CHAPTER 2
THE RIGHTS OF PATIENTS

2.1. INTRODUCTION

The doctor-patient relationship is inherently fiduciary in nature.[1] This two-way trust relationship obligates the more knowledgeable physician to benefit the less informed and vulnerable patient.[2] Under such a trust, patients recognize and accept physician who uses his specialized knowledge and training to provide medical benefit to them. Here, the doctors decide unilaterally as to what treatment constitutes 'benefit' to patients without obtaining consent of patients.[3] Besides, physicians due to their supremacy in medical knowledge often perceive themselves as absolute authorities in judging patient's needs. They also do not perceive a need to discuss diagnosis and proposed treatment with patients.[4] However, due to developments in science, technology, and information revolution, medical professionals increasingly find themselves confronted with moral questions and ethical dilemmas.[5] Susan Sherwin[6] states the issue of doctor supremacy in the following words:

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1 Simon R I, Shuman D W, "The Doctor-Patient Relationship", 5 *The Journal Of Life Long Learning In Psychiatry* 423 (2007).

2 Between doctor and the patient there is an imbalance of power. A doctor has knowledge and skill which often patient's lack. Among the powers possessed by a doctor is to touch and even invade the body of another, such a power of doctor must be subject to control and scrutiny. See, Kennedy I, *Treat Me Right: Essays in Medical Law and Ethics*, Clarendon Press, Oxford (1991), p.387; Hall, MA, E. Dugan, E, Zheng, B, and Mishra, AK , "Trust in Physicians and Medical Institutions: What Is It, Can It Be Measured, and Does It Matter?", 79 *Milbank Quarterly* 613, (2001), p. 614.

3 Chin, J J, "Doctor-patient Relationship: From Medical Paternalism to Enhanced Autonomy", 43 *Singapore Med J* 152 (2002).

4 Neda Milevska, '*Patients' Rights as a Policy Issue in SEE - the Transition Context*', IPF fellow, Kostova, Open Society Institute-Budapest, (2005), p.2. viewed 15 March 2013, http://www.policy.hu/milevska/ResearchPaper(nmilevska-kostova).pdf

5 Dya Eldin M. Elsayed, Rabaa Elamin M. Ahmed, "Medical Ethics: What is it? Why is it important?", 4 *Sudanese Journal of Public Health* 234 (2009), p.284. One cannot deny the fact that most of the major ethical problems arise as a direct result of the new philosophies and methodologies from modern medicine. For example, see, *Baby Doe* 464 US 961 (1982), *Airdale N.H.S Trust* v *Bland*[1993]AC 789, and *Baby Manji Yamada* v *Union of India & Anr* JT 2008 (11) SC 150 are to name a few.

6 Susan Sherwin, "A Relational Approach to Autonomy in Healthcare" in Francoise Baylis, Marilynne Bell, Maria De Koninck, Jocelyn Downie, Abby Lippman, Margaret Lock, Wendy Mitchinson, Kathryn Pauly Morgan, Janet Mosher, Barbara Parish, *The Politics of Women's Health: Exploring Agency and Autonomy*, Temple University Press, Philadelphia (1998), p.21.

> Until very recently, conscientious physicians were actually trained to act paternalistically toward their patients, to treat patients according to the physician's own judgment about what would be best for their patients, with little regard for each patient's own perspectives or preferences. The problem with this arrangement, however, is that health care may involve such intimate and central aspects of a patient's life- including, for example, matters such as health, illness, reproduction, death, dying, bodily integrity, nutrition, lifestyle, self-image, disability, sexuality, and psychological well-being- that it is difficult for anyone other than the patient to make choices that will be compatible with that patient's personal value system…

As medical treatment in the modern era involves issues of privacy, self determination, etc. the paternalistic approach, where patients meekly submit to the instructions of a physician has become a part of history. Patients are now more knowledgeable, have higher expectations of the healthcare they receive, and have a desire to participate in healthcare decisions.[7] Thus, the advent of rights of patients has become more widespread worldwide.

2.2. WHO IS A PATIENT?

The word patient is derived from Latin word *patiens*, which means to endure or to suffer.[8] In law, patient may be defined as a person under medical or psychiatric treatment and care.[9] Accordingly, a patient is a person who receives, or received health care services at a hospital or at a clinic. One can be an in-patient [10] or an out-patient[11]. The *European Declaration on the Promotion of Patients' Rights*, the only international instrument which defines the term 'patient' went on to state them as 'a user of health

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7 Henrietta Hughes, "The Patient's Responsibilities in the NHS and Around the World", 1991 *Public Policy* 9.It is to be noted that participation of patients' in healthcare decisions arose due to the widespread consumer movement of 1960s that affirmed the consumers right to safety, the right to be informed, the right to choose and the right to be heard. See also, Goic A , "It is Time to Think about Patient's Rights", 128 *Rev Med Chil* 371 (2000), pp.371-73.

8 Henry Campbell Black, *Black's Law Dictionary*, 6th edn., West Publishing Co. (1993), p.1126.

9 Id. See also, Defining the Patient-Physician Relationships for the 21st Century, 3rd Annual Disease Management Outcomes Summit October30- November 2, 2003, Phoenix, Arizona, V.1,American Healthways,Inc.(2004),p.28.viewed on 12th March 2013, http://www.cardiophonics.com/ PatientPhysician.pdf. Patient is defined as 'an individual who receives medical attention, care or treatment'.

10 An 'in-patient' means a person admitted overnight or longer in a hospital.

11 An 'out-patient' is a person who is examined, treated and goes away without having to sleep in a hospital.

care services, whether healthy or sick'.[12] The countries which have their own legislations recognizing rights of patients have defined the term patient thus: for example, Cyprus went on to state that patient means a 'natural person suffering from any disease or illness, or any person seeking or provided with health care'[13].In Finland, the term patient is used for a person 'who uses health care services or is otherwise an object of them'.[14] Lithuanian law denotes patient as 'a person who avails himself of health care irrespective of whether he is in poor health or well'[15]and Iceland defines patient as 'a user of the health service'[16]. In Kansa[17], a patient is defined as a person 'who, for the sole purpose of securing preventive, palliative, or curative treatment, or a diagnosis preliminary to such treatment, of his or her physical or mental condition, consults a physician, or submits to an examination by a physician'. This definition indicates that the purpose of the examination is foremost in determining whether or not a person is a patient within the meaning of the statute. The privilege does not exist when the examining doctor does not intend to offer treatment or advice. Moreover, the above definitions are silent in respect of patients who seek treatment from doctors other than a physician employed in health institutions. There are various instances where patients depend upon their family doctor or a doctor in case of an emergency or where a doctor is invited to a patient's home or other place and medical treatment are obtained. Such persons too are 'patients' in the eyes of law as one finds that a doctor is held liable for negligence in treatment in such instances too.[18] Among the countries which have statutes specifically protecting rights of patients one finds that it is Belgium and Israel

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12 Art.7, viewed on 12 March 2013,http://www.who.int/genomics/public/eu_declaration1994.pdf. A patient is defined as 'an individual who receives medical attention, care or treatment' in an international summit held at Arizona. See, Defining the Patient-Physician Relationships for the 21st Century, 3rd Annual Disease Management Outcomes Summit October30- November 2, 2003, Phoenix, Arizona, V.1,AmericanHealthways,Inc.(2004),p.iv,http://www.cardiophonics.com/PatientPhysician.pdf. see also, Fallberg, LH, "Patients' Rights in Europe: Where Do We Stand and Where Do We Go?" 1 *European journal of health law* 1 (2000), pp.1-3. A "patient" is a person who is receiving medical treatment or that is registered with a particular physician — a person who suffers or may suffer from a disease or health problem.

13 See, Art.2, Law on the Protection of the Rights of Patients and Related Issues,2005.

14 s.2(1),Law on the legal status and rights of the patients, 1992.

15 Art.1(1), Law on the rights of patients and damage done to patients, 1996.

16 Art.2, Law on the rights of patients, 1997.

17 K.S.A.60-427(a) (1).

18 A patient finding himself in a distressful state never bothers to enter into a formal agreement. Sometimes, he may never even bother to discuss about the fee. Thus, a physician rendering service gratuitously to the 'patient' owes duty of care to the patient. In *R* v *Bateman* (1925) 94 LJKB 791, a doctor was convicted of manslaughter as the woman who was under his care for treatment died during her delivery, Lord Hewart clearly stated that there is no necessity of establishing a contractual relationship between the patient and the doctor.

which have attempted to define the term patient, taking this aspect into consideration. For instance, as per Belgium law, patient is a 'natural person to whom health care services are provided, whether at his request or not'[19] and similarly Israel defines patient as 'a sick person or any person requesting or receiving medical care'[20]. It is to be mentioned here that while defining the term patient, statutes are silent on the circumstances when an individual becomes a patient in the eyes of law. This is essential, so as to determine when a physician has a legal duty to treat, or when he can be sued for malpractice, or to determine when a physician can be deemed to have abandoned a patient, and such other serious matters.

The fundamental interaction in health care is the one between patient and physician. The patient-physician relationship is fundamental to providing and receiving excellent care, to the healing process and to improved outcomes.[21] Moreover, the relationship between patient and doctor has been described as '…one of the most unique, but also problematic, forms of human relationship'.[22] Research reveals that there are no statutes outlining the circumstances that create a patient-physician relationship. The legal definition of a patient and the corresponding duties of the physician have been debated for over a century, and many aspects of their relationship are still not resolved. Hence, before arriving at an all encompassing definition of the term 'patient', the following paragraph briefly delves into physician-patient relationship and the way judiciary has time and again interpreted this relationship.

2.2.1. Doctor-Patient Relationship

2.2.1.1. *Contractual Relationship*

When a patient enters into a doctor's clinic with a particular problem, he or she is offering to enter into a contract with the physician. The physician accepts the person as a patient by initially examining the patient, thereby, rendering a diagnosis or treatment. Therefore, physician-patient relationship can be described as a

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19 Art.2 (1), Law on the Rights of Patients, 2002.

20 s.2, Law on the Rights of Patients, 1996.

21 Susan Dorr Goold, "The Doctor-Patient Relationship Challenges, Opportunities, and Strategies", 14 *JGIM* 26 (1999).

22 Helman C, *Introduction: The Healing bond*, in Helman C, (ed.) Doctors and Patients. An Anthology, Radcliffe Medical Press, Abingdon (2003),p.1

consensual one to which both parties must agree.[23] This relationship is a result of contract, express or implied that a doctor will treat the patient with proper professional skill.[24] In *Sidaway* v *Bethlem Royal Hospital Governors*[25], Lord Templeman said 'the relationship between doctor and patient is contractual in origin, the doctor performing services in consideration for fees payable by the patient'. Thus, it is the general belief that medical care is rendered under a contract, where a patient is treated privately by a doctor or in a nursing home.[26] Accordingly, in *QT, Inc.* v. *Mayo Clinic Jacksonville*[27], physician-patient relationship was explained as a consensual relationship in which patient knowingly seeks physician's assistance and in which the physician knowingly accepts the person as a patient. Generally, this relationship is limited to physicians seen directly by the patient.[28] Physicians in private practice may contract for their services as they see fit, and retain substantial

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23 Simon RI, Shuman DW, "The doctor-patient relationship", 5 *The Journal of Lifelong Learning in Psychiatry* 423 (2007).

24 James L, Rigelhaupt, "What Constitutes Physician-Patient Relationship for Malpractice Purposes", 17 *A.L.R.* 132 (2001). See also, *Reynolds* v *Decatur Mem'l Hosp*., 660 N.E.2d 235, 239 (Ill. App. Ct. 1996). A minor had a fall from the couch in the family living room and was taken to the hospital. The doctor after examining him made a telephonic call to the specialist for an advice but never requested him to attend to the patient. The issue in this case is whether a telephone conference between treating paediatrician and Fulbright concerning Kevin's condition created a physician-patient relationship between Kevin and Fulbright so as to raise a duty which is enforceable in a medical malpractice action in light of the standards of protocol of the hospital at which Kevin was being treated and in which both physicians were allowed to practice. The Court found there was no physician-patient relationship and, therefore, no duty was owed by Fulbright to plaintiffs.

25 [1985] 1 All ER 643, 693. The claimant suffered from pain in her neck, right shoulder, and arms. Her neurosurgeon took her consent for cervical cord decompression, but did not include in his explanation the fact that in less than 1% of the cases, decompression caused paraplegia. She developed paraplegia after the spinal operation. Rejecting her claim for damages, the court held that consent did not require an elaborate explanation of remote side effects.

26 Andrew Grubb, *The Law of Tort*, 2nd edition, Lexis Nexis Butterworths (2007), p.858. See also, Tom LB, James FC, *Principles of biomedical ethics*, Oxford University Press, New York (1994), pp.195-7. Kennedy I, Grubb A, *Medical law*, 3rd ed, London: Butterworths (2000), pp.272-7.

27 2006 U.S. Dist. LEXIS 33668 (N.D. Ill. May 15, 2006). In this case, hospital and the manufacturer agreed to conduct a study on the effectiveness of an ionized bracelet upon the health of patients. As part of the study, hospital conducted a survey and found that the bracelets were ineffective. The manufacturers sought access to the questionnaires of participants and this was agreed by the hospital provided the names of the participants are altered, claiming the questionnaires contained confidential medical information. The District Court of Illinois denied manufacturer access to the questionnaires.

28 *Corbet* v *McKinney*, 980 S.W. 2d 166, 169 (Mo. Ct. App. 1997). Plaintiffs, an emergency room patient and her husband, filed medical malpractice suit against defendant physician alleging that defendant's failure to diagnose patient caused her to suffer permanent deafness in her right ear. Defendant argued that he did not owe patient a duty of care as telephone conversation did not give rise to a physician-patient relationship between himself and patient. This was affirmed by the court.

control over the extent of their contract with patients.[29] They may refuse to enter into contract with a patient or to treat patients, even under emergency conditions.[30] In *Hurley* v *Eddingfield*[31] the question before the Supreme Court of Indiana was whether licensed doctors are obligated to help patients who are in dire need of medical attention? The court while deciding the case distinguished doctors from innkeepers who are required to serve anyone who comes to their door and went on to stay that 'the State does not require, and the medical licensee does not engage, that he will practice at all or on other terms than he may choose to accept'.[32] Similarly in *Childs* v *Weis*[33], the court held that 'a physician is not to be held liable for arbitrarily refusing to respond to a call of a person even urgently in need of medical…assistance provided that the relation of physician and patient does not exist'. Physicians may limit their specialty, their scope of practice, their geographic area, and the hours and conditions under which they will see patients.[34] They have no obligations to offer services that a patient may require that are outside the physician's competence and training[35]; or services outside the scope of the original physician-patient agreement, where the physician has limited the contract to a type of procedure, to an office visit, or to consultation only.[36] They may transfer responsibility by referring patients to other specialists.[37] But once the relationship has been created, physicians are subject to an obligation of giving continuing

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29 Barry R Furrow, Thomas L Greaney, Sandra H Johnson, Timothy Stoltzfus Jost, Robert L Schwartz, *Health Law*, 2nd edn, West Group, St. Paul, Minn (2000), p.260.

30 *Hiser* v *Randolph*, 617 P.2d 774,776 (Ariz.App.1980). The spouse of deceased patient instituted malpractice suit against physician in hospital emergency room whose refusal to treat patient suffering from acute hyperglycemia resulted in 40-minute delay in patient's testing and treatment.

31 *Hurley* v *Eddingfield*, 156 Ind 416, 59 NE 1058 (Ind 1901). Mrs. Burk suffered complications during her childbirth, her husband sent a messenger to Dr. Eddingfield. But he refused to treat. As a result the patient and her unborn child died.

32 Id.

33 *Childs* v *Weis*, 440 SW2d 104 (Ct Civ App Tx 1969). In this Texas case, when the petitioner who was seven months pregnant, arrived in the emergency room with bleeding and labor pains was advised by the doctor that she must consult her own physician who was staying in Dallas. During travel she lost her baby.

34 Barry R Furrow, Thomas L Greaney, Sandra H Johnson, Timothy Stoltzfus Jost, Robert L Schwartz, *Health Law*, 2nd edn, West Group, St. Paul, Minn (2000), p.260.

35 The AMA's Code of Medical Ethics, E-9.12 *Patient-Physician Relationship: Respect for Law and Human*, viewed 10th April 2013, https://catalog.ama-assn.org/MEDIA/ProductCatalog/m1100080/AMA%20Code%20of%20Ethics.pdf .

