A COMPARATIVE ANALYSIS OF THE INTERNATIONAL AND INDIAN CODE OF MEDICAL ETHICS

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ABSTRACT

Medical ethics constitutes the foundation of professional medical practice, which helps physicians to reconcile patient care, societal responsibility, and individual accountability. The following article is based on a comparative study of the International Code of Medical Ethics adopted by the World Medical Association and the Indian Medical Council (Professional Conduct, Etiquette, and Ethics) Regulations, 2002, pointing out their commonalities and differences in context. Basic ethical principles like beneficence, non-maleficence, autonomy, justice, and confidentiality are discussed together with recent issues in medical ethics such as end-of-life care, commercialization, conflict of interest, telemedicine, and genetic testing. Important Indian case laws like IMA v. V.P. Shantha, Aruna Shanbaug v. UOI, and Common Cause v. UOI are discussed to demonstrate the application of ethical principles in court settings. The discussion highlights the imperative for ongoing education, effective accountability measures, and application of international ethical standards to domestic healthcare environments. By syncretizing universal ethical principles, Indian legal and cultural paradigms, the research identifies the significance of upholding professional integrity, patient confidence, and equitable health care provision.

Keywords: Medical Ethics, Professional Conduct Regulations, World Medical Association (WMA), National Medical Commission (NMC), Universal Ethical Principles.

INTRODUCTION

Moral obligation has always been one of the main guiding principles to the profession of medicine, in addition to science itself. Medical ethics, which has been the physicians' guiding light, from the ancient Hippocratic Oath in Greece to all the successive professional conduct codes, has always been a leading one in the delicate interplay between saving a life, respecting the human rights, and restoring the public trust. On the other hand, with the rapid changes of healthcare systems and technology revolution in doctor–patient relationships, a moral norms codification is still very necessary.

At a global scale, the International Code of Medical Ethics (ICME) which was set forth by the World Medical Association (WMA) is a global standard for doctors and it is supposed to be the moral compass guiding the doctors of different countries. The ICME is anchored on the principle of autonomy with a particular focus on values like beneficence, confidentiality, and equal treatment and it also establishes reckoning points for morally different healthcare systems.

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, are in charge of medical practices in India, which is now under the jurisdiction of the National Medical Commission (NMC). The Indian method, while also being based on the same universal principles as the ICME, is a reflection of the local realities, cultural values, and the legal context of the country. For instance, it not only put high emphasis on the mutual responsibilities of doctors and patients but also explicitly enumerates disciplinary actions in the case of professional misconduct such as the code of ethics.

Even though both codes are structured and written classifying the Common Good, the patient welfare as the main purpose of the medical profession, and the maintenance of the professional integrity, they also differ in parts regarding the approach and the priority given to a certain aspect. As per ICME, patient autonomy should have the highest precedence akin to rights-based global discourse, while Indian regulations often related autonomy with a physician's duty to ensure patients' best interests at times thereby exhibiting a paternalistic character more prominently.

This article is a comparative study of the International and Indian Codes of Medical Ethics seen from the perspective of universal ethical principles. The paper dealt with the comparison of the

two sets of codes, their similarities and differences with respect to the major ethical issues in the doctor–patient relationship, confidentiality, research ethics, commercialization of medicine, and end-of-life decision-making. Through the parallels and contrasts, the research acquires the balancing act between embracing global ethics standards and at the same time being culturally and legally diverse countries.

MEANING OF MEDICAL ETHICS

Medical ethics can be defined as the set of moral principles and values that guide healthcare professionals in making decisions and providing care to patients. It is an applied branch of ethics that analyzes the practice of clinical medicine and related research, focusing on respecting patient autonomy, beneficence (doing good), non-maleficence (avoiding harm), and justice (fairness in treatment).

Authoritative definitions:

According to the World Medical Association, "Medical ethics is concerned with the moral principles which should guide the medical profession in their relationship with patients, colleagues, and society".[1]

The WMA underlines that medical ethics is the one set of ethical principles common for doctors all over the world, covering the areas of rights and duties of patients, other healthcare workers, and the society in general. It lays emphasis on defining universal norms of behavior for therapeutic practice, professional qualities and ethical aspects related to the physician's role.

