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Chapter 3

MEDICAL LAW AND MEDICAL ETHICS

“The medical profession is unconsciously irritated by lay knowledge.”

— John Steinbeck

Medical ethics is the study of moral values and judgments as they apply to medicine, encompassing history, philosophy, theology, and sociology. The earliest evidence of professional oath is recorded in the 12th-century in the Byzantine manuscript. These may be traced to guidelines for physicians in the Hippocratic Oath, early Christian teachings, Formula Comitis Archiatrorum, Muslim medicine, Jewish thinkers, Roman Catholic scholastic thinkers Catholic moral theology. These intellectual traditions continue in Catholic, Islamic and Jewish medical ethics.

Thomas Percival, a British physician and author, crafted the first modern code of medical ethics in 1794 and expanded it in 1803. In 1815, the Apothecaries Act of the United Kingdom introduced compulsory apprenticeship. In 1847, the American Medical Association adopted its first code of ethics. In the 1960s and 1970s, building upon liberal theory and procedural justice, much of the discourse of medical ethics went through a dramatic shift and largely reconfigured itself into bioethics. Since the 1970s, the growing influence of ethics in contemporary medicine can be seen in the increasing use of Institutional Review Boards, the hospital ethics committees and integration of ethics into many medical school curricula. Values in medical ethics were recognized as four principles, respect for autonomy (the patient has the right to refuse or choose treatment), beneficence (the doctor should act in the best interest of the patient, non-malfeasance - "first, do no harm" and Justice (fairness and equality). Other values include respect for the patient, (right to be treated with dignity), truthfulness and honesty (informed consent) moral values in conflict (conflict of interest)

The practice of medicine has a special characteristic not found in so pronounced manner in other occupations. The dependence of patient on the doctor's technical knowledge and integrity is, thus, of highest order. The doctor's involvement with the patient is therefore

special, but this relationship between doctor and patient is not equally balanced. The patient's attitude is that of trust, which comes from perceived competence and integrity of doctor, and paradoxically, also that of distrust which comes from the state of uncertainty and vulnerability. This ambivalence in doctor patient relationship is controlled by medical ethics which, is supposed to guarantee the patient that the doctor would not abuse his or her superiority in the relationship. Thus, the medical ethics is essentially a publicly announced self-regulation or legal regulation, voluntarily accepted by the doctor that, though the medical practice would be a source of his or her living, it would be practised for the benefit of patient and not for mere personal aggrandizement.

3.1 CODE OF ETHICS:

Historically, the first use of code of ethics in the practice of medicine can be traced back as in the 5th and 4th century B. C.113 The Hippocratic code of medical ethics declares notions of duty, honor and integrity that are all parts of the professionalism that needs to be exhibited. The Ethical duties by which the medical professionals are bound: beneficence, non-malfeasance, fidelity, patient autonomy and distributive justice, are not to be taken in isolation. Add to that the ethics of working in a managed care environment interactions with the pharmaceutical industry, and the commission of medical errors, human experimentation, and the new study of generics.114

3.2 MEDICAL ETHICS IN ANCIENT INDIA:

The proof of recorded medical practice has been found in Aryan’s ruling in Central Asia in 1500 BC. These proofs are in Sanskrit language and are inspired with the Vedas i.e. Rigveda, Samveda and Yagurveda. The Atharva Veda was the principal source for information on medicine during the early Vedic period.115

Much useful information is also to be found in the seminal Ayurvedic classics - Charaka Samhita, Susruta Samhita and Bhela Samhita. The early Vedic healers were members of the priestly community. The medicine they practised and taught was heavily influenced

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113 Between 460 and 377 B.C. the accepted life period of the “Father of Medicine”, Hippocrates.)
114 Indian Instruments of ethical obligations and supervisory regulations- Module-2- NLSIU, Bangalore, p. 93.
by the philosophy of the times. Medical works also emphasized the concept of the cycle of life-death-rebirth.

The training of doctors, and their code of ethics and practice, in ancient India holds a salutary position in the history of medicine. The high ideals of medical practice and the responsibility of the physician are emphasised in Caraka’s poignant statement: ‘No other gift is better than the gift of life’\(^\text{116}\).

Charaka Samhita clearly outlined four ethical principles of a doctor: ‘Friendship, sympathy towards the sick, interest in cases according to one’s capabilities and no attachment with the patient after his recovery’. The Charaka samhita emphasizes the values central to the nobility of the profession, thus: ‘Those who trade their medical skills for personal livelihood can be considered as collecting a pile of dust, leaving aside the heap of real gold’.\(^\text{117}\) Furthermore, ‘He who regards kindness to humanity as his supreme religion and treats his patients accordingly, succeeds best in achieving his aims of life and obtains the greatest pleasures’\(^\text{118}\).

3.3 ETHICS IN MEDICAL PROFESSION IN INDIA:

India is not an underdeveloped country, but a highly developed one in an advanced state of decay.\(^\text{119}\) It is part of our folklore that once we were a free people, with free professionals, physicians, lawyers and others, carrying on their professions free from burdensome regulations, exercising their best professional and ethical judgements, responsible only to themselves and to their professional peers, in accordance with norms expressed in codes of professional societies in which they were free and voluntary members.\(^\text{120}\)

It is true that absolute autonomy and moral self-regulations are nothing but folklore in the modern context. Historically, the doctors themselves had fought bitterly against the established medical vested interests and other political powers to persuade the society to

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\(^{117}\) *Ibid*

\(^{118}\) G. D. Singhal (ed.). *Surgical Ethics in Ayurveda*. 74 (Chowkhamba Sanskrit Series, Varanasi, 1985).


\(^{120}\) Prof. Frank Grad “Medical Ethics and the Law” Article published in *The Annals of the American Academy of Political and Social Science* (May 1978)
promulgate laws for registration (licensure) of doctors and for getting power to have monopoly control over the medical education. The 18th and 19th centuries were marked by the struggle of doctors to get legal recognition of their autonomy and self-regulations. This of course was necessitated by the emergent new socio-political order based on private property, liberal democracy, industrialization and formation of nation states. Within medicine, the monopoly of a small, learned group to be harbinger of medical knowledge was challenged by the emergence of scientific medicine. These factors created historical movement in the Western world, starting from England, for affecting transition from informal, voluntary autonomy to formal and legal autonomy and self-regulations in the form of Medical Councils.

