medicine both as practitioners and authors of treatises and manuals. Not surprisingly, the relief of suffering is central to Buddhist practice and the Vinaya Pitaka gives guidance to monks in their ministrations to the sick (Paranavitana 1954). Elsewhere in the Vinaya Pitaka the following is stated

... Buddha has exhorted the monks to attend on the sick ... : He should be able to prescribe; he should know what is good and what is not good for the patients; he should wait upon the sick out of love and not out of greed; he should not revolt from removing evacuations, saliva or vomit; he should from time to time administer religious consolation to the patient.

This ethic is rooted in a deeper Buddhist philosophy which it is worthwhile briefly elaborating upon.

According to the ethical teachings of Buddhism, there are two principal grounds on which the moral rightness or wrongness of an
action is to be determined. One ground is the beneficial consequences of the action on the agent as well as others affected by the action. (Majjhimanikāya Vol. 1, p. 415; 2. p.114; Anguttaranikāya Vol. 1, p. 189 Pali Text Society, London). The second refers to a principle which is comparable with the ‘Golden Rule’: not doing to others what one would not want done to oneself (Saūyuttanikāya Vol. 5, p. 354 Pali Text Society, London).

The moral precepts for both lay persons and monks in the Sri Lankan Buddhist tradition are derived from these two guiding principles for ethical behaviour. The minimum requirement of morality in the case of the lay person consists of the non-doing of harm by observing strictly the five precepts of abstaining from killing, stealing, lying, sexual misconduct and taking intoxicating substances. The corresponding positive moral virtues to be cultivated for the promotion of one’s own well-being and that of others are (1) love, sympathy, concern and care regarding all life forms, (2) honesty in all one’s dealings with others, (3) truthfulness, trustworthiness and reliability, (4) purity of conduct relating to the enjoyment of sense pleasures (5) maintaining a healthy and unconfused mind, which is not debilitated by substance abuse. The moral precepts for the Buddhist monks go far beyond these minimum requirements because those who adopt the lifestyle of a Buddhist monk are expected to renounce all mundane patterns of behaviour that feed the three roots of evil, greed, hatred and delusion. (A full account of the morality expected of the monk is given in Dighanikāya Vol. 1, pp. 63-69 Pali Text Society, London). It is to be noted that the Buddhist precept against killing or causing injury to life applies not only to the life of human beings, but also to all sentient beings (Metta Sutta, Suttanipata verses 146 ff.).

As in the wider Asian philosophical tradition, Buddhism does not confine its ethical concerns to the narrow sphere of human interrelationships, but extends it to relationships between humans and the natural world. The consequence of such an extension is the recognition of hum-
an moral duties towards lower animals and correspondingly, recognition of their moral rights in Buddhism.

In Buddhist ethics, more attention is focused on the psychological sources of human action than the external act itself. Ethically unwholesome behaviour is considered as proceeding from certain states of mind described in Buddhism as the roots of evil (akusalamula). Action that is productive of harm to oneself and others is explained as a behavioural manifestation of the three roots of evil, (1) greed or lust, (2) illwill or hatred and (3) lack of insight or delusion. Morally right actions are a behavioural manifestation of the opposite states of mind, non-greed, non-hatred and non-delusion. These are often stated more positively in the contexts of Buddhist ethical teachings as action proceeding from a mental attitude of (1) self-sacrifice, sharing or charitableness, (2) of compassion, sympathy, sympathetic joy and equanimity (3) of understanding, insight or wisdom (Majjhimanikaya Vol. 1, p. 46 Pali Text Society, London). A deontological standpoint characteristic of an authoritarian commandment theory of ethics or of an ethical intuitionism that subscribes to absolute rules cannot be justified on the basis of the Buddhist ethical teachings (Kalama Sutta – Anguttaranikaya Vol. 1, p. 189 Pali Text Society, London). Questions regarding what is ethically right and wrong should be determined on the basis of a critical and balanced application of the two grounds specified above taking into account all the relevant facts of a situation that demand a moral decision.

The fact that the primary concern of Buddhism is the alleviation of human suffering immediately aligns its goals with those of medicine. According to Buddhism there is a considerable proportion of human suffering that could be averted through the ethical transformation of human beings. This is true not only in the general conduct of humans in their day-to-day social interactions but also in their social interactions involving the performance of specific roles and functions. The ethical
teachings found in Buddhism are aimed at alleviating human suffering in every conceivable situation achieving the desirable kind of ethical transformation. One cannot expect to find an established code of medical ethics in traditional Buddhism (except in the Vinaya Pitak quoted above). Profound ethical insights could be drawn out of the general ethical principles implicitly contained in the Buddhist teachings and usefully applied even in the context of contemporary biomedical ethics.