Similarly, the World Health Organization (WHO) refers to medical ethics as "the norms of conduct that distinguish acceptable and unacceptable behavior in medical practice, research, and public health."[2]

Medical ethics, according to the World Health Organization, are a set of leading behavioral principles that regulate the relations in healthcare, scientific research, and more extensive public health programs. The framework devised by the organization is universal, with an

[1] World Medical Association, International Code of Medical Ethics, adopted by the 3rd General Assembly of the WMA, London, 1949, amended 2006 and 2022, available at https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/ (last visited Sept. 11, 2025).
[2] World Health Organization, Ethics and Health, available at https://www.who.int/health-topics/ethics (last visited Sept. 11, 2025).

emphasis on patient safety, respect, and the establishment of trust in health systems as the main pillars.

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 emphasizes that "the prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."[3]

The Indian Medical Council talks about the giving back to the society as the topmost value among the ethical virtues of medical practice and the rules go even further to declare that any financial or personal benefit should be put aside in favor of the welfare of patients and the society. Moreover, the Indian code also highlights the necessity of professional behavior, help, and respect, by basing its principles on the distinct socio-cultural aspects of India.

Medical ethics, in reality, is about the right decisions in medicine besides those which are possible. For instance:

Should a doctor honor a patient's rejection of a treatment that can save his/her life?

To what extent should information be revealed regarding the risks and results?

Would the importance of the research innovation be greater than the welfare of the patient?

Therefore, the functions of medical ethics are:

1. Save the dignity and rights of patients.

2. Be a moral guide to physicians when confronted with difficult situations.

3. Keep the public's trust in the medical profession.

It keeps on changing with the introduction of new biotechnologies, changes in the cultures, and legal reforms, which assures that medicine is both scientific and humane.

SOURCES OF MEDICAL ETHICS

Ancient Foundations and religious texts:

Medical ethics gets its power and direction from various sources, which represent the

[3] Medical Council of India, Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, available at https://www.nmc.org.in/rules-regulations (last visited Sept. 11, 2025).

authorities of the past times and the present institutional frameworks. The most important and very first source in fact is the ancient philosophical and religious ideas, that established the moral grounds of medical practice. To give examples, the Hippocratic Oath in Greece, the ethical precepts in Charaka Samhita and Sushruta Samhita in India[4], as well as Confucian or Buddhist healthcare principles in East Asia were all stressing out the main concepts of the medical ethics – compassion, non-maleficence, and the practice of medicine as a service to the humanity.[5]These writings not only defined the moral obligations of the doctors but also imposed the ethical norms among peoples that governed the expectations of the healthcare system.

Legal and professional regulations:

Another source is the legal and professional regulation which converts moral principles into standards that can be enforced. On an international level, the World Medical Association (WMA) has provided authoritative guidance through the International Code of Medical Ethics (1949)[6] and the Declaration of Geneva (1948)[7]. On a national level, India's Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, also establishes codified ethical obligations for physicians that contain duties towards patients, colleagues, and society.[8] These also provide grounds for accountability in cases of professional misconduct which ensures that ethical principles will not be only aspirational but also actionable.

Contemporary and scholarly bioethics literature:

Another important source is the scholarly and contemporary literature on bioethics, which examines traditional and legal codes in the context of modern challenges, including genetic research, the application of artificial intelligence in healthcare, and public health crises.[9] This

[4] Francis CM. Medical ethics in India: ancient and modern (I). Issues Med Ethics. 1996 Oct-Dec;4(4):115-8. PMID: 16267896.
[5] Michael Young & Angela Wagner, Medical Ethics, StatPearls, StatPearls Publishing, Treasure Island (FL), 2023, available at https://www.ncbi.nlm.nih.gov/books/NBK535361/ (last visited Oct. 4, 2025).
[6] World Medical Association, International Code of Medical Ethics, adopted 1949, revised 2022, available at https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/ (last visited Oct. 4, 2025).
[7] World Medical Association, Declaration of Geneva, WMA, adopted 1948, amended 2017, available at https://www.wma.net/policies-post/wma-declaration-of-geneva/ (last visited Oct. 4, 2025).
[8] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, Gazette of India, Part III, Section 4, available at https://www.nmc.org.in/rules-regulations/professional-conduct-ethics/ (last visited Oct. 4, 2025).
[9] Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics, 8th edn., Oxford University Press, New York, 2019.

academic work serves to connect ethical philosophy with practical decision-making, offering valuable guidance to physicians, hospital administrators, and policymakers.

Judicial interpretations:

Judicial interpretation and case law provide a constantly evolving perspective on medical ethics, particularly in India. Important cases like Parmanand Katara v. Union of India (1989)[10] and Common Cause v. Union of India (2018)[11] help clarify what's expected regarding patient rights, end-of-life care, and the responsibilities of medical professionals. The courts play a key role in upholding ethical standards and merging them with existing laws, resulting in a continuous feedback loop that influences medical practice. This blend of sources means that medical ethics stays relevant, adapting to changes in history, culture, law, and science.