Thus, in brief, the larger framework of autonomy and self-regulation within which the medical profession is governed is also a legal framework. However, there are two broad aspects which distinguish the medical self regulation from the law:

1. Within the legal autonomy, the profession, i.e. its Medical Council\textsuperscript{121}, has been given sufficient powers to formulate its own self-regulations. The profession does these things using its "scientific" and "moral" expertise. The morality of ethics has therefore helped shape the codes of ethics; and thus they have strong roots in the Hippocratic tradition. The scientific expertise has of course helped in shaping the medical training and the standards of medical care. While such regulations are formulated under legally created Medical Councils, the voluntary professional associations have always played a very dominant role. Indeed, in the Western societies, the representatives of medical associations have found highly significant representation on the medical councils.

2. The profession is also given power to implement the self-regulation formulated by itself. That is, the profession not only decides the details of the regulatory mechanism, but also uses its own members to implement it. Here, to use an example, the liberal democratic principle of separating functions of legislation/executive and judiciary is waived in favour of providing autonomy to the profession.

It is normally accepted rule that ethics is something more than the law. The wording of

\textsuperscript{121} Established in 1934 under the Indian Medical Council Act, 1933
the various aspects of the code of ethics is based on the ethical principles that are in many ways different from the legal principles. The ethical respectability that - and that is in finer aspects of doctor's behavior. Ethics and its principles also addressed to resolve recurring ethical dilemmas in medical practice. If the presence of a certain dilemma is greater and in its resolution on a certain way, currency or the general acceptance within the profession, on the time that integrated in the code itself. The result is a dynamic which the ethical code more and more extensive. The specific laws are usually limited, their preparation by the judiciary also significantly limited. Since the application acts as a law maker, as well as the implementing agency, the preparation by is always greater.

3.4 ETHICAL CODE AND PRINCIPLES:

India has been blessed with a glorious code on medical ethics since the days of Charaka and Susruta. This Ayurvedic code embodies the criteria for a good teacher and who should study medicine. It also offers counsel on behavior with patients and their relatives and pointers that can be used by us when dealing with such issues as brain death and organ transplantation. Especially striking is the emphasis on transcending the needs of the body, mind and intellect in order to reach a state where the cycle of birth - death - rebirth is broken. The code of ethics for medical professionals adopted by the Indian parliament as a part of the Medical Council Act,1956 governs the conduct of the medical professionals in their medical work, in their economic activity and with regards to their relationship with other professionals and the society at large. Medical ethics, particularly those related to medical practice and societal responsibility, are essentially formulated on the basis of the justice theory developed by the moral philosophers. There are four principles, which form the fundamentals of justice theory as applied to the medical care. They are as follows:

3.4.1 Principle of non-Maleficence: It is also summed up in the axiom, first do no harm, or that the medical intervention should not cause harm to the patient seeking care.

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122 No. MCI-211 (2) / 2001/Registration. In the exercise of the powers conferred under section 20A read of chapter 33 (m) of the Indian Medical Council Act of 1956 (102 in 1956), the Medical Council of India, with the prior consent of the Central Government, recommends that the Indian Medical Council (professional conduct, Etiquette and Ethics) Regulations, 2002.

123 M. S. Kamath, “Elections: The True Story” in Medical Ethics; Vol. 1, No. 1 Indian Journal on Medical Ethics, (August-October 1993, pp. 1-3).
3.4.2 Principle of Beneficence: This principle stipulates that the medical intervention not only should not harm, but should also be intended for the benefit of the patient.

3.4.3 Principle of Autonomy: This principle has developed to its fullest extent only in last quarter century and has replaced what was earlier called 'medical paternalism'. It is also in harmony with the liberal democratic ethos of individual liberty and choice. Essentially it means that the patient is an independent individual and any medical intervention should be done only after full information is given and the patient has expressly consented for such an intervention. This also gives the patient a right to make choice as to what kind of medical intervention is best suited for him or her.

3.4.4 Principle of Justice: This principle makes it clear that the doctors are responsible to the society and that they must follow the non-discriminatory way of medical practice.

The professionals do face ethical dilemmas in day to day medical practice. These dilemmas are sought to be resolved, in a case to case basis, by weighing each principle as applicable to the situation.

The economic activity of the professionals is governed by restrictions to minimize the negative outcome of the monopoly control over the practice of medicine. This helps patients and at the same time creates good public image. In fact, historically, in the 19th and early 20th centuries, this aspect of the code was enforced with extra zeal, but not others, particularly the principle of autonomy. Accordingly, the medical professionals are prohibited from advertising their skills and services, the poaching of each other’s patients, etc. However, in the last quarter century there has been increasing popular and professional pressure, created by the operation of market, to reduce controls exercised for maintenance of monopoly and due to increasing litigation, emphasizes patient’s autonomy.

3.5 THEORIES OF MEDICAL ETHICS:

3.5.1 Moral Relativism:
Moral relativism has the unusual distinction both within philosophy and outside it of being attributed to others, almost always as a criticism, far more often than it is explicitly
proessed by anyone. Nonetheless, moral relativism\textsuperscript{124} is a standard topic in metaethics, and there are contemporary philosophers who defend forms of it: The most prominent are Gilbert Harman and David B. Wong. The term ‘moral relativism’\textsuperscript{125} is understood in a variety of ways. Most often it is associated with an empirical thesis that there are deep and widespread moral disagreements and a metaethical thesis that the truth or justification of moral judgments is not absolute, but relative to some group of persons. Sometimes ‘moral relativism’ is connected with a normative position about how we ought to think about or act towards those with whom we morally disagree, most commonly that we should tolerate them.

Though moral relativism did not become a prominent topic in philosophy or elsewhere until the twentieth century, it has ancient origins. In the classical Greek world, both the historian Herodotus and the sophist Protagoras appeared to endorse some form of relativism. It should also be noted that the ancient Chinese Daoist philosopher Zhuangzi\textsuperscript{126} (formerly spelled Chuang-Tzu) put forward a non-objectivist view that is sometimes interpreted as a kind of relativism.

Among the ancient Greek philosophers, moral diversity was widely acknowledged, but the more common non-objectivist reaction was moral skepticism, the view that there is no moral knowledge, rather than moral relativism, the view that moral truth or justification is relative to a culture or society. This pattern continued through most of the history of Western philosophy\textsuperscript{127}. There were certainly occasional discussions of moral disagreement—for example in Michel de Montaigne's \textit{Essays} or in the dialogue David Hume attached to \textit{An Enquiry Concerning the Principles of Morals}. These discussions pertained to moral objectivity, but moral relativism as a thesis explicitly distinguished from moral skepticism ordinarily was not in focus. Prior to the twentieth century, moral philosophers did not generally feel obliged to defend a position on moral relativism.