36 Id.

37 Id.

attention. In *Ricks* v *Budge*[38], a patient got treatment from one Dr. Budge for an injury to his hand. Several days later, the hand became severely infected, but doctor refused to treat it because the patient had unpaid bills. Budge told the patient to go to a nearby hospital. The hospital physician immediately operated, but the hand was eventually amputated. In this case, the court decided that a patient-physician relationship had been established when the patient saw Dr. Budge at the first visit because it is well settled that a physician or surgeon, upon undertaking an operation or other case, is under the duty, in the absence of an agreement limiting the service, of continuing his attention, so long as the case requires attention. A withdrawal is permitted only if the patient is given sufficient notice to procure other medical treatment. A physician who does not do so can be ethically and legally responsible for abandoning the patient.'[39] Further, in *Shirk* v *Kelsey*[40] it was laid down that after surgery, where follow-up care is needed, a surgeon must continue to care for the patient until the threat of post-operative complications has passed. In *Jewson* v *Mayo Clinic*[41], it was held that treatment obligations cease if the physician can do nothing more for the patient. It is to be mentioned here that an express written contract is rarely drafted for specific physician-patient interactions.[42] Where a

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38 91 Utah 307, 64 P2d 208 (Utah 1937). See also, *Hongsathavij* v *Queen of Angels Etc. Medical Ctr.*, 62 Cal App 4th 1123, 1138 (1998). A patient in premature labor arrived in the emergency room. The emergency room doctor contacted Dr. Hongsathavij. But doctor refused to treat the patient because he discovered she was not a County-referred patient. It was laid down that a physician cannot walk away from responsibility after accepting the patient for treatment. A physician cannot withdraw treatment from a patient without due notice and an ample opportunity afforded to secure the presence of another medical attendant. In the absence of the patient's consent, the physician must notify the patient he is withdrawing and allow ample opportunity to secure the presence of another physician.

39 Id.

40 617 N.E.2d 152 (Ill.App.1 Dist.1993). Plaintiff Denise Shirk brought an action for medical malpractice and negligent infliction of emotional distress against the defendant, Judith Kelsey, who performed an incomplete abortion at National Health Care Services in Peoria, Illinois. After returning home the plaintiff was bleeding heavily, had more severe cramps, unusual clotting and experienced a loss of bladder control. She returned to the defendant who performed a pelvic examination and told her she had a urinary tract infection and prescribed an antibiotic. The defendant did not repeat a pregnancy test or perform an ultrasound. But plaintiff was pregnant and delivered a baby boy who lived for 90 minutes.

41 691 F.2d 405 391. Mayo Clinic diagnosed Jewson as suffering from lymphosarcoma. Jewson underwent radiation therapy and was being treated for ailments unrelated to the lymphosarcoma. Later on from some independent sources he came to know that pathologist amended Jewson's initial diagnosis of lymphosarcoma to follicular and reticular hyperplasia and was given treatment for the same. Jewson initiated the present medical malpractice action against the clinic.

42 *Jones* v *Malloy*, 412 N.W.2d 837, 841 (Neb.1987). Ms. Jones underwent surgery in her lower back and when she approached Dr. Malloy for shoulder and neck pain, she was specific that she does not require any further treatment for her lower back. Contrary to her demand he treated her lower back without her express consent.

physician provides an evaluation of a patient for the benefit of a third party, or as a professional courtesy for a colleague, a patient-physician relationship is typically not established. For example, in *Lopez* v *Aziz*[43] it was held that there is no consensual physician-patient relationship when a doctor merely offers advice to a colleague rather than to the patient, and does no more than answer the colleague's professional inquiry. In *Mead* v *Adler*[44] the on-call neurologist was held to a have a duty that the court contrasted with "curbside consults", in which a physician provides a professional courtesy to another physician and no duty to the patient exists. Likewise, examinations conducted at the behest of a third party, such as for an employer, insurance company, or court (independent medical examination) do not typically entail the establishment of a patient-physician relationship because the intent is to inform the third party, not to treat or diagnose the patient.[45] In *Johnston* v *Sibley*[46] it was held where a doctor examines a person for the sole purpose of a worker's compensation assessment, no physician-patient relationship exists and the doctor's only duty is to conduct the examination in a manner not to cause harm to the person being examined. The above discussion brings to the conclusion that a patient-physician relationship is formed when a physician affirmatively acts in a patient's case by examining, diagnosing, treating, or agreeing to do so.[47] The doctor must take some action to treat the patient before the relationship can be established.[48] Once the

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43 852 S.W.2d at 306. Appellants brought suit against Dr. Salar Akhtar Aziz, alleging that he consulted with Mrs. Lopez's treating physician Dr. Manuel A. Martinez on her behalf and with her implied consent, and that he failed to recommend correct treatment.

44 231 Or App 451, 220 P3d 118 (Or 2009). This case decided on the issue whether a neurosurgeon formed a physician-patient relationship with the injured plaintiff when an ER physician telephoned the defendant neurosurgeon for a consult on plaintiff's lower back pain.

45 *State* v *Herendeen et al*, 613 SE2d 647 (Ga 2005). Two psychologists received a subpoena to appear before the Douglas County grand jury and to bring with them all records and transcripts on minor patients. These two children were molested by their father.

46 558 S.W.2d at 135-36. The defendant was employed by the insurance company for the purpose of evaluating the physical condition of the plaintiff and to make a report showing the extent of his disability.

47 Bush S., Formation of the physician-patient relationship: the Oregon Court of Appeals clarifies, but questions remain, 13 *Physician Organizations* 11 (2010), p.13, viewed 1 April 2013 http://www.healthlawyers.org/Members/PracticeGroups/PO/Documents/Newsletters/Physicians_June10.pdf.

48 *Day* v *Harkins & Munoz*, 961 S.W.2d 278. The summit contracted with two physicians, to provide emergency first-aid care to Summit patrons. The underlying suit arose while the two physicians were on-call at the Summit for a rock concert. After the concert had ended and while the patrons were clearing the premises, Pradipta Day, the Days' son, suffered from an asthma attack and died. Because the concert had ended and the two physicians had already left the Summit premises, they did not provide treatment. Harkins & Munoz filed a wrongful death and medical malpractice suit against the physicians and the Summit on the Days' behalf, alleging that the physicians had a duty to treat Pradipta's asthma attack.

physician consensually enters into a relationship with a patient in any of these ways, a legal contract is formed in which the physician owes a duty to that patient to continue to treat or properly terminate the relationship. The mere act of agreeing to see the patient at a later time does not establish a physician-patient relationship.[49] Therefore, only someone who is party to the contract may sue though, it is possible to be a party even if payment is made by someone else, such as a relative.[50] The doctor's duty of care is not predicated on the payment of a fee and arises even when care is provided gratuitously.[51] It derives from the agreement by the physician to render and the patient's reliance on that expectation. Hospitals owe a primary duty of care to those who present themselves for treatment.[52] Their primary liability arises as a result of occupier of the hospital premises, and a vicarious liability for the acts of employees.[53] A question often posed is whether a doctor has duty to continue to treat whom he has seen at the hospital. The Texas Court of Appeals in *Gross* v *Burt*[54] held the following in this regard:

> The examination of a patient at a hospital by a consulting or referred specialist physician does not create a continuing duty upon that physician to insure follow-up is maintained once the physician has supplied the primary or referring physician with the results unless the patient and the consulting or referred specialist physician take some further affirmative action to continue the relationship. If we were to expand the duty of continued care to all patients who are seen at

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49 *Jackson* v *Isaac*, 76 S.W.3d 177, 182. The family doctor of Jackson after seeing the results of EKG referred him to a cardiologist. The doctor made a telephonic call to Dr. Isaac and requested him to undertake the treatment of Jackson which he readily agreed.

50 *Lockett* v *AM Charles Ltd*., [1938] 4 All ER 170. This case is not related to doctor-patient relationship. The facts of the case are the plaintiffs, husband and wife, in the course of a motor journey stopped at a hotel for lunch. Wife was taken ill with food-poisoning and that there was a breach of an implied term of the contract under which the meal was supplied. The defendants contended that it is presumed that each party is contracting separately with the proprietor, and there is no precise evidence as to who ordered the food.

51 Simon RI, Shuman DW, "The doctor-patient relationship", 5 *The Journal of Lifelong Learning in Psychiatry* 423 (2007).

52 Andrew Grubb, *The Law of Tort*, 2nd edition, Lexis Nexis Butterworths (2007), p.860.

53 Id.

54 *Gross* v *Burt*, 149 SW3d 213, 227. The neonatologist determined that the twins needed to be screened for retinopathy of prematurity. The actual screening is performed by a pediatric ophthalmologist who is a consulting physician requested or ordered by the attending physician, and who then reports back directly to the attending physician. Dr. Gross performed the screening tests. Dr. Gross determined one of the twins had Stage I ROP in his right eye. He forwarded an ROP initial evaluation report of his findings and recommendations back to the admitting neonatologist and recommended that the child seek a follow-up visit within two weeks. The parents of the child did not follow-up as instructed and missed several appointments. When both twins were finally examined after discharge they were diagnosed as being legally blind. The parents filed a lawsuit against Dr. Gross, alleging negligence.

> hospitals by consulting physicians beyond the hospital setting based solely upon the fact that they were seen by the physician in the hospital, there would be no end to the physician-patient relationship.

Though, it is clear that Texas law recognizes self-limiting relationships, physicians should be careful in attempting to rely entirely upon this concept as it is difficult to determine exactly when the professional relationship has terminated. In the dissenting opinion for the *Gross* v *Burt*[55] case, Justice Sue Walker stated that the majority opinion relies upon cases that 'address only whether an initial physician-patient relationship was created, not whether an existing physician-patient relationship later continued or was terminated'.[56]A physician may agree in advance with a hospital to the creation of a physician-patient relationship that leaves the physician no discretion to decline treatment of the hospital's clients.[57] Likewise, a patient's health care plan can create a physician-patient relationship if the physician is the designated doctor for the health care plan.[58]

2.2.1.2. *Fiduciary Relationship*

In the modern era of telephonic consults and remote records review, can a relationship be formed with a physician who has never even met the patient? Though, contract-based approach is still one way to assess formation of the physician-patient relationship, it is essentially been overtaken by a tort-based approach focusing on the existence of a special relationship arising from the physician's actions, even in the absence of mutual consent, a meeting of the minds

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55 Id.

56 Id. p.247.

57 *St. John* v *Pope*, 901 S.W.2d at p.423. In this case, the patient came to the emergency room of a hospital with fever and back pain following recent back surgery, and the emergency room physician phoned the hospital internist on call. The on-call physician listened to the description of the patient's symptoms and recommended that the patient either be referred to a hospital that had a neurosurgeon or to the physician who had performed the surgery. For reasons unclear in the record, the patient was not transferred but went home. Ultimately, the patient had meningitis and suffered permanent disabilities.

58 *Hand* v *Tavera*, 864 S.W.2d at 680. In this case Dr. Tavera was the physician responsible for authorizing admissions. When the patient, a member of the Humana HMO, went to the HMO-approved hospital and complained of a 3-day headache, the severity of which fluctuated with blood pressure. The patient was sent home and suffered a stroke several hours later. When Dr. Tavera was sued, he argued there was no established patient-physician relationship because he had never seen the patient. The court held that a relationship did exist because the patient had essentially 'paid in advance for the services of the Humana plan doctor on duty that night, who happened to be Tavera. When the health care plan's insured shows up at a participating hospital emergency room, and the plan's doctor on call is consulted…there is a physician-patient relationship'

or other traditional indicia of a contract.[59]One must remember that the practice of medicine is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering.[60] The relationship between patient and physician is based on trust and gives rise to physicians' ethical obligations to place patients' welfare above their own self-interest and above obligations to other groups, and to advocate for their patients' welfare.[61] It is possible for a doctor to owe a fiduciary duty to a patient.[62] In general, any professional engaged in health care owes a tortuous duty of care to the patient.[63] This is so whether or not there is a concurrent duty in contract.[64] Further, it was said in *Pippin* v *Sheppard*[65] that 'to hold to the contrary would be to leave such persons in a remediless state'. In *Dowell* v *Mossberg*[66], the Oregon Supreme Court noted in dicta that 'failure to exercise due care in the treatment of a patient is a breach of a legal duty which arises, not out of contract, but out of the relationship of physician and patient'. Furthermore, in *Ramirez* v *Carreras*[67], the court recognized that the duty to refrain from negligently injuring others generally requires no prior relationship. In the context of the physician-patient relationship, the implied contract is a very different concept.[68] It does not require formalities of a contract; a contract can be *implied in fact*, which means it 'arises from the acts and conduct of the parties, it being implied from the

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59 *Mead* v *Adler* 231 Or App 451, pp.459-460.

60 AMA policy E-10.015(I, II, VI, VIII) Issued December 2001 based on the report "*The Patient-Physician Relationship*", adopted June 2001, viewed 10th April 2013,Rights https://catalog.ama-assn.org/MEDIA/ProductCatalog/m1100080/AMA%20Code%20of%20Ethics.pdf .

61 Simon RI, Shuman DW, "The doctor-patient relationship", 5 *The Journal of Lifelong Learning in Psychiatry* 423 (2007).

62 See I Kennedy, 'The Fiduciary Relationship and its Application to Doctors and Patients' in P Birks (ed) *Wrongs and Remedies in the 21st Century* (1996), Ch.5.

63 Andrew Grubb, *The Law of Tort*, 2nd edition, Lexis Nexis Butterworths (2007), p.859.

64 *Gladwell* v *Steggall* (1839) 5 Bing NC 733,132 ER 1283. Cited in NSW Law Reform Commission, 10. Consents, Counselling and Legal Liability Discussion Paper 15 (1987) - Artificial Conception: In Vitro Fertilization, viewed 10th April 2013, http://www.lawlink.nsw.gov.au/ lrc.nsf/pages/dp15chp10.

65 *Pippin* v *Sheppard* (1822) 11 Price 400. Cited in NSW Law Reform Commission, 10. Consents, Counselling and Legal Liability Discussion Paper 15 (1987) - Artificial Conception: In Vitro Fertilization, viewed 10th April 2013, http://www.lawlink.nsw.gov.au/lrc.nsf/pages/dp15chp10.

66 226 Or 173, 190 (1961) .The defendants failed to diagnose a serious case of diabetes mellitus, failure of which the plaintiff claims caused a long delay in receiving proper treatment, with resultant permanent injury.

67 10 S.W.3d at 762. Simon Ramirez filed a worker's compensation claim, and the worker's compensation insurance carrier hired Dr. Carreras to perform an impairment rating on him. Ramirez contends Dr. Carreras injured him while performing the exam. He sued for medical negligence, common law negligence, and assault and battery. See also,St. *John* v *Pope*,, 901 S.W.2d at 423

68 An implied contract requires no actual agreement. It is not a creation of the doctor or the patient. Rather, the law as a matter of reason and justice infers it by the conduct of the doctor.

facts and circumstances that there was a mutual intention to contract'. [69] In *Dougherty* v *Gifford*[70], it was noted:

> A consensual relationship between a physician and a patient may exist where others have contracted with the physician on the patient's behalf.... The important fact in determining whether the relationship is a consensual one ... is not who contracted for the service but whether it was contracted for with the express or implied consent of the patient or for his benefit.... Where ... healthcare services are rendered on behalf of the patient and are done for the patient's benefit, a consensual physician-patient relationship exists for the purposes of medical malpractice.

Therefore, in *State* v *Pitchford*[71] the court laid down that when physician attends a person for purpose of giving professional aid, even though person attended is unconscious or unaware of physician's presence and does not consent, or actually objects to being treated is a patient in the eyes of law. In *Stanford* v *Cannon*[72], the

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69 *St. John* v *Pope,* 901 S.W.2d at 424; see also, *Haws & Garrett Gen. Contractors, Inc.* v *Gorbett Bros.Welding Co.*,480 S.W.2d 607, 609 (Tex.1972). Haws & Garrett General Contractors, Inc., sued Gorbett Brothers Welding Company, Inc., for damages to a bridge allegedly incurred as a result of the negligence of Gorbett Brothers. The incident occurred during the operation of two cranes and hoisting equipment which Haws & Garrett had rented from Gorbett Brothers. Gorbett Brothers alleged in defense that Haws & Garrett had contracted to indemnify Gorbett Brothers for any liability arising out of the operation of the rented equipment.

70 826 S.W.2d at 675. Gifford developed a hernia of the esophagus that worsened to the point that his family physician referred him to a specialist. The specialist, Dr. Josie Williams, took a biopsy and sent it to the pathology department of McQuistion Regional Medical Center in Paris. Dougherty & Associates had a contract to perform all pathology work for the medical center. The actual pathology work on Gifford's biopsy, however, was performed by Dr. Jaime Molina, who worked under an arrangement with Dougherty. Molina's work was done at the medical center laboratory, which Dougherty directed. Dougherty billed Gifford for the pathology services. Molina diagnosed malignant cancer. After six weeks of treatments, a second biopsy was taken, and it revealed that there was no malignancy. The jury found that Molina was negligent in making the cancer diagnosis

71 10 Kan.App.2d 293. A car met with an accident in a highway. On reaching the spot, the officers found that the driver was missing. Later a man was found about 60-70 yards away from the accident site, believing him to be the driver police asked to stop but he started running. Police after a chase got him and found that the defendant needed medical assistance which was strongly resisted by him. He was handcuffed and brought to the hospital for medical aid. The state argued that physician-patient privilege does not apply in this case because the defendant was not a patient because he neither consulted the physician nor voluntarily submitted to the physician's examination and also the examining doctor was not the defendant's personal physician. The court rejected these arguments.