HISTORICAL EVOLUTION OF MEDICAL ETHICS:

Medical ethics has developed over the centuries to reconcile the twin obligations of medical science: the pursuit of knowledge and respect for human dignity. This development is a response to shifting social values, technological advances, and professional moral maturation. From classical philosophical schools to contemporary global codes, the ethical principle informing physicians has been progressively improved to address the needs of successive epochs.

Ancient Roots – Hippocratic Oath

The Hippocratic Oath in the 5th century BCE is the first systematic exposition of medical ethics in Western medicine. The oath focuses on ideals like non-maleficence ("do no harm"), beneficence, patient confidentiality, and professional integrity. Doctors were told to honor teachers, uphold moral behavior, and put patient interests ahead of self-interest. The oath was not just a personal commitment but also a social contract, defining one's expectations of trust between physician and society.

Modern versions of the oath, such as the Declaration of Geneva, uphold its ethical ethos but add sensitivity to modern concerns such as gender equality, patient autonomy, and international

[10] Parmanand Katara v. Union of India, AIR 1989 SC 2039.
[11] Common Cause v. Union of India, (2018) 5 SCC 1.

standards of care.[12] This consistency proves that core moral obligations of physicians are timeless and universal, crossing time and space. The Hippocratic Oath is therefore foundational source of international and Indian medical ethics.

Post-War Ethical Reform – The Nuremberg Code (1947)

The Nuremberg Code was promulgated in 1947 after the conviction of Nazi doctors for unethical experiments on prisoners in concentration camps.[13] It propounded ten principles that became the very first set of international specifications for research ethics. Chief among these is the principle of voluntary informed consent, which protects the autonomy and dignity of subjects. Others insist on the scientific basis of an experiment, on minimizing harm to subjects, and on producing results that benefit society.[14]

The Nuremberg Code set the rock-solid precedent in global research ethics from declaring that the welfare of the individual cannot be sacrificed for scientific or societal interests.[15] It thereby opened the gateway to later regulations such as the Declaration of Helsinki and continues to remain the basic framework on which ethical oversight of human experimentation rests.

Humanitarian Renewal – The Geneva Declaration (1948)

Adopted by the World Medical Association in 1948, the Declaration of Geneva was drafted to reaffirm medical moral commitments in the aftermath of wartime atrocities.[16] It recognizes a physician's responsibility to serve humanity with conscience and dignity, to respect human life, and to work for the good of their patients without discrimination. This declaration modernizes the Hippocratic Oath by dealing with moral accountability in modern medicine on an international scale.

[12] Michael Young & Angela Wagner, Medical Ethics, StatPearls, StatPearls Publishing, Treasure Island (FL), 2023, available at https://www.ncbi.nlm.nih.gov/books/NBK535361/ (last visited Oct. 4, 2025).
[13] United States Holocaust Memorial Museum, The Doctors' Trial — The Medical Case of the Subsequent Nuremberg Proceedings, available at https://encyclopedia.ushmm.org/content/en/article/the-doctors-trial-the-medical-case-of-the-subsequent-nuremberg-proceedings (last visited Oct. 6, 2025).
[14] George J. Annas & Michael A. Grodin, The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation, Oxford University Press, 1992.
[15] Primary (BMJ reproduction / reliable PDF):
Nuremberg Military Tribunal, The Nuremberg Code (1947), reproduced in British Medical Journal, available at https://media.tghn.org/medialibrary/2011/04/BMJ_No_7070_Volume_313_The_Nuremberg_Code.pdf (last visited Oct. 6, 2025).
[16] World Medical Association, Declaration of Geneva, WMA, adopted 1948, amended 2017, available at https://www.wma.net/policies-post/wma-declaration-of-geneva/ (last visited Oct. 4, 2025).

The declaration has been amended several times-the last time in 2017-when matters of contemporary concern such as patient autonomy, confidentiality, and equity in healthcare delivery were incorporated. Traditionally it serves as an oath taken at graduations in symbolizing a physician's continuing moral obligation toward patients and society.

Research Ethics Standardization-Declaration of Helsinki (1964)

Considered the first, the Declaration of Helsinki promulgated by the WMA in 1964, lays down ethical outlines for clinical research on human subjects.[17] This declaration expanded the Nuremberg Code to include the differentiation between research and treatment, insisted on the creation of ethics committees, established the necessity of informed consent from the research subject or patients themselves, and gave primacy to the safety of the subject over the objectives of research. The Declaration addressed issues concerning vulnerable populations, placebo use, and scientific validity, thus building a structure within which ethically justified research could take place.

