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Ethical Practice of Ayurvedic Medicines: A Mixed-Methods Study of Practitioner Knowledge, Attitudes, and Systemic Safeguards

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Abstract

Background: Ayurvedic medicine is widely used in India and globally. Expansion of use highlights ethical issues — standards of education and practice, transparency of evidence and advertising, patient informed consent, pharmacovigilance, and commercialization. International and national frameworks (WHO benchmarks; India's AYUSH pharmacovigilance programs and NCISM regulations) guide practice, but empirical data on how ethics are implemented at the clinician and institutional level are limited.

Objectives: To evaluate (1) knowledge and attitudes of practising Ayurvedic clinicians regarding core ethical domains (informed consent, advertising/claims, safety monitoring, continuing education, and conflicts of interest), (2) institutional adoption of WHO/NCISM safety and educational benchmarks, and (3) barriers and facilitators to ethical practice.

Methods: Cross-sectional mixed-methods design. Quantitative component: a nationally stratified online survey of 600 registered Ayurvedic clinicians (BAMS/MD/clinical faculty) assessing knowledge, attitudes, self-reported practices, and pharmacovigilance reporting behaviour. Qualitative component: 25 semi-structured interviews with clinicians, regulators, and pharmacists; and document analysis of institutional policies from 20 Ayurvedic hospitals/colleges.

Results (summary): In a simulated illustrative sample (n=600), 42% reported routinely documenting written informed consent; 28% had ever submitted an adverse-event report; 61% reported confidence in distinguishing evidence levels but only 23% regularly disclose evidence limitations to patients. Thematic analysis revealed barriers including lack of time/resources, incomplete institutional policies, and commercial pressure.

Conclusions: Gaps between policy benchmarks and clinical practice suggest the need for strengthened curricular ethics training, mandatory AE reporting with simplified tools, standardized consent templates, and enforcement of truthful advertising.

Keywords

Ayurveda, ethics, pharmacovigilance, informed consent, WHO benchmarks, NCISM, regulation, mixed-methods

1. Introduction

Ayurveda — a traditional system of medicine originating in South Asia — continues to be widely practised and is increasingly integrated with mainstream health systems. The World Health Organization published Benchmarks for the Practice of Ayurveda (2022) to provide minimum technical requirements for education, practitioner competency, and safety. In India, the Ministry of AYUSH and implementing bodies (including the National Commission for Indian System of Medicine, NCISM) have developed regulatory frameworks and a national pharmacovigilance program for ASU&H drugs to monitor safety and misleading advertisement. Despite these frameworks, real-world adoption of ethical practice elements remains uncertain.

2. Methods

Study design: convergent mixed-methods study, combining a national survey of Ayurvedic practitioners with interviews and institutional document analysis.

Setting and participants: The survey targeted BAMS/MD clinicians, stratified by region, practice setting, and urban/rural. Interviews included clinicians, regulators, and pharmacists. Institutional policies from Ayurvedic hospitals were reviewed.

Measures: The survey assessed knowledge of benchmarks, attitudes towards ethics, self-reported practices, and AE reporting behaviour. Interviews explored experiences, barriers, and facilitators. Document analysis identified presence of SOPs.

Data analysis: Descriptive statistics and logistic regression for survey data; thematic analysis for qualitative data; integration in joint interpretation.

3. Results (Simulated Data)

Sample characteristics: n=600; mean age 38.6 years; 58% male; 68% BAMS, 20% MD, 3% PhD, 9% others.

Primary outcomes: 42% routinely documented written consent; 28% had ever reported an AE; 23% disclosed evidence limitations; 39% screened for herb–drug interactions; 31% had formal ethics training.

Predictors: Postgraduate qualification was associated with higher odds of consent documentation. Hospital practitioners were more likely to report AEs.

Qualitative themes: (1) Resource constraints, (2) Inadequate SOPs, (3) Commercial pressures. Document analysis showed few institutions with formal consent or AE reporting SOPs.

4. Discussion

The study highlights a gap between WHO/NCISM policy benchmarks and real-world Ayurvedic practice. Written consent and AE reporting rates are low, and evidence disclosure is inconsistent. Structural and cultural barriers contribute. Recommendations include SOP implementation, consent templates, simplified AE reporting, and curriculum reform.

5. Conclusion

Bridging policy and practice is essential for ethical Ayurvedic care. Steps include standardized consent procedures, streamlined AE reporting, curricular reforms, audits, and advertising enforcement. These measures can protect patients, support professionalism, and strengthen trust in Ayurveda.

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