\textsuperscript{124} Stanford Encyclopedia Philosophy available at http://plato.stanford.edu/entries/moral-relativism/ (visited on 23\textsuperscript{rd} December 2014 at 9:00 PM).
\textsuperscript{125} The truth or falsity of moral judgments, or their justification, is not absolute or universal, but is relative to the traditions, convictions, or practices of a group of persons.
\textsuperscript{126} One of the earliest thinkers to contribute to the philosophy that has come to be known as Daojia, or school of the Way.
\textsuperscript{127} Western philosophy is the philosophical thought and work of the Western or Occidental world.
3.5.2 Right-Based Theories and Duty – Based Theories\textsuperscript{128}:

Both right-based and duty-based theories focus on the interests of individuals rather than the collective. Unlike utilitarianism, they do not allow the aggregation or averaging the individual interests. They are distributive rather than aggregative. In the rights ethical theory the rights set forth by a society are protected and given the highest precedence. Rights are considered to be ethically correct and valid for a large or ruling population endorses them. People may also bestow rights upon others if they possess the power and resources to act thusly. For example, a person may say that her friend may borrow the car for the afternoon. The friend who was given the ability to borrow the car now has a right to the car in the afternoon.

The difference between right-based and duty-based theories rests on the waivability of the benefit of any moral obligation. Right-based theories hold that all moral obligations reduce to moral rights, understood as justifiable claims imposing corrective duties, the benefits of which are waivable by the rights-holder. Rights are justifiable claims against unwanted interference or justifiable claims for wanted assistance or both. Both duty-based and right-based theories are sometimes described as “Kantian” because of their association with the work of Immanuel Kant. Kant’s theory is, however, often viewed as a duty-based theory because he is usually taken to reject the view that the benefits of all duties can be waived by the duty holder.\textsuperscript{129}

A major complication of this theory on a larger scale, however, is that one must decipher what the characteristics of a right are in a society. The society has to determine what rights it wants to uphold and give to its citizens. In order for a society to determine what rights it wants to enact, it must decide what the society's goals and ethical priorities are. Therefore, in order for the rights theory to be useful, it must be used in conjunction with another ethical theory that will consistently explain the goals of the society.

3.5.3 Deontological Theory\textsuperscript{130}:

The deontological theory states that people should adhere to their obligations and duties when analyzing an ethical dilemma. This means that a person will follow his or her

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{128} Bentham, Jeremy, Introduction to \textit{the principles of morals and legislation} (1789), the work of Jeremy Bentham, edited by John Bowring (London: 1838-1843).
\item \textsuperscript{129} Beyleveld and Brownsword 2001, 109-110.
\item \textsuperscript{130} \textit{Ibid}
\end{itemize}
\end{footnotesize}
obligations to another individual or society because upholding one's duty is what is considered ethically correct. For instance, a deontologist will always keep his promises to a friend and will follow the law. A person who follows this theory will produce very consistent decisions since they will be based on the individual's set duties.

Deontology provides a basis for special duties and obligations to specific people, such as those within one's family. For example, an older brother may have an obligation to protect his little sister when they cross a busy road together. This theory also praises those deontologists who exceed their duties and obligations, which is called "supererogation." \[131\]

Although deontology contains many positive attributes, it also contains its fair number of flaws. One weakness of this theory is that there is no rationale or logical basis for deciding an individual's duties. For instance, a businessman may decide that it is his duty to always be on time to meetings. Although this appears to be a noble duty, we do not know why the person chose to make this his duty. Perhaps the reason that he has to be on time to the meeting is that he always has to sit in the same chair. A similar scenario unearths two other faults of deontology including the fact that sometimes a person's duties conflict, and that deontology is not concerned with the welfare of others. For instance, if the deontologist who must be on time to meetings is running late, how is he supposed to drive? Is the deontologist supposed to speed, breaking his duty to society to uphold the law, or is the deontologist supposed to arrive at his meeting late, breaking his duty to be on time? This scenario of conflicting obligations does not lead us to a clear ethically correct resolution nor does it protect the welfare of others from the deontologist's decision. Since deontology is not based on the context of each situation, it does not provide any guidance when one enters a complex situation in which there are conflicting obligations.

3.5.4 Utilitarianism Theory\[132:\]

Utilitarianism is a collection of moral theories holding that we are morally required to seek the best possible balance of utility over disutility. It is one of the most powerful and

\[131\] If a person hijacked a train full of students and stated that one person would have to die in order for the rest to live, the person who volunteers to die is exceeding his or her duty to the other students and performs an act of supererogation.

\[132\] Id at 100
persuasive approaches to normative ethics in the history of philosophy. Though not fully articulated until the 19th century, proto-utilitarian positions can be discerned throughout the history of ethical theory.

Though there are many varieties of the view discussed, utilitarianism is generally held to be the view that the morally right action is the action that produces the most good. There are many ways to spell out this general claim. One thing to note is that the theory is a form of consequentialism: the right action is understood entirely in terms of consequences produced. What distinguishes utilitarianism from egoism has to do with the scope of the relevant consequences. On the utilitarian view one ought to maximize the overall good — that is, consider the good of others as well as one's own good. Utilitarianism can be characterized as a quantitative and reductionist approach to ethics. It is a type of naturalism. It can be contrasted with deontological ethics, which does not regard the consequences of an act as a determinant of its moral worth; virtue ethics, which primarily focuses on acts and habits leading to happiness; pragmatic ethics; as well as with ethical egoism and other varieties of consequentialism.

As to the word 'Utilitarianism' John Stuart Mill, defines utilitarianism as a theory based on the principle that "actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness." The theory of utilitarianism has been criticized for many reasons. Critics hold that it does not provide enough protection for individual rights, that not everything can be measured by the same standard, and that happiness is more complex than reflected by the theory. Mill's essay represents his attempt to respond to these criticisms, and thereby to provide a more complex and nuanced moral theory.

The utilitarian ethical theories founded on the ability to predict the consequences of an action. To a utilitarian, the choice that yields the greatest benefit to the most people is the

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133 The Classical Utilitarians, Jeremy Bentham and John Stuart Mill, identified the good with pleasure, so, like Epicurus, were hedonists about value. They also held that we ought to maximize the good, that is, bring about "the greatest amount of good for the greatest number.
choice that is ethically correct. One benefit of this ethical theory is that the utilitarian can compare similar predicted solutions and use a point system to determine which choice is more beneficial for more people. This point system provides a logical and rationale argument for each decision and allows a person to use it on a case-by-case context. 

There are two types of utilitarianism, act utilitarianism and rule utilitarianism. Act utilitarianism adheres exactly to the definition of utilitarianism as described in the above section. In fact utilitarianism, a person performs the acts that benefit the most people, regardless of personal feelings or the societal constraints such as laws. Rule utilitarianism, however, takes into account the law and is concerned with fairness. A rule utilitarian seeks to benefit the most people but through the fairest and most just means available. Therefore, added benefits of rule utilitarianism are that it values justice and includes beneficence at the same time.