Later amendments, including in the year 2000 and 2013, have adapted the declaration to fit the more modern challenges that confront the biometric arena, such as genetic research, data privacy, and international multi-center trials.[18] Today, the Declaration of Helsinki stands as the most well-known international code of practice for ethical human research and has also found its way into national codes of practice, such as India's ICMR Ethical Guidelines.

Modern Bioethics Framework – The Belmont Report (1979)

In trying to make a response to several historical ethical breaches, including the infamous Tuskegee Syphilis Study, The Belmont Report (1979), issued by the U.S. National Commission for the Protection of Human Subjects,[19] had established three core principles of research ethics: respect for persons (autonomy), beneficence, and justice. These principles therefore became the basis of institutional review boards (IRBs) and now inform ethical practices on a global

[17] World Medical Association, Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects, WMA, 1964, last amended 2013, available at https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/ (last visited Oct. 4, 2025).
[18] Ezekiel J. Emanuel et al., "What Makes Clinical Research Ethical?", JAMA, Vol. 283, No. 20 (2000).
[19] The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, U.S. Department of Health and Human Services, 1979, available at https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html (last visited Oct. 4, 2025).

scale.

By combining moral philosophy and legal regulation, the Belmont Report gave emphasis to the fair selection of subjects, informed consent, and the weighing of risks and benefits.[20] Till date, these principles continue to form the foundation of ethical oversight worldwide, including in India, where research ethics align with Belmont-style frameworks for the protection of human subjects.

THE INTERNATIONAL CODE OF MEDICAL ETHICS:

Adoption and Evolution

The International Code of Medical Ethics (ICoME) was originally adopted by the 3rd General Assembly of the World Medical Association (WMA) in London, October 1949. It has been subject to significant revisions in 1968 (Sydney), 1983 (Venice), 2006 (Pilanesberg), and most recently in 2022 (Berlin). The 2022 revision enlarged the Code into 40 specific principles, taking into account contemporary issues like telemedicine, environmental ethics, and digital health.

Preamble

The Code is a global ethical guide that supports the WMA Declaration of Geneva and establishes physicians' obligations to patients, colleagues, society, and themselves. It underscores that ethical responsibilities prevail over national or institutional regulations when human rights are involved.

General Principles (1–12)

1. Physicians' fundamental responsibility is to work for the health and well-being of their patients based on competent and compassionate care.

2. Respect for human dignity, autonomy, and rights shall inform every medical intervention.

3. Medical practice should be equitable, fair, and non-discriminatory.

[20] Ruth R. Faden et al., A History and Theory of Informed Consent, Oxford University Press, 1986.

4. Physicians have a responsibility to ensure integrity, honesty, and accountability in all decisions.
5. Prevent conflict of interest; disclose and manage it ethically.
6. Professional judgment should be independent and evidence-based.
7. Promote collaboration with other qualified professionals.
8. Give only truthful certifications based on personal verification.
9. Provide only assistance in medical emergencies with due regard to safety and competence.
10. Forbid torture or degrading treatment in all situations.
11. Maintain competence through a commitment to lifelong learning.
12. Practice in an environmentally sustainable way to safeguard public health.

Duties to the Patient (13–29)

1. Respect for dignity, autonomy, and rights is fundamental.
2. The patient's well-being and benefit must be prioritized, avoiding harm.
3. Informed, voluntary consent is required before any care.
4. For patients with limited decision capacity, involve representatives ethically.
5. In emergencies, physicians may act without prior consent in best interests.
6. Consent must be obtained once the patient regains capacity.
7. Communication with patient's close contacts must respect confidentiality.
8. Refer or consult when outside one's competence.
9. Ensure timely and accurate documentation.