72 *Stanford* v *Cannon,* 2011 WL 2518856 (Tex.App.—Texarkana2011, no pet.) An individual went to the office seeking laser hair removal treatment. The patient filled out a medical history form and a consent form explaining the mode of action of the treatment, the proposed benefits of treatment, the probability of success and the possible complications of treatment. The laser hair removal was performed by the technician. The physician signed and dated the notes *after* the treatment, having never seen the patient nor participated in the procedure.

court found a physician-patient relationship existing based on the acts and conduct of the parties, despite the fact that physician never saw the patient nor directly influenced the patient's care. Courts have been reluctant to extend liability to specialists consulted informally by the patient's primary physician. Such informal consultations, variously called "curbside", "hallway", or "sidewalk" consultations, typically involve a presentation of the patient's history, recitation of the diagnostic test results obtained to date and discussion of potential avenues of treatment for patient and others with similar symptoms.[73] Usually, the specialist does not know the patient's identity, the patient is unaware of the consultation, and the specialist does not bill for his or her advice.[74] In the past, such informal consultations would not establish a physician-patient relationship as a matter of law.[75] In *Mead* v *Adler*[76], the court went on to discuss the novel question whether an on-call physician's advice to an emergency room physician over the telephone concerning a specific patient will give rise to a physician-patient relationship. The Oregon Court held:

> In summary, the consensus of the jurisdictions that have considered the question is that a physician-patient relationship can arise by implied consent of the physician based on indirect contact between the physician and patient through telephone communication between a hospital emergency room physician and an on-call physician concerning the care of an emergency room patient; the pivotal inquiry is whether the on-call physician affirmatively participates in the care of the patient. That affirmative participation exists if the on-call

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73 Patricia C. Kuszler, "Telemedicine and Integrated Health Care Delivery: Compounding Malpractice Liability", 25 *AM. J.L. & MED* 297 (1999), p. 313.

74 Id.

75 See, e.g., *Oliver* v *Brock*, 342 So. 2d 1, 4 (Ala. 1976). The defendant doctor had never seen the plaintiff; neither the plaintiff's parents nor her treating doctor had ever requested or engaged the defendant to serve as a consultant in the plaintiff's treatment. The court found that there was no evidence from which it could conclude that the defendant had consented to treat the plaintiff.; *Rainer* v *Grossman*, 107 Cal. Rptr. 469, 472 (Ct. App. 1973. The case concerned with a professor of medicine recommending surgery for patient during discussion with patient's personal physician; *Reynolds*, 680 N.E.2d at 238. The defendant gave informal opinion over phone to plaintiff's doctor; *NBD Bank* v *Barry*, 566 N.W.2d 47, 49 (Mich. Ct. App. 1997). The issue in this case was whether a doctor who is contacted by a patient's treating physician to discuss treatment alternatives owes a duty of care to the patient whose case is discussed; *Corbet* v *McKinney*, 980 S.W. 2d 166, 169 (Mo. Ct. App. 1997) Plaintiffs, an emergency room patient and her spouse, filed this medical malpractice action against defendant physician alleging that defendant's failure to diagnose patient caused her to suffer permanent deafness in her right ear. It was held by the court that there is no evidence that defendant contracted to provide medical services to plaintiff. Moreover, defendant never examined plaintiff and he did not make diagnosis. He only offered recommendation for treatment, which was communicated directly to treating physician and not indirectly to patient.

76 231 Or App 451, pp.461-62.

> physician undertakes to diagnose or treat the patient…… we also conclude that an on-call physician who affirmatively undertakes to diagnose or treat an emergency room patient over the telephone has impliedly consented to a physician-patient relationship for purposes of negligence liability.

The advice rendered by the defendant was not 'merely casual or informal advice to a colleague'.[77] A developing area of the law is when a physician-patient relationship may be established even where the physician does not personally see the patient. It is laid down in *Mead* case that 'special relationship' may exist even when the on-call physician refused to see the patient or was unavailable to attend the patient.[78]

Increasingly, courts are allowing medical malpractice suits to proceed against specialists consulted informally by a patient's primary doctor, either to decide the preliminary question of whether a physician-patient relationship existed or, having made such a determination as a matter of law, to decide further whether the resulting duty of care was breached by the consultant physician. In that regard, several cases have turned on whether the consultant went beyond giving general advice to patients or has actually participated in the patient's care. Some results were premised on whether a pre-existing contract between the consultant physician and the hospital created the requisite physician-patient relationship. Several others were based on whether the consultant's expertise made it foreseeable that the treating physician would subordinate his or her own medical judgment in reliance on the consultant's opinion. In review, these cases reveal a discernible shift away from the longstanding policy that favors physicians' expectations over those of patients when determining whether a particular physician owed a duty of care to a particular patient. Consequently, physicians who entertain what are otherwise informal discussions about the management of patient complaints and illnesses, usually considered a protected professional domain, may be at greater risk for medical malpractice liability. To sum up, it might be stated that a physician-patient relationship is formed if a physician affirmatively undertakes to diagnose, treat or prescribe; his or her responsibility for failure to possess and use the skill and care

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[77] Id. p.464.
[78] Id. p.777.

of an ordinary physician is not dependent upon an express agreement of employment or a promise to pay for services. A duty of care and a physician-patient relationship exist where a physician has undertaken either gratuitously or for a consideration to render a medical service, no matter how slight. Mere contact with a patient or the administrative facilitation of services by another provider, however, is not enough to form a physician-patient relationship.

With the sweeping changes within and outside the health care sector, such as the growing preponderance of chronic illnesses, new medical technologies, shifting reimbursement practices, the Internet, government regulations, rising costs and changing social norms are constantly molding patient and physician behavior.[79] Traditionally, the term patient implied an inferior position relative to that of the provider. The type of care given to patient was often being viewed from the illness model perspective, which emphasizes the illness or health crisis rather than prevention.[80] However, the role of the patient is changing. With evolving wellness models that emphasize illness prevention and maintenance of good health, it places the patient in the driver's seat directing healthcare needs.[81] Hence, as Rebecca S. Busch notes a more appropriate term may be 'health consumer, health care consumer, or client'[82]. As a consumer, a patient is entitled to many rights including the right to receive information in a timely fashion, as well as to receive it in a form that they can easily understand, access to quality health care, emergency healthcare services, to participate in treatment decisions, considerate and respectful care, communicate with healthcare providers in confidence and finally to complaint and receive compensation. Therefore, amid the changes, one of the clearest themes to emerge is the centrality of patients. Increasingly, they are not simply recipients of care or subjects of research but active, informed

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79 Anthony Scott, Sandra Vick, "Patients, Doctors and Contracts: An Application Of Principal-Agent Theory To The Doctor-Patient Relationship", 46 *Scottish Journal of Political Economy* 111(1999), p.112.

80 Rebecca S. Busch, *Healthcare Fraud Auditing and Detection Guide*, John Wiley & Sons, Inc., New Jersey, (2008), p.18.

81 Id.

82 Id. The term 'consumer' implies a financial relationship as the purchaser of a healthcare service. With the rise of the electronic world comes the arrival of the e-patient. The e-patient is the evolving patient consumer who uses the Internet to obtain a variety of health information. But one must acknowledge the fact that in medicine it is the doctor who is more knowledgeable and has information about the patient's anatomy. Therefore, I don't think a term like health consumer, client could be used.

individuals who wish to know more about their condition and exert greater control over their own care.[83] A four day conference held at Arizona[84] identified seven principal elements that both physicians and patient believe are essential. They are communication [85], office experience [86], hospital experience [87], education [88], integration[89], decision-making[90] and outcomes[91]. Therefore, while defining the term patient one must also keep in mind the modern trends of physician-patient relationship. In view of the above discussion, a patient can be defined as an individual who receives medical attention, care or treatment, at his request or not. The treatment obtained by the patient may be for his own interest or in the interest of society.

2.3. RIGHTS OF PATIENTS: AN OVERVIEW

Conventionally, patients' rights were protected through ethical rules or codes of conduct. These codes acted as guidelines that the medical professionals imposed in order to ensure that doctor's behavior towards their colleagues and their patients met appropriate standards. Though, doctors were under a duty to act in their patients' best interests, it was they who decided what those interests were. Thus, for centuries all focus of the discussion on rights of patients has been centered on 'particular obligation' of individual physician towards their patients. But, a closer analysis of various medical codes during this period clearly demonstrates that patient's rights were in fact impliedly protected. For example, the Hippocratic Oath remains one of the famous and relevant ethical code which is

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83 Defining the Patient-Physician Relationships for the 21st Century, 3rd Annual Disease Management Outcomes Summit October30- November 2, 2003, Phoenix, Arizona, V.1 American Healthways, Inc. (2004), p.28. viewed on 12 March 2013, http://www.cardiophonics.com/ PatientPhysician.pdf.

84 I d. p.v.

85 Meaning of communication includes means of communicating; information gathering; the role of patient self-assessments and feedback; delivery of information; and adequacy of information.

86 This includes access to care; office-patient communication; processes for obtaining prescriptions and refills; information forms; and the care environment.

87 It includes expectations for personalizing care; the physician in charge; communication among members of the health care team, patients, family and patient advocates; discharge planning and the emergency room experience.

88 It is concerned with the information provided by physicians to patients; addressing patients' individual situations; non-physician sources of information; and the role of self-care.

89 This means sharing of information among all members of the health care team; navigation of the health care system; medical records; and health plan information.

90 This includes patient's role; the patient advocate's role; the right of patients to know all evidence-based options; and non-clinical factors that impact medical decisions.

91 Outcome here means clinical outcomes; patient-centered outcomes; and physician centered outcomes.

being followed by physicians till today. It was only towards the midst of twentieth century that patients began to challenge medical paternalism. It may be due to the increase in medico-legal cases involving physician's misconduct and a subsequent public perception that there exists a desire by the members of the profession to protect their peers in such situations. In addition to it the technological revolution and resultant change in access to medical information caused the physicians and patients to reexamine the existing relationship of benevolent paternalism.

2.3.1 Ancient Period

In ancient period, medicine arose out of the primal sympathy of man with man.[92] It arose out of the desire to help those in sorrow, need and sickness. In those times, medical profession was however associated with superstition and magic.[93] The sick person was believed to be under the influence of ghosts or evil spirit.[94] The doctor's duty was to free the body from the clutches of demons and to remove the evil spirit, thereby, cleansing the body.[95] In primitive societies, medicine was concerned with magical power over natural objects, exercised through rites, spells and charms.[96] Amongst the ritual and magic, primitive man sometimes arrived at a cure that was passed through oral tradition and memory.

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92 Douglas Guthrie, *History of Medicine*, Thomas Nelson and Sons Ltd., London, (1945), p.2, viewed 19 Feb 2013, http://archive.org/details/historyofmedicin035119mbp.

93 KPS Mahalwar, *Medical Negligence and the Law*, Deep and Deep Publications, New Delhi, (1991), p.1. see also, William Osler, *The Evolution Of Modern Medicine* A Series Of Lectures Delivered At Yale University On The Silliman Foundation In April, 1913 (2006), viewed 12 may 2012**,** http://www.gutenberg.org/files/1566/1566-h/1566-h.htm.

94 All diseases were believed to be result of anger of Gods hence, to be averted by prayer and sacrifice. Besides the major Gods, representatives of Apollo, AEsculapius and Minerva, there were scores of lesser ones who could be invoked for various diseases. Romans appealed to no less than fourteen goddesses, from Juno Lucina to Prosa and Portvorta . Temples were erected to the Goddess of Fever, and she was invoked to be free from disease. Primitive man also used magic as a spiritual power to heal or to cause injury to the individual. Some of the recognized superhuman agencies relating to disease, are, the spirits of the dead, either human or animal, independent disease demons, or individuals who might act by controlling the spirits or agencies of disease. See generally, William Osler , *The Evolution Of Modern Medicine A Series of Lectures Delivered At Yale University on the Silliman Foundation In April, 1913* (2006), viewed 12 may 2012**,** http://www.gutenberg.org/files/1566/1566-h/1566-h.htm.

95 Dan Mayer, *Essential Evidence-Based Medicine*, 2nd edn, Cambridge University Press, Cambridge (2010), p.2. Holes were made in the skull known as trephination (a round piece of skull in this way was removed).This kind of operation was done for epilepsy, infantile convulsions, headache, and various cerebral diseases believed to be caused by confined demons, to whom the hole gave a ready method of escape. Also, other religious rituals were too performed to vent evil spirits. With advances in civilization, healers focused on "treatments" that seemed to work. They used herbal medicines and became more skilled as surgeons.

96 M Swanepoel, "The Development Of The Interface Between Law, Medicine And Psychiatry: Medico-Legal Perspectives In History", 12 *PER* 124 (2009), p.127.

The first documented Code of Laws ever used by human civilisation is to be found from the *Code of Hammurabi*[97] in Mesopotamia. In ancient Mesopotamia, medicine was considered as a part of 'magic'.[98] The Code is a textual source of evidence concerning the skills of Mesopotamian physicians, surgeons, the conduct expected of physicians at that time, including fees that could be charged, for lifesaving operations based on result[99] and also legal issues connected with medicine.[100] In Mesopotamia, the practice of medicine was regulated by the State.[101] The Code imposed strict accountability to the patient with uncomfortably severe penalties for

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97 Price IM, "The relation of certain gods to equity and justice in early Babylonia", 52 *J Am Oriental Soc* 174, (1932), pp.174-78. King Hammurabi of Babylon created the '*Hammurabi Code'*. It is generally believed to have been written between the second year of his reign, circa 1727 BCE, and the end of his reign, circa 1680 BCE. This extraordinary document is a black diorite block 8 feet high, once containing 21 columns on the obverse, 16 and 28 columns on the reverse, with 2540 lines of writing of which now 1114 remain, and surmounted by the figure of the king receiving the law from the Sun-god. The Hammurabi Code is divided into three sections: *Ius actionum*, *Ius rerum* and *Ius personarum* . The code contains laws both civil and religious, many of which relate to the medical profession. The laws were codified for the first time to regulate public health and enumerated the duties and responsibilities of physician-priests and thus became the first code of 'ethics' imposed by the state on the medical profession. See also, Miguel A. Faria, "On Ethics, Guidelines, and Medical Progress"**,** 1 *Medical Sentinel* 6 (1996), pp.6-9*;* Akram, Mohd Shair, "Ethics and Medicine", 7 *Journal of Applied Sciences Research* 2394 (2011).

98 Disease was believed to be as a result of evil spirits or demons. These 'demons', invisible to the naked eye were the precursors of the modern 'germs' and 'microbes', while the incantations recited by the priests are the early equivalents of the physician's prescriptions. There were different incantations for different diseases; and they were as mysterious to the masses as are the mystic formulas of the modern physician to the bewildered, yet trusting, patient. Recitations, ceremonies, prayers, and sacrifices were common religious means of beseeching the Gods for a cure; however, along with these veritable drugs were used in the treatment of disease. Further, references to bronze lancets in the Code of Hammurabi and elsewhere indicate the use of instruments in surgical operations, and there have been a few isolated archaeological recoveries of knives.

99 para 215. If a doctor has treated a gentleman for a severe wound with a bronze lances and has cured the man, or has opened an abscess of the eye for a gentleman with the bronze lances and has cured the eye of the gentleman, he shall take ten shekels of silver.
para 221. If a doctor has cured the shattered limb of a gentleman, or has cured the diseased bowel, the patient shall give five shekels of silver to the doctor. see, Hammurabi B.C. 2285-2242, The Code of Hammurabi, in Johns, C.H.W, *The Oldest Code of Laws in the World*, viewed 4 April 2012,http://www.gutenberg.org/files/17150/17150-h/17150-h.htm.

100 The code for the first time dealt with the issue of 'medical malpractice' and for the first time the concept of civil and criminal liability for improper and negligent medical care was introduced to the public. See, Cyril H. Wecht, "The History of Legal Medicine", 33 *J Am Acad Psychiatry Law* 245 (2005) , p.245.

101 see, Hammurabi B.C. 2285-2242, "The Code of Hammurabi", in Johns, C.H.W, *The Oldest Code of Laws in the World*, viewed 4 April 2012, http://www.gutenberg.org/files/17150/17150-h/17150-h.htm.

physician.[102] Medical malpractice was for the first time recognised and was punished under law.[103] Carelessness and negligence were punished with severe penalties.[104] Thus it can be seen that practice of medicine was well organized and regulated. The veterinary medicine was also recognised.[105] However, it may be noted that laws only specified liability in connection with surgery. This means that physicians were not held liable for any non-surgical mistakes or failed attempts to cure an ailment.[106] The Code was extremely oppressive to medical practitioners but also very stifling to medical innovation.[107] Thus medical progress was slow to flourish in the Mesopotamian land.[108]

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[102] The striking feature of the code is the application of "*lex talionis*"-an eye for an eye, bone for a bone, and tooth for a tooth. This is clear from the wordings of the code:
para 218. If the doctor has treated a gentleman for a severe wound with a lances of bronze and has caused the gentleman to die, or has opened an abscess of the eye for a gentleman and has caused the loss of the gentleman's eye, one shall cut off his hands.
para 219. If a doctor has treated the severe wound of a slave of a poor man with a bronze lances and has caused his death, he shall render slave for slave.
para 220. If he has opened his abscess with a bronze lances and has made him lose his eye, he shall pay money, half his price. The code was enforced by king and his jurists throughout the kingdom. see, Hammurabi B.C. 2285-2242, The Code of Hammurabi, in Johns, C.H.W, *The Oldest Code of Laws in the World*, viewed 4 April 2012, http://www.gutenberg.org/files/17150/17150-h/17150-h.htm. see also, Faria MA., "*Vandals at the Gates of Medicine-Historic Perspectives on the Battle over Health Care Reform*", Hacienda Publishing, Inc., Macon GA (1995), p.5. The code was enforced by king and his jurists throughout the kingdom.

