MEDICAL ETHICS IN INDIA

Introduction

Ancient Indian legal thought, philosophy and ethics developed with a rational synthesis and went on gathering into itself, new concepts. The fundamental basis of ethics arises from the Hindu belief that we are all part of the divine Paramatman.

The ultimate aim is for our atman to coalesce with Paramatman or Brahman to become one. According to the Vedas, the call to love your neighbour as yourself is “because the neighbor is in truth the very self and what separates you from him is mere illusion.” Closely allied to Hinduism are Jainism and Buddhism. These religions proclaim ahimsa as Paramodharma, the most important of all our action is ahimsa, non-violence. Patanjali defined ahimsa as Sarvathra Sarvada Sravabutanam anabhidroha a complete absence of ill-will to all beings.

Ayurveda is the ancient science of life. It lays down the principle of management in health and disease and the code of conduct for the physicians. Charaka has described the objective of medicine as two fold: preservation of good health and combating disease. Ayurveda emphasized the need for a healthy life style, a teacher of Ayurveda who established the science on the foundation of spirituality and ethics was Vagbhata, the author of Astanga Hridaya. Vagbhata says, “Sukarthah Sarvabutanman, Matah Sarvah pravarthayah, Sukham Cana Vina dharmat, thasmaddharmaparo bhavel” (All activities of man are directed to the end of attaining happiness, whereas happiness is never achieved without righteousness. It is the binding duty of man to be righteous in his action).

1. Vedas (400 BC to 1006 BC)
3. Ibid.
Charak Samhita prescribes an elaborate code of conduct. The medical profession has to be motivated by compassion for living beings (Bhutadaya). Charaka’s Humanistic ideal is evident in his advice to the physician. He who practices not for money or for caprice but out of compassion for living beings is the best among all physicians. It is hard to find a conferrer of religious blessings comparable to the physician who snaps the snares of death for his patients. The physician who regards compassion for living beings as the highest religion, fulfils his mission and obtains the highest happiness. Brace Jennings has observed that moral decision making within medicine is becoming increasingly institutionalised and subject to formalized procedures and constraints across a broad range in the landscape of contemporary medicine, such as human subject’s to research, organ procurement and transplantation, assisted reproduction, the rationing of health care and the forgoing of life sustaining treatment.

Thus science and medicine are increasingly drawn and driven into ethical debate which raises the clash between scientific method (small, step by step approaches and trial and error and answering small questions) and philosophical, mental, physical and ethical questions. Such rules are increasingly institutionalized; they are embedded in statutes, regulations, directives, court opinions, administrative mandates and institutional protocols. In decisions regarding terminal care, the rules inform about counseling and educational mechanisms, encouraging patients and their families to engage in treatment and discussions and to give prior statements about wanted and unwanted treatment.

This ‘embedded’ quality has important relationships with the kind of that ethical concerns and the way in which they are expressed. Jennings agrees there has been an important recent shift away from epistemological relations about the relationship between a rational, knowing subject and a rationally knowable, objective morality as

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7 See the Discussion of Laws J at first instance in *R v Cambridge HA expB (AMinor)* (1995), 23 BMLR, 1 p.16
8 Re Ak (2001) 58 BMLR
the primary focus of ethical theory, towards an approach which aims to understand morality “as a sociality embedded practice.” These transformations have important consequences for the ways in which we conceptualise and even describe the setting of a legal framework and the establishment of ethical standards for regulating scientific and technical societies. Medical ethics can be defined as follows.

**Medical Ethics**

This is a field which separates a legal obligation from a moral obligation and the relationships expect the confidence of fiduciary duty of the doctor to his patient. The reasons underlying the need for confidentiality are complimentary. First, if those who are sick do not trust doctors to maintain the information they disclose in confidence, they will not approach for treatment. It is particularly important in case of an infectious disease like infection with the *Human Immunodeficiency Virus* (HIV). The doctor must also believe that the patient has given the whole history of their disease, otherwise, risks may arise, as the doctor may reach a wrong diagnosis and prescribe a wrong treatment.\(^9\) The legal duty is not absolute and is subject to modification. On analysis of the cases which help to shape and delimit the law in this area shows the importance of the patient’s disclosure of full information of the patients in the public interest. The individual’s private interest is given comparatively little prominence.

**Understanding Medical Ethics**

From the date of creation of the Hippocratic Oath ethics has played an important role. By dealing with the beginning, and end process of human life, medicine and medical law are rendered ineluctably ethical in nature. Law is connected to medical law and medical ethics. Morality is sometimes explicitly incorporated into legal doctrine and it is unavoidably incorporated with the law in the ethical controversial issues raised by medical care system.\(^{10}\)

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Medical law is inseparable from medical ethics. We will not be able to understand medical law without understanding the ethical tensions in play.

1. Theories of Medical Ethics

The main theories of Medical Ethics are Moral relativism, Moral objectivism and Moral pluralism, Utilitarianism, Right–based theories and duty based theories, Virtue Ethics, Compromise Positions. The knowledge in philosophy of Medical Ethics and the detailed analysis of these theories are necessary. The first theory is Moral relativism moral objectivism, and moral pluralism.

A. Moral Relativism Moral Objectivism and Moral Pluralism

There are two diametrically opposed views about the validity of moral beliefs. On one hand the moral objectivists, who hold that moral beliefs are capable of being objectively valid in the sense of being true or false, or capable of being rational or irrational. On the other hand the moral relativists, who hold that moral beliefs are not capable of being objectively valid. According to moral relativists all moral theories are based on truth or rational relativity. Denials of moral values can be objectively true or rational when made by those who deny all moral knowledge and those who wish to claim that moral values are relative to a particular culture or individual.\(^\text{11}\)

Moral beliefs do, in fact, differ from person to person, culture to culture, and generation to generation. Some issues seem to attract almost as many ethical views as view holders. Moral objectivism holds that many beliefs are wrong. It does not imply that every moral question must have a single uncontroversial answer.\(^\text{12}\)

The reality of pluralism need not be over emphasised. Even in large secular societies moral consensus is quite common. If it were not, no stable polity could exist. English legal doctrine encompasses many moral values shared by the majority of the population. In the developed-world, consensus can be seen in international instruments such as the Helsinki declaration\(^\text{13}\) and the innumerable human rights

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11 http://www.jme in/124hl/126 htm/ visited on 4th March 2010
12 Ibid.
13 The Helsinki Declaration is a set of principles for medical research on human subjects issued
instruments that pepper the international arena. These instruments proclaim the universal nature of moral values such as respect for patient autonomy and the democratic process. There is no universally accepted ethical theory, and no consensus on the underlying ethical principles or their application. It is better to examine the five major groups of moral theories Utilitarianism, Duty-based theories, and Right based theories, Virtue ethics and Compromise positions. The second theory is Utilitarianism.

**B. Utilitarianism**

Utilitarianism is a collection of moral theories that are morally required to seek the best possible balance of utility over disutility. Classical or hedonistic utilitarianism is the most famous version that requires seeking of maximum pleasure over pain. All forms of utilitarianism invoke a calculus in which the relevant interests of all individuals count equally. This commitment to equality has led to the common association of utilitarianism with the phrase “the greatest benefit to the greatest number.” This association is somewhat misleading, because the difference between utilitarianism does not stop with the difference in classical and preference utilitarianism. Faced with the objection that utilitarianism roughshod over widely accepted moral norms and requires endless utility evaluation, and another version appeared requiring to adopt rules that generally achieves the best utility balance. This version, known as rule- utilitarianism, seeks to answer concerns that act-utilitarianism creates uncertainly, is impractical, and can result in what are generally considered abhorrent conclusions. Standard act- utilitarianism can have a difficult time considering the consequence of every act. Imagine a doctor faced with a number of patients in need of life saving donation of organs and tissues in circumstances where there is a suitable but unwilling potential “donors” from whom such

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14 Ibid.

15 See, Gandyour and Lauterbach 2003 for a brief summary of many popular versions of utilitarianism.
tissues can be removed relatively safely.\textsuperscript{16} For an act of utilitarianism to set on maximising utility, and the permissibility of removing some tissue (say, a single kidney, a liver segment, some bone marrow, and some blood) to save the lives of four patients will be designed on the overall utility balance of so doing.\textsuperscript{17} The utility of saving four patient’s lives is likely to be very high, especially where those patient’s contribute to the lives of others. High enough that in some circumstances the disutility of using an unwilling “donor” could be oughtweighed. Image, for example, that the donor patient’s has no loved ones, needs major surgery for an unconnected purpose, and is unlikely to complain about any mistreatment, in circumstances where many of the participating medics could be kept in the dark to protect them from any feeling of guilt. Utilitarian have presented many responses to such difficult and controversial consequences balancing. Rule-utilitarianism, adopting rule that track the best utility balance, rather than evaluating all individual acts, avoid the needs for such calculations and the possibility of concluding that removing these organs is permissible.\textsuperscript{18}

Utilitarian are unified by acceptance of at least four tenets. First, utility is nor itself a moral property. Utility is defined as something non-moral (such as pain or preferences), rather than something that is itself inherently moral (such as rights or duties). Second, principle is to achieve the best balance of utility over disutility. It is the supreme principle of morality. Third, individual interest can be meaningfully added together (for aggregation or averaging) and compared. Utilitarianism holds that it makes sense for A,B, and C’s interest to be added in some way and weighed against the interest of D. In classical (pain/pleasure) utilitarianism, it is possible to aggregate the suffering of the four patients in need of life saving tissue to outweigh the suffering of the unwilling donor patient. Fourth, what matter are the predicted consequences to the utility balances and nothing is intrinsically good irrespective of its consequences.\textsuperscript{19}

The third theory is right based theories and duty based theories.

\textsuperscript{16} See further Harris 1975 and Thomson 1985 and 1976. Thomson considers situations where numbers also cause initiative difficulties for right and duty- based theories

\textsuperscript{17} \textit{Ibid.}

\textsuperscript{18} \textit{supra, n.10}

\textsuperscript{19} \textit{Ibid}
C. Right Based Theories and Duty Based Theories

Both right based and duty-based theories are based on the interest of individuals rather than the collective. Unlike utilitarianism, they do not allow aggregation or averaging of individual interest. They are distributive rather than aggregative. What matter is the weight of the relevant right or duty, not the number of persons involved? It follows that, unlike many versions of utilitarianism, if everything else is equal, the combined moral claims of a large number in need of wart removal cannot outweigh the claim of someone dying of heart disease.