10. Respect privacy and confidentiality even in death; disclose only when ethically required.

11. Disclose third-party reporting functions and seek patient consent.

12. Refrain from false or misleading advertising or self-promotion.

13. Professional judgment shall remain independent of commercial or financial interests.

14. Remote care (telemedicine) shall ensure safety, consent, and confidentiality.

15. Respect professional boundaries; refrain from exploitative or sexual relationships.

16. Doctors need to look after their own health in order to practice safely.

17. Conscientious objection is permitted only if access and patient welfare are safeguarded.

Duties to Other Physicians and Health Professionals (30–33)

1. Act respectfully and cooperatively without harassment or discrimination.

2. Respect patient–physician relationships; intervene only to avoid harm.

3. Report abusive work environments or impediments to ethical care.

4. Respect teachers, students, and maintain ethical learning environments.

Duties to Society (34–38)

1. Promote fair healthcare and the resolution of social determinants of inequality.

2. Deliver scientifically accurate, responsible public communication.

3. Ensure ethical standards in medical research according to Declaration of Helsinki and Declaration of Taipei.

4. Preserve public trust and report unethical behavior.

5. Exchange medical knowledge for development of global health.

Duties as Members of the Profession (39–40)

1. Respect and uphold the ethical principles of the Code; oppose unethical legislation or regulation.

2. Aid fellow physicians in maintaining ethical standards and defend them against abuse or coercion.

Global Significance

The ICoME (2022) is the most detailed ethical framework that the WMA has ever adopted on contemporary issues surrounding digital medicine, artificial intelligence, environmental health, and well-being of physicians. In fact, it reiterates the evergreen belief that the loyalty of a physician always lies with the health and dignity of the patient.[21]

THE INDIAN MEDICAL COUNCIL (PROFESSIONAL CONDUCT, ETIQUETTE AND ETHICS) REGULATIONS 2002:

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, were notified under Section 33 of the Indian Medical Council Act, 1956.[1] These regulations lay down professional obligations, moral duties, and conduct standards for all registered medical professionals in India. The National Medical Commission (NMC) still adheres to and revises these ethical provisions after having replaced the Medical Council of India (MCI) in 2020.[2]

The Regulations are a code of conduct in law — failure to comply may mean inviting disciplinary action, from warning and temporary suspension through to permanent expulsion from the medical register. They are designed to promote integrity, dignity, and service orientation in the practice of medicine.

[21] World Medical Association, Explanatory Note and Implementation Guide to the International Code of Medical Ethics (2022), available at https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/ (last visited Oct. 6, 2025).

Structure of the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002:

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, made under Section 20A read with Section 33(m) of the Indian Medical Council Act, 1956, consist of eight chapters and four appendices. The Regulations prescribe the ethical responsibilities, duties, and disciplinary provisions for registered medical practitioners in India.

Chapter I – Code of Medical Ethics:

Includes the doctor's declaration and general responsibilities such as keeping of records, exhibition of registration numbers, prescription of generic drugs, quality assurance, exposure of unethical practice, and compliance with public-health legislations.

Chapter II – Physicians' Obligations to Their Patients:

Establishes the physician–patient relationship, emphasizing duty to the ailing, confidentiality.

Chapter III – Physicians' Obligations in Consultation:

Governs consulting ethics—punctuality, patient interest, confidentiality, written opinions, and fee disclosure.

Honest prognosis, non-neglect of patients, and moral conduct in obstetric cases.

Chapter IV – Relations of Physicians to Each Other:

Stresses collegiality, respect for peers, ban on rivalry, and regulations for substitution or shared care.

Chapter V – Obligations towards the Public and Paramedical Profession:

Imposes civic and social obligations of physicians, such as cooperation with health authorities and collaboration with nurses and pharmacists.

Chapter VI – Unethical Acts:

Lists prohibited acts like advertising, commissions, secret remedies, torture, euthanasia,

and conflicts of interest with the drug industry (as amended in 2009 and 2016).

Chapter VII – Misconduct:

Enumerates professional offences—violation of rules, bogus certificates, female-foeticide, moral offences, unauthorized practice, violation of confidentiality, unethical research, and misleading publicity.

Chapter VIII – Punishment and Disciplinary Action:

Allows for enquiry process, sanctions (censure, suspension, dismissal), rights of appeal, and peer assessment of professional incompetence.

Code of Medical Ethics (Chapter I)

The chapter establishes the ethical basis of the profession and defines the physician's responsibilities towards patients, society, and the profession.

A. Declaration

All doctors, on registration, are required to sign a solemn declaration to commit life to the service of humanity, uphold respect for human life, keep secret, and treat all patients equally.

B. Duties and Responsibilities

Physicians must maintain the honour of the profession, work for humanity as their first object, and ensure professional purity and diligence. Only those registered with the MCI or State Medical Councils are authorized to practice modern medicine.

The Regulations lay great stress on continuous learning and ethical behavior. All practitioners must undergo a minimum of 30 hours of Continuing Medical Education every five years.