[103] Halwani TM, Takrouri MSM, "Medical laws and ethics of Babylon as read in Hammurabi's code", 4 *IJLH&E* 2 (2007), pp. 2-7.

[104] See generally, William Osler 2006, *The Evolution Of Modern Medicine A Series Of Lectures Delivered At Yale University On The Silliman Foundation In April, 1913*, viewed 12 may 2012**,** http://www.gutenberg.org/files/1566/1566-h/1566-h.htm.

[105] para 224. If a cow doctor or a sheep doctor has treated a cow or a sheep for a severe wound and cured it, the owner of the cow or sheep shall give one-sixth of a shekel of silver to the doctor as his fee. see, Hammurabi B.C. 2285-2242, The Code of Hammurabi, in Johns, C.H.W, *The Oldest Code of Laws in the World*, viewed 4 April 2012,http://www.gutenberg.org/files/17150/17150-h/17150-h.htm.

[106] Amundsen DW, 'The Liability of the Physician in Roman Law' in Karplus H (ed) *International Symposium on Society, Medicine and Law*, Jerusalem, Elsevier, Amsterdam (1972), p.17. He opines that as medicine was strictly enforced by the State as a result little surgery was practiced during this time. According to him, lack of competence on the part of the surgeons may be the reason for the promulgation of a stricter legislation by Hammurabi.

[107] Miguel A. Faria, "On Ethics, Guidelines, and Medical Progress"**,** 1 *Medical Sentinel* 6, *(*1996), pp.6-9.

[108] See, Miguel A. Faria, "On Ethics, Guidelines, and Medical Progress"**,** 1 *Medical Sentinel* 6, (1996), pp.6-9. From the writings of the great historian, Herodotus (c.484-424 B.C.), the father of history, we learn that, so oppressive had become the state of affairs for medical practitioners, that physicians had become scarce or non-existent, and thus, the whole community was forced to act as a sort of medical collective, utilizing a communal approach to treat the many illnesses and afflictions suffered by the common folks. Hence, it becomes eminently clear from the Mesopotamian medical history that the practice of medicine cannot thrive in a milieu of government oppression, coercion, and intimidation. See also, Amundsen DW, 'The Liability of the Physician in Roman Law' in Karplus H (ed) *International Symposium on Society, Medicine and Law*, Jerusalem, Elsevier, Amsterdam (1972), p.17.According to him lack of competence on the part of the surgeons may be the reason for the promulgation of a stricter legislation by Hammurabi. He opines that as medical regulations were strictly enforced by State it is assumed that little surgery was practiced during this time.

In Egypt the duties of physician were documented in *papyri.* [109] The reputations of Egyptian physicians were consistently high. [110] Physicians of ancient Egypt were probably trained in the temples, as were the priest- magicians and sorcerers. [111] The '*shaman*' or priest/physician was considered as holy men. [112] Though they were respected, they were not fully trusted by the patients.[113] In fact, there was not much interaction between physicians and patients.[114] However, an

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[109] The 16th century Egyptian papyri documented the duties of the priest/physicians. Of these, six or seven are of the utmost important. The most famous is that discovered by *Ebers*, dating from about 1500 B.C. This document is one of the great treasures of the Leipzig Library; it is 20.23 metres long and 30 centimetres high and in a state of wonderful preservation. Others are the *Kahun, Berlin, Hearst* and *British Museum* papyri. See generally, William Osler, *The Evolution Of Modern Medicine A Series Of Lectures Delivered At Yale University On The Silliman Foundation In April, 1913*, (2006) viewed 12 may 2012**,** http://www.gutenberg.org/files/1566/1566-h/1566-h.htm.

[110] Egyptian physicians were also priests. It was common for different priests to act as physicians for different parts of the body, in much the same way that doctors specialize now, as they believed that different Gods governed different sections of the human body. Herodotus, a Greek historian who is regarded as the father of history (484 BC-425 BC), noticed the remarkable fact that besides general practitioners, there were many who devoted themselves to special branches of medical science, some being oculists, some dentists, some skilled in treating diseases of the brain, and other for treating diseases of the intestines etc. Among these were *Iry*, called 'Keeper of the King's Rectum', a court physician who, about 2500 BC attended to diseases of the eye and belly as well as the anus. *Hawi* was an Old Kingdom healer of the teeth and anus. The standards of training and of practice seem to have been set by the pharaoh's physician (head of the palace doctors), who stood at the apex of the hierarchy. Beneath him were the palace physicians (the Egyptian term is *saw*, meaning 'guardian'), among whom one may have been the supervisor of physicians. The others were inspectors of physicians, a group of lesser chief physicians, and a lower order of physicians comprising the great bulk of practitioners. There were also physicians who took care of workmen and a special cadre of doctors for miners (the Egyptian term is *wabw*, meaning 'pure of the goddess Sekhmet'). Temple physicians (the Egyptian term is *swnw* meaning 'doctor of people'), possibly of lower social standing, were available to all people and visited patients' homes as well. Army physicians accompanied military expeditions and gave service to soldiers in the barracks. See, Laurie SS, "The history of early education II: The ancient Egyptians", 1 *School Rev* 353, (1893), p.358; Stephen B. Webster,"Medical Ethics From Our Professional Ancestors to the Present", 4 *Gundersen Lutheran Medical Journal* 33, (2006).

[111] It must be noted here that medicine as practiced by the ancient Egyptians was not primitive, however. Some medical papyri are predominantly religious, but others are predominantly empiric rational. They prescribe many rational methods of treatment, such as diet, physiotherapy and drugs.

[112] Laurie SS, "The history of early education II: The ancient Egyptians", 1 *School Rev* 353 (1893), p.358

[113] Id.

[114] Id.

example of organized medicine is to be found in Egypt.[115] Several features were found to be outstanding in comparison with modern practice. A concept of National Health Service seems to have been well developed during that period. Patients were not charged for visits to the healers, who were themselves, supported by the community. [116] It is also a fact that physicians were in fact subject to many strict rules and harsh regulations as a result of the pervasive influence of the Code of Hammurabi.[117] Patients were treated free of charge, as the physicians received a salary from the State.[118] Physicians provided their services according to a written law compiled by many famous physicians of ancient times.[119] They were safe from any accusation where they had followed the relevant laws.[120] But if they acted contrary to the written law, even capital punishment was awarded. Thus, Egyptian physicians were wary of treating those

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115 Egyptian medicine was a mixture of magic explanations, acute observation and great empirical knowledge. Before physicians could prescribe any treatment, they had to make a diagnosis by employing their powers of observation and experience in determining the nature of the illness. He would then refer to the medical papyri to determine the most appropriate course of treatment. However, Egyptian methods of diagnosis relied on information from the patient, but the actual taking of a detailed patient history had not yet developed. They mastered human anatomy and they were very skilled in applying bandages and using sutures. It is supposed that they had obtained all this knowledge through the practice of mummification. Many authors think that if the Alexandria Library had not been burnt down, Imhotep's books would have been preserved and he would have been considered, together with Hippocrates, one of the fathers of modern medicine. He was so good that after his death people considered him a healing God and his temples functioned as a sort of hospital. Imhotep was an outstanding- man since he was not only a great physician but also a poet, a priest, a judge, prime minister (*visir*) of the Pharaoh Zoser and even the architect who drew the pyramid of Saqqara See, Lyon DG, "When and where was the Code of Hammurabi promulgated?", 27 *Journal of the American Oriental Society* 123, (1906), pp.123-134; Carlos G. Musso, "Imhotep: The Dean among the Ancient Egyptian Physicians - An Example of a Complete Physician", 5 *Humane Medicine*, (2005), http://www.hekint.org/documents/AncientEgyptianPhysicians.pdf.

116 Akram, Mohd Shair, 'Ethics and Medicine', 7 *Journal of Applied Sciences Research* 2394, (2011).

117 Id. This is corroborated in the world's oldest surgical textbook, the '*Edwin Smith Papyrus*' and to a lesser extent in the 'Ebers papyrus'. The Egyptians considered their ancient medical texts to be sacred and binding. These texts, in fact, functioned as a kind of law code, complete with the authority to inflict severe penalties for deviants. see also, Ritner RK, "Innovations and Adaptations in Ancient Egyptian Medicine", 59 *Journal of Near East Studies* 107 , (2000). Miguel A. Faria, "On Ethics, Guidelines, and Medical Progress", 1 *Medical Sentinel*,(1996), viewed 14 Feb 2012,http://www.haciendapub.com/medicalsentinel?field_articletype_value_many_to_one=All&field_issue_value_many_to_one=Summer+1996;See also, Okasha, A, "Egyptian Contribution to the Concept of Mental Health",7 *EMHJ* 377, (2001), at pp.377-380; O'Mathuna DP, Amundsen DW 1998, "Historical and Biblical References in Physician-Assisted Suicide Court Opinions", 12 *Notre Dame Journal of Law, Ethics & Public Policy* 473 (1998), pp. 473-496.

118 Faria, MA, *Vandals at the Gates of Medicine - Historic Perspectives on the Battle over Health Care Reform*, Hacienda Publishing, Inc., Macon GA (1995), p. 24.

119 Abelle Vinel and Jacques Pialoux, *Ancient Egyptian Medicine and Traditional Chinese Medicine*, Conference given at the R.E.F.S. Congress, on 31 October 2005 in Aix-en-Provence, p.7, viewed 7th April 2013, http://www.cornelius-celsus.org/documents/MedEgypt_English.pdf.

120 Hamed A. Ead, *Medicine In Old Egypt* (1998), viewed 7th April 2013, http://www.frcu.eun.eg/www/universities/html/hamed2.htm.

injuries which carried a high degree of failure or risk.[121] It may be noted that protection given to patients by reference to medical standards given in medical text underlies much of the modern medical practice. [122] The Egyptian practice however attracted attention of Greek intellectuals because it illustrated, in microcosm, the collision between traditional wisdom and artistic innovation and, even more importantly, the problematic authority of written rules.[123] It is said that ancient Egyptian medicine was adopted by the Greeks who purified it from its magical concepts.[124]

Rights of patients and a true patient-physician relationship were first emphasized by the Greek physician Hippocrates, who is traditionally regarded as the founder of medicine, and medical ethics. [125] The Oath of

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121 Faria, MA, *Vandals at the Gates of Medicine -Historic Perspectives on the Battle over Health Care Reform*, Hacienda Publishing, Inc., Macon GA (1995), p. 26.

122 Ritner RK, "Innovations and Adaptations in Ancient Egyptian Medicine", 59 *Journal of Near East Studies* 107 (2000).

123 See, Nightingale AW, "Plato's Law Code in Context: Rule by Written Law in Athens and Magnesia", 49 *Classical Quarterly* 116 (1999), pp.116, 117. According to Nightingale the practices of Egyptian doctors raised a number of questions that were being debated in 4th century Athens. Eg, are rules by written law the best kind of government? Should written laws be sovereign over every citizen (including a true expert in political affairs)? Should the laws be subject to alteration? If so, how and when should it be carried out?

124 Like in other cultures early Greek medicine too centred on the belief in supernatural powers. For Greeks, *Apollo* was the Greek God of health, who taught the healing art to *Chiron*, a centaur (a mythical half horse, half-man species) who later became the god of surgery. Chiron in turn taught Apollo's most famous son *Aesculapius*, who thereafter came to dominate the Greek medicine. Apollo's first healing temple on earth was initially at Delphi, but later, additional temples were erected. There, in an ambience of sanctity and awe, the sick gathered for spiritual healing. Temple priests with their sacred snakes that licked the patient's wounds (the origin of the caduceus – the staff and snake symbol of the medical profession) interpreted these oracles, prescribing therapy that generally consisted of diet, exercise or purging. It was Hippocrates, the physician, who forever changed the art of medical diagnosis by replacing supernatural precepts with observation-based methodology. Natural, rather than supernatural causes, henceforth explained all disease processes. The cumulative experiences gathered from careful observations also allowed the Hippocratic physicians to be the first to develop the art of medical prognosis. See, Tan, Y, "Medicine in Stamps Hippocrates: Father of Medicine", 43 *Singapore Med J* 5, (2002), p.5.

125 Romankow J, "Hippocrates and Schweitzer - Comparison of their Concepts of Medical Ethics", 62 Arch *Hist Filoz Med* 245 (1999), p.245-50. Hippocrates was the first person who believed that diseases are not a direct result of superstition or intervention of the gods, but are caused naturally. Interestingly, for a man considered by many to be the Father of Medicine, little is known about Hippocrates of Cos. Literatures show that he lived circa 460-380 BC. He was a practicing physician and was the contemporary of Socrates. Over 60 treatises of medicine, called the Hippocratic Corpus have been attributed to him.
The Hippocratic Oath rose to prominence only at the end of the fifteenth century. Even then, there were different versions of the Oath, some based on mistranslations of the original Greek text. Other modifications were deliberate; translators changed the ancient text because Hippocrates was a revered source lending authority to their personal belief system. See also,Thomas Rütten, "Receptions of the Hippocratic Oath in the Renaissance", 51 *Journal of the History of Medicine and Allied Sciences* 456, (1996), p.466; Tan S Y, "Medicine in Stamps Hippocrates: Father of Medicine", 43 *Singapore Med J* 5 (2002), p.6.; George Merikas, "Hippocrates: still a contemporary", 8 *Humane Medicine* 212 (1992), pp. 212-18.

Hippocrates [126] establishes such a link. The Oath includes the virtues of professional self respect, and competence, as well as the principles of respect for patient confidentiality, beneficence, non-maleficence, respect for life and, arguably, egalitarian treatment. [127] It requires high ethical standards from medical doctors and its principles are considered important in professional and ethical education of medical doctors even today. [128] While the Oath provides

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[126] I swear by Apollo the physician, by Esculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgement, the following Oath.

> 'to consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone the precepts and the instruction. I will prescribe regimen for the good of my patients according to my ability and my judgement and never do harm to anyone. To please no one will I prescribe a deadly drug nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art. In every house whee I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.'

The basic concepts included in the oath are summarized as follows: to share knowledge of medicine with the profession and to have no secret remedies; to do no harm by the misapplication of the knowledge of medicine; to undertake only that which is within the competence of the individual practitioner; to keep in confidence anything learned from the professional relationship with the patient that should not be divulged; and to refrain from the abuse of the patient-doctor relationship. Stephen B. Webster, "Medical Ethics From Our Professional Ancestors to the Present", 4 *Gundersen Lutheran Medical Journal* 33 (2006), p.33. The oath was probably not formulated entirely by Hippocrates himself, but also by the Pythagorean School. These were physicians and philosophers who were followers of Pythagoras.

[127] Faunce, TA, "Will International Human Rights Subsume Medical Ethics? Intersections in the UNESCO Universal Bioethics", 31 *J Med Ethics* 173 (2005), pp.173,174; Fallberg, LH, "Patients' Rights in Europe: Where do we Stand and Where do we Go?", 7 *European journal of health law* 1 (2000), pp.1-3.

[128] Notwithstanding some modern-day modifications, the oath retains the two broad categories of the original version: the first, on physician obligation towards teaching; and the second, on the doctor's ethical conduct towards patients. Further, for an influential minority, the Hippocratic Oath appears to have been a source of professional inspiration, encouraging conscience to overcome rules of etiquette, or even law if necessary, to assist in relieving the suffering of patients. For e.g., Dr Bourne, relied on its hallowed injunctions to do good and no harm when he openly performed an abortion, then deemed illegal, at the request of a 14 year old girl who had become pregnant after being violently raped. see. *R* v *Bourne* [1938] 3 All ER 615.

rules on professional etiquette, it lays equal emphasis on the doctor–patient relationship.[129]

Apart from the science of medicine, Hippocrates emphasized on care of patients. For the first time, it was mentioned that physicians should treat a patient with love and humaneness.[130] Hippocrates was successful in replacing superstition

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[129] Michael Peel, "Human Rights and Medical Ethics", 98 *J R Soc Med* 172 (2005). The oath includes the virtues of professional self respect, collegiality, and competence, as well as the principles of respect for patient confidentiality, beneficence, non-maleficence, respect for life and, arguably, egalitarian treatment. see also, Bujalkova M, "Hippocrates and his principles of medical ethics", 102 *Bratisl Lek Listy* 117 (2001), pp.117-20. The first medical institution that included the classical Hippocratic Oath to its curriculum was the German University of Wittenberg in 1508. However, it did not become a standard part of graduation ceremony until 1804, when the Montpellier medical school in France fully incorporated it into the commencement exercises. During the nineteenth century several European and American universities adopted the oath, but this practice was not common. As indicated by the 1928 survey undertaken by the Association of American Medical Colleges only 19% of the medical schools in the United States required their students to swear any type of oath. See also, Jose Miola, *Medical Ethics and Medical Law A symbiotic Relationship*,Hart publishing,(2007), p.20. One must note here that despite the technological advances since they were first written, their fundamental principles continue to be seen as relevant in modern medicine. No doubt its language may appear odd in the modern context but, its precepts are as valid today as they were in Hippocrates' time. This can be ascribed to the Oath's emphasis on mostly non-specific ethical principles which is capable enough to adapt to any situation. His golden rule, 'First do no harm', still an essential cornerstone of medical practice, would help us avoid the common abuse of incompletely evaluated diagnostic and therapeutic methods, the neglect of public health education with respect to the rational use of drugs and the neglect of cost-effective competing therapies and unchecked therapeutic professionalism. Hippocrates considered ethical behaviour the foremost characteristic of a physician. His ethical concepts are described in five books, namely The Physician, The Oath, The Law, Medical Decorum and his Aphorisms. They explore the ethical attitudes necessary in medicine and underscore the many difficulties inherent in medical practice, namely, the need for self-control, respect toward one's teacher, caring for the patient, dedication to duty, sincerity and humility, stability, calmness, the collegial spirit, disinterest in wealth, a commitment to the education of the new generation of physicians, confidentiality and reverence toward ethical laws. Its first premise is that the doctor owes loyalty to his teachers and his brethren. An obligation to exercise skill for the benefit of patients' health comes second. Abortion, direct euthanasia and abetting suicide are prohibited. Improper sexual relations with patients are banned. Confidentiality in all dealings with patients is imposed. In 2,500 years, these basic precepts of medical practice changed little. To this day, we believe that adherence to the Hippocratic Oath secures a measure of quality in medical practice, ethical satisfaction and spiritual comfort for the doctor and is recited by all graduating medical students even today. See also, Mateusz Radomyski, "Medical Oaths: When Religion And Ethics Collide", 3 *Amsterdam Law Forum* 68, (2011), p.70; Carey JE, "The Formal use of the Hippocratic Oath for Medical Students at Commencement Exercises", 3 *Bulletin of the Association of American Medical Colleges* 159 (1928), p.161; Porter, "*The Greatest Benefit to Mankind. A Medical History of Humanity from Antiquity to the Present"*, Harper Collins, London (1997), p.369.