As with all ethical theories, however, both act and rule utilitarianism contain numerous flaws. Inherent in both are the flaws associated with predicting the future. Although people can use their life experiences to attempt to predict outcomes, no human being can be certain that his predictions will be true. This uncertainty can lead to unexpected results making the utilitarian look unethical as time passes because his choice did not benefit the most people as he predicted.

3.5.5 Virtue Ethics:

Virtue ethics is a broad term for theories that emphasize the role of character and virtue in moral philosophy rather than either doing one’s duty or acting in order to bring about good consequences. A virtue ethicist is likely to give you this kind of moral advice: “Act as a virtuous person would act in your situation.”

3.6 MODERN MEDICAL ETHICS:

It is normally accepted rule that ethics is something more than the law. The wording of the various aspects of the code of ethics is based on the ethical principles that are in many ways different from the legal principles. The ethical respectability that - and that is in

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138 Utilitarianism is a theory in normative ethics holding that the moral action is the one that maximizes utility. Utility is defined in various ways, including as pleasure, economic well-being and the lack of suffering. Utilitarianism is a form of consequentialism, which implies that the “end justifies the means.”

139 Trianosky, G.V. "What is Virtue Ethics All About?" in Statman D., Virtue Ethics (Cambridge: Edinburgh University Press, 1997)
finer aspects of doctor's behavior. Ethics and its principles also addressed to resolve recurring ethical dilemmas in medical practice. If the presence of a certain dilemma is greater and in its resolution on a certain way, currency or the general acceptance within the profession, on the time that integrated in the code itself. The result is a dynamic which the ethical code more and more extensive. The specific laws are usually limited, their preparation by the judiciary also significantly limited. Since the application acts as a law maker, as well as the implementing agency, the preparation by is always greater.

There is another interesting relationship between the law and ethics. Since autonomy and self- regulation are merely not ethical principles but also a legal fact, the self-regulatory code has legal value and implication. Once code, or specific clauses of the code, is accepted by the profession as self- governing code at a given time, it becomes a legal fact and the aggrieved patients can demand remedy from the profession. It is true that Medical Council\textsuperscript{140} in our country, and for that matter, to an extent even in the countries of their origin (Western Europe) have shown inadequate efficiency in implementation of self-regulations. However their existence provides ample scope for patients and public organisations to create pressure to make them respect the legal obligations. For instance, Courts in our country entertain cases against the decision taken or orders passed by the Medical Councils in response to the complaints filed by the patient or his/her relatives. Similarly, on medical education too, the courts do scrutinise proper implementation of the standards and procedures set by the Councils and the Government.

Different parts of the world had developed different health care system ever since history is being recorded. The Ancient Chinese, Egyptian, Greek, Indian, Islamic, Romanian and Western medicine all had developed differently and at their own pace. Medicine today, is a derivative of those that was developed around the 1450s by the Western world during the early Renaissance. Only in the 19\textsuperscript{th} and 20\textsuperscript{th} Century that medicine as being practiced now had developed enormously. The new and science-evidence based medicine had gradually taken over the practices of traditional medicines such as Herbalism and the Greek’s ‘four humours’. However, many still do practice the traditional and ancient

\textsuperscript{140} Ibid
medicine such as the Chinese\textsuperscript{141} medicine, Indian Ayurvedic\textsuperscript{142} medicine and Herbal\textsuperscript{143} medicine.

The basis leading to the rising of clinical medicine and thinking was the ‘Black Death’\textsuperscript{144} incident in the 1400s which had taken many lives. Another reason was due to the improvement and queries on the theories of the great initiators such as Hippocrates and Ibnu Sina. Increase in health awareness and human knowledge also lead to the progression in medicine world. Furthermore, the downfall of the power of the church (i.e. Roman Catholic Church) had lead to the great shift towards modern medicine. Modern medicine integrates the practice of old medicine as well as scientifically proven medicine via means of experimentation, diagnosis, analysis and evidence of a hypothesis.

3.7 DECLARATION OF GENEVA, 1948:

The World Medical Association at its general assembly at Geneva in September’ 1948, adopted certain codes of ethics, in the form of oath to be taken by a member of the profession, at the time of being admitted as a member of the medical profession:

The declaration of Geneva\textsuperscript{145} is as follows:

- I solemnly pledge to consecrate my life to the service of humanity;
- I will give to my teachers the respect and gratitude that is their due;
- I will practice my profession with conscience and dignity;
- The health of my patient will be my first consideration;
- I will respect the secrets that are confided in me, even after the patient has died;
- I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;
- My colleagues will be my sisters and brothers;

\textsuperscript{141} Traces of therapeutic activities in China date from the Shang dynasty (14th–11th centuries BCE)

\textsuperscript{142} Originating in prehistoric times, some of the concepts of Ayurveda have been discovered since the times of Indus Valley Civilization and earlier

\textsuperscript{143} Archaeological evidence indicates that the use of medicinal plants dates at least to the Paleolithic, approximately 60,000 years ago

\textsuperscript{144} One of the most devastating pandemics in human history, resulting in the deaths of an estimated 75 to 200 million people and peaking in Europe in the years 1346–53. Although there were several competing theories as to the etiology of the Black Death, analysis of DNA from victims in northern and southern Europe published in 2010 and 2011 indicates that the pathogen responsible was the \textit{Yersinia pestis} bacterium, probably causing several forms of plague.

\textsuperscript{145} Declaration of Geneva (1948) adopted by general Assembly of the World medical association and amended by 22\textsuperscript{th} World medical Assembly, Sydney, Australia in August’ 1968.
I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

- I will maintain the utmost respect for human life;
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
- I make these promises solemnly, freely and upon my honour.

3.8 THE INTERNATIONAL CODE OF MEDICAL ETHICS:

The World Medical Association, in its General Assembly in London in October, 1949, adapted the following code of ethics, popular as International Code of Medical Ethics. This dictates the different duties of the doctors considered from different angles. The duties laid down in the International Code of Medical Ethics are as follows:

3.8.1 Doctor’s Duty to the Sick:

- A doctor must always bear in mind the obligation of preserving human life from conception. Therapeutic abortion may only be performed if the conscience of the doctors and the national laws permit.
- A doctor owes to his patient complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond his capacity he should summon another doctor who has the necessary ability.
- A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.
- A doctor must give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

3.8.2 Doctor’s Duty to another Doctor:

- A doctor ought to behave towards his colleagues in a way which he will like to have from them.
- A doctor must not entice away patients from his colleagues.