The difference between right based and duty based theories rest on the availability of the benefit of any moral obligation. Right based theory hold that all moral obligations reduce to the moral rights, understood as justifiable claim imposing correlative duties, the benefits of which are available to the rights- holder. Right are justifiable claims against unwanted interferences (negative right) or justifiable claims for wanted assistance (positive rights), or both. In contrast, duty-based theories are do not automatically entitle the recipient of the duty to waive its benefit, in the sense of releasing the duty- bearer from his obligation. Duty- based theories are thus more compatible with paternalism. For some this distinction is one within right-theories a distinction between the will (or choice) conception of rights and the benefit (or interest) conception. This is simply a matter of terminology. Care must be taken with labels.

All right and duty- based theories must deal with conflicting between rights and duties. There can be only one absolute right or duty. The conflict between them creates as insurmountable impasse. A patient confides to his physician that he has an overwhelming desire to kill his girl friend. If the physician has a duty to

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20 Supra, n.57
21 Some theorist equate waving the benefit of a right (ie, the duty that is correlative to the right) with waiving the right itself. There is, however a conceptual difference. The difference turns on whether it is possible to waive one’s claim to being a right- holder (which waiving one’s right would imply). Thus, used the narrower expression to allow for those theories holding that individuals cannot posses the properties of a right holder without possessing rights. See eg. the theory of Gewirth (1978)
22 This was the situation faced by the psychotherapist in the California case of tarasoff v Regents of the University of California (1976) 131 cal. Repr 14
keep the confidence of his patient and a duty to protect innocent people from being harmed by a dangerous patient (i.e., there is a conflict between the right of the patient and the right of the patient’s girlfriend) both duties (rights) cannot be of equal weight. This means that all such theories require a hierarchy of rights or duties, which in turn requires an objective criterion ranking those rights or duties. The fourth theory is Virtue Ethics.

D. Virtue Ethics

Virtue ethics rejects all action based on moralities— including utilitarian, rights based and duty based theories in favour of character-based values. 23 Such positions reject the idea that of judgment of duty and obligation to perform the right action, or moral rules and principles are the most basic moral concepts. Instead, ethics is understood to be primarily concerned with character and virtuous traits. Virtuous traits are held to be intrinsically good and, typically, linked with human flourishing (assessed according to some “objective” criterion). In this, way virtue ethics contrasts with action based moralities, for which a virtuous character is simply one predisposing towards actions consistent with one’s moral obligations. For virtue theory, virtuous character traits are not dispositions that are merely instrumental to compliance with moral rules or principles, and are dispositions about feeling, reaction, and acting that are in some sense intrinsically valuable or linked to human flourishing.

Virtue ethics is an ancient Greeks philosophy placed in the work of Aristotle. Different version offer different criteria of value. What virtuous a doctor must have and adheres to if he is to be virtuous varies from theory to theory. According to Hursthouse, three tenets unify such theories; an action is only moral right if a virtuous persons would choose that action, a virtuous person is one who has or exercise virtues, and the virtue tracks human flourishing. 24 To have any Practical application,


virtue theories need to tell us how to recognize virtuous person or virtuous traits. Even then, virtues ethics do not aim to provide universal rules or principles like the principles of utility (the aim is not to maximize virtuous conduct) or those associated with rights and duty based theories. The fifth theory is compromise positions theory.

E. Compromise Positions

Compromise Positions, is a collection of moral positions drawing elements from the other four. These positions are rarely foundationalist and usually adhering more closely to the ethical reasoning of a layperson. It is essentially a miscellaneous category, capturing almost innumerable moral positions, not all of which are coherent. Some consider rule-utilitarianism to be a compromise position because of its reliance on general rules even where the strict application of the principle of utility requires a different conclusion.

The classical compromise position in medical ethics is represented by the ‘principism’ of Beauchmp and Childress.25 These two authors advocate four principles of biomedical ethics. Their position explicitly seeks a compromise between overarching deep moral theory and practical ethics by adopting element of utilitarianism, right and duty-based theory, and virtue ethics. Beauchamp and Childress make no claims to foundationalist grounding for these principles. Nonetheless, ‘very few critics argue that any one of the four principles is incompatible with his or her preferred theory or approach to biomedical ethics.’ 26

‘Beauchmp and Childress’ principles are intended to act as rules of thumb, providing a checklist of ethical issues to consider when evaluating a medical issue. The problem is that just about all contentious medical issues can be understood as conflict between one or more of these principles. Consider, for example, the question of whether it is permissible to allow living persons to voluntarily sell their organs.

26. Ibid.
Beauchamp and Childress do not directly address commercial dealing in human organs, except to say that it is ‘appropriate to consider potential donor’ motives, at least to the extent of investigating whether financial gain is the motivating factor’. This issue raises a conflict between, at least, two principles. On the one hand, the principle of autonomy tells us to respect the autonomous decision of the person who wishes to sell, say, a kidney or a liver segment. On the other hand, the principle of nonmaleficence tells the doctor not to inflict harm on a patient by removing an organ where there is no medical indication for its removal. The resolution of this conflict must either revert to deep theory or rely on the idiosyncratic, contingent institutions of the decision maker. The main problems relating to Medical Ethics are explained as follows.

11. Problem Area Relating to Medical Ethics

There are some conflicting areas relating to medical ethics like Informed consent, Disclosure of information, Confidentiality, Patient’s autonomy, Euthanasia and Organ transplantation. For the clear understanding of this problem a detailed explanation is necessary. The first controversy is relating to informed consent.

A. Informed Consent and Medical Ethics

There is a general belief among doctors in India that it is not possible to get informed consent because of rampant illiteracy. They believe that patients are unable to make reasoned choice because they could not appreciate the intricacies of alternative medical treatment, procedures or drug trials and so, often a paternalistic view is taken “The doctor knows best.”

In contrast every human being has a right to determine what shall be done with his or her own body. A Surgeon who performs an operation without the patient’s consent commits an assault for which he is liable. 27

What is the ancient teaching in such circumstances? Charaka advises the physician to take into confidence the close relatives, the elders in the community and even the State officials before undertaking treatment which might end in the patient’s death. The physician is then to proceed with the treatment.

In India, great trust is reposed to the doctor, but now more and more people are questioning the practice. Trust based on the ‘goodness’ of the doctors is slowly vanishing and giving way to the concept that making the decision is the right of the patient. Patient’s consent is relevant in this context.

The Patient Consents

People would quarrel with a doctor who by disclosure information has withdrawn form his duty in confidentiality. In this context the patient would be entitled to know what, and how much, information is being disclosed and; to whom it was being disclosed. So disclosure of information is another problematic area in Medical Ethics and disclosure of information also attracts conflicts.

Disclosure of Information

In Canada\(^{28}\) and many of the American States the courts have imposed a high obligation upon a doctor to disclose information about a proposed medical procedure in order to understand the patient’s right to a rational choice whether to undergo the procedure. This reflects good medical ethics.

In England, majority of the judges decided that the proper standard of disclosure must be followed by “reasonable doctor,” in the treatment process. This was decided in White House v. Jordan\(^ {29} \) and also in Maynard v. West Midland RHA.\(^ {30} \) In normal circumstances, the Surgeon who complied with a practice accepted by a responsible body of the profession would not be negligent.

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Lord Scarman, disagreed with the other, Law Lords, in dismissing the plaintiff’s appeal, but applied the Canadian and American cases of *Reibl v. Hughes* 31 and *Caterbury v. Spence*. 32 Lord Scarman held that, the legal standard of disclosure was not to be measured with the standard of the medical profession, although that would be relevant, instead it was to be judged by the risks of a “provident patient.”

Even though Sidaway affirms the existing law and its significance, the Law Lords recognised that if a patient asks questions, in the word of Lord Bridge, the doctor’s duty must be to answer both faithfully and as fully as the questions require. 33 Lord Diplock thought that in such a case “the doctor could tell (the patient) whatever it was he wanted to know” 34 more than, if he sits back and waits in the consulting room for the doctors to volunteer information. If the doctor is satisfied that the question is seeking out information and not simply reassurance he is required to tell the truth the whole truth and nothing but the truth.

The requirement of full disclosure is strange in view of the “therapeutic discretion” recognised by the Law Lords, The obligation not to harm his patient-ethically, the principle of non malice is as potent in both cases, although the harm which might result must be clearly foreseen and be of a serious nature.

Sidaway, recognised this defence for a doctor and authority for this is derived from the case *Lee v. South West Thames RHA*. 35 Sir John Donaldson M.R, recognised the power to withhold information. His Lordship said, the duty to disclose is subject to the exercise of clinical judgment as to the terms in which the information is given and the extent to which in the patient’s interest’s to that information should be withheld. 36

32 (1972) 464 F 2nd 772. The development of the law in the United States can be seen in the excellent report of the Presidents Commission entitled, Making Health Care Decision (1982), volume 3, Appendix. L
34 *Ibid*
35 [1985] 2 All ER 385
36 *Ibid*
In *Blyth v. Bloomsbury Health Authority* 37 Leonard J. held that a health authority was negligent when a doctor employed by them and had not informed a woman patient fully of the side effects of the contraceptive drugs; *Depo-provera* was administered by injection, after she had requested for the information. The judge relied upon the views of the Law Lord’s in *Sidaway* where the court declared the duty to answer if “truthfully and fully”. His Lordship found that had the patient been made aware of the risks, she would not have consented to the injection. In allowing the Health Authority’s appeal, the Court of Appeal 38 held that there was no obligation to disclose to the patient all the available information. The court held that the doctor’s obligation must depend upon the circumstances, the nature of the inquiry, the nature of the information which was available, its reliability and its relevance.

*Sidway* may prove significant concerns of Lords Bridge’s reluctance to leave the standard of disclosure wholly to the medical profession. 39 His Lordship held 40 “even in a case where…. no expert witness in the relevant medical field condemns the non-disclosure as being in conflict with accepted and responsible medical practice … the judge might in certain circumstances come to the conclusion that disclosure of a particular risk was so obviously necessary for an informed choice on the part of the patient that no reasonably prudent medical man would fail to make it.”

Lord Bridges overrides the expert evidence of accepted professional practice counter to statements made in *White House v. Jordan*, 41 and *Maynard v. West Midland RHA* 42 and in the classic statement concerning treatment and diagnosis of M.C Nair J in *Bolam v Friern HMC* 43 case. These statements should be looked in the context they were made. All decisions taken by doctor’s concern within the exclusive competence of the medical profession, and with these matters the court should not act

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39 Supra, n.33

40 Ibid.

41 Supra, n. 29

42 Supra, n. 30

43 1957) 1WLR 582 applying in the dictum of Lord Clyde in the Scottish case of Hunter v. Hanley 1955 SLT 213
as if evidence of any common and approved practice was determinative. 44

It is difficult to imagine the sort, of cases where practice will not be

determinative.45 The example given by Lord Bridge is based upon the fact of Reibl v. Hughes 46 that a patient who is not told about “substantial risk of grave adverse consequence” such as 10 percent, risk of a stroke inherent in an operation is an extreme one. In Reibl the non- disclosure was one that was not even in compliance with professional practice. It is more difficult to think of a situation where the medical professional practices without disclosing of such risk unless on a cogent clinical reason. Lord Bridge recognised and justified non- disclosure about the substantial risk.