[130] Mateusz Radomyski, "Medical Oaths: When Religion and Ethics Collide", 3 *Amsterdam Law Forum* 68, (2011), p.70. This is essential as there are instances where 'some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician'. He believed that this kind of treatment brings in a measure of quality in medical practice, ethical satisfaction, protection of human rights and also spiritual comfort for the doctor. See also, Tan SY, "Medicine in Stamps Hippocrates: Father of Medicine", 43 *Singapore Med J* 5 (2002), p.6; George Merikas, "Hippocrates: still a contemporary", 8 *Humane Medicine* 212, vol. 8, (1992), at pp.213.

with benevolence, social responsibility and the law of ethics.[131] However, the ancient Greeks enforced no mechanisms for legal redress of any medical injury.[132]Thus, physicians could acquire their knowledge by making experiments at the cost of lives.

A number of medical ethicists have questioned the Oath's relevance to today's medical practice as the Oath has no legal status; it has only moral weight.[133] Further, the increasing incorporation of medical technology coupled with social demands has brought about significant changes in medical practice. This situation has in turn sparked a growth in the philosophical debate over problems pertaining to ethical practice.[134] It is argued that these issues no longer find answers in the Hippocratic ethical model. There is a great distance between the thinking of Hippocrates and present scientific medicine.[135] It is postulated that the oath does not harmonize with present bioethical concepts and that the principles of beneficence, lack of harm, autonomy and justice, elaborated by Anglo- Saxon philosophers, does not find a place. However, the contents of the Oath have been restated in Declaration of Geneva adopted by World Medical Association, thereby, asserting that these principles has withstood the test of time.[136]

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131 Id.

132 Amundsen DW, "The Liability of the Physician in Classical Greek Legal Theory and Practice", 32 *J Hist Med & Allied Sci* 172 (1977), pp.172. The treatise entitled *Law in the Hippocratic Corpus* opens with the following assertion that medicine is the most distinguished of all the arts, but owing to the ignorance of those who practice it and of those who rashly judge its practitioners; it is by far inferior to all the other arts. The chief cause of this mistake is that for medicine alone, in the city-states, no penalty has been defined except that of ill repute.

133 See, Veatch RM, "The Hippocratic ethic is dead", 33 *The New Physician* 41 (1988), pp. 41-42; Pellegrino ED, "Toward an expanded medical ethics: The Hippocratic ethic revisited", in Bulger, RJ (ed.),*Search of the modern Hippocrates*, University of Iowa Press, Iowa City (1987), pp.45-64; Pellegrino ED 1990, "The Hippocratic Oath and clinical ethics", 1 *J Clin Ethics* 290 (1990), pp.290-91; Goic A, "It is Time to Think About Patient's Rights. An Introduction", 128 *Rev Med Chil* 371 (2000), pp371-73.

134 W. Qidwai , **"**The Hippocratic oath: Has it Ceased to be Relevant?", 54 *J Pak Med Assoc* 229 (2004), p.229-30; see also Joyce Arthur , **"**Hypocrisy and the Hippocratic Oath"**,** 32 *Humanist in Canada* 26 (1999), pp. 26-28.

135 Goic A, "It is Time to Think about Patient's Rights. An Introduction", 128 *Rev Med Chil* 371 (2000), pp371-73.

136 Declaration of Geneva adopted by the General Assembly of World Medical Association at Geneva Switzerland, September 1948. Viewed 17 Jan 2013, http://www.mma.org.my/ Portals/0/Declaration%20of%20Geneva.pdf

'Roman medicine' is significantly influenced by the medicine practiced in Greece.[137] Romans were the first to give importance to the development of public health facilities.[138] The expansion of the Roman Empire through military activity constituted a means for the military doctors to discover new techniques for treatment of wounded and sick soldiers. This led to the development of *hospitals*.[139] But, hospitals were restricted to slaves and soldiers. The rich could stay at doctors' house for treatment, but provision for the poor was almost non-existent.[140] Their only recourse might be a visit to healing shrine.[141]

A common assumption is that the western civilization brought medical knowledge to the world. Such a belief belies the fact that many other civilizations too possessed the knowledge and ethical theories in respect of the healing professions.[142] In China, *Sun Ssu-miao*, the father of medicine in China, discussed the duties of a physician towards patients as well as public.[143] It is believed that the

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137 Primarily, the Romans followed the teachings of Hippocrates in treating patient. Instead of the Greek method of simply observing the symptoms and recording them in order to treat the patient, Romans also included many prayers and offerings to the Gods. Despite the availability of a number of medical services, particularly in urban areas, the majority of patients were understood to have relied on simple self-help remedies before considering consulting a practitioner. Surgery was only considered as a last resort following the failure of more conservative measures such as diet modification or pharmacology. See, Nutton V, "Healers in the medical market place.Towards a social history of Graeco-Roman medicine", in Wear A, *Medicine in Society: Historical Essays*,Cambridge Univesity Press,Cambridge (1992), p.15–58.; King H, *Greek and Roman medicine*, Bristol Classical Press, London (2001), p.32–37.

138 The use of soaps, stepping stones to cross roads so as not to have to walk through the muck, use of drainage systems, piped water, public toilets and extensive public baths are but some examples. They realized it was unhealthy to bury the dead in the city and so the roads outside the city were lined with the burials. Nutton V, "Healers in the medical market place.Towards a social history of Graeco-Roman medicine", in Wear A, *Medicine in Society: Historical Essays*, Cambridge Univesity Press, Cambridge (1992), p.15–58.; King H, *Greek and Roman medicine*, Bristol Classical Press, London (2001),p.32–7; J Walsh,J, *Roman Medicine*, (2001), viewed 17th may 2012,http://www.dl.ket.org/latin1/mores/medicine/history.htm.

139 Nutton V, "Medicine and the Roman Army. A further Reconsideration", 13 *Med Hist* 260 (1969), pp.260–70.; Davies RW, "The Roman Military Medical Service", 27 *Saalburg Jahrbuch* 84 (1970), pp.84–104; Baker P, *Medical care for the Roman army on the Rhine, Danube and British frontiers in the first, second and early third centuries AD*, PhD thesis, Newcastle University, Newcastle. By Albert S. Lyons, 'Medicine in Roman Times', *Medical History*, (2000) viewed 16th Jan 2012, http://www.healthguidance.org/entry/6340/1/Medicine-in-Roman-Times.html.

140 Scarborough J, "Roman medicine and the Legions. A Reconsideration".12*Med Hist* 254 (1968),pp.254–61.

141 Id.

142 J.A.Devereux, *Australian Medical Law*, 3rd edn., Routledge-Cavendish,London (2007), p.110.

143 Guo, Z, "Chinese Confucian culture and the medical ethical tradition", 21 *J Med Ethics* 239 (1995), p.240. Chinese medical ethics is closely integrated with ancient Confucian, Buddhists, and Taoist teaching. The traditional ethical standards require that a physician reach the moral standard of an ideal Confucian person or *chun-tzu*, the superior man. Confucian medical ethics embodies the spirit of humanity and reflects the social responsibility of medicine and the characteristics of the medical profession.

ancient Chinese medical ethics was established on the foundation of Confucian ethics whose central theme is humaneness (*jen*) and whose distinctive features are deontology and virtue ethics. Confucian medical ethics professed that physician should reflect on each case very conscientiously and should not engage in deceitful practice; they must regard their profession as a career of philanthropy, acting generously and selflessly to help the sick.[144] Ancient Chinese medical ethics teaches that doctors should provide medical services indiscriminately to those who come to seek help, that is, they should provide equal access to medical care for everyone in need, including financial help to the destitute patients.[145] The concepts of respect for autonomy, beneficence, non-maleficence, and justice and the moral values of these four prima facie principles have been expressly identified in Confucian ethics.[146] These principles are found to be similar, in certain respects, to Hippocratic Oath.[147]

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144 Tsai DFC, "Ancient Chinese Medical Ethics and the Four Principles of Biomedical Ethics", 25 *J Med Ethics* 315 (1999) , p.319.

145 Lee T, "Medical ethics in ancient China", in Veatch RM, ed. *Cross Cultural Perspectives in Miedical Ethics*, Jones and Bartlett, Boston (1989), pp.134-6.

146 Tsai DFC, "The Bioethical Principles and Confucius' Moral Philosophy", 31 *J Med Ethics* 159 (2005), p.162. It would be plausible to say that Confucius' moral philosophy, professing *jen* (humaneness), *yi* (righteousness, appropriateness, justice), *li* (rule of propriety), and *chun-tze* (the self cultivated, autonomous man committed to altruism), is compatible with and even perhaps asserts the bioethical principles of respect for autonomy, beneficence, non-maleficence, and justice.

147 Lee, T, "Medical ethics in Ancient China" in Veatch, RM (ed),*Cross Cultural Perspectives in Medical Ethics*,Jones and Bartlett, Boston (1989), pp.132-139.Cited in J.A.Devereux, *Australian Medical Law*,3rd edn, Routledge-Cavendish,London (2007), p.110. Sun Ssu-miao , the father of medicine in China, discussed the duties of a physician to his patients and to the public in his book, *The Thousand Golden Remedies* The essential points are translated as follows: A great doctor, when treating a patient, should make himself quiet and determined. He should not have covetous desire. He should have bowels of mercy on the sick and pledge himself to relieve suffering among all classes. Aristocrat or commoner, poor or rich, aged or young, beautiful or ugly, enemy or friend, native or foreigner, and educated or uneducated, all are to be treated equally. He should look upon the misery of the patient as if it were his own and be anxious to relieve the distress, disregarding his own inconveniences, such as night-call, bad weather, hunger, tiredness, etc. even foul cases such as ulcer, abscess, diarrhoea, etc, should be treated without the slightest antipathy. One who follows this principle is a great doctor, otherwise, he is a great thief. A physician should be respectable and not talkative. It is a great mistake to boast of himself and slander other physicians.
Sun Szu-miao (AD581-682), also wrote a monograph entitled '*On the absolute sincerity of great physicians*'. In this he emphasised the necessity of a thorough education, rigorous conscientiousness and self-discipline, and explained that compassion (*tz'u*) and humaneness (*len*) were the basic values of medical practice. After Sun Szu-miao, literature concerning the ethics of medical practice and the moral character of physicians appeared sporadically from time to time. The most relevant and important works include: Chu Hui-ming's (AD 1590) *Tou chen chuan hsin lu* (Medical cures learnt by heart), Kung Hsin's (AD 1556) *Ming i jen* (Exhortation for enlightened physicians), Kung Ting-Hsien's (AD1615) Ten maxims for physicians and ten maxims for patients in Wan-ping *hui-ch'un* (Back to life from a myriad ofsickness),Chen Shih-kung's (AD 1605) Five commandments and ten requirements for physicians in *Wai-ko cheng-tsung* (An orthodox manual of surgery), Chang-Lu's (AD1627-1707) Ten commandments for physicians in *Chang-shih-i-tung* (Chang's general medicine), and so on. see, Daniel Fu-Chang Tsai, "Ancient Chinese medical ethics and the Four Principles of Biomedical Ethics", 25 *Journal of Medical Ethics* 315 (1999), p.315.

In ancient India, contributions to medical ethics and surgical training are found to be remarkable and evidence of a medical system practice can be traced from the ruins of Harappa and Mohenjodaro.[148] The archaeological evidence points to development of a public health system in these cities.[149] With the downfall of Harappan civilization, Aryans from Central Asia arrived, with them the Vedas and the roots of modern medicine found in these sacred texts.[150] Most of the early Vedic medicine was compiled in *Atharvaveda,* which was an amalgam of religion, magic and empiric elements.[151] *Ayurveda* was the name given to the art of healing. [152]The ancient Indian medical system of Ayurveda had a well defined code of medical ethics, expounded in its ancient texts *Charaka Samhita*[153] and *Susruta Samhita*[154]. The oath of initiation of medical students similar to Hippocratic Oath can be found

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148 Sunil K. Pandya, **"**History of medical ethics in India"**,** 10 *Eubios Journal of Asian and International Bioethics* 40 (2000).

149 Sigerist Henry E, *A History of Medicine*: *Early Greek, Hindu and Persian Medicine*, Vol. II, Oxford University Press, Oxford (1987), pp.142-3. Public health facilities of Mohenjo Daro were superior to those of any other community of the ancient civilization. Unfortunately, we do not have much evidence on the way these societies were governed and the kind of entitlements provided by the state or the community to the individuals and the households. However, the extent of development of public health system points to some kind of state or community planning which enabled the citizens to get entitlement to hygienic public health arrangements. These cities had well-planned drainage system, almost all houses had bathrooms, many houses had latrines and most houses had wells for water supply.

150 Chattopadhyay Debiprasad, *Science and Society in Ancient India*, Research India Publication, Calcutta (1977), p.21.There are four Vedic texts, namely the *Rigveda*, the *Samaveda*, the *Yajurveda*, and the *Atharvaveda*. Medicine was compiled in *Atharvaveda*.

151 See, Robert E Svoboda, *Ayurveda Life, Health and Longevity*, The Ayurvedic Press, Albuquerque (2004), p.6; Raju VK, "Susruta of ancient India", 51 *Indian J Ophthalmol* 119 (2003) , pp.119-22. The earliest known protagonists of Indian medicine such as Dhanvantari, Atreya, Kashyapa and Bhela based their work on these ancient texts about spiritual philosophy and ethics.

152 See generally, KPS Mahalwar, *Medical Negligence and the Law*, Deep and Deep Publications, New Delhi (1991), pp.1-15.; Mitra, Dr. Jyotir, *Glimpses of Advancement of Medical Sciences as presented in the Ramayana of Valmiki*, Nagarjun, Vol.II (1968), p.266. According to mythological traditions, Dhanvantri has been regarded as an expounder deity of Ayurveda. Lord Dhanvantri, after churning the ocean by Gods and devils appeared as an authority of ayurveda possessing the stick (*Danda*) and waterpot (*Kamandal*).Ayurveda emphasized the need for a healthy lifestyle; cleanliness and purity, good diet, proper behaviour, and mental and physical discipline. Purity and cleanliness were to be observed in everything: *jalasuddi* (pure water), *aharasuddi* (clean food), *dehasuddi* (clean body), *manasuddi* (pure mind) and *desasuddi* (clean environment).Ayurveda calls upon the physician to treat the patient as a whole: "*Dividho jayate vyadih, Sariro manasasthatha, Parasparanz tavorjanma, Nirdvadvam nopalabhyate"*. (Diseases occur both physically and mentally and even though each part might be dominant, they cannot be compartmentalised.) Ayurveda treats man as a whole body, mind and what is beyond mind.

153 The *Charaka Samhita* is an early text on Indian traditional medicine.

154 The *Sushruta Samhita* is a sanskrit text on surgery, attributed to *Sushruta*.

in *Charaka Samhita*[155]. *Charaka Samhita* prescribes an elaborate code of conduct. Here, the ethical principles to be followed by a doctor are included. They must be friendly and have a sympathetic approach towards the sick, attending cases according to one's capabilities, non attachment with the patient after his recovery, and not to trade medical skills for personal livelihood are emphasised.[156] Furthermore, Charaka advised the physician to take into confidence the close relatives, the elders in the community and even the officials before undertaking procedures which might end in the patient's death.[157] A few aspects that are mentioned in the Oaths of *Charaka* that are not found in the Hippocratic Oath, namely student asceticism, the duty to withhold services under specified conditions, and the value which places the patient's life above that of the physician.[158] In *Susruta Samhita* too, the doctor's obligations to patients are stressed.[159] A patient may doubt his relatives, his sons and even his parents but he must have full faith in the physician.[160] In other words, he completely gives himself up in the doctor's hand

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155 Caraka Samhita, in A. L. Basham, *The Wonder That was India*, Sidgewick & Jackson, London (1954), p.500.
If you want success in your practice, wealth and fame, and heaven after your death, you must pray every day on rising and going to bed for the welfare of all begins, especially of holy people and sacred creatures, and you must strive with all your soul for the health of the sick. You must not betray your patients, even at the cost of your life… You must not get drunk, or commit evil, or have evil companions… You must be pleasant of speech, and thoughtful, always striving to improve your knowledge.
When you go into the house of a patient, you should direct your words, mind, intellect and senses nowhere but to your patient and their treatment…Nothing that happens in the house of the sick person must not be told outside, nor must the patient's condition be told to anyone who might do harm by that knowledge to the patient or to another.
See also for English translations, Caraka Samhita 1963, in Singhal GD, Gaur DS, *Surgical Ethics in Ayurveda*, Vol. XL, Varanasi, India (1963), p.30.