3.8.3 Duties of Doctors in General:

- A doctor must always maintain the highest standards of professional conduct.

• A doctor must practice his profession uninfluenced by motives of profit.
• A doctor should consider the following practices unethical:
• Any self advertisement except such as is expressly authorized by the national code of medical ethics;
  a. Collaborate in any form of medical service in which the doctor does not have professional independence;
  b. Receiving any money in connection with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.
• Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest.
• A doctor is advised to use great caution in divulging discoveries or new techniques of treatment.
• A doctor should certify or testify only to that which he has personally verified.

3.8.4 Professional Misconduct (Infamous Conduct)\textsuperscript{147}:
As per Medical Council of Indian Amendment Act No.24 of 1964, the council has specified a WARNING NOTICE that violation of this code shall constitute “INFAMOUS CONDUCT IN A PROFESSIONAL SENSE” i.e. it will be professional misconduct.

“It is defined as that conduct which is considered as reasonably disgraceful or dishonorable by the professional brethren of good repute and competency.”

There are more than 25 headings under which professional misconduct are listed. Most indictable misconduct in the professional sense comprises of the following: -

3.8.4.1 Dichotomy or Fee Splitting: It is wrong and unethical for a medical practitioner to demand or accept a commission for referring a patient to a consultant or specialist. Dichotomy or fee splitting is not only unethical but also illegal. Same thing applies to when doctor sends a patient for various investigations like radiological, pathological etc.

3.8.4.2 Adultery of Improper Conduct with a Patient: A Medical practitioner must maintain honorable code of conduct and highest standard of morality with

\textsuperscript{147} http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002
his/her association with patients of opposite sex or other members of the patient’s family. If the medical practitioner abuses his professional practice by committing adultery of setting up improper association with the patient at the material moment, he is liable to disciplinary action by the medical council.

3.8.4.3 Association with unqualified or unregistered Assistants:
   a) in his day to day practice by employing them
   b) assists unqualified practitioner or quack in his private practice in any way-giving anesthesia, attending delivery cases etc.
   c) Cover up the unqualified practitioner by issuing medical certification of “Ill Heath” to patients not treated by himself.

3.8.4.4 Medical Students, Technician and Dispensers etc, their training is not an act of professional misconduct.

3.8.4.5 Advertising: Canvassing and advertising directly or indirectly to promote private practice is unethical.
   a. Displaying unusually large signboards depicting anything other than his name, qualification and nature of his specialization (e.g. giving photographs, diagrams of the equipment).
   b) Displaying signboards at other than at his residence and clinic e.g. at chemists shops, religious places.
   c) Guaranteeing a cure for certain ailments by notifying in the lay press.
   d) By publicly exhibiting his scale of fees or refund if not cured.
   e) Advertising his name while notifying his association with social welfare activities. However, writing an article in the lay press or giving a talk on the Radio/TV on subject matters of public health, Community welfare etc. are not acts of professional misconduct.

3.8.5 Duties of Physician to the Public and Paramedical Professionals:

3.8.5.1 Physicians as Citizens: Physicians, as good citizens, possessed of special training should disseminate advice on public health issues. They should play their part in enforcing the laws of the community and in sustaining the institutions that advance the interests of humanity. They should particularly co-operate with the authorities in the

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administration of sanitary/public health laws and regulations.

3.8.5.2 Public and Community Health: Physicians, especially those engaged in public health work, should enlighten the public concerning quarantine regulations and measures for the prevention of epidemic and communicable diseases. At all times the physician should notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities. When an epidemic occurs a physician should not abandon his duty for fear of contracting the disease himself.

3.8.5.3 Pharmacists / Nurses: Physicians should recognize and promote the practice of different paramedical services such as, pharmacy and nursing as professions and should seek their cooperation wherever required.

3.9 LEGISLATIONS THAT REGULATES MEDICAL PROFESSION IN INDIA:

The list of legislations which regulates the nature and conduct of medical profession are:

- The Constitution of India.
- The Indian Medical Council Act, 1956, the Indian Medical Council Amendment Act, 2001 with the Code of medical ethics, 1972, the Medical Council of India regulation, 2000, Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002.
- Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2009 Part I.
- The Indian Nursing Council Act, 1947.

Medicine is the art of healing. This is how it is considered traditionally. And all that which goes under the title of medical education was directed to teach that art. However, gradually in the explanation of that art of the greatest happiness for the greatest number of people, science has become its indispensable ally. Science helped the art of medicine
in rationalizing its notions and concepts so that they should become more and more functional. Thus science became necessary to support health services.\textsuperscript{149}

The main object of medical profession is to render service to humanity and reward or financial gain is less important consideration.

\textbf{3.9.1 Indian Medical Council Act, 1956:}

This Act was promulgated after repealing the Indian Medical Council Act of 1933. The purpose of the act is to provide re-constitution of Medical Council of India for practice and training in Medical Profession. Its jurisdiction extends to all over India except the state of Jammu and Kashmir. This act provides for the constitution, composition, power and functions of the Medical Council of India.

The Medical Council of India is body corporate, having perpetual succession and a common seal, with power to acquire and hold property, both movable and immovable, and to contract, and shall by the said name sue and be sued (Section 6). It has representatives from different universities of state and union territories, which have undergraduate or post-graduate medical education in their circular. It has representatives from different State Governments. Eight members are nominated by the central Government and one elected member from each State medical Council in which a State Medical Register is maintained, to be elected from amongst themselves by persons enrolled on such Register who possess the medical qualifications included in the First or the Second Schedule or in part II of the Third Schedule (Section 3C).

The Council maintains three schedules. The First Schedule (Section 11) contains the list of recognized medical degree offered by different Universities or Institutions in India, by the medical council and the Government of India. The Second schedule (Section 12) contains the list of medical degrees conferred outside India and are recognized by the Medical Council of India and the Government of India. The Third schedule (Section 13) has two parts. Part-I of the Third Schedule contains the list of medical degrees granted by different Universities or Institutions in India but not included in the First Schedule. Part-II of the Third Schedule contains the list of medical qualifications of foreign countries which are not included in the Second Schedule.

The Indian Medical Council maintains a register known as Indian Medical Council

\textsuperscript{149} Dr. Pragya Kumar, \textit{Medical Education in India}, Edn. 1987, P. 106.
register. The register contains the names, address, qualifications of all medical practitioners, who are enrolled with any State Medical Council. If a medical graduate with a recognized medical degree registers himself with any State medical Council, his name also enrolled in the register of the Medical Council of India. Similarly, if the name of any enrolled medical practitioner is erased or removed from the register of the concerned State Medical council, then the name of medical practitioner is also removed from the register of the Medical Council of India.