To Tell or Not to Tell.

According to Charaka and Susrata, the physician must be careful in disclosing to the patient the incurable nature of his illness. It should not be told bluntly.47 It may shock the patient, and it is preferably made known to the patient’s relatives. Treatment of a heroic nature is also to be undertaken only with the consent of the patient’s relatives.

Present-day doctors differ in their opinion about when to tell the truth, and how much to disclose to the dying patient. There are many conflicting interests like the patient’s right to know; the benefit to the patient and possible harm.

(a) Arguments against Full Disclosure

There are four main arguments against full disclosure. The first is that there is an ethical and professional obligation not to injure the patients. Some information would cause harm to patients for example by causing distress or anxiety, in which

44 It has been suggested that the medical profession has not evolved practice of disclosure or non-disclosure of risks unlike treatment and other technical matter. This would make the whole legal notion compliance with professional practice in this area nonsense see J Kenedy 47 MLR 454 (1984)
45 Ibid.
46 Supra, n.31
47 Bhattacharya NL, Susrata Samhita, University of Mysore, Mysore ,1973
case the doctor is compelled to withhold it. There is no doubt that some kinds of knowledge may cause harm to patients.\(^{48}\)

The second argument, which is an extension of the first, suggests that the doctor/patient relationship is like a contract, with an implied warranty that the doctors could act for the best interest of their patients, and do no harm. As part of the contract, patients give the doctor, the authority to make decision on their behalf.\(^{49}\)

The third argument is the inability to understand. The doctor is entitled to withhold information because disclosing it would serve no purpose and the patient would not be able to understand what was told. Of course, some medical information may be highly technical, but the patient’s concerns are essentially human.\(^{50}\)

Fourth argument against disclosure is pragmatic that it is impractical to tell a patient absolutely everything about the risks, benefits and alternatives involved in the treatment. There is no time to do so. A general practitioners appointment lasting about 10 minute is not enough to discuss everything which the patient might think is relevant. In addition, from the doctor’s point of view it is a horrible situation. In United States, patients are deluged with excessive information in order to safeguard the clinician from litigation. This is unhelpful in the long run and a policy that does nothing to enhance the doctor/patient relationship.\(^{51}\)

(b). Arguments in favour of full Disclosure

The primary argument in favour of full disclosure about the pros and cons and alternatives to specific treatments is that patients have the right to make their own decisions whether to accept recommended treatment. That helps patient’s right to determine their own destiny or to exercise their autonomy. They can do this only if they are given enough information to help them to understand the consequence of

\[\text{\begin{tabular}{l}
49 Ibid. \\
50 Ibid. \\
51 Ibid. 
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their choice. Autonomy has become the trumping ethical value in the last 50 years and so, it is not less important in health care delivery.

Another argument in favour of disclosure is that involvement of patients in treatment allows them to take a meaningful role in their health and improve their relationship with the doctors and other healthcare workers. So, full involvement in therapeutic decisions goes beyond the goal of maximizing patient autonomy and can lead to benefits of the individual health. These are main arguments in favour and against disclosure. Another relevant aspect is sharing of information within the Healthcare team.

c. Sharing of Information Within the Healthcare Team

Medical profession is now practiced as a team work but it would be absurd to suggest that the physician should obtain specific consent every time he wanted to discuss a case with, the radiologist or the ward sister. The trust is backed up by the knowledge of the medical and nursing staff, together with members of the professions allied to medicine. It is incumbent on the hospital to ensure that their employees are instructed in the duty of medical profession with confidence and obedience. Thus, a secretary in the hospital who breached confidence would be subjected to the disciplines of fair dismissal.  

But, what of the ‘Second opinion’ of a doctor who is not a member of the team with whom the patient is associated. It is doubtful whether the doctor is guilty of breach of confidence. The disclosure and the extent of information provided, in conversation would have to be conducted privately and only necessary information should be disclosed. Equally, such disclosure may be deemed to be in the patient’s best interest. In the latter instance, it is perfectly possible that the patient may not like his or her medical details to be disclosed, either is a specific or a general sense. For their reasons, ideally such a consultation ought to be subject to the patient’s consent. The same would apply in the event of the patient’s case being the subject

52 Ibid.
of a ‘staff case conference.’ Which is, after all, as much for the education of the staff as for advantage to the patient, and the preservation of anonymity in such a situation would be difficult if not impossible to achieve.

The role of those who are not part of the team, but who are an essential part in hospital must be discussed. For example, a charity worker who discloses confidential matter that he saw or heard in the wards. Would such a breach be actionable? In general the matter would be decided as in the case of a reasonable person who in that situation handles the information with element of confidentiality.

d. Disclosure to Insurance Companies and Employees

Not infrequently a doctor will be asked for confidential information about a patient’s health for the purpose of employment or insurance. This may be at the patient’s request but, even the doctor should ensure the purpose of the request and for what purpose that information is required. In the case of MS Kap funde, the Court of Appeal in 1998, held that an employed medical officer is subject to a contract for services with the employer and has no duty of care to the other person. But the wise doctor will always obtain written consent to disclosure, which may after all have a profound effect on the examinee’s future. Disclosure is permitted on two grounds. Following are the permitted grounds of disclosure

e. Disclosure is the Patient's Best Interest

If the patient is unable to give a valid consent to disclosure of his health status, yet the doctor felt that it would be in best interest to do so. This may arise in situation where patients are in comatose, mentally retarded or aged. In such circumstance, the doctor can rely on the legal doctrine of necessity. It is necessary to safeguard the life or health of the patient. To invoke ‘necessity’ successfully the action must be capable of subsequent legal justification and, in the present context, of vindication before the GMC.  


54 Me Lean SAM, A Patient's Right to know, Aldershot Dartmouth, 1989
The necessity doctrine is applicable in the case of comatose patient and it is reasonably assumed that he or she would certainly relate to know the likely diagnosis. There may, however be times when disclosure of certain kind of information would be a matter requiring further justification- this being still, subject to the rule of necessity. 55

Whether or not a patient is competent depends upon the assessment of his or her capacity. Another permitted ground is disclosure to the Police.

f. Disclosure to the Police

The doctors very often handle patients who are victim of assault and crime. There is no legal duty to inform the police (with limited statutory exceptions). The doctor must not give false or misleading information when approached.

The doctor’s liability to disclose to the police is defined under the Medical Council Act. Thus, ‘a person’ who has knowledge of acts or anticipated acts of terrorism must inform the police and for these purposes ‘a person’ includes a doctor. Similarly, in the case of Hunter v. Mann 56 it was held that the same application of the word ‘any person’ must provide information to identify the driver of a vehicle involved in a serious accident. The main authority here is the police and Criminal Evidence Act of 1984 which classified these records as ‘excluded material’ which cannot be accessed. The police investigations of a ‘non cognizable offence’ must obtain an order from a circuit judge if they wish to search the records. The medical records are the documents relating to the physical or mental health of an identifiable person. A police search in a murder case sought the examination of record of patient’s regarding the absence from a psychiatric hospital. The consultants protest on ground of confidential medical matters was upheld by the Divisional Court and the police were denied access. 57

55 Indian Medical Council Act
56 (1974) 2 All ER 414
57 Dennis Brodear, Ethics and Health Care Reform; Institutional Contributions, Saint Louis University Law Journal, Vol.32, p.878
The court in this case expressed ‘considerable reluctance’ to apply the law and denied access to confidential documents. Once again it is back to a balancing act-between the nature of the confidential information and the importance to the public interest and the police enquiry and the administration of justice. 58 There is little doubt that the GMC would support the doctor whenever the imbalance was sufficient to justify the action. Individual’s private interest is given comparatively little prominence. Refusal of treatment is something relating to disclosure of information.

g. Refusal of Treatment

Another relevant area of medical practice is refusal of treatment. As Professor Skegy points out this beneficent practice might be unreasonable as it does not allow the patient the “right to choose.” 59 Lawton L.J. in a speech on extra Judicially in 1983 when he addressed the “Royal Society of Medicine” said “I Suspect that some doctors say nothing about risks because they are confident that if they did, their patients would not accept this as a good reason.” Lord Denning sought to restrict doctor’s liability for fear of encouraging in this country the disease of ‘defensive medicine’ or damaging the doctor’s reputation. 60

C. Confidentiality and the Health Care Profession

The rule relating to confidentiality and medical ethics are decided by the members of the healthcare profession through their control of professional bodies. Looking back into the history, of the Hippocratic Oath is the basis of the medical profession. The policy that drives the GMC is derived from it, and so the oath still binds the doctor-at least theoretically.

The GMC lays very great importance on professional secrecy but, before considering this is more detail, it is worth noting two conditions of the Hippocratic Oath. First, the confidential relationship is not confined to what passes between

60 Seeking patients consent the Ethical Constructions medical Council 1999
patient and doctor. The doctor is equally bound to maintain confidence even if it is a casual conversation, irrespective of the source of the information.

There are some matters which will not attract sanction for disclosure. There are some matters which are so serious and they ought to be disclosed for the private or the public interest. It is suggested that a prudent doctor will be very worried before relying on such interpretations.\footnote{Ibid.} This is well discussed in the case of *Winston Churchill*. After his death, it transpired that he had been seriously ill for much of the time and his physician. Lord Meran, was criticized for not revealing it at that time, for the national interest. This is the doctor’s dilemma at his highest level.

The Declaration of Geneva states that the duty of confidentiality survives the patient’s death. The GMC have taken a different view, and taken step of censuring the Editor of the British Medical Journal for publicizing details of the mental health of dead celebrity in what he considered, for the interest of history.\footnote{Geneva Declaration.}

The wording of the declaration of Geneva is rather different from that of the Hippocratic Oath. The former refers to ‘respect’ for the secrets confided in doctors. Respect is an indefinite word, which leaves open the degree of respect to be paid and this will depend on the circumstances of each individual case. Thus the professional code as to patient confidentiality does not offer an absolute imperative- there is room for discretion. The GMC itself has always considered its code of conduct as subject to interpretation in the light of public standards. Thus, the rule of the GMC, is considerably stronger than those of the law and, at the same time, carrying more severe penalties, and a technical breach of confidence will attract penalty. What are the accepted exceptions that provide as the basis for derogation from the general rule, these can be briefly described as follows.