156 Id.

157 See Menon IA, Haberman H F, "The Medical Students' Oath Of Ancient India",14 *Med. Hist.* 295 (1969), p.387. Susruta Samhita 1963, in Singhal GD, Gaur DS, *Surgical Ethics in Ayurveda*, Vol. XL, Varanasi, India (1963), p. 33; Prakash UBS, 'Shushruta of Ancient India', 146 *Surg Gynecol Obstet* 263 (1978), p.272.

158 Gabriel Van Loon, *Charaka Samhita*, Handbook on Ayurveda, Vol 1, viewed 12th Feb 2013, http://www.rencapp.com/TamilCube_Charaka_Samhita.pdf.

159 Singh RK, Vyas MK, "Surgical Procedures in Sushruta Samhita", 2 *IJRAP* 1444 (2011).

160 See,Bhishagratna KK, *Introduction in: The Susruta Samhita*, Vol. 1,Varanasi, India (1963), pp. 18-19. It is to be noted that the prospective medical students were carefully selected according to the criteria of the noble ethos of the profession. Students were expected to study for 6 years before being allowed to practise the art of healing. At the onset of training, a solemn injunction was delivered to the student, who had to: '… renounce lust, anger, greed, ignorance, vanity, selfishness, envy, rudeness, miserliness, falsehood, sloth and all other acts that bring a man to disrepute. At the proper time, you must clip your nails and trim your hair, and put on the saffron robe of the student. You must live the truthful, disciplined life of a student and obey and respect your teacher. At rest, asleep or awake, at meals, at study and in all your acts, at all times you must be guided by my instructions. All actions should be pleasant and beneficial to me, otherwise your knowledge and study will be ineffective and you will never achieve fame'.

and has no misgivings about him. Therefore, it is the physician's duty to look after him as his own son.[161]

It is important to understand that these codes were adopted by the physicians to bring about self-regulation.[162] They were not part of any legal system of the State, and therefore the State had no responsibility to enforce it amongst the doctors.[163] The written evidence of the State's involvement and the regulatory function is available from the Kautilya's *Arthashastra*.[164] The *Arthashastra* makes mandatory for the doctor to report to State whenever the doctor is called to a house to treat a severely wounded person.[165] Such immediate reporting was mandatory in order not to get accused by the crime committed by such patients.[166] Where a doctor failed to provide information to State, he would be charged with the same offence which was committed by such patient.[167] This also applied to treating any person suffering from unwholesome food or drink.[168] It laid great stress on doctors providing information to patients, particularly when the medical intervention involved risk or injury.[169] *Arthashastra* also prescribed monetary compensation to patients, and in certain circumstances punishment for doctors.[170] According to the Arthasastra, the doctor is also subject to punishment and fine for not providing proper information to the patient, for committing a mistake and for negligent treatment.During the Buddhist period there are evidences to show that University of Taxila, which was supported by the State, provided medical education to students.[171] During the reign of Ashoka,

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161 See, Bhishagratna KK, *Introduction in: The Susruta Samhita*, Vol. 1,Varanasi, India (1963), pp. 18-19.

162 Aditi Iyer, Amar Jesani, *Medical Ethics For Self-Regulation Of Medical Profession And Practice*, CEHAT
Prepared for Independent Commission on Health in India (1996), p.5.

163 Id.

164 Rangarajan LN, *Kautilya: The Arthashastra*, Penguin Books, New Delhi, (1992), p.360

165 Id.

166 Id

167 Id.

168 Id.

169 Id.

170 Id.p.251,112. See also, Kangle RP, *The Kautiliya Arthasastra*, Part II, Bombay: University of Bombay, Bombay (1972), p.258. It prescribes the following punishment for 'negligence' in treatment: Doctor not giving prior information about treatment involving danger to life with the consequence of, physical deformity or damage to vital organ-Same punishment as causing similar physical injury
Death of patient Lowest level standard penalty (primarily fine)
Death due to wrong treatment Middle level standard penalty (primarily fine but high amount).

171 Kosambi DD, *The Culture and Civilization of Ancient India in Historical Outline*, Vikas Publishing House, Kosambi, New Delhi (1970), pp.176-77.

State founded hospitals all over the empire with medical attendance at State expense.[172]

2.3.2. Medieval Period

There were no great contributions to the medical profession in the middle ages. This may be attributed to the fact, that medicine was predominantly practiced by monks in monasteries. Due to this, medicine ceased to be a profession.[173] Therefore, the medical ethics of this age were simply the restatement of Christian principles.[174] The church was more interested in preserving itself and its faith rather than focusing on protection of rights of patients.[175]

A reading of religious books clearly conveys the message that physicians shall protect and respect the rights of patients.

Hinduism and Buddhism believe that all living creatures are manifestations of the laws of *karmic* rebirth.[176] As a result, one may show great respect for preservation of life and non-injury of sentient beings. Acts destructive of life are morally condemned by the principle of *ahimsa*[177], which is the conceptual equivalent of the Western principle of the sanctity of life.

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172 Thapar Romila, *Ashoka and the Decline of the Mauryas*, Oxford University Press, Delhi (1973), p.154. During his period the state also undertook planting of medicinal herbs, planting of trees and supply of potable water from wells along the highways. Ashoka also assisted in the establishment of medical centers in the neighboring countries.

173 As Jose Miola, notes 'it became something that monks also did. There was thus little need for a professional ethic unique to medicine'. See, Jose Miola, *Medical Ethics and Medical Law A Symbiotic Relationship*, Hart Publishing, Oregon (2007), p.28.

174 Miola, Jose, *Medical Ethics and Medical Law A Symbiotic Relationship*, Hart Publishing, Oregon (2007), p.28.The Church's priority was the eternal salvation of the soul. This reflected the limited interest that the church had in any issues that did not involve either sex or death. Hence, the church had little inclination to adhere to any notions of patient autonomy.

175 See, Scorer G, "Moral Values, Law and Religion", in Scorer G and Wing A(eds), *Decision Making in Medicine*, Edward Arnold Publishers Ltd, London (1979), p.2.

176 See, Manickavel V, **"**Love in Medical Ethics in South Asia"**,** 9 *Eubios Journal of Asian and International Bioethics* 40 (1999), pp.40-2; Sarah M Whitman, "Pain and Suffering as Viewed by the Hindu Religion", 8 *The Journal of Pain* 607 (2007), pp.607-13**;** Sri Swami Sivananda, *All About Hinduism,The Divine Life Society*, Himalayas, India, viewed 1st june 2012, http://www.rsl.ukans.edu/~pkanagar/divine/. See, James J Hughes, Damien Keown, **"**Buddhism and Medical Ethics: A Bibliographic Introduction", *Journal of Buddhist Ethics*, Volume Two, (1995), viewed 10th Mar 2012, www.changesurfer.com,p.105-124. Damien Keown, "Buddhism, Brain Death, and Organ Transplantation", 17 *Journal of Buddhist Ethics* 1 (2010), pp.1-34.

177 *Ahimsa* means non-violence, non-injury or non-killing. This means that we must not be indifferent to the sufferings of others. One must consider all living beings in the image of one's own self and thus not commit acts of violence in thought, word or deed against other living creatures. Therefore, protection of rights of patients is a natural derivative of the concept.

Islamic medical ethics is much more explicitly religious in tone.[178]It works very closely with the Quranic texts which stand out as a perfect model for all mankind, all professionals and all time. [179] They include guidelines for the physician's behaviour and attitude, both at the personal and professional levels.[180] The same standard of moral and ethical values may guide the physician in his private life and while conducting his professional business as well.[181] The physician may render help to the needy, regardless of financial ability or ethnic origin of the patient.[182] It is advised that the physician may protect patient's confidentiality.[183] It also requires that physicians may examine patients of the opposite sex in presence of a third person whenever feasible.[184]

Christians believe that humans are created in God's image and are simply stewards of the divine trusts of life and body.[185] Hence the value of human life is beyond human evaluation and authority. [186] From this emphasis on life, church stands against abortion and euthanasia.[187] It further maintains that as long as the patient does not feel their rights are infringed upon, and the doctor is acting in accordance to the standards of practice, all kinds of interaction between physician and patient is justified.[188] For Jesus, right relationships with other people are based

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178 Veatch, RM (ed), *Cross Cultural Perspectives in Medical Ethics*, Jones and Bartlett, Boston (1989), p.120.

179 Id. Medicine was defined by Muslim physicians such as Al-Razi (841-926 AD) and Ibn Sina (Avicenna,980-1036 AD) as the art concerned with the preservation of good health, combating of diseases and restoration of health to the sick.

180 See also, Amine ARC, Elkadi A, Islamic Code of Medical Professional Ethics, in Veatch, RM (ed), *Cross Cultural Perspectives in Medical Ethics*, Jones and Bartlett, Boston (1989), pp.120-23.

181 Id.

182 See, Amine ARC, Elkadi A, "Islamic Code of Medical Professional Ethics", in Veatch, RM (ed), *Cross Cultural Perspectives in Medical Ethics*, Jones and Bartlett, Boston (1989), at pp.120-23.This hint is found in the following Quranic verses:
'And they feed, for the love of God, the indigent, the orphan, and the captive, (saying) 'We feed you for the sake of God alone: no reward do we desire from you, nor thanks.'

183 Id.

184 See, Aasim I. Padela , "Islamic Medical Ethics: A Primer", 21 *Bioethics* 169 (2007), pp. 169-78; Sahin Aksoy, "The Religious Tradition of Ishaq ibn Ali al- Ruhawi: The Author of the First Medical Ethics Book in Islamic Medicine", 3 *JISHIM* 9 (2004), pp.9-11.

185 Matthew 22:38-40, in David Stone, *Christian views on ethics*, Christian Medical Fellowship,1998viewed5Feb2012,http://admin.cmf.org.uk/pdf/cmffiles/03_christian_views_on_ethics.pdf.

186 Id.

187 Id.

188 J S Habgood, "Medical ethics - A Christian view", 11 *Journal of medical ethics* 12 (1985), pp.12-13.

on a right relationship with God.[189] The Christian view of the sick was based on philanthropy. With the advent of Christianity in Europe and Asia, there was inclusion of the poor and the old into the health services.[190]

By eighteenth century, the medical ethical model reflected social change by adhering to the class system rather than a religious one.[191] Thus, medical practitioners could make their own decisions regarding treatment without the interference of the Church.[192] This paved way for the increase in scientific knowledge and development and scientists freely experimented which led to many creative innovations in the medical field.[193]

2.3.3. Modern Period

In 1803, Thomas Percival published *Code of Medical Ethics* which used the term patient instead of sick.[194] The Code became an influential guide for Western physicians rather than a work focused on ethical decision making.[195] It employed an attitude of "what was good for the guild was good for the patient" and was guided by a paternalistic view of patient care.[196] Under therapeutic privilege, Percival found that truth could be withheld from the patients and his immediate family members, if, in the opinion of the physician, knowledge of it would be detrimental to the patient.[197]

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189 As the Bible states: "*Love your neighbour as yourself*"
Matthew 22:38-40, in David Stone 1998,*Christian views on ethics*, Christian Medical Fellowship,viewed5Feb2012,http://admin.cmf.org.uk/pdf/cmffiles/03_christian_views_on_ethics.pdf.

190 Vivek Neelakantan, *Tracing Human Rights In Health*, Centre for Enquiry into Health and Allied Themes, viewed 6th Feb 2013, www.cehat.org.

191 Jose Miola, *Medical Ethics and Medical Law A Symbiotic Relationship*, Hart Publishing, Oregon (2007), p.29.

192 Id.p.31

193 Id.

194 McCullough LB, "The ethical concept of Medicine as a Profession: Its origins in modern Medical ethics and implications for Physicians", in Kenny N, Shelton W (eds), 10 *Advances in Bioethics* 17, Elsevier, New York (2007), at pp.17–27.

195 It is to be noted that the first *Code of Ethics of the American Medical Association* (AMA), adopted in 1847, was actually no more than a condensation of Percival's book. This is the first code of ethics adopted by any national professional society anywhere, and the first to be denominated a 'code of ethics', which remained largely unchanged for more than 100 years. In the code the physicians were given discretion over what to divulge to patients and were to exercise good judgment about these matters. Percival's writing provided the American physicians an understanding that ethics was intrinsic to the practice of good medicine.

196 Morgan H, Mayo TW, "Ethical aspects of Neurosurgical practice", in Batjer HH, Loftus CM (eds)., *Textbook of Neurological Surgery: Principles and Practice*, Lippincott Williams & Wilkins, Philadelphia (2003) , pp.3271-3205.

197 John Collins Harvey, "Clinical Ethics: The Art Of Medicine", in Pelegrino, Edmund D, Anthony E. Hartle, Edmund G. Howe, *Military Medical Ethics*, Vol.1, TMM Publications, Borden Institute, Washington (2004), p.28. The role of the physician, he asserted, was always "to be the minister of hope and comfort".

With the formation of General Medical Council established by Medical Act 1858 and the Provincial and Surgical Association in 1832, which became the British Medical Association in 1856, the nineteenth century witnessed institutionalization of medical ethics.[198]. Thus, medicine became a recognized and distinctive profession of physicians and surgeons which, in turn, laid the foundations of the Health Service that we know today. Inevitably, the law played an increasingly significant role in this regulation and, in parallel with this, a new culture of medical ethics has grown up to supplement the legal requirement.[199] In India, legislative framework for doctor's registration and regulation has been laid down in the Indian Medical Council Act, Dentist Act and the Nursing Councils Act.[200]It is interesting to see that the medical ethics belonged, and still belongs, to medical practitioners. Benevolent paternalism reigned for centuries. However, the twentieth century witnessed a change to this concept. This was due to two reasons. Firstly, the Nazi medical experiments during the Second World War culminated in Nuremburg Code[201] which presented the world with evidence of medical maleficence so shocking that it changed the public's perception of doctors that they are benevolent and beneficent. The Nuremberg Code

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198 Andrew Grubb, *Principles of Medical Law*, 2nd edition, Oxford University (2004), p.83.The GMC is a statutory body empowered by Parliament to govern the training of doctors and the practice of medicine. It has the right to provide the medical profession with ethical advice and treatment. The GMC can solely decide who can and who cannot practice medicine. It is to be specifically mentioned here that GMC considered medicine as a self-regulatory profession as self- regulation has often been seen as the hallmark of professional status.

199 McLean SAM, Mason JK, *Legal and Ethical Aspects of Healthcare*, Greenwich Medical Media Limited, London (2003), p.ix.

200 The Medical Council of India was first established in 1934 under the Indian Medical Council Act, 1933. The Council was later reconstituted under the Indian Medical Council Act, 1956. Regulatory councils are also there at the National and State levels. National Councils prescribe norms and standards of education, while the State Councils primarily deal with registration and enforcement of standards.

201 Nuremberg Code, viewed 22nd June 2012, http://ori.dhhs.gov/education/products/RCRintro/c03/b1c3.html. This code is considered as a basic text of modern medical ethics. The principle in this code is articulated in the context of Nuremberg trials (*United States of America* v *Karl Brandt et al*, US Military Tribunal Nuremberg, Judgement of 19 July 1947)in 1947. The Code contained 10 ethical standards to which doctors should adhere to when conducting research involving human subjects. These standards founded the way forward for further development of the other ethical codes in the future. The main ethical standard clearly addressed in the Code was the voluntary consent of the involved human subject in the research which was described by the Code as being absolute. However, the code centered exclusively on war crimes and failed in its attempt to protect individuals against harm induced by scientific practices at large, including not only human beings as subjects of medical experiments but also as consumers and beneficiaries of science's outcomes. See also, Michel Thieren , Alexandre Mauron, "Nuremberg code turns 60", 85 *Bulletin of the World Health Organization* 573 (2007), ,p.573; Mustafa Khidir Mustafa Elnimeiri, "Nuremberg Code: A landmark document on medical research ethics", 3 *Sudanese Journal of public health* 94 (2008), pp.94-96.

established the principle of self-determination.[202] Further, the Nuremburg trials focused attention on the moral questions of human experimentation, and resulted in World Medical Association[203], the International Code of Medical ethics[204], Declaration of Geneva, modification of the ancient Hippocratic Oath.[205] The second reason was the rapid rise in medical technology which has presented society with ethical dilemmas not previously considered.