Regulation and maintenance of the standard of under-graduate and post-graduate medical curriculum and examination all over the country is important function of the Council. On the basis of the report of the enquiry, the medical council recommends to the Government of India for temporary or usual recognition or non-recognition of a degree or de-recognition of an already degree including a foreign degree. The recommendation of the Council is mandatory on the Central Government.

Indian Medical council has one of the main functions concerning maintenance of Indian Pharmacopeia. The Medical Council of India advises and assists the Government of India to maintain and revise the Indian Pharmacopeia.

It is made clear that any complaint with regard to professional misconduct can be brought before the appropriate Medical Council for disciplinary action. Upon receipt of any complaint of professional misconduct, the appropriate Medical Council would hold an enquiry and give opportunity to the registered medical practitioner to be heard in person or by pleader. If the medical practitioner is found to be guilty of committing professional misconduct, the appropriate Medical Council may award such a specified period, from the register of the name of the delinquent registered practitioner. Deletion from the Register shall be widely publicized in local press as well as in the publications of different medical Associations/Societies/bodies.

In case the punishment of removal from the register is for a limited period, the appropriate Council may also direct that the name so removed shall be restored in the register after the expiry of the period for which the name was ordered to be removed. Decision on complaint against delinquent physician shall be taken within a time-limit of six months.

The medical profession is a noble profession. The satisfaction of seeing a patient
improving far outweighs the value of money that can not be earned. A ground level contribution could be in terms of training health workers who can attend to basic medical needs. Facilities of telemedicine can be made available in rural areas.

In fact, the advent of information and Communication technology and the resultant highways for flow of information along with, can make this a reality. The Council should harness Information and Communication technology in its working, so that the citizens can benefit. For example, the Indian Medical Register can be useful in informing a patient whether the doctor being consulted holds recognized medical qualifications or is recognized with the council. This database should be regularly updated and made user friendly. People should be made aware of it, so that they can guard against being exploited by the “quacks”.

With the advent of globalization, geographical boundaries are withering away and the planet is becoming increasingly inter-connected, changing the contours of medical education and offering new opportunities like medical tourism. In these changed circumstances, the role and responsibility of the Medical Council of India increases to ensure that the training of our students does not fall short when compared with global standard.150

3.9.2 The Indian Medical Degrees Act, 1916:

The object of enacting this act is to regulate the grant of titles implying qualifications in Western Medical science, and the assumption and use by unqualified persons of such titles.

“Western Medical Service” means the western methods of allopathic medicine, obstetrics and surgery, but does not include Homoeopathic system of Medicine.151 Section 4 of this act, deals with the prohibition of unauthorized conferment of degrees etc. penal liability for contravention of section 4 is that the person shall be punished with fine. This act also specifically provide the penalty for falsely assuming or using medical titles, i.e. fine of two hundred and fifty rupees or if convicted of an offence punishable under this section

150 A part of the speech by Her Excellency, The President of India Smt. Pratibha Devi Singh Patil, at the concluding A definition while not covering a ‘duty of care’ doesn’t function helpful definition. Of the Platinum Jubilee celebration of the Medical Council of India- New Delhi 14 March, 2009.
151 Section 2 of Indian Medical Degrees Act, 1916.
then punished with fine which may extend to five hundred rupees.\textsuperscript{152} These provisions of the Indian Medical Degrees Act, 1916 are relevant for checking the cases of Medical Negligence.

\textbf{3.9.3 The Indian Medicine Central Council Act, 1970:}

This is an act to provide for the constitution of a Central Council of Indian Medicine and the maintenance of a central Register of Indian medicine and for matters connected therewith central Government shall by notification in the official gazette constitute for the purposes of this act a central Council consisting of following members, namely:\textsuperscript{153}

\begin{itemize}
  \item[a.] Such number of members not exceeding five as may be determined by the Central Government in accordance with the provisions of the First Schedule for each of the Ayurveda, Siddha and Unani systems of medicine from each State in which a State Register of Indian Medicine is maintained.
    These number of members to be elected from amongst themselves by persons enrolled on that Register as practitioners of Ayurveda, Siddha or Unani.
  \item[b.] One member for each of the Ayurveda, Siddha and Unani systems of medicine from each University to be elected from amongst themselves by the members of the Faculty or Department (by whatever name called) of the respective system of medicine of that University;
  \item[c.] Such number of members, not exceeding thirty per cent of the total number of members elected under clauses (a) and (b), as may be nominated by the Central Government, from amongst persons having special knowledge or practical experience in respect of Indian medicine. The President of the Central Council shall be elected by the members of the Central Council from amongst themselves.\textsuperscript{154} There shall be a Vice-President for each of the Ayurveda, Siddha and Unani systems of medicine who shall be elected from amongst themselves by members representing that system of medicine.\textsuperscript{155} The Central Council shall constitute from amongst its members:
    \begin{itemize}
      \item[i.] A committee for Ayurveda
    \end{itemize}
\end{itemize}

\textsuperscript{152} Section 6 of Indian Medical Degrees Act, 1916.
\textsuperscript{153} Section 3, The Indian Medicine Central Council Act, 1970.
\textsuperscript{154} Section 3 (2), The Indian Medicine Central Council Act, 1970.
\textsuperscript{155} Section 3 (3), The Indian Medicine Central Council Act, 1970.
ii. A committee for Siddha; and

iii. A committee for Unani

Representing the Ayurveda, Siddha or Unani system of medicine. The Vice-resident for each of the Ayurveda, Siddha and Unani systems of medicine shall be, respectively, the Chairman of the committees, subject to such general or special directions as the Central Council may from time to time give, each such committee shall be competent to deal with any matter relating to Ayurveda, Siddha or Unani system of medicine, as the case may be, within the competence of the Central Council.156 The Central Council may constitute such other committees for general or special purposes, as the Central Council deems necessary.157 No person shall establish a medical college nor any medical college shall open a new or higher course of study or training and cannot increase its admission capacity except with the previous permission of the Central Government.158 Central Government shall refer the scheme for the purpose of obtaining permission to the central council for its recommendations. On the receipt of a scheme central council shall give its recommendation to the central government within a period not exceeding six months from the date of receipt of the reference from the central government. The central government either approve the scheme with such conditions, as it may consider necessary of disapprove the scheme. The Central Council while passing an order shall have due regard to following factors.

i. Whether the proposed medical college or the existing medical college seeking to open a new or higher course of study or training, would be in a position to offer the minimum standards of medical education as prescribed by the Central Council under section 22;

ii. Whether the person seeking to establish a medical college or the existing medical college seeking to Open a new or higher course of study or training or to increase its admission capacity has adequate financial resources;

iii. Whether necessary facilities in respect of staff, equipment, accommodation, training, hospital or other facilities to ensure proper functioning of the medical college or conducting the new course of study.