**a. Confidentiality and the Child**

Both consent and confidentiality in respect of children is defined in the important case by Mrs.Victoria Gllick long ago on 1983. The Department of health had issued a directive that empowered doctors, in limited circumstances, to provide
contraceptive assistance to minors below the age of 16 without the knowledge of their parents. Mrs. Gillick raised this before the court to declare it as wrong in law.\textsuperscript{63} The Judge, who first heard the case considered the child’s capacity to understand the issue as the most important factor and held that it is the duty of parents to look after their child’s welfare and on this ground, they decided unanimously in favour of Mrs. Gillick. The House of Lords then reverted it by relying on the importance of the autonomy or right to self-determination of the ‘mature-minor’. It was also held that the doctor who advised the minor in this way was not aiding or abetting the criminal offence of under-age sexual relations.\textsuperscript{64}

In the treatment of the minor in the absence of parental consent when controlling or assisting pregnancy, the doctor is protected by a statutory ‘conscience clause.’ In such circumstances, the doctor has no open mandate to breach confidentiality but should refer his or her patient to a professional colleague. The confidential nature of the treatment in minors below the age of 16 is, unsatisfactory and vague.

b. Confidentiality within the Family

Situation often arises when the doctor has to decide whether he must treat the individual or the family as a whole. Decisions taken by or on behalf of the former will have a wider effect and the questions then arise as to how far these should be taken into consideration.

What, to say, if the wife seeks a termination of pregnancy without her husband’s knowledge? The doctor is firmly bound by his duty of confidentiality to his or her patient, both legally and ethically. Pregnancy is an intimate matter for a pregnant woman and her husband or partner has no intrinsic right to interfere in the child within the uterus. But what if the wife seeks sterilization and a practitioner may take decision unilaterally. The doctor’s first responsibility may well be to attempt to convince his or her patient that this should be a joint decision.

\begin{itemize}
\item[\textsuperscript{63}] Gillick v. West Norfolk and Wisbech Area Health Authority [1985] 3 AllER 402
\item[\textsuperscript{64}] Though, lest then be any doubt, the under-age girl who has sexual intercourse commits no offence criminality is confined to the man involved.
\end{itemize}
If secrecy creates danger to other members of the family the condition may be different, for example if the spouse or partner is suffering from a sexually transmissible disease, which he or she is unwilling to disclose to the others? There should be open discussion with the affected person, which might include seeking consent to disclosure.

Perhaps the most intractable problem associated with confidentiality within the family lies in the management of genetic information. A dexterous gene may express itself with another specific gene or with certain environment factors relating to certainty of disease. Genetic knowledge has a different significance. The fact that some persons may not want to give genetic information despite the importance for them. The genetic confidentiality has a unique feature that needs separate consideration. Confidentiality and Legal Process have some relevance in this context.

c. Medical Confidentiality and the Legal Process

The confidentiality of communication between solicitor and client is protected by professional privilege. The communications related to the conduct of the client’s case are protected from disclosure to outside parties. The confidential communication between the solicitor and an expert witness acting on instructions will be protected under an umbrella of secrecy.

Medical records of treatment must be disclosed in the court proceedings if it is needed. The claimant (in Scotland) can obtain medical records from the defendants even before proceedings have begun. During trial either side can demand hospital’s records and the court can order for production of the documents to the applicant or to legal advisers. Court order must be obtained and it justifies the disclosures.

The judge in the United Kingdom and States of the European Union can order for breach of medical confidentiality whenever it is necessary in the interest of justice. The doctor complying with such order is protected from action for breach of confidence. Confidentiality is always in conflict with public interest.

d. The Public Interest

Throughout this discussion the concept of the public interest aspects of a legitimate disclosure of medical confidence raises a question whether the public interest in disclosure is of greater or lesser importance than the public interest in preserving medical confidentiality. No final rule can be laid down because every case differs in its details. The solution depends on a subjective balancing of interest by the individual doctors.66

It has been admitted is many cases, that the balancing of interests in favour of the public, compels the doctor to disclose what would otherwise be confidential medical information. These are unnecessary in twenty-first century conditions. 67 A great majority feels that it would be a derogation of duty for an authority to allow, a person with typhoid fever, to be employed in a restaurant’s kitchen. In some occasions the doctor must disclose information because he is a “member of the public.”

There are other instances where public interest is very strong but reporting is not demanded by law. A car driver with uncontrolled epilepsy who refuses to report the fact, as required by regulation. The doctor must act on ‘balancing exercise’- debate the way the balance tips.68 In conclusion, the doctor would be guided by three major principles already alluded. First, disclosure must be to the authority nominated by statute ‘with a need to know’- in case of the above, the Drivers Vehicle Licensing Authority. Secondly, the doctor should make a genuine attempt to persuade the patient to report the matter to him. And, finally, disclosure must be justifiable to the General Medical Council which itself is subject to a serious thought before taking action.

More interest may, however, attach to problems associated with disclosure and criminality, problems which can be approached from two directions- first, where a person’s committed the crime, and second, who he or she may do so.

67 Ibid.
The first is relatively uncontroversial. As has already been stated in connection with co-operation with the police, a doctor is not bound to assist the apprehensions of a criminal but when there is a moral duty to assist, there is also a moral duty to promote the arrest of the patient. The public can expect positive action to the detection and punishment of offenders in serious crimes. But at the same time, criminal patient could not claim doctor/patient relationship to ethical quality equal to a law-abiding counterpart. There would be no legal obligation to help a person at risk but if the doctors do so, the breach of confidentiality would be justified. The confidentiality would probably be lesser issue within the wider envelope of a duty to protect those at risk of physical harm. Patient autonomy and Ethics is the most controversial aspect today.

D. Patient Autonomy, Ethics and the Law

Patient’s expectations are that everything told about their illness are noted ground in the ethical concept of autonomy or self-determination. At the same time, it is generally accepted that the right to behave autonomously may sometimes be overridden by the interest of others. There is no autonomous right to kill someone, even if making a self-determined choice to do so, because the greater good of society demands such behavior should be outlawed. The respect for autonomy is one of the cornerstones of the doctor patient relationship. Doctor’s professional ethics requires them to use their expertise with the patient’s right to self-determination firmly in mind and by and large, doctors will take this obligation very seriously—even in cases where the capacity of the patient may be in doubt. Both ethically and practically the self-determining patient is the ideal model from the point of view of doctors and patients alike.

Many doctors left them to make all the decisions according to their discretion. It is a problem for the doctor who is committed to involve patient’s healthcare decisions. One can act autonomously by refusing information. A choice not to know

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69 Jacob J M, confidentiality the dangerous of anything weaker than the medical ethics, *Journal of medical Ethics*, 1982, Vol: 8, p.18
70 Ibid.
71 Ibid.
is not less autonomous choice, and it not less worthy of respect, than is a wish to be informed. Doctors must give equal respect to refusal of information provided that they are satisfied that the refusal is well informed.\(^{72}\)

If the notion of autonomy is taken seriously, it would be expected that respect for it would attract a mere forceful commitment than that due to simple ethical concept. It would, then, be reasonable and strongly supported in law and failure to respect it would be censured. Touching others without their consent is assault or battery thus, a doctor who, operated a patient, or examined physically, without his or her agreement would be guilty of assault or battery even though the doctor was certain that the surgery or the examination would benefit the patient. No special exemption applies to doctors in this respect. Doctor is liable to compensate for assuming unwanted authority over his or her body.\(^{73}\)

In United Kingdom the patient could not seek compensation using law of assault or battery, but must raise it in case of negligence. Thus when an invasion of bodily privacy results from failure to provide enough information, the aggrieved patient has not consented without the basis of sufficient information. The missing information, been provided, and they would not accepted in the treatment and would, have avoided the harm to the complainant.\(^{74}\) Patient autonomy is something pertaining to a person. Medical choices are personal to a person and they would affect matters which are non-clinical. One may reasonably feel that personal circumstances are critical to the evaluation of what it was and was not proper to disclosure in the circumstances.\(^{75}\)

a. Application in Case of Children and Young Persons

In case of children and Young Persons, the capacity to take decision or to give consent to medical treatment is governed by common sense or common law. It is

\(^{72}\) Brahams D, Medical Confidentially and Expert Evidence, Lancer, Journal of Medical Ethics, 199 , Vol51, p.337

\(^{73}\) Supra, n.267


\(^{75}\) Ibid.
obvious that someone must speak for a child. The law upholds this principle virtually in every case subject to certain restrictions. The parents could not demand treatment which the doctor is unwilling to provide on the basis of a reasonable clinical opinion.76

Incapacity due to mental disorder in the adult is governed by law. Perhaps, contrary to popular belief- the next of kin has no decision-making powers, although their opinion will of course, be valuable in reaching a conclusion.77 The courts in England and Wales have no mandate to consent on behalf of an adult and can declare that providing treatment would not be unlawful. Whereas if doctors decide a treatment is in the patient’s best interest, it is for the court to decide whether it is in the patient’s best interest or not. Human dignity has some direct relation with medical ethics.

b. Human Dignity and Medical Ethics

Recently, bioethical debates have been peppered with claims that certain practices violated human dignity irrespective of their beneficial consequences or the existence of free and informed consent. Practice like reproductive cloning, gene therapy, sex selection, the commercialization and commodification of the human body (particularly organ selling and commercial surrogacy) and research on embryos have been rejected as violating human dignity. Utilitarianisms are reluctant to present their concerns about disutility in the terminology of human dignity, but they have at times, quite happily hijacked the terminology of rights and might well start to use dignity in this way. The premise of human rights is grounded in human dignity that was reflected in Post-Second World War human rights instruments. The preamble and Article 1 of the Universal Declaration of Human Rights takes it as a fundamental premise. In human rights tradition, dignity is used to emphasize individual choice and its autonomy, rather than constraint. Beyleveld and Brownsword referred this concept as “dignity is empowerment.”78 The constraint is from the rights of others, rather than

76 Starch M. Rationality and the refusal of Medical treatment, A critique of the recent approach of the English Court, Journal of Medical Ethics, 1995, Vol. 21 p.162
77 Ibid.
78 Supra, n.57
one’s duties to oneself. There are two concepts of human dignity “dignity as constraint” and “dignity is empowerment.” The human dignity can be acted from opposing sides on issues of medical controversy. The request of a patient to be put to death by his doctor is known as “voluntary euthanasia.”