**How might an ‘indigenous ethics’ be incorporated into medical education?**

Up until this point, discussions have taken place at a rather abstract level. In this penultimate section we turn to a discussion of the fundamental question of how indigenous ethical perspectives might usefully be brought into local medical curricula. We would suggest that any such strategy might be thought of in terms of two distinct levels:

First, is the relatively simple endeavour to make students aware that there are other possibilities when it comes to ethical values and reasoning. Notwithstanding the extremely pressing question of how to find space within an already crowded medical curriculum, making students aware that western traditions of bioethics are not the only ones that have considered the relationship between suffering and intervention and that there are others that may have been overlaid and obscured. These are medical traditions, such as those described above which have wide currency beyond the medical profession in Sri Lanka in particular and across South Asia generally. Making reference to the bioethics that are built into such traditions is not only to alert students to other ethical ‘languages’ but to highlight the extent to which they themselves embody their own indigenous traditions. As we have seen, the Ayurvedic tradition, places its own distinctive emphasis on ethical obligations...
towards patients and their own prescriptions regarding the desirable traits of doctors’ mannerisms, character, attire and professionalism (Francis 1993).

Attempts to incorporate traditions from the region and to present them alongside the more canonical principles of western bioethics begin to be visible in parts of the medical curriculum in Sri Lanka. For example, in the Faculty of Medicine, at the University of Ruhuna, a wider perspective on medical ethics is delivered in two courses i) History of Medicine, an introductory course for new medical students initiated in 1981 and ii) Medical Ethics, initiated 1995 (Anoja Fernando 2007; Also see Arseculeratne and Babapulle 1996). In the Ruhuna courses the life and work of Emperor Asoka of India are covered; according to historical sources, King Asoka rose to greatness through bloody conquest. However, having established his empire, he is recorded as trying to run it based on the highest moral and humanitarian values and in accordance with Buddhist teaching. These courses counter-balance teaching about the Hippocratic Oath with reference to documents such as the Code of Hammurabi (Babylon 2000 BCE) and Buddha’s advice concerning the five characteristics of the good physician given in the Vinaya Mahavagga. (6th Century BCE). Students are invited to compare the Hippocratic Oath with documents such as the Charaka Samhita and the work of Rhazes (Islamic philosopher and physician 869-925 ACE).

Placing references to indigenous bioethics alongside mainstream bioethics might represent a kind of progress but, mere juxtaposition does not begin to harness the full potential of different traditions. To do this we would suggest that there is another level, which reflects more closely on the relationship between self, action and its consequences. In other words, the most effective route to the consolidation of ethical ideas in a student is to use his or her own conditioning as a kind of lens through which to view the actions and experiences of others. Indeed, Buddhism
might offer some students the potential to facilitate this kind of reflection through its elaboration of a ‘situation ethics’. Premasiri, for example, has observed that “…there are no absolute moral commandments in Buddhism. Buddhism affords a core of moral values and principles which is open to constant examination and evaluation by the moral agent on the basis of his or her own observation and experience” (1996). Essentially, the thrust of ethics in Buddhism is experiential and not analytical.

Similarly, this approach to ethics teaching has important implications for the styles of teaching in use:

Both the responsibility as well as the opportunity of improving the standards of medical ethics are associated with the clinical components of the undergraduate curriculum in medicine in which the example set by the teachers, rather than didactic teaching, could have a more profound and lasting impact upon student perceptions and attitudes. (Arseculeratne 1995)

In short, awareness of ones’ social environment and the ways in which values and orientations are shaped therein makes it clear that there are ‘languages’ to be translated and moral orders to be negotiated rather than a simple choice between two apparently divergent traditions: one familiar but obscured, the other alien but highly visible.

We would suggest that bringing these different traditions together in practice could provide an important tool for helping doctors to become the kind of reflexive practitioners that are needed to work effectively in societies that are pluralistic and rapidly changing. For example, taking some of the directives arising from the treatises and guidelines referred to above, it would be instructive to ask students to triangulate between their own responses to an ethical dilemma, the principles laid out in an indigenous bioethics and the widely embraced principles of western
bioethics. Such strategies would counter the tendency of bioethical reasoning to decontextualise the dilemmas it attempts to resolve and, furthermore, to help identify the crucial distinction between convergence at the level of metaethics, or what Rawls referred to as an ‘overlapping consensus’ (Rawls 1993), on the one hand, and divergence when it comes to normative ethics on the other. Taking the ‘four principles’ of bioethics (Beauchamp and Childress 1989), we lay out a few of the issues that might be considered as opportunities for medical students to test their own experience against maxims drawn from East and West:

- Non-maleficence: The idea that physicians should first do no harm, the *primum non nocere* maxim, is one that also features in Asian as well as European traditions. Yet, in both contexts, terminal illness and the decision to withdraw treatment has often resulted in serious conflicts when it comes to this principle. In Ayurvedic medicine, the idea is stated that ‘as long as the patient breathes, so long provide treatment’; however, as Francis notes (1993) there was an opposing instruction: ‘withdraw treatment in the moribund patient’. As Francis suggests, it may be possible to reconcile these two positions by making a distinction between treatment and care; the former might be withdrawn (because it is futile) whereas the latter continues (in order to provide relief from suffering and possible comfort). Yet, for the medical student, what would these debates look like in context? Is the distinction between treatment and care one that is meaningful in the contemporary Sri Lankan setting. Should patient understandings of death and what follows influence the way that the physician responds to the wishes of the patient and his or her relatives? How do advances in lifesupport technology play out in this context?