156 Section 9, The Indian Medicine Central Council Act, 1970.
iv. Whether adequate hospital facilities, having regard to the number of students likely to attend such medical college or course of study or training or the increased admission capacity have been provided or would be provided within the time-limit specified in the scheme;

v. Whether any arrangement has been made or programme drawn to impart proper training to students likely to attend such medical college.

vi. The requirement of manpower in the field of practice of Indian medicine in the college.159

Where any medical college is established without the previous permission of the central government, medical qualification granted to any student of such medical college shall not be deemed to be a recognized qualification.

Where any medical college opens a new or higher course of study or training including a post-graduate course of study or training without the previous permission of the Central, medical qualification granted to any student of such medical college on the basis of such study or training shall not be deemed to be a recognized medical qualification. Where any medical college increases its admission capacity in any course of study or training without the previous permission of the Central Government, medical qualification granted to any student of such medical college on the basis of the increase in its admission capacity shall not be deemed to be a recognized medical qualification.160

No person other than a practitioner of Indian medicine who possesses a recognized medical qualification and is enrolled on a State Register or the Central Register of Indian Medicine, -

i. Shall hold office as Vaid, Siddha, Hakim or physician or any other office in Government or in any institution maintained by a local or other authority;

ii. Shall practice Indian medicine in any State;

iii. Shall be entitled to sign or authenticate a medical or fitness certificate or any other certificate required by any law to be signed or authenticated by a duly qualified medical practitioner;161

159 Section 13 A (8), The Indian Medicine Central Council Act, 1970.
161 Section 17(2), The Indian Medicine Central Council Act, 1970.
Any person who acts as a practitioner without possessing a recognized medical qualification shall be punished with imprisonment for a term which may extend to one year, or with fine which may extend to one thousand rupees, or with both. The central council may prescribe the minimum standards of education in Indian Medicine, required for granting recognized medical qualifications by universities, Boards or medical institutions in India.

The Central Council shall maintain in the prescribed manner, a register of practitioners in separate part for each of the system of Indian medicine to be known as the Central Register of Indian Medicine which shall contain the names of all persons who are for the time being enrolled on any State Register of Indian Medicine and who possess any of the recognized medical qualifications. It shall be the duty of the Registrar of the Central Council to keep and maintain the Central Register of Indian Medicine. The Central Council may prescribe standards of professional conduct and etiquette and a code of ethics for practitioners of Indian medicine. Regulations made by the Central Council may specify which violations thereof shall constitute infamous conduct in any professional respect, that is to say, professional misconduct.

3.9.4 Medical Council of Indian Regulations, 2000:

Medical Council of Indian Regulations, 2000 are given by the Medical Council of India with the Central Government in exercise of the powers conferred by section 33 of the Indian Medical council Act, 1956. Regulation 54 deals with the appointment of a person as a Registrar shall maintain Central Register of Indian Medicine the whole-time inspector shall perform following duties namely:

i. Carry out comprehensive inspection of the medical colleges, associated training institutions, hospitals and other teaching centers to ascertain that the standards or facilities provided therein in regard to staff, equipment and academic ambience and other teaching and training of undergraduate and Postgraduate courses including research, conforms to the standards laid down by the Indian Medical Council;

162 Section 17(4), The Indian Medicine Central Council Act, 1970.
ii. Prepare an annual general review of medical education in the country and

iii. Make suggestions for introduction of common assessment standards.166

Registrar shall periodically ascertain from the examining bodies and institutions the date and place of examination, which may be inspected by the council. Executive committee shall appoint not less than three inspectors, to inspect such medical colleges. Visitor shall be appointed by the Indian Medical council who attends personally every examination which he is required to visit. He shall report to the President of the council independently and separately on every examination visited by him.

3.9.5 Indian Medical Council (Professional Conduct Etiquette and Ethics) Regulations, 2002:

The Medical Council of India, with the previous approval of the central government makes regulations in exercise of powers conferred under section 20 A read with section 33(m) of the Indian Medical Council Act, 1956.

The regulation is divided into eight chapters. Chapter 1 deals with the Code of Medical Ethics in which there is elaborate discussion of duties and responsibilities of the physician such as maintaining good character, good medical practice, highest quality assurance in patient care, payment of professional services, shall observe the laws of the country regulating the practice of medicine, etc. Chapter 2 of this regulation deals with duties of physicians to their patients. This chapter elaborate the duties of physicians to their patients which include no physician shall arbitrarily refuse treatment to a patient.167 The physician should neither exaggerate nor minimize the gravity of a patient’s condition. The patient must not be neglected. A physician is free to choose whom he will serve. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family.168 Chapter 3 elaborate the duties of physician in consultation and Chapter 4 elaborate the responsibilities of physicians to each other. Chapter 5 discuss the duties of physician to the public and to the paramedical profession. Chapter 6 discuss the unethical acts. Act resulting in soliciting of patients directly or indirectly by a physician

166 Regulation 56 Medical Council of India Regulations, 2000.
167 Regulation 2.3, the Indian Medical Council (Professional Conduct Etiquette and Ethics) Regulations, 2002.
168 Id. at Regulation 2.4
is unethical.\textsuperscript{169} Any physician may patent surgical instruments, appliances and medicine. However, it shall be unethical if benefits of such patents or copyrights are not made available in situations where the interest of large population is involved.\textsuperscript{170} All the drugs prescribed by the physician should always carry a proprietary formula and clear name. The prescription of secret remedies by a physician constitute an unethical act.\textsuperscript{171} Chapter 7 elaborates the acts of commission or omission on the part of physician which shall constitute professional misconduct rendering him of her liable for disciplinary action. These misconducts include violation of the regulations, adultery or improper Conduct, conviction by a Court of law for offences involving moral turpitude or criminal acts, etc.

Last chapter deals with the punishment and disciplinary action. Any complaint with regard to the professional misconduct can be brought the appropriate Medical Council for disciplinary action. Upon receipt of any complaint an enquiry is conducted.\textsuperscript{172} If the medical practitioner is found guilty of committing professional misconduct, the appropriate medical council may award such punishment as deemed necessary or may direct the removal for a specified period from the register of the name of the delinquent registered practitioner.\textsuperscript{173} In case the punishment of removal from the register is for a limited period, the appropriate council may also direct that the name so removed shall be restored after the expiry of the period.