It is also possible to use “dignity” to refer to something, as this prohibiting the doctor denies the action on the patient’s request. Which may prevent the patient from “dying with dignity.” The language of dignity is as an articulation of conflict within bioethics. It explains why opposed moral positions find themselves in what appear to be a two-cornered contest between, an “empowerment” and attracting the support of rights-based theories and “constraint” or “dignitarian” alliance or duty based and (conservative) compromise position. Moral status of human being has some direct relation with medical ethics.

c. The Moral Status of Human Being

The view’s of life adopted by Orthodox Catholicism grants full moral status to all those who are biologically humans. All human being use the same level of moral duties. Different moral positions imply or rest on different criteria of moral status and take different positions on whether all members of the human species have the same status. The moral status of the person is ethically controversial in the infant (as embryo or foetus) or a person who is permanently unconscious (such as an anencephalic baby or a human in a permanent vegetative State). Such “patients” could be granted full or limited moral status, depending on the positions taken with regard to the moral duties that owe directly to them. This is accepted by all the major theories of medical ethics. With regard to the embryo, the full status position would grant the embryo the same moral protection as the mother’s hair or nails, and the limited status position would grant the embryo a fixed or gradual status between

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79 Bey leveld, Deryck and Brown word Roger, Human Dignity in Bioethics and Bio law, Oxford University Press, Oxford, 2001, p.161
80 A http://www.biomedical central.com/bm cm medical ethics viewed on 4th March 2010
81 Ibid.
82 Ibid.
83 Supra, n. 79
84 Supra ,n. 57
these two extremes. It is highly necessary to protect the rights of patient under medical ethics.

d. Protection of Rights of Patient under Medical Ethics

The Data Protection Act of 1988 (as amended in 2006) which now applies to written and computerised medical records and which, in general protects the privacy rights of individual’s personal data.\(^{85}\)

The Act provides right to give information as a personal data. It is a qualified right. The access to such records need not be granted only with a satisfactory opinion of the Health Authority, that the disclosure would cause serious mental or physical harm to the patient or any other person. The major failure of the law is that a patient is not entitled to examine the notes. It may nullify the element of ‘professional privilege.’ Apart from the Act, there are common law rights under Articles of the European Convention on Human Rights, refusing the access to interfere with a person’s private life.\(^{86}\)

The ‘breach of medical confidentiality’ can be justified by some writers. Many of the exceptions are, ‘exceptional ‘and strict confidentiality remains only as a general rule in medical practice. Later the ‘patient’s rights’ were incorporated in UK through the Human Rights Act of 1998\(^{87}\) enabling the patient to suffer tangible harm as a result of the breach. Even then, a successful action for the loss of reputation can be initiated. In most litigation, shutting the stable door after the horse has bolted and obviously, prevention would be far better than cure. In this respect, the importance of professional bodies, such as the General Medical Council is relevant.

\(^{85}\) Section 12 of Data Protection Act

\(^{86}\) Supra, n.72

\(^{87}\) Article 8 of European Conventions on Human Rights through the Human Rights Act of 1998

1. Everyone has the right to respect for his private and family life, his home and his correspondence.
2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.
e. Control of Fertility

The government of India is more concerned about the increase in population and method proposed to control it by incentives and disincentives. So the State promoted sterilization by giving some incentives. These guidelines for sterilization are not acceptable due to moral and ethical issues. Medical ethics and right to life are controversial issues.

f. Medical Ethics Right to Life

Intervention in human life should be for improving the quality of life. Therapeutic procedure on the human embryo is illicit if the integrity of the person (embryo/foetus) is subjected to disproportionate risk. The treatment procedures must be directed towards healing, improvement in health and survival. The growing child in the wombs could not be considered as an object to be disposed.88

g. Abortion

Indian law allows abortion if the continuance of pregnancy would cause a risk to the life of the pregnant woman or grave injury to her physical or mental health.89 The Medical Termination of Pregnancy Act allowed medical termination of pregnancy for the, ‘greater good’ of the country in the light of the expanding

88 Supra, n.79
89 Section 3 of Medical Termination of Pregnancy Act.

When pregnancy may be terminated by registered medical practitioners-

(1) Notwithstanding anything contained in the Indian Penal Code, a registered medical practitioner shall not be guilty of any offence under that code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provision of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner

(a) Subject to the provisions of the pregnancy does not exceed twelve weeks if such medical practitioner is, or
population. Abortion is severely condemned in *Vedic, Upanishadic, Puranic* and *Smriti literature.*\(^9^0\) It is also against the Code of Medical ethics stipulated by the Medical Council of India.\(^9^1\)

Here there is conflict of the rights of two persons: the mother and the growing foetus. Has the mother the right to destroy the life of the child she is carrying in the womb. All we are denying rights of the unborn child. Another relevant area is relating to sex-pre selection, sex determination and female foeticide.

**h. Sex-Pre-Selection, Sex Determination and Female Foeticide**

There are a number of methods available for sex determination and sex selection. Some doctors in India have been carrying out sex determination. The pre-natal determination of sex leads to abortion of female foetus and such abortion clinics thrive in the country.

There are quite a few who justify female foeticide in India due to the social custom of dowry. And there are few physicians who take advantage of this situation for making quick money. The government declared female foeticide as an offence. The sex ratio in India is (929 women to 1000, men).\(^9^2\) The availability of sex pre-selection, sex determination and female foeticide worsens the situation. Infanticide is another unethical act.

\[\text{(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are of opinion in good faith that}
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\[\quad (i) \quad \text{the continuance of the pregnancy would involve a risk to the life of the pregnancy women or of grave injury to her physical or mental health; or}
\]

\[\quad (ii) \quad \text{there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to seriously handicapped.}
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\(^9^0\) Manu Smriti III.55

\(^9^1\) Paragraph 3 of the code of Ethics of the Medical Council of India

\(^9^2\) According to 2010 Census of Government of India.
i. Infanticide

Manu, the law giver, recommended that the king award the death sentence to one who kills a woman, a child or Brahman. The persons who perform Vratas (religious ceremonies) but whose minds against killing can lead to heaven.93 Artificial insemination, assisted pregnancy, and surrogate motherhood create new controversy relating to Medical Ethics.

j. Artificial Insemination/Assisted Pregnancy /Surrogate Motherhood

The desire to have children is strong in humans. What is to be done when there are impediments to have a child in a natural way and there is no way to overcome sterility. One way out is adoption, but many desire children with their own genes.

Artificial insemination by the husband or an unknown donor is practiced and accepted among the upper middle classes. In Vitro fertilization and other forms of assisted reproductive techniques are gradually increasing. The practice of surrogated motherhood is rare in India. Procedure of artificial insemination is against the concept of medical ethics. Even though artificial insemination is debatable procedure in context of either, one finds that it is increasingly used.

E. Medical Ethics Relating to Euthanasia

The right to die not implicit in the right to life.94 India does not permit suicide or aiding and abetting of suicide. The Law commission in its 42nd report stated that “It is a monstrous procedure to inflict further suffering on an individual who has already found life so miserable, his chances of happiness so slender, that he is willing to face pain and death to cease living.”

None of our ancient laws allow euthanasia but among our ancient physicians there were advocates for abandoning treatment when the disease reaches a stage from which recovery is not possible.

93 Sarkar Benoy Kumar, Indian Culture, Patna, 13 Corportaion: 1936
94 Das Guptra SM, Mercy Killing an analysis, based on human rights. In proceedings of the
People by large; accept suffering as part of their fate, resulting form karma. Many favour omission of treatment and life prolonging devices. They also favour measures to relieve agony, even if these fasten death.

**F. Organ Transplantation and Medical Ethics**

There is growing demand for organ transplants, like kidneys, and these demands often raise ethical nightmares. A small number of kidneys are donated by relatives and the large majority of transplants are carried out on a commercial basis.

Some doctors are engaged in kidney business, curing rich patients in India and Middle East. A New class of agents actively participate as middle men. Doctors are not bothered about the ethics and steal kidney from persons without their knowledge or consent. The illiterate people, and the downtrodden are forced to donate their kidney because of the desperate need of money. This kind of organ transplantation raises many ethical issues. Another area of ethical issue is treatment to terminally ill.

**G. Terminally ill**

A physician preserves human life and prevents death. As long as the patient breathes, it is the duty of the physician to offer treatment (tatvat pratikriya karya yavae chvasiti manavah). There is another view, on when to stop treatment. The physician may withdrawing treatment when the condition is definitely moribund (upekshnam prakristuheshu).

Patient who is terminally ill must be given care so as to reduce suffering. The present thinking is in with this view and not favouring prolonging life with the help of machines when there is no chance of recovery. Another confusing area of medical ethics is disclosure of medical information. Now this problem has been regulated by some authoritative bodies. The mechanism of control is explained as follows.

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96 Paragraph 2 of the Code of the Medical Council of India

97 *Supra*, n. 91

111. Regulatory Bodies

A. Position in England

The medical law and ethics has grown in England, through the evolution of several doctrines. What must be understood is that several issues that are new emerging area are new to the court. New technology have evoked fresh debates on either of using such technique in bring into the world a new life or to put an end to the life of a person who can no longer comprehend the meaning of life. Thus in orders to deal with new emerging areas in medical science and health care regulatory bodies have been set up in various countries such as in England.

a. Role of Medical Council in England

A major function of the General Medical Council is to keep a register of medical practitioners. Since a person could not practice medicine in the National Health Service or in the armed forces unless he is registered, and the GMC can register or de-register a practitioner. The disciplinary actions of the GMC are the most basic form of control over the doctor’s actions. The disciplinary action regarding practice can be challenged on five grounds. Misconduct which, covers the old, serious professional misconduct, Deficient professional service under the provisions of the 1995 Act, Conviction or Caution following a Criminal offence, Impaired physical or mental health and Decision by an authority regarding the fitness. These are statutory grounds for disciplinary action.

In the event of adverse findings the doctor’s name can be removed from register. As a result in the event of misconduct, criminal convictions or determination by another body, the doctor can be reprimanded.

99 Supra, n. 76.

Ibid. 100

The authority of CHIMP does not extend to Scotland where similar functions are undertaken by the Clinical Standard Board, which is now part of NHS Quality Improvement Scotland.
b. Controlling Bodies for Other Health Care Professions

The Council for regulation of health care professionals are empowered to regulate the profession. The council was established under the National Health Service Reform and Health Care Professions Act of 2002 with the aim of promoting the interest of patients. It also has the positive duty of formulating principles for the professional’s self regulation. The bodies can investigate and report on the performance of the individual councils. It can direct the regulatory bodies to change their rules and give directions. It is also able to investigate the complaints, refer any disciplinary action to a regulatory body to the High Court in England or the Court of Session in Scotland.

c. Regulation of Medical Profession through Statutory Bodies in UK

The statutory bodies are constituted to redress the grievance. Through this ex post facto mechanisms capable of addressing patient grievances- complaint, litigation, and other professional accountability procedures—patients gained consumer-like status. Health care provision has ethical and regulatory implications in maintaining a standard in general. The first of these is the National Institute of Clinical Excellence or NICE’s which advises the other health authorities as to what are the most useful and cost- effective treatments. The second is the Commission for Health Improvement (CHIMP) under the Health Act of 1999 is a ‘enforcement agency’. CHIMP’s officers can visit the various NHS Trust and ensure that the facilities are in tune with the national standards. The functions of CHIMP have been extended recently by allowing the commission to instigate and analyse data.