Thus, the age-old guiding principle of beneficence in which the good of the individual was paramount, was replaced by one that shifted the focus considerably towards recognizing the *autonomy* of the patient. It means that a physician may treat a patient according to the patient's own judgment and wishes.[206] The concepts of autonomy, liberty, dignity, and capacity of a patient

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202 Mustafa Khidir Mustafa Elnimeiri, "Nuremberg Code: A landmark document on medical research ethics", 3 *Sudanese Journal of public health* 94 (2008), pp.94-96. Stephen B. Webster, "Medical Ethics from our Professional Ancestors to the Present", 4 *Gundersen Lutheran Medical Journal* 35 (2006), p.35. It is to be mentioned here that during this trial, as a defense, the Nazi doctors said they were responsible to the State and not to the patients. This defense was appropriately turned down by the court

203 An international medical organization "*l'Association Professionnelle Internationale des Médecins* was replaced by the international organisation called '*World Medical Association*' in 1947 as a response to the archaic abuses by German and Japanese doctors in World War II, which included their unethical forced participation of humans and prisoners for research and human experimentation. Since its formation in 1947, the World Medical Association (WMA) has been a leading voice in international medical ethics. Although it addressed the burning issue of the war crimes committed by German doctors and pledged to recognize the sanctity, moral liberty, and personal dignity of every human being, the focus was on doctors' rights-not patients' rights. This organization represented physicians and laid foundation of ethical codes for the world medical doctors in their professional conduct in medical practice. The WMA's mission is to serve humanity by endeavouring to achieve the highest international standards in medical education, medical science, medical practice and medical ethics, and health care for all people in the world. See generally, John R. Williams, "The Ethics Activities of the World Medical Association", 11 *Science and Engineering Ethics* 7 (2005) , pp.7-12*;* Pridham, JA, "Founding of the World Medical Association", 3 *World Medical Association Bulletin* 207 (1950), pp.207-9.;Tessa Richards, "The World Medical Association : Can hope triumph over experience?", 308 *BMJ* 262 (1994), pp.262-66.; Holm S, "The WMA on medical ethics—some critical comments", 32 *J Med Ethics* 161 (2006), pp.161-62.; Sohl P, Bassford HA, "Codes of medical ethics: Traditional foundations and Contemporary practice", 22 *Soc Sci Med* 1175 (1986), pp.1175-79.

204 International Code of Medical Ethics, viewed 23rd June 2012, http://www.wma.net/en/ 30publications/ 10policies/c8/.

205 Declaration of Geneva, viewed 23rd June 2012,http://www.mma.org.my/Portals/0/ Declaration%20of%20Geneva.pdf.

206 John Collins Harvey, "Clinical Ethics: The Art Of Medicine", in Pelegrino, Edmund D, Anthony E. Hartle, Edmund G. Howe, *Military Medical Ethics*, Vol.1, TMM Publications, Borden Institute, Washington (2004), p.70.

are highly prized and needs to be closely protected. The advent of *human rights* concept gave impetus to this need.[207]

Following the social, cultural and political support of human rights throughout the world, a progressive tendency to support various aspects of patient rights through human rights instrument gained popularity in the beginning of 20th century as it has the potential to offer enhanced protection against abuses because they are concerned with the protection of individual rights.[208] It is important to note that the objective of medical ethics is to protect and defend human dignity and patients' rights.[209] The Preamble to the Charter of United Nations reaffirms faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women.[210] The tripartite international Bill of Human Rights Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social and Cultural Rights (ICESCR) contained many principles and obligations that resembled norms of medical ethics. Provisions which overlap with medical ethics in these documents are right to life, liberty and dignity[211], right not to be subjected to inhuman or degrading treatment and prohibition of medical or scientific experimentation without free

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207 Human rights place a duty on the state and on healthcare providers to comply with minimum standards. Medical ethics place a duty on individual doctors to comply with parallel standards. Human rights and medical ethics are complementary, and use of the two together maximizes the protection available to the vulnerable patient. Since 1970, following the social and cultural supports of human rights throughout the world, a progressive tendency to support various aspects of patient rights has been commenced. Since this evolution, an awareness of patient rights by the healthcare providers on one hand and the lawyers on the other hand has been emphasized, and attempts have been made to make the patients familiar to their rights. See, Michael Peel, "Human rights and medical ethics", 98 *J R Soc Med* 171 (2005), p.173. Seyyed Hassan, Emami Razavi, Narjes Asadi Khalili, Aliasghar Saidi, Fatemeh Shidfar, "An Evaluation of Adherence to the Patients Rights Charter among Patients and Physicians at the Emergency Department of Imam Khomeini Hospital, Tehran", *DARU Suppl.No.1*, (2006), p.17.

208 Seyyed Hassan Emami Razavi, Narjes Asadi Khalili, Aliasghar Saidi, Fatemeh Shidfar, "An Evaluation of Adherence to the Patients Rights Charter among Patients and Physicians at the Emergency Department of Imam Khomeini Hospital, Tehran", *DARU Suppl.No.1*, (2006), p.17; Aurora Plomer, "*The Law and Ethics of Medical Research: International Bioethics and Human Righs"*, Cavendish Publishing ,London (2005), p.16.

209 Dya Eldin M. Elsayed, Rabaa Elamin M. Ahmed, "Medical Ethics: What is it? Why is it important?" 4 *Sudanese Journal of Public Health* 234 (2009), p.285. The statements of medical ethics require the physician to do what is best for the patient and place the patient's interests before the interests of the physician. see also, World Medical Association Declaration on the Right of the Patient: Lisbon, 1981.

210 Charter of The United Nations, viewed 17 June 2012, http://www.un.org/en/documents/charter/preamble.shtml

211 Art.3 of UDHR states: Everyone has the right to life, liberty and security of person,
Art.6 (1) of ICCPR states: Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.

consent[212], equality and non-discrimination[213], privacy[214], right to information[215], medical care[216]. The other components resembling medical ethics are right of everyone to the enjoyment of highest attainable standard of physical and mental health[217] and also a right to share in scientific advancement and its benefits.[218] Hence, as Faunce[219] notes, 'many of the traditional norms of medical ethics are carried over into international human rights declarations and conventions. And, moreover, that many of the medical and nursing professions' international guidelines and restatements of ethical principles take on forms closely comparable to human rights

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212 Art.5 of UDHR states: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
Art. 7 of ICCPR states: No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

213 Art.7 of UDHR states: All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.
Art. 26 of ICCPR states: All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

214 Art. 12 of UDHR states: No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference or attacks.
Art. 17 of ICCPR. 1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
2. Everyone has the right to the protection of the law against such interference or attacks.

215 Art.19 of UDHR states: Everyone has the right to freedom of opinion and expression; this right includes freedom to hold opinions without interference and to seek, receive and impart information and ideas through any media and regardless of frontiers.
Art. 19 (2) of ICCPR states: Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.

216 Art. 25(1) of UDHR states: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

217 See, Art.12, ICESCR states: 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
(b) The improvement of all aspects of environmental and industrial hygiene;
(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

218 Art. 15 of ICESCR.

219 Faunce, "Will International Human Rights Subsume Medical Ethics? Intersections in the UNESCO Universal Bioethics Declaration", 31 *Journal of Medical Ethics* 173 (2004).

declarations and conventions'. Apart from the above important international instruments, certain provisions in Convention on the Elimination of All Forms of Discrimination Against Women[220], Convention for the Elimination of All Forms of Racial Discrimination, Convention Against Torture and Other Forms of Cruel, Inhuman, or Degrading Treatment or Punishment[221], Convention on the Right of Child[222], International Convention on the Protection of the Rights of All Migrants Workers and Members of their Families[223], Convention on the Right of Persons with Disabilities[224], reflected principles of medical ethics.

Late nineteenth and the beginning of twentieth century witnessed unprecedented developments in science and technology. The introduction of scientific and experimental methodology into clinical medicine in the nineteenth century brought with it an increased demand for experimentation on human subjects, particularly in bacteriology, immunology, and physiology.[225] This research was done mainly on patients in hospital, often without their consent, under an ethos of science and medical progress.[226]This has opened up innumerable possibilities in healthcare along with new ethical and social dilemmas. Among these dilemmas and controversies is the issue of how to harness the benefits of science and technology in a way that addresses rather than augments inequalities in healthcare.[227] In this context, the Nuremberg code of 1947 is generally regarded as the first document to set out ethical regulations in human experimentation based on informed consent.[228] These guidelines shed light on the still contentious issue of the concepts of

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220 See, Art.12 (1) states: States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
Art. 14(2)(b) states: States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right to have access to adequate health care facilities, including information, counselling and services in family planning;

221 See,Art.5(1)(e).

222 See, Art. 24.

223 See,Art.28, Art.43 and 45(1)(c).

224 See, Art. 5, Art.6, Art.7, Art.9, Art.10, Art.14, Art.17,Art.21,Art.22.

225 Jochen Vollmann, Rolf Winau, "Informed consent in human experimentaton before the Nuremberg code" 313 *BMJ* 1445 (1996).

226 Id.

227 Adèle Langlois, "The Global Governance of Bioethics: Negotiating UNESCO's Universal Declaration on Bioethics and Human Rights (2005)", 5 *Global Health Governance* 1 (2011).

228 See, Nuremberg Code, viewed 22nd June 2012, http://ori.dhhs.gov/education/products/RCRintro/c03/b1c3.html.

autonomy, informed consent, and therapeutic and non-therapeutic research. Similarly, the Declaration of Helsinki adopted by WMA provides guidance to physicians engaged in clinical research and its main focus is the responsibilities of researchers for the protection of research subjects.[229] In comparison to the Nuremberg Code, however, the Declaration of Helsinki represented a subtle shift in the balance between the responsibilities of the researcher to individual research participants and to further scientific knowledge and to help suffering humanity, i.e. for public health.[230] This shift is most evident in the requirement to obtain the informed consent of participants. This requirement was absolute in the Nuremberg Code but was softened in the Declaration of Helsinki to allow research on children, especially for vaccines, and on incompetent or 'captive' populations, such as prisoners and military personnel.[231] Still, the Declaration of Helsinki was composed mainly of restrictions on medical research designed to safeguard the interests of individual participants.

It is not essential that biomedical advances will always be used for the well-being of humanity. Also, it is important that the ethical issues raised by rapid advancements in science and technology should be examined with due respect to the dignity of the human person and universal respect for, and observance of, human rights and fundamental freedoms. The role of United Nations is to promote peace, respect for human rights, and social and economic development. It is precisely in this context that the Universal Declaration on Bioethics and Human Rights was adopted by UN Education, Scientific, and Cultural Organization (UNESCO) in 2006. The preamble states that 'it is necessary and timely for the international community to state universal principles that will provide a foundation for humanity's response to the ever-increasing dilemmas and controversies that science and technology present for humankind and the environment'.[232] Though a non-binding instrument it comprehensively deals with the linkage between human rights

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229 See, Declaration of Helsinki, viewed 22nd June 2013, http://www.wma.net/en/30publications/10policies/b3/17c.pdf

230 John R Williams, "The Declaration of Helsinki and public health", 86 *Bulletin of the World Health Organization* 650 (2008).

231 Lederer SE, "Research without borders: the origins of the Declaration of Helsinki", in Schmidt U, Frewer A, eds., *History and theory of human experimentation: the Declaration of Helsinki and modern medical ethics*, Stuttgart: Franz Steiner Verlag (2007), pp. 155-6.

232 See, Universal Declaration on Bioethics and Human Rights, http://unesdoc.unesco.org/images/0014/001461/146180e.pdf.

and bioethics. The declaration thus, is aimed primarily at States, but can also be implemented by individuals, groups, communities, institutions and corporations, public and private where appropriate. It covers a wide range of bioethical principles, several of which had already become customary in bioethics and feature in documents such as the Helsinki declaration and the Council for International Organizations of Medical Sciences (CIOMS) guidelines, informed consent, for example. Some of the other principles of particular relevance to bioethics are beneficence and non-maleficence, [233] autonomy, [234] protection of vulnerable persons,[235] privacy and confidentiality[236], equality, justice and equity[237] and access to healthcare and essential medicines[238].

It is to be specifically mentioned here that the above documents refers to the applications of general human rights principles that are universal and can be applied to the health care delivery just as they can be in any other context. But, it marks the introduction of an external set of standards and procedures by which the medical

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233 Id. Article 4 states that in applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such individuals should be minimized.

234 Id. Article 5 states that the autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.

235 Id. Article 5 states that the autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.

236 Id. Article 9 states that the privacy of the persons concerned and the confidentiality of their personal information should be respected. To the greatest extent possible, such information should not be used or disclosed for purposes other than those for which it was collected or consented to, consistent with international law, in particular international human rights law.

237 Id. Article 10 states that the fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably.

238 Id. Article 14 states: 1. The promotion of health and social development for their people is a central purpose of governments that all sectors of society share.
2. Taking into account that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition, progress in science and technology should advance:
(a) access to quality health care and essential medicines, especially for the health of women and children, because health is essential to life itself and must be considered to be a social and human good;
(b) access to adequate nutrition and water;
(c) improvement of living conditions and the environment;
(d) elimination of the marginalization and the exclusion of persons on the basis of any grounds;
(e) reduction of poverty and illiteracy.

profession's own standards may be judged, against which it may be held legally accountable by victims seeking redress.[239]

The right of patients,[240] for the first time was announced in French National Assembly in 1973 by stipulating that 'every patient has the right to have his or her own bed'.[241] In 1973, the American Hospital Association adopted the first official text of its kind, the *Patients' Bill of Rights*.[242] Since then, the protection of patients' rights has been a focal point on the agenda of many national and international organizations and has become part of national legislation.[243] The *Declaration on the Rights of the Patient* adopted by WMA in 1981 at Lisbon was the first international document to look specifically at patients' rights. [244] The Preamble of the declaration[245] states:

> While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice. Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.

This document recognizes both social and individual rights of patients. The Declaration of Lisbon is an international statement of the rights of patients in

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239 Aurora Plomer, "*The Law and Ethics of Medical Research: International Bioethics and Human Rights"*, Cavendish Publishing, London (2005), p.1

240 The term was used by the theologian Thomas Gisborne (1758–1846) in his book entitled *Citizens' duties*. In the chapter 'Doctors' duties to the patient' it is mentioned that patients are human beings with rights and that doctors have to devote all their competence to patients' treatment. See, Koula Merakou, Panagiota Dalla-Vorgia, Tina Garanis-Papadatos,Jeny Kourea-Kremastinou , "Satisfying Patients' Rights: A Hospital Patient Survey", 8 *Nursing Ethics* 499 (2001), p.499.

241 Fluss SS, "Comparative overview of international and national developments in regard to patients' rights legislation", in Proceedings of the Symposium on the Rights of Patients in theHealth Care System 1993 Apr 21–25 cited in Koula Merakou, Panagiota Dalla-Vorgia, Tina Garanis-Papadatos,Jeny Kourea-Kremastinou, "Satisfying Patients' Rights: A Hospital Patient Survey", 8 N*ursing Ethics* 499 (2001).

242 Id

243 Panagiota Dalla-Vorgia, Tina Garanis-Papadatos,Jeny Kourea-Kremastinou, "Satisfying Patients' Rights: A Hospital Patient Survey", 8 *Nursing Ethics* 499 (2001). The concept behind the term, however, is not new. As Koula Merakou *et al* argues although 'the first text protecting patients' rights Hippocratic Oath no doubt gives emphasis on physicians' obligations towards patients and not directly to what we call 'patients' rights' today, they constitute a precious source for the protection of these rights.'

244 The Declaration on the Rights of Patients was last amended in Oct.2005.

245 See, Declaration on the Rights of Patients, viewed 22nd June 2012,http://www.wma.net/en/30publications/10policies/l4/.

general. In conjunction with the International Code of Medical Ethics, it illustrates the relatively recent emphasis placed on 'the rights of patients' in addition to the traditional 'duties of physicians'. It emphasizes that physicians not only ought to behave in certain way, but patients also are entitled to have them to do so. The Declaration of Lisbon amended by the 171st WMA Council Session, Santiago, Chile, in October 2005 dealt in detail regarding the nature of the rights patients possessed, particularly right to quality information and health education.[246]

The *Declaration on the Patient-Centred Healthcare*[247] is the first globally agreed declaration on patient-centered healthcare developed and agreed by patients and patients' organizations themselves.[248] This declaration is based on the following five principles: respect[249], choice and empowerment[250], patient involvement in health policy[251], access and support[252], and information[253]. These principles provide

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246 See, Declaration on the Rights of Patients, viewed 22nd June 2013, http://www.wma.net/en/30publications/10policies/l4/.

247 See, Declaration on the Patient-Centred Healthcare, viewed 22nd June 2012,http://www.patientsorganizations.org/attach.pl/547/494/IAPO%20Patient Centred%20Healthcare%20Review%202nd%20edition.pdf. this declaration is adopted by International Alliance of Patients' Organizations' in 2006.The International Alliance of Patients' Organizations (IAPO) is a global coalition of patient groups, representing people of all nationalities and across all disease areas, which promotes patient-centred healthcare. The members of IAPO are organizations that at the local, national, regional and international levels support patients and their families and care takers.

248 Jo Groves, "International Alliance of Patients' Organizations perspectives on person-centered medicine", 10 *International Journal of Integrated Care* 27 (2010).

249 Patients and care-givers have a fundamental right to patient-centered healthcare that respects their unique needs, preferences and values, as well as their autonomy and independence.