3.9.5.1 Duties and responsibilities of the Physician in general:

1. Character of Physician (Doctors with qualification of MBBS or MBBS with post graduate degree/ diploma or with equivalent qualification in any medical discipline):

2. A physician shall uphold the dignity and honour of his profession.

3. The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Who- so-ever chooses his profession, assumes the obligation to conduct himself in accordance with its ideals. A physician should be an upright man, instructed in the art of healings. He

\textsuperscript{169} Id. at Regulation 6.1.1
\textsuperscript{170} Id. at Regulation 6.2
\textsuperscript{171} Id. at Regulation 6.5
\textsuperscript{172} Id. at Regulation 8.2
\textsuperscript{173} Id. at Regulation 8.3
shall keep himself pure in character and be diligent in caring for the sick; he
should be modest, sober, patient, prompt in discharging his duty without anxiety;
conducting himself with propriety in his profession and in all the actions of his
life.
4. No person other than a doctor having qualification recognised by Medical
Council of India and registered with Medical Council of India/State Medical
Council (s) is allowed to practice modern system of medicine or surgery. A
person obtaining qualification in any other system of Medicine is not allowed to
practice modern system of medicine in any form.

3.9.5.2 Maintaining good Medical Practice:
The Principal objective of the medical profession is to render service to humanity with
full respect for the dignity of profession and man. Physicians should merit the confidence
of patients entrusted to their care, rendering to each a full measure of service and
devotion. Physicians should try continuously to improve medical knowledge and skills
and should make available to their patients and colleagues the benefits of their
professional attainments. The physician should practice methods of healing founded on
scientific basis and should not associate professionally with anyone who violates this
principle. The honoured ideals of the medical profession imply that the responsibilities
of the physician extend not only to individuals but also to society.

3.9.5.3 Duties of Physicians to their Patients:
1. Obligations to the Sick: Though a physician is not bound to treat each and every
person asking his services, he should not only be ever ready to respond to the calls
of the sick and the injured, but should be mindful of the high character of his
mission and the responsibility he discharges in the course of his professional
duties. In his treatment, he should never forget that the health and the lives of
those entrusted to his care depend on his skill and attention. A physician should
endeavour to add to the comfort of the sick by making his visits at the hour
indicated to the patients. A physician advising a patient to seek service of another
physician is acceptable, however, in case of emergency a physician must treat the

http://www.medindia.net/education/mci-guidelines.asp
http://www.medindia.net/education/mci-guidelines.asp
patient. No physician shall arbitrarily refuse treatment to a patient. However for good reason, when a patient is suffering from an ailment which is not within the range of experience of the treating physician, the physician may refuse treatment and refer the patient to another physician.

2. Medical practitioner having any incapacity detrimental to the patient or which can affect his performance vis-à-vis the patient is not permitted to practice his profession

3.9.5.4 Duties of Physician in Consultation

4. Unnecessary consultations should be avoided: However in case of serious illness and in doubtful or difficult conditions, the physician should request consultation, but under any circumstances such consultation should be justifiable and in the interest of the patient only and not for any other consideration.

5. Consulting pathologists/radiologists or asking for any other diagnostic Lab investigation should be done judiciously and not in a routine manner.

6. Consultation for Patient’s Benefit: In every consultation, the benefit to the patient is of foremost importance. All physicians engaged in the case should be frank with the patient and his attendants.

3.9.5.5 Misconduct:
The following acts of commission or omission on the part of a physician shall constitute professional misconduct rendering him/her liable for disciplinary action

1. Violation of the Regulations: If he/she commits any violation of these Regulations.

2. If he/she does not maintain the medical records of his/her indoor patients for a period of three years as per regulation 1.3 and refuses to provide the same within 72 hours when the patient or his/her authorised representative makes a request for it as per the regulation 1.3.2.

3. If he/she does not display the registration number accorded to him/her by the State Medical Council or the Medical Council of India in his clinic, prescriptions and certificates etc. issued by him or violates the provisions of regulation 1.4.2.

4. Adultery or Improper Conduct: Abuse of professional position by committing

http://www.medindia.net/education/mci-guidelines.asp
adultery or improper conduct with a patient or by maintaining an improper association with a patient will render a physician liable for disciplinary action as provided under the Indian Medical Council Act, 1956 or the concerned State Medical Council Act.

5. Conviction by Court of Law: Conviction by a court of law for offences involving moral turpitude / Criminal acts.

3.9.5.6 Punishment and Disciplinary Action:

1. It must be clearly understood that the instances of offences and of Professional misconduct which are given above do not constitute and are not intended to constitute a complete list of the infamous acts which calls for disciplinary action, and that by issuing this notice the Medical Council of India and or State Medical Councils are in no way precluded from considering and dealing with any other form of professional misconduct on the part of a registered practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care should be taken that the code is not violated in letter or spirit. In such instances as in all others, the Medical Council of India and/or State Medical Councils have to consider and decide upon the facts brought before the Medical Council of India and/or State Medical Councils.

2. It is made clear that any complaint with regard to professional misconduct can be brought before the appropriate Medical Council for Disciplinary action. Upon receipt of any complaint of professional misconduct, the appropriate Medical Council would hold an enquiry and give opportunity to the registered medical practitioner to be heard in person or by pleader. If the medical practitioner is found to be guilty of committing professional misconduct, the appropriate Medical Council may award such punishment as deemed necessary or may direct the removal altogether or for a specified period, from the register of the name of the delinquent registered practitioner. Deletion from the register shall be widely publicized in local press as well as in the publications of different Medical Associations/ Societies/Bodies.

177 http://www.medindia.net/education/mci-guidelines.asp
3. In case the punishment of removal from the register is for a limited period, the appropriate council may also direct that the name so removed shall be restored in the register after the expiry of the period for which the name was ordered to be removed.

4. Decision on complaint against delinquent physician shall be taken within a time limit of 6 months.

5. During the pendency of the complaint the appropriate council may restrain the physician from performing the procedure or practice which is under scrutiny.

6. Professional incompetence shall be judged by peer group as per guidelines prescribed by Medical Council of India.

3.10 CONCLUSION:

In the present chapter we have studied the code of ethics prepared for medical professionals as medical profession needs strict disciplinary action. Medical Council of India in the controlling and supervising body for this work. Advancement of medicine and technology has created new challenges in the medical field. Problem relating to infertility treatment, artificial nutrition and hydration, treatment of patients in coma are some of the controversial issue in this regard. The regulations to medical practice could not be done by the council alone. In the new world of medical technology formal and informal regulations by professionals and institutions are necessary. So an effective law can provide better atmosphere in medical practices.

Next chapter of thesis deals with legislative provisions regarding medical negligence in India, which articulates different legislative provisions dealing with adjudication of medical negligence in India.