- Beneficence: the idea that the doctor will always act in the best
interests of the patient is also shared by both traditions. However, beneficence is a notion that has been criticised as paternalistic and potentially in violation of a patient’s autonomy – the doctor might not always know best! (Veatch 1995). In the Susruta Samhita, there is a clear endorsement of the power of the physician (Francis 1993): ‘the patient may doubt his relatives, his sons and even his parents, but he has full faith in the physician. He gives himself up in the doctor’s hand and has no misgivings about him’. This stance is reinforced from within Buddhism which exhorts individuals, and physicians in particular, to acts of charity, humaneness, loving kindness, sympathy, compassion, equanimity, endearing speech, and service to others. However, how is the powerful rhetoric about a physician’s persona and practice translated into contemporary practice? What are the limits of beneficence? Where does the power and authority of the medical practitioner end and the autonomy of the patient begin?

• Autonomy: Perhaps one of the most contentious issues for a cross-cultural bioethics to address is that of autonomy and the notions of informed consent, privacy and confidentiality used to realise it in practice. In the Asian context, different ideas of personhood and relationship are likely to be in play. In confidentiality, the eastern concepts go beyond the patient to include the family (I. Goonaratne, 2007, personal communication). Likewise the need for doctors to observe privacy is also acknowledged in the Charaka Samhita: ‘do not reveal to others what goes on in patients’ households’ (Francis 1993). Yet, for doctors practising in Asian contexts, balancing expectations is a major practical challenge. On the one hand is a received bioethical wisdom which presents a highly individualised reading
of autonomy expressed through informed consent. On the other hand, patients see themselves as suspended in webs of family and community relationships which gravitate away from such individualised statements. Given these competing orientations, how should the desires of the patient be accommodated into consent procedures? What are the sentiments of kinship and obligation that underpin patient’s decision-making under these circumstances?

Justice: Finally, the question of fairness in the distribution of health care is of profound importance in circumstances where resources are limited. Sri Lanka is no exception in this regard. Statements about non-maleficence, beneficence and autonomy are rendered entirely secondary for doctors and their patients if their encounter takes place in a context in which medication and treatment is not available or unaffordable. Both traditions have fine aspirations for the achievement of welfare and the relief of suffering at a societal level. However, what are the current political and economic arrangements, intra-nationally as well as internationally, for the distribution of resources? What role can doctors meaningfully play in achieving justice in the move towards the realisation of justice and welfare that is both effective and sustainable?

As stated earlier, this paper is the product of a conversation that has been ongoing for several years and, indeed, will continue beyond this essay. Our primary aim has been to consider the relationship between culture, ethics and medical education in Sri Lanka. We have touched upon major and perennial questions of cultural relativism and how one squares the circle of universal principles which, perforce, have to be put to work in diverse cultural and social contexts. We have identified medical education as a key context in which processes of contextualisation
and translation need to take place and offered some preliminary thoughts as to how awareness of different cultural traditions might be brought more effectively into contemporary medical education in Sri Lanka.

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NOTES

1. This paper is the first of a pair of papers dealing with questions of relativism and cultural context. The second introduces a comparative and empirical element by way of an analysis of survey data collected in the UK and Sri Lanka regarding attitudes towards ethical dilemmas thrown up in relation to contemporary biomedicine and biotechnology.

2. The Tower of Babel, described in Genesis 11:1-10 of the Bible, was intended to reach from earth to heaven but its construction was prevented when God introduced different languages to those who were building the tower: 'Therefore is the name of it called Babel because there did the Lord confound the language of all the earth and from thence did the Lord scatter them abroad upon the face of the earth'

3. The Buddhist king Buddhadasa who lived in fourth century Sri Lanka is credited in the Pali Chronicle literature with the administering of a cure through surgery and medication the abscess suffered by a snake (Culavamsa Chapter 37, vv. 112-121)

4. It is important to note that, in ancient times, responsibility for health and well-being was made explicit in Buddhist notions of a just political order. It is the duty of the ideal universal monarch, the Cakkavatti ruler, to provide watch, ward and protection to humans as well as to birds and beasts (Cakkavattisihanada Sutta Dighanikaya). The Buddhist emperor Asoka of India adopted this as a policy in his state as indicated in his rock edicts. Asoka’s edicts say that everywhere in the lands conquered by Asoka “two systems of cure, cure for men and cure for brutes” were instituted and herbs useful for men and brutes were planted (Piyadasi Inscriptions Kalsi Edict II, edited and published by Ramavatara Sarma, Muradpur, Patna 1915).


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