Other system is ‘quargo control’ of the professions by the National Clinical Assessment Authority. The main function of which is to provide assistance to NHS bodies with regards to the performance of individual doctors.

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The most important aspect of the commission is that the patient and public can be involved in health care functions. It advises the Secretary of State on matters relating to the Health Service in England and give services for patient’s wishing to make complaints. It also provides assistance to Patient’s Forum and Patient’s Councils and set quality standard for the organization. 103 A Patient Forum,104 designed to monitor and review the operations of the service provided, is established for each NHS and Primary Care Trust in England. Patient’s Council is, essentially, established in each local authority area with the power to overview the health and social service provided. The basic function of the councils is to co-ordinate the activities of the patients and Forums in the area and to ensure that the directions are followed. Such Forums are not established in Scotland. 105

In view of contract, the doctor is providing a service by way of a contract with primary care and to provide services for patients. Allegations of breach of trust in respect of that contract can be brought before the Health Authority or Health Board who can take disciplinary action. The matter is referred to the disciplinary committee of Health Authority which may recommend the action to be taken or imposed a fine.106

Depending on the nature of the allegation, the Health Authority can refer the matter to the GMC or to the police authority or it can remove a practitioner from its list. In addition to this the authority can remove the increases of inefficiency or fraud. The authority can also suspend a practitioner when it feels that this is necessary in the public interest. 107 All this will be subject to appeal to the Family Health Services Appeal Authority; likewise the Health Authority may seek the FHSAA to extend the period of suspension beyond 6 months.108 The FHSAA can, as a last resort, disqualify the doctor- or any other NHS professional such as a dentist or pharmacist on

103 (1974) 2 All ER 414
104 Ibid.
105 Ferner R.E, Medication error that have led to Manslaughter Changes, British Medical Journal, 2000, p.32
106 Sec: 24 Medical Court Act in England
107 Sec: 28, Ibid.
108 Supra, n. 102
a national scale which is, effectively saying that the person concerned is unfit to practice. Structure and responsibilities of NHS is relevant for effective control.

d. The Structure and Responsibilities of NHS

The vast majority of health care cases in UK is controlled by section 1(1) of NHS Act 1977, which requires the Secretary of State to promote “a comprehensive health service designed to secure improvement (a) in the physical and mental health of the people of (England and Wales) and (b) in the Prevention, diagnosis and treatment of illness. In the absence of contrary legislation, such health care services must be provided free of charge. The secretary of state and Department of Health has power to delegate other bodies within the NHS. The structure of these bodies is constantly undergoing reforms. Twentyeight strategic health authorities replaced the ninetyfive health Authorities as the local headquarters of the NHS and Health Authorities have some important role in control mechanism.

e. Special Health Authorities

The strategic Health Authorities are the Special Health Authorities providing service to the NHS or the public in health care. These are constituted under section 11 of the NHS Act, 1977 (as amended by the Health Act, 1999). There are a number of such bodies, which are part of the NHS and accountable, to the secretary of State for Health. Their decisions are amenable to judicial review. Other Special Health Authorities are the Council Health Care Regulatory Excellence and the NHS Appointing Commission. The NHS Litigation Authority, the National Patient Safety Agency, and NHS Blood and Transplant.

109 Sec 1 (2) of NHS Act.

NICE was subjected to criticism that the NHS was operating as a “postcode lottery”, where the quality of services available depended on geographical location. NICE provided guidance on best practices, and evaluated the cost effectiveness of drugs and treatments, especially on new drugs and treatment. The role, with its effect on the allocation of Health Care resources, has received intense academic scrutiny. NICE has not ended the postcode lottery. The resources needed to fund and follow its guidelines came from some where and different regional bodies and redistribute resources in different ways. Assessing the cost- effectiveness of health treatments and procedures could not be ethically natural or purely technical. The departmental Commissions appointed for the purpose of the health care, are not formed part of any government department or the NHS. One commission deserving particular attention is the commission for Health Care Audit and inspection known as the Health Care Commission. The Audit Commission’s work relating to economic activities of health care, and the responsibility of the National Care Standards Commission is to regulate and inspect the independent (private and voluntary) health care sector. The functions of the Commissioner include the independent assessment of the performance of health services (including the publication of rating of NHS hospitals and trusts) the coordination of inspections, investigation into whether public funds are being used effectively within healthcare system. This Commission is reviewing the implementation of the National Service Frame works (NSFS),with National standards. In the future this commission is expected to merge with Mental Health Act Commission. This is to become a mammoth overweight body. To perform all these functions, the health care commission has been given extensive powers.

112 There have the status of influential guidance but, in practice, they will be used to assess the performance of senior NHS mangers
113 Supra, n.59
114 Health and Social care (Community health and Standard) Act 2003 S. 68
f. Primary Care Trusts and NHS Trusts

Local Health organization namely Primary Care Trusts (PCTS) is managing health services in their geographical area. PCTS are part of the NHS. They are responsible for planning both primary care (though family doctors, dentists, optician, and pharmacist) and secondary care (though hospitals and ambulance services) for patients. PCTS are still relatively new one and is anticipated to control 75 percent of the NHS budget. This will be no doubt mean that the majority of litigation with Health Authorities, will be directed to PCTS.

There is a statutory duty on NHS organisations to consult patients and the public in the planning and management of health care provisions, under Section 11 of the Health and Social Care Act 2001. Patients Forums have been established for each NHS Trust and PCT, which seek to enable patient’s representation to monitor health care services, to obtain patients views about the suggestion to improve the system and provide advice to Trusts and PCTS. Regulation, discipline and complaints are relevant in the controlling mechanism.

g. Regulation, Discipline and Complaint

A number of procedures exist to ensure that medical practitioner is held accountable for his action. If a doctor’s conduct is not proper it may lead to following consequences-

(a) a patient’s complaint to the Health Services Provider.

(b) Litigation by a patient;

(c) Disciplinary action by the employing body;

(d) Investigation by Health Care Services Commissioner (the Ombudsman)

115 Sec NHS ACT 1977 (as amended) sec 16A-16B.
116 NHS Act 1977 (as amended) sec15-19 PCT Patients Forums are required to commission and / or provide independent complaints advocacy services (ICAS) for the local population. Sec 16 the trust PCTS were created in Dec 2003.
(e) Investigation by the General Medical Council (GMC) \(^{117}\); or

(f) investigation by the police

These are the main procedures and in exceptional circumstances there could also be a public enquiry.\(^ {118}\) Another aspect is regulation of the medical profession.

h. Regulation of The Medical Profession

The regulation of the Medical Profession has been entrusted with the General Medical Council (GMC) since its creation by the Medical Act 1858.\(^ {119}\) This professional body maintains a register of qualified and disqualified practitioners.

According to the NHS plan and a recommendation by the Bristol Inquiry Report, the regulation of these bodies is supervised by the Court for Health Care Regulatory Excellence (CHRE).\(^ {120}\) The power of this body to refer for the disciplinary action of the professional bodies is considered to be “unduly lenient” according to the High Court.\(^ {121}\) Regarding regulation of medical profession GMC is the responsible body. GMC is responsible for performing for the public interest.\(^ {122}\) The constitution and functions of the GMC is very relevant in this aspect.

i. Constitution and Functions of the GMC

The GMC is a smaller body with 35 members, 19 are elected by registered doctors, 14 are members from the public appointed by the NHS appointment commission, and two are appointed by educational bodies (the universities and royal medical colleges). The majority of its members are medical practitioners.

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117 Ibid.
118 Supra, n.59
119 It was originally called the “General Council of Medical Education and Regulation.”
120 See NHS reform and Health Care Profession Act 2002 such as 25-29, and www.chre.org.uk. This body was for the regulation of the Health Care Professionals.”
121 NHS Reform and Health Care Profession at 2002 sec 29 referrals are to the Court of Session in Scotland and High Court and Northern Ireland is Ireland.
122 According to the new section 1A of the medical act 1983, “The main objective of the general council in exercising there function is to protect, promote and maintain the health and safety of the public.”
The duty of the GMC is to maintain official registers of medical practitioners and supervise medical education, dealing with professional misconduct, professional performance and medical ethics. The maintenance of the register is one of the most important responsibilities. This register gives information to the public about doctor’s qualifications. A criminal offence is attracted when a person “willfully and falsely” pretends to be a registered medical practitioner or possess a medical qualification.

This amendment Order of 2002 significantly reformed the GMC’S committees. In the place of the old committees new Medical Act provides an investigation committee. It also includes Interim order panels, Fitness to practice panels, Registration Decision Panels, and registration appeal Panels. These committees can include non- council members. In fact, only persons who are not members of the Council will not be allowed to sit on the Interim orders in Registration Appeals, or Fitness to practice panels. These are the adjudicatory committees. This restriction is to ensure a separation of prosecution and adjudicatory functions of the GMC and thereby avoid challenges under the HRA 1998.

Article 6 of the European Convention on Human Rights and Fundamental Freedoms determine the individuals civil rights and obligation to be undertaken in a fair and public hearing by an independent and impartial tribunal. The old procedure and failure to separate these functions had undermined their independence and impartially. In the fifth report of the Shipman inquiry, Dame Janet Smith declared that the GMC had kept a “complete control over the investigative function” and had “not relinquished control of adjudication”. Further reforms are inevitable. New law relating to license to practice is explained as follows:

123 Medical Act 1983, sec 2 and 32,34 sec 5-8 (education) and sec 38 (advise)
124 Medical Act, 1983, S 49A.
125 This includes engaging in conduct calculated to falsely suggest that on has such a license medical Act 1983 S.49A
126 Medical Act 1983 (Amendment) order 2002/3135 Art.5
127 Medical Act 1988, sch 1 para 25(1A) inserted by 2002 Order 93.Sech1para23 (a)
128 Sch lpara 23(a)
129 Ghosh v GMC [2001] UKPC 29
j. The ‘License to Practice” and Revalidation Procedure

One significant change of the responsibilities of the GMC is the introduction of a “license to practice.” After giving license, revalidation is required. It is expected that doctors will reregister every five years. Periodic reassessment is required for the continued practice in this profession where incompetent doctors are not allowed to register. The fifth Shipman report scathingly attacked the GMC’S proposals, resulting in the postponement in the implementation of the new procedure until after a consultation led by the Chief Medical Office.