250 Patients have a right and responsibility to participate, to their level of ability and preference, as a partner in making healthcare decisions that affect their lives. This requires a responsive health service which provides suitable choices in treatment and management options that fit in with patients' needs, and encouragement and support for patients and care givers that direct and manage care to achieve the best possible quality of life. Patients' organizations must be empowered to play meaningful leadership roles in supporting patients and their families to exercise their right to make informed healthcare choices.

251 Patients and patients' organization deserve to share the responsibility of healthcare policy making through meaningful and supported engagement in all levels and at all points of decision-making, to ensure that they are designed with the patient at the centre. This should not be restricted to health policy but include, for example, social policy that will ultimately impact on patient's lives.

252 Patients must have access to the healthcare services warranted by their condition. This includes access to safe, quality and appropriate services, treatments, preventive care and health promotion activities. Provision should be made to ensure that all patients can access necessary services, regardless of their condition or socio-economic status. For patients to achieve the best possible quality of life, healthcare must support patients' emotional requirements, and consider non-health factors such as education, employment and family issues which impact on their approach to healthcare choices and management.

253 Accurate, relevant and comprehensive information is essential to enable patients and careers to make informed decisions about healthcare treatment and living with their condition. Information must be presented in an appropriate format according to health literacy principles considering the individual's condition, language, age, understanding, abilities and culture.

a basis which recognizes that patients are individuals and have different needs and that the healthcare system can be responsive to this, encouraging patients to take responsibility for their health and healthcare whilst recognizing and respecting the limits in people's ability or individual preferences.[254] By promoting greater patient responsibility and optimal usage, patient-centered healthcare leads to improved health outcomes, quality of life and optimal value for healthcare investment.

In the regional sphere, *The European Union Charter of Fundamental Rights* recognizes the individual rights of the people living in the European Union and also lays down the implementing machinery in case of violation of human rights. Article 35 of this Charter has direct link to issues regarding patients' rights and is considered as a basis of the European Charter of Patients' Rights.[255] The *European Charter of Patients' Rights*, 2002, enumerates 14 important rights which guarantees protection to patients[256]: Right to Preventive Measures[257], Right of Access[258], Right to Information[259], Right to Consent[260], Right to Free Choice[261], Right to Privacy and

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254 Jo Groves, "International Alliance of Patients' Organizations perspectives on person-centered medicine", 10 *International Journal of Integrated Care* 27 (2010), p.28.

255 Article 35 provides everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union's policies and activities.
In addition the Charter of Fundamental Rights contains many provisions that refer either directly or indirectly to patients' rights, mention should also be made of
Article 1 which states Human dignity is inviolable. It must be respected and protected.
Article 2 (1) provides everyone has the right to life.
Article 2(2) provides no one shall be condemned to the death penalty, or executed
Article 8 states: 1. everyone has the right to the protection of personal data concerning him or her.
2. Such data must be processed fairly for specified purposes and on the basis of the consent of the person concerned or some other legitimate basis laid down by law. Everyone has the right of access to data which has been collected concerning him or her, and the right to have it rectified.
3. Compliance with these rules shall be subject to control by an independent authority.

256 European Charter of Patients' Rights was adopted in 2002 in Rome. Viewed 25th June 2012,http://www.eesc.europa.eu/self-and-coregulation/documents/codes/private/085-private-act.pdf

257 See, European Charter of Patients' Rights, *Fourteen Rights of the Patient*, Part Two. 1. Every individual has the right to a proper service in order to prevent illness.

258 Id. 2. Every individual has the right of access to the health services that his or her health needs require. The health services must guarantee equal access to everyone, without discriminating on the basis of financial resources, place of residence, kind of illness or time of access to services.

259 Id. 3. Every individual has the right to access to all kind of information regarding their state of health, the health services and how to use them, and all that scientific research and technological innovation makes available.

260 Id. 4. Every individual has the right of access to all information that might enable him or her to actively participate in the decisions regarding his or her health; this information is a prerequisite for any procedure and treatment, including the participation in scientific research.

261 Id. 5.Each individual has the right to freely choose from among different treatment procedures and providers on the basis of adequate information.

Confidentiality[262], Right to Respect of Patients' Time[263], Right to the Observance of Quality Standards[264], Right to Safety[265], Right to Innovation[266], Right to Avoid Unnecessary Suffering and Pain[267], Right to Personalized Treatment[268], Right to Complain[269], Right to Compensation[270]. The Charter aims at implementing patients' rights policies among EU member states and is successful in creating awareness among public institutions that the issue needs to be addressed at the community level. But, it is the *European Declaration on the Promotion of Patients' Rights* which gives an overview of the rights of patients throughout the European Union. This is the first international document which defines the term 'patient' as 'a user of health care services, whether healthy or sick'.[271] The Declaration provides a general framework for the right to health care, the freedom of choice of a health care provider, the right to be treated with dignity and to die in dignity, protection of personal privacy and integrity, the right to complaint and the right to participation in decision-making in health care. [272] This document seeks to reflect and express people's aspirations not only for improvements in their health care but also for fuller recognition of their rights as 'patients'. In so doing, it keeps in mind the perspectives of health care providers as well as of patients. This implies the complementary nature of rights and responsibilities:

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262 Id. 6.Every individual has the right to the confidentiality of personal information, including information regarding his or her state of health and potential diagnostic or therapeutic procedures, as well as the protection of his or her privacy during the performance of diagnostic exams, specialist visits, and medical/surgical treatments in general.

263 Id. 7.Each individual has the right to receive necessary treatment within a swift and predetermined period of time. This right applies at each phase of the treatment.

264 Id. 8.Each individual has the right of access to high quality health services on the basis of the specification and observance of precise standards.

265 Id. 9. Each individual has the right to be free from harm caused by the poor functioning of health services, medical malpractice and errors, and the right of access to health services and treatments that meet high safety standards.

266 Id. 10. Each individual has the right of access to innovative procedures, including diagnostic procedures, according to international standards and independently of economic or financial considerations.

267 Id. 11. Each individual has the right to avoid as much suffering and pain as possible, in each phase of his or her illness.

268 Id. 12. Each individual has the right to diagnostic or therapeutic programmes tailored as much as possible to his or her personal needs.

269 Id. 13. Each individual has the right to complain whenever he or she has suffered harm and the right to receive a response or other feedback.

270 Id. 14. Each individual has the right to receive sufficient compensation within a reasonably short time whenever he or she has suffered physical or moral and psychological harm caused by a health service treatment.

271 See, European Declaration on the Promotion of Patients' Rights, *7. Definitions*, viewed 6th June 2013, http://www.who.int/genomics/public/eu_declaration1994.pdf.

272 See generally, *European Declaration on the Promotion of Patients' Rights*, viewed 27th June 2013, http://www.who.int/genomics/public/eu_declaration1994.pdf.

patients have responsibilities both to themselves for their own self-care and to health care providers, and health care providers enjoy the same protection of their human rights as all other people. There is a basic assumption in the text that the articulation of patients' rights will in turn make people more conscious of their responsibilities when seeking and receiving or providing health care, and that this will ensure that patient/provider relationships are marked by mutual support and respect.[273] The text does not directly cover questions of implementation, since these are necessarily specific to a country or situation.[274] Similarly, the *European Convention on Human Rights and Biomedicine* provides a common framework for 'the protection of human rights and human dignity in both longstanding and developing areas concerning the application of biology and medicine'.[275] This is the first legally binding international document aimed at protecting human dignity, rights and freedoms from misuse in biological and medical science. Examples of matters covered by the ECHRB include consent[276], the human genome[277], scientific research[278] and transplantation of tissue and organs from living donors'[279]. In addition more detailed issues in the biomedical field are dealt with in five additional protocols on cloning, transplantation, biomedical research, the human

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273 World Health Organization, WHO Regional Office for Europe, Declaration on the Promotion of Patients' Rights in Europe , University of Minnesota, viewed 6th June 2013,http://www1.umn.edu/humanrts/instree/patientrights.html.

274 Principles Of The Rights Of Patients In Europe: A Common Framework ,viewed 6th June 2013, http://www.who.int/genomics/public/eu_declaration1994.pdf

275 Article 1, ECHRB.

276 Article 5 states: An intervention in the health field may only be carried out after the person concerned has given free and informed consent to it.
This person shall beforehand be given appropriate information as to the purpose and nature of the intervention as well as on its consequences and risks.
The person concerned may freely withdraw consent at any time.

277 Article 11 states any form of discrimination against a person on grounds of his or her genetic heritage is prohibited.
Article 12 states tests which are predictive of genetic diseases or which serve either to identify the subject as a carrier of a gene responsible for a disease or to detect a genetic predisposition or susceptibility to a disease may be performed only for health purposes or for scientific research linked to health purposes, and subject to appropriate genetic counseling.
Article 13 states an intervention seeking to modify the human genome may only be undertaken for preventive, diagnostic or therapeutic purposes and only if its aim is not to introduce any modification in the genome of any descendants.

278 Article 15 states that scientific research in the field of biology and medicine shall be carried out freely, subject to the provisions of this Convention and the other legal provisions ensuring the protection of the human being.

279 Article 19(1) states that removal of organs or tissue from a living person for transplantation purposes may be carried out solely for the therapeutic benefit of the recipient and where there is no suitable organ or tissue available from a deceased person and no other alternative therapeutic method of comparable effectiveness.

embryo and foetus and human genetics.[280] The European Court of Human Rights may give advisory opinions concerning the interpretation of the ECHRB at the request of a state government or the steering committee on bioethics,[281] and the Court may also, at the request of the Secretary-General of the Council of Europe, require any party to explain the manner in which its law ensures effective implementation of the ECHRB. Although an initiative of the Council of Europe, other non-European states also participated in its formation and are permitted to be its signatory including Australia, Canada, Japan, United States and the Vatican.[282] It is to be mentioned here that United Kingdom is not yet a signatory to the ECHRB.

Incorporating the rights of the patients' in a charter is another way of earning formal recognition for patient's rights. A document like this may have jurisdiction over specific institutions, a region or a country. It does not have a legal force. But, Charter is very important because it lists the rights and duties of all patients who seek care in government hospitals and clinics. It sets out guidelines which health care workers and patients are expected to follow. It is based on rights and duties in different health laws, and tries to explain these rights in a simple way, for example: it explains the constitutional right of access to health care services, so that patients know what they can expect from state health care services. The Charter says that all health care workers, like nurses and doctors, must treat patients with human dignity, respect, courtesy, patience and tolerance. Countries like Austria, Czech Republic, France, Germany, Hong Kong, Ireland, Malaysia, Portugal, Poland, San Marino, Spain, South Africa, Slovakia, and UK have used Patients' Charters as a tool to promote patients' rights.

Declaration of Patients' Rights and the Patients' rights Charter play an important role in protecting the rights but a major drawback of these documents is that they lack legal force. Statutes adopted by individual States confer patients with the direct legal rights and remedies in their relationships with health care providers. The legislator may also help to improve the position of the patient through administrative health law and regulations. Some countries have recognized rights of

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280 Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.6.
281 Article 29 ECHRB.
282 Elizabeth Wicks, *Human Rights and Healthcare*, Hart Publishing, Oregon (2007), p.6.

patients through a single law or Act defining the rights of patients whereas others use multiple pieces of legislation.[283]

A deeper analysis of statutes of different countries brings to the light that the patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms. Also some states have given more emphasis on the rights of patients while others more on the specific obligations of the healthcare providers. However, all the states more or less recognize the following basic rights of patients: Right to health care, Right to participation in decision-making in health care, Right to be treated with dignity, Right to information, Right to informed consent, Right to make an advance directive, Right to refuse treatment, Right to privacy, Right to die with dignity, Right to complaint, Right to compensation.

It is true that until 1970s, giving protection to patients did not include a meaningful role for the patient in the decision-making process.[284] Reforms in health systems, progress in medical technology, respect for human rights, and other relevant factors like changing doctor-patient relationship have influenced patients'

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283 Here is the list of countries which have adopted legislation in protecting rights of patients either explicitly or implicitly**.** **Austria**:Federal Physicians Law,1998; Federal Hospitals Act,1957;Protection of Personal Data,2000**;** **Belgium**: Law on the rights of patients,2002 **;** **Bulgaria**: Human Medicinal Drugs and Pharmacies Act,1995; the Health Insurance Act,1998; The Act for Professional associations of physicians and dentists,1998; The Food Act,1999 and the Health Act,2004**;** **Cyprus**: Law on the Protection of the Rights of Patients and Related Issues,2005**;** **Denmark**: Law on the rights of patients, 1998**;** **Finland**: Law on the legal status and rights of the patients, 1992**;** **Greece**: Act of Modernisation and Organisation of the Health System,1992 Israel: Law on the rights of patients, 1996**;** **India**: Consumer Protection Act, 1986(In India, there are plethora of laws that covers aspects of health and healthcare as there are no comprehensive legislation. Some of the important legislations are Hospital and Clinical Establishment Registration Acts of different states; Epidemic Disease Act, 1897; Medical Council of India Act,1956; The Transplantation of Human Organs Act,1994; Drugs and Cosmetics Act, 1940; Medical Termination of Pregnancy Act, 1971; Pre conception and Pre Natal Diagnostic Technique Act,1994 etc. However, it is the Consumer Protection Act which is been widely popular among citizens to seek remedy in case of violation of rights)**;** **Iceland**: Law on the rights of patients, 1997; **Lithuania**: Law on the rights of patients and damage done to patients, 1996**;** **Turkey**: Patient's Bill of Rights, 1998**;****The Netherlands**: Medical Treatment Contracts Act,1995 **;** **United States**: The Patient Protection and Affordable Care Act, 2010;Health Insurance Portability Accountability Act,1996.
Here I am mentioning only the relevant legislation used in protection of rights of patients in different countries. Deeper and careful analyses of these laws are made in the following chapters at relevant places.

284 Contemporary bioethics, with its emphasis on patient rights and autonomy, requires a sharing of decision-making authority, the final power residing with the patient not the doctor. See, Ronald MacKenzie C, "Professionalism and Medicine", 3 *HSSJ* 223 (2007). Jonathan F. Will, "A Brief Historical and Theoretical Perspective on Patient Autonomy and Medical Decision Making : Part I: The Beneficence Model", 139 *Chest* 673 (2011) ,p.673.

attitudes towards health services.[285] Society has increasingly rejected paternalism, a '*rights*' based model is replacing it which encourages patients to be involved in decisions about their care, making use of whatever capacity they have, and providing legal frameworks to allow clinical decisions to be reviewed regularly.[286]

2.4. CONCLUSION

It is important to point out here that patients' rights have been protected since the beginning, covered by almost every civilization. Modern medical care gives thrust on the concept of patient-centered care[287] and this is considered as a leeway for high quality health care. Currently, there is wide agreement about the need to place patients at the centre of their own care, and at the centre of the health system more generally.

As mentioned in the beginning of the chapter, medicine is an ethical profession and a doctor is deeply confronted with complex and sensitive medical issues coupled with the increasing public demand in decision- making process in the modern day advanced technological era. As Ebert[288] notes:

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[285] Fallberg LH, "Patients' rights", in Vienonen M ed., *European health care reforms: citizens' choice and patients' rights*, World Health Organization Regional Office for Europe, Copenhagen (1996), pp.11–20 According to a study of the New York Health Strategy Group, patients were very passive thirty years ago, but nowadays they are changing their attitude and becoming more health conscious and willing to make themselves heard.; see also, Ancona HD , "Patients' rights: our common concern", in World Health Organization, Regional Office for Europe, *Promotion of the rights of patients' in Europe*, Kluwer Law International, Hague (1995), pp.1–6; Gillon R 1994, "Medical ethics: four principles plus attention to scope", 309 *BMJ* 184 (1994) , pp.184-88.

[286] Gostin LO, "Human rights of persons with mental disabilities: the European Convention of Human Rights" 23 *Int J Law Psychiatry* 125 (2000), p.135. The human rights principle clearly states that every human being is endowed with will and with a right to self-determination.

[287] It is to be noted that the World Health Organization (WHO) uses the term 'responsiveness' in preference to 'patient- centred care'. Responsiveness describes how a healthcare system meets people's expectations regarding respect for people and their wishes, communication between health workers and patients, and waiting times. WHO states that recognizing responsiveness as an intrinsic goal of health systems reinforces the fact that health systems are there to serve people. See generally, World Health Organization, *The World Health Report 2000 -Health Systems: Improving Performance*, World Health Organization, Geneva, viewed 15 Mar 2012,http://www.who.int/whr/2000/en/ ,pp.1-215.

[288] R H Ebert, "A Twentieth Century Retrospective", in Ginzberg E (ed), *Medicine and Society-Clinical Decisions and Societal Values*, Westview Press, Boulder and London (1987), p.15-16.

> Advances in medicine have created ethical dilemmas not previously of concern to moral philosophers. When is a birth control method an abortifacient? When is the foetus viable? What are the ethical issues created by amniocentesis and the resulting ability to diagnose genetic defects *in utero*? How should society view the possibility that the sex of an unborn child can be chosen in advance of artificial insemination with appropriately selected sperm?... these questions are being debated by religious denominations, by philosophers, by lay groups, and even by the courts.

Hence, before discussing the rights of patient's in detail and also the role of judiciary in solving various ethical issues in this regard there is a need to understand the various theories relating to medical ethics. The next chapter discusses the important theories in medicine.