New procedure was introduced at the beginning of November 2004, subject to transitional arrangements for cases opened before that date. Under the new procedure, the investigation committee will investigate into the allegations of whether a doctor’s “fitness to practice” is impaired by one of a large number of factors, only one of which is misconduct. Any complainants that would not, if proven, call into question doctor’s fitness to practice will be referred directly to local procedure for consideration. If the committee considers there to be substance in the allegation; the can be referred to a fitness to practice panel. Where the committee considers referral inappropriate, it may give a warning to the doctor regarding his future conduct or performance. The matter can be also referred to the Interim Orders Panel, which has the power to suspend conditions on a doctor’s registration. This is a wide range power investigative panel. These new procedures have ironed out many of the problems of the old systems. One important reform is that the GMC (including its licensing authority) can now act on its own initiative and refer a doctor to the investigative committee, rather than having to wait for a complaint.

130 Medical Act 1983, Sec 29A -29
131 Ibid
132 Medical Act 1983 (Amendment) order 2002/3135 sch. 2
133 Sec.35 c(2), Ibid.
134 35 c (4), Ibid.
135 S 35 (c) (6) Ibid.
136 Ibid
The fitness to practice panel has greater powers to address matters of discipline and performance than the investigative committee. In addition to being able to issue a warning,\textsuperscript{137} a panel findings that a doctors fitness to practice is impaired can remove the doctors name from the register (except where a doctor is unfit to practice due to ill health) suspend him for up to 12 months, or make his registration conditional and compliance with condition laid down by the panel for up to three years.\textsuperscript{138} Erasure carries negative connotation that is thought to be in appropriate in health care. In an extreme case of ill health, after two years a panel can suspend a doctor indefinitely\textsuperscript{139} though he can apply to have the suspension lifted away two years thereafter.\textsuperscript{140}

The substantive test for determining whether a doctor’s fitness to practice is impaired has also changed. There is now a concept of “impaired fitness to practice” on reason of misconduct, deficient professional performance, advise in connection with physical or mental health or a determination of another regulatory body,\textsuperscript{141} subject to the transitional provision in schedule 2 of the 2002 order, this replaces the old grounds of “serious professional misconduct”, and “seriously” before “deficient” performance. These changes should make it easier for relevant committee to find a doctor unfit to practice.\textsuperscript{142}

The reform regarding the standard of proof used by the GMC’S committees, is made equal to criminal standard (“beyond reasonable doubt,” sometimes expressed as “satisfied so as to try), rather than the civil standard ( “the balance of probabilities, requiring decision on the basis of what is more likely then not). In Mc Allister v. GMC, the privy Council expressed the view that the criminal standard is appropriate for changes tantamount to criminal allegation, but then standard was “neither necessary for disabled person” for every charge of professional misconduct.\textsuperscript{143}

\begin{flushright}
\textsuperscript{137} S.35 D(3)) Medical Act 1983(Amendment ) order 2002
\textsuperscript{138} S.35 D (5) \textit{Ibid}
\textsuperscript{139} S. 35 D(6) \textit{Ibid}
\textsuperscript{140} S 35 D(7) \textit{Ibid}
\textsuperscript{141} S 35c (2) and 35 D (1) \textit{Ibid}
\textsuperscript{142} The GMC has provided guidance or good medical practice declaring that “serious or persistent failures to meet the standards in this booklet may put your registration at risk (GMC 2001C)
\textsuperscript{143} [1993 A.C 388,339] (Lord Jouncey)
\end{flushright}
These reforms lead to increase in the number of doctors unfit to practice. Doctors who could be previously found guilty of “serious professional misconduct” by the “professional conduct committee” again found guilty of “misconduct” by a “Fitness to practice panel 144 which would have previously got off, scot-free should now be warned or otherwise sanctioned. The main action is through local resolution and independent review.

k Local Resolution and Independent Review

All NHS bodies (strategic Health Authorities, NHS Trusts, and PCTs) and primary care practitioners (GPS, dentists, opticians, and pharmacists) must have a procedures for resolving complaints. For NHS bodies the ground rules are laid down by NHS (complaints) regulation 2004/1768,( hereafter the complaints regulations) whereas other regulations apply to primary care practitioners.145 As a consequence of the obligation placed on NHS Trusts or PCTS when they contract with independent providers, all private hospitals providing care to NHS patients must have complaint arrangements as if the complaints regulations applied to them.

I. Patient Compliant Procedures

An aggrieved patient can also lodge a complaint utilizing the complaints system of the NHS or, in the case of private patient, the complaints system of the private provider. The NHS procedure has been standardized by a number of major reforms. The new system was introduced in 1996 following the recommendation of a review committee chaired by professor Alan Wilson.146

The new reforms were put in place by the Health and Social Care (Community Health and Standards) Act 2003 and NHS (complaints) Regulations 2004/1768 are passed. The complaints regulations apply to England alone and came into force on July 30, 2004. The Department of Health has produced detailed guidance to support

144 The following discussion relates to England. On the Welsh system: see O Reurke and Holl Allen 2004, 125
145 Eg. NHS (General Medical Services Contract ) Regulation 2004/291
146 See the Report of Review Committee on NHS compliant Procedures, chaired by Professor Alan Wilson in May 1994.
the implementation of these regulations. The formal complaints system is a two stage procedure. Stage 1, local resolution, seeks to enable NHS trust and primary care practitioner to deal with complaints locally and it is hoped quickly. If stage 1 does not resolve the matter, the claimant can invoke stage 2 and request an independent review. The responsibility for managing the independent review falls to the Healthcare Commission. After the NHS procedure has been exhausted, a dissatisfied complainant can take the matter to Health Services Commissioner popularly known as the Health Service Ombudsman.147

Every NHS Trust and PCT has a Patient Advice and Liaison Service (PALS) to listen to patient’s concerns and offer information, advice and support. This service seeks to deal with problems before a formal complaint is made. It also acts as a gateway to Independent Complaints Advocacy Services (ICAS) which assist patients. ICAS supported some 10,422 complaints in its first year alone.148 The top three issues were brought to the ICAS were complaints regarding clinical treatment, the attitude of staffs, and communication with and the information given to patients.

The complaints Regulations require NHS bodies to have a person dedicated hearing complaints; a compliant manager ensure a minimal level of consistency across the NHS, the Department of Health has adopted good practice as a guide for complaints management.149 Complaints can be about any matter connected with health care. Patient’s complaints will not be considered if he gives a statement that he intends to go in for legal proceedings.150 The compliant will not be considered if the disciplinary proceedings are against the subject matter of the complaint and the information gathered during the complaints procedure could be used in a subsequent disciplinary investigation.151

147 Ibid.
148 See ICAS 2004,4
149 DH 2004
150 See NHSE Compliant Regulation 2004, para 3.32
151 Ibid paras 3.17 and 3.19
152 See NHSE Compliant Regulation 2004, para 4.11
Complaints must be lodged within six months of the incident or date of knowledge of the incident. The delay may be condoned on good reasons and to investigate the matter. One year is the limitation for such an extension.\textsuperscript{152} The manager must acknowledge the complaint in writing within two working days and a written response must be sent to the complainant within 20 working days. The complaint need not be in writing and can be in electronic form.

Most complaints do not proceed beyond local resolution. The independent review is by a, non-departmental body. The Health Care Commission is dealing with 3000 cases in a year, but received 7000 requests within the first months of taking over responsibility of second stage complaints.\textsuperscript{153}

A complaint to the Health Care Commission must be filed before this body within two months of receipt of the formal written response of the local review.\textsuperscript{154} It has wide power to deal with complaints, including the power to investigate further or refer the complaint to an independent regulatory body (such as the GMC) or the Ombudsman.\textsuperscript{155} Further changes are likely to be in the form litigation based on the reports and public inquiries.\textsuperscript{156} The role of Health Services Commissioner is very important in implementing disciplinary actions.

\textbf{m. Health Services Commissioner}

The Health Service Commissioners Act 1993 establishes an Ombudsman in England and an Ombudsman for Wales.\textsuperscript{157} The Ombudsman of the NHS and the Government has power to deal with administration of clinical complaints within the NHS. It has very wide jurisdiction, but there are a number of notable limitations.\textsuperscript{158}

\begin{itemize}
\item \textsuperscript{153} National Audit Office 2005
\item \textsuperscript{154} NHSE, para 6.1
\item \textsuperscript{155} House of Common Select Committee on Health 1999, para 73
\item \textsuperscript{156} Shipman Inquiry 2004, chp7 and 27
\item \textsuperscript{157} This provision also established an Ombudsman for the Scottish NHS. Reference to this 1998 Act below is to it as amended by the Health Services Commissioner (Amendment) Act 1996 and 2000
\item \textsuperscript{158} Supra n.102
\end{itemize}
The time limit of the action is one year jurisdiction. The Ombudsman hears a complaint after this period if “it considers it reasonable to do so. The justification for the fixation of time limit is due to difficulties created by the passing of a long period of time and the need to protect professionals” from being in permanent jeopardy. The Ombudsman’s jurisdiction is restricted to complaints of patient’s against “injustice or hardship.”

The Ombudsman can only investigate where the complainant has exhausted the NHS processes, unless it is not reasonable to expect the complaints to invoke or exhaust these procedures. Since the process is meant to be separate from disciplinary procedures.

The Ombudsman could not investigate where the complainant has a remedy in the courts unless satisfied that it is not reasonable to expect the complainant to resort to that remedy. Many cases before the Ombudsman would not give rise to legal actions or this is one of the most significant limitations of the ombudsman’s jurisdiction. Litigation is often a lottery, legal aid is heavily limited and many potential litigants could not afford an action in the courts. Harpwood argues that this limitation seeks to prevent “fishing expeditions” at public expense, as “it would be unfair if the commissioner proceeds with an investigation and upheld a complainant, only to open the way to litigation by having produced all the relevant evidence and made a recommendation in favour of the complainant.”

Ombudsman has the power to demand the production of documents and records, and compel staff to testify. These powers are equivalent to those of the High Court.
NHS body any, person against whom a compliant is lodged and to the Health Secretary. He may recommend remedies, such as an apology or an ex gratia payment of the patient’s out-of-pocket expenses. The Ombudsman’s report has absolute privilege for the purposes of the law of defamation. Fear of the adverse publicity invites inaction of health services bodies to act up on the Ombudsman’s report.

n. Disciplinary Control

In England the Medical Disciplinary Committee acts as a Court in Medical discipline and Conduct. Medical Act of 1969 gives to the Disciplinary Committee of the General Medical Council the power to order suspension not exceeding 12 months in addition to that of erasure. New concept of professional offence is being introduced. Greater concern is given to the offences of doctors who disregard their personal responsibilities to Patients, and abuse the professional conduct. This is considered serious professional conduct. This serious professional misconduct is known as “infamous conduct in the professional respects. So also includes the offence of improper conduct impermissible association with a patient or family member.

B. Position in American

AMA (American Medical Association) is the apex body granting the education and license to physicians. The AMA has the exclusive right and power to regulate the medical profession. The association is trying to give the best and most efficient medical care to the society. Society’s expectation is that it would rely upon physicians who fulfill their responsibilities of their profession. American health care system is at risk due to growing expenditure of health care, and conceded about the

168 S.14 (5) HS Act
169 Ibid
170 Section 14 (3) NHS Act
171 Section 12 of Medical Council Act of England 1969
172 Sc 21 Ibid.
organized medical system and their efficiency and quality.\textsuperscript{175} There is also great concern about professional’s inability or unwillingness to regulate its members to prevent unnecessary and inappropriate services.

Professional Standards Review Organization (PSRO) is constituted in America for reviewing the patient’s hospital care, and now they review outpatient services also. The authority reviews physician services both for over utilization and for substandard care.

C. Position in India

The Medical Council Act of 1956 as amended by Act\textsuperscript{176} is dealing with the professional misconduct of the medical practitioners in India. The apex body to deal with the professional misconduct is the General Medical Council acting at state level. The decision of the General Medical Council is final in the case of appeal.

The State Medical Council has also powers to remove and suspend medical practitioners from their service. They are also empowered to register the doctors who undergo disciplinary actions. The State Medical Council takes action on complaints if there is any violation regarding professional misconduct.

The Code of Medical Ethics is for the upholding medical ethics of the doctors. The prime object of the medical profession is to render service to humanity. The professionals are supposed to act in accord with its ideals. He must be keep noble in character and should be modest, sober, patient, and prompt to do his whole duty without anxiety, with propriety in his profession and in all the actions of life.\textsuperscript{177}

The Code specifies the responsibilities of physicians. The prime objective of the medical profession is to render service to humanity. Physician should be available to their patients and colleagues and also for the benefits of their professional attainments. The physician should practice method of healing founded on scientific

\textsuperscript{175} Code of Medical ethics
\textsuperscript{176} Indian Medical Council Amendment Act of 1957
\textsuperscript{177} Code 1 of Medical Ethics
basis and should not associate professionally with anyone who violates this principle. The honoured ideals of the medical profession imply the responsibilities of the physicians which extend not only to individuals but also to society.\(^{178}\)

Code of medical ethics has specified guidelines for the payment of services. Remunerations received for their services should be in the form and prescribed amount should be specifically announced to the patient at the time of service. It is unethical for the doctors to follow the 'no payment no care' service.\(^{179}\) Obligation to the sick specified in the code of ethics. Though a physician is not bound to treat each and every one seeking his services, except in emergencies for the sake of humanity with the noble traditions of the profession. He should not neglect the calls of the sick and the injured, but should mind his mission with responsibility.\(^{180}\)

The Code of medical ethics provides provisions for confidentiality, patience and delicacy of the physician. Confidences concerning individual life of the patients should not be revealed unless it is required by the laws of the state. A physician may determine whether his duty to society requires him to disclose the confidential communication in the interest of society. The physician should act as he would desire another to act toward one of his own family in like circumstances.\(^{181}\)

A physician is free to choose the patients. But he should, respond to any request for his assistance in emergency situations. The physician should not neglect the patient and should not withdraw treatment without giving notice to the patient or his relatives. No registered medical practitioner shall willfully commit an act of negligence that may deprive his patient or patients from necessary medical care.\(^{182}\)

\(^{178}\) Code 10 of Medical Ethics
\(^{179}\) Code 11, \textit{Ibid.}
\(^{180}\) Code 13, \textit{Ibid.}
\(^{181}\) \textit{Ibid.}
\(^{182}\) 1\textsuperscript{st} Schedule of Medical Council Act.
The code also makes provision for exposing unethical conduct. A physician should expose, without fear or favour, in competent or corrupt, dishonest or unethical conduct by the other members of the profession. The professional misconduct is addressed first before medical tribunals. If any question arises as to the legality of the physician’s conduct, another investigation may be placed before officers of the law.

a Medical Ethics under Medical Council Act

In the year 1993 the Indian Legislative Assembly passed the Indian Medical Council Act, 1933 which repeals and a new act, the Indian Medical Council Act, 1956 is passed which extends to the whole of India.

b. Constitution of Indian Medical Council

The Medical Council of India consists of (a) one member from each State and other from a union territory nominated by the Central Government in consultation with the State Government concerned\(^{183}\) (b) One member from each university selected from the members of the Medical Faculty of the Universities by members of the senate of the university \(^{184}\) (c) The member from each State should be elected from the qualified medical practitioners of the State. (d) seven members to be elected from person posses the medical qualifications specified in part 1 of the Third schedule (e) Eight members to be nominated by the central Government. The president and Vice president of the council shall be elected by the members of the council from amongst themselves.\(^{185}\) They shall hold office for a term not exceeding five years and not extending beyond the expiry of term as member of the council. The members of the council shall hold office for five years.\(^{186}\)

The council has to maintain a register of medical practitioners under Indian Medical Register. Disciplinary action is the main function of Indian Medical Council.

\(^{183}\) 11nd Schedule of Ibid.
\(^{184}\) Ibid
\(^{185}\) Section 19 of Indian Medical Amended Council Act 1964
\(^{186}\) Section 20 of Ibid.
Disciplinary Action

There are so many provisions envisaged in the Medical Council Act to prevent unethical misconduct. The professional misconduct may be brought before the Medical Council of India and/or State Medical Councils for disciplinary action constituted under Indian Medical Council Act, 1956 or State Council Acts.\(^{187}\)

The appropriate Councils extend such punishment in necessary cases or direct the removal of doctors for a specified period from the Register. The Medical Council of India and/or State Medical Council should hear in person or by pleader, of the offenders guilt of serious professional misconduct.\(^{188}\) The appropriate Medical Council may also give direction to remove or to restore.\(^{189}\)

In many circumstance the questions of professional misconduct may not come within any of these categories. In such instances the Medical Council of India and/or State Medical Council have to decide upon the facts brought before the Medical Council of India and/or State Medical Councils. Indian Medical Council Act provided various punishment systems. Any medical practitioner who abuses his professional position by committing adultery or improper conduct with a patient or by maintaining an improper association with a patient is liable for disciplinary action.\(^{190}\) Apart from this there is chance of criminal conviction by criminal court for offences involving moral turpitude.\(^{191}\)

It was observed by the Apex Court\(^{192}\) “Medical Profession is one of the oldest professions of the world and is the most humanitarian one. There is no better service than to serve the suffering, wounded and the sick. Inherent in the concept of any profession is a code of conduct, containing the basic ethics that underline the moral values that govern professional practice and is aimed at upholding its dignity” Medical ethics underpins the values as the heart of the practitioner client relationship.

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\(^{187}\) Ibid.

\(^{188}\) Section 19 of Indian Medical Council Act, 1956

\(^{189}\) Ibid

\(^{190}\) Sec 20 Indian Medical Council Act, 1956

\(^{191}\) A.S Mittal and Another v. State of U.P and others (1989) 3 SCC 223

\(^{192}\) Ponnam Varma v. Ashwin Patel AIR 1996 SC 2111
In recent times, professionals are developing a tendency to diverge from self-regulation which is at the heart of their profession. It is a privilege and not a right and a profession obtains this privilege in return for an implicit contract with society to provide good, competent and accountable service to the public. It must always be kept in mind that the job of doctor is a noble profession and the aim must be to serve humanity, otherwise this dignified profession will lose its true worth. The prime object of the medical profession is to render service to humanity, reward or final subordinate consideration. Who-so-ever chooses his profession, assume the obligation to conduct in accordance with its ideals. A physician should be an upright man, instructed in the act of healings himself pure in character and be diligent in caring for the sick; he should be modest, sober, patient discharging his duty without anxiety conducting himself with propriety in his profession and in all his life.  

At the same time no person other than a doctor having qualification recognized by Medical Council of India or State Medical Council is allowed to practice modern system of surgery. A person obtaining qualification in any other system of medicine is not allowed to practice under this system.  

The physician should practice methods of healing founded on scientific basis and not associate professionally with any one who violates this principle. The honored ideals of the medical science imply that the responsibilities of the physician extend not only to individuals but also to society.  

Medical Council Act considers advertising of profession as unethical. Soliciting of patients directly or indirectly, by a physician or by a group of physicians or by institution or organisation is unethical. A physicians shall not make use of his name as subject of any form or manner of advertising as to invite attention to him or his professional position, skill, qualification, achievements. A physician shall not give any person, any approval, recommendation, endorsement, certificate, report or

193  Ibid
194  Ibid.
196  Section 16 of Medical Council Act
statement with respect of any drug, medicine, nostrum remedy, surgical, or therapeutic article, apparatus or appliance or any commercial product or article with respect of any property, quality, or use thereof or any test, demonstration or trial thereof, for use in connection with his name, signature or photograph in any form or of manner of advertising through any mode nor shall he boast of cases, operations, cures or remedies or permit the publication of respect there of though any mode. A medical practitioner is however permitted to make a formal announcement in press regarding starting practice, change of type of practice, changing address, temporary absence from duty, resumption of another practice, succeeding to another practice and public declaration of change. Printing or self photograph, or any such material of publishing in the letter head or on sign board of the consulting room or any such clinical establishment shall be considered as acts of self advertisement and unethical conduct on the part of the physician.

In recent times the self-regulatory standards in the profession have declined due to commercialisation of the sector. There are reports against exploitative medical practices, misuse of diagnostic procedures, booking deals for sale of human organs etc. There is a need for external regulation as well as enhanced self regulation. The balance between service and business is shifting disturbingly towards business. There is need for introspection by doctors individually and collectively. They must rise up to the occasion and maintain discipline and high standards in their profession.
Conclusion

Even after implementation of Medical Council Act many unethical activities exist in medical profession. So it is highly necessary to amend Medical Council Act with provision to remove all deformities. Medical profession needs strict disciplinary action. MCI takes up disciplinary actions only on complaints. Most of the victims of medical negligence may not interested in proceeding against the doctor or may not be aware of the procedures to be followed. In such cases the council has nothing to do. Apart from this, the Medical Council Act, 1956 does not provide any procedure to be followed for conducting an enquiry or neither have they specified any time for its completion. Such investigation is often conducted by adhoc committees and they take a long time to submit reports due to their unaccountability. To sum up there are rarely any disciplinary action instituted against doctors guilty of negligence and hardly ever are the doctors punished for the same.

Some kind of legal machineries should be required in the context of new emerging medical tourism, and its impact on markets. Medical tourism are rampant in India just like visiting shopping centers.

Advancement of medicine and technology has created new challenges in the medical field. Problem relating to infertility treatment, artificial nutrition and hydration, treatment of patients in coma are some of the controversial issue in this regard. The regulations to medical practice could not be done by the council alone. In the new world of medical technology formal and informal regulations by professionals and institutional are necessary. So an effective law can provide better atmosphere in medical practices.