Doctors have to keep medical records for three years, provide them in 72 hours if required, and keep a register of all the medical certificates that are issued. The doctor's registration number has to be exhibited in clinics and on prescriptions. Drugs should be prescribed using generic names in uppercase letters.

Besides, they have to abide by legislations of health, which include the Drugs and Cosmetics

Act, 1940, MTP Act, 1971, Transplantation of Human Organs Act, 1994, and so on.

Duties of Physicians to Their Patients (Chapter II)

The initial responsibility of a physician is to care for the sick with care and competence. Although not under obligation to treat all patients, they are not free to decline treatment arbitrarily, especially in cases of emergencies.

Confidentiality is a foundation: patient secrets may only be revealed where it is a requirement of the law or for the protection of public health. Doctors have to inform patients about prognosis honestly and not leave patients without proper notice.

In obstetric work, if an alternative delivers in the absence of the engaged doctor, the latter has a right to fees on return.

Duties of Physicians in Consultation (Chapter III)

Consultations should be requested only in the interest of the patient, not for commercial or personal objectives. The chapter emphasizes mutual respect, punctuality, and confidentiality between consulting physicians. Disagreements must be dealt with tact and expressed openly.

Written advice should be given by consultants to referring doctors, and prescriptions ought to carry the physician's full name, title, and registration number.

Duties of Physicians to One Another (Chapter IV)

The medical practice is based on camaraderie. Physicians are obliged to provide free service to other doctors and their relatives.

Professional competition, jealousy, and disparagement in front of patients are unethical.

A consultant must not take on another doctor's case unless asked to formally do so.

For temporary absence, the replacements should respond with fidelity and return patients to the original doctor upon their return.

Duties to the Public and Paramedical Profession (Chapter V)

Physicians, as members of society, have a duty to advance public health, collaborate with officials, and give lectures about hygiene and protection against diseases.

They should also respect and work with paramedical experts such as nurses and pharmacists and treat them as vital collaborators in the care of patients.

Unethical Acts (Chapter VI)

This chapter defines acts that constitute professional impropriety.

Advertising: Self-advertisement or canvassing of patients is not allowed.

Patents and Copyrights: Allowed only if public interest is not prejudiced.

Open Shop Practice: Selling drugs to other's patients is unethical.

Rebates and Commissions: Giving or receiving money inducements for referrals is banned.

Secret Remedies: Prescribing unfamiliar compositions is unethical.

Human Rights: Doctors should not assist or facilitate torture.

Euthanasia: Forbidden, but withdrawal of life-support may be permissible by a medical board in cases of brain-death.

The 2009 amendment added an extensive Code of Conduct regarding interactions with the pharmaceutical industry.

Physicians are not allowed to receive gifts, travel, hospitality, or money from businesses. Contraventions draw increasing penalties—from censure to the deletion of a doctor's name from the medical register for more than a year based on the quantum of money involved.

Misconduct (Chapter VII)

The following acts amount to professional misconduct:

Violation of the above regulations.

Failure to keep records.

Failure to exhibit registration number.

Adultery or misconduct with patients.

Conviction for offences for moral turpitude.

Sex determination for female foeticide.

Issuing false certificates.

Sale or prescription of restricted drugs in an improper manner.

Illegal abortions or operations.

Representing oneself to be a specialist without qualification.

Revealing patient confidences except under legal compulsion.

Publishing photographs of patients without permission.

Using agents or touts.

Carrying out clinical research in contravention of ICMR regulations.

Punishment and Disciplinary Action (Chapter VIII)

Disciplinary action against erring doctors can be done by the State Medical Council or the Medical Council of India. Complaints can be lodged by anyone; doctors deserve a just hearing. Punishments can be ranging from censure to suspension for a period of time or exclusion from the register permanently.

Cases should be determined within six months. Delayed cases can be taken over by the MCI from State Councils. Appeals should be filed to the MCI within 60 days of order.

Appendices: Supporting Ethical Tools

Appendix 1: The physician's declaration, based on the Declaration of Geneva, affirming dedication to humanity and secrecy.

Appendix 2: Format for medical leave and fitness certificates.

Appendix 3: Template for medical record-keeping.

Appendix 4: List of statutory certificates issued by doctors under various laws including the Births and Deaths Act, Mental Health Act, and Workmen's Compensation Act.

Note: While the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 mention the Medical Council of India (MCI), the MCI was substituted by the National Medical Commission (NMC) in the year 2020 as per the National Medical Commission Act, 2019. Therefore, all the regulatory powers, control, and enforcement of the 2002 Regulations are now vested with the NMC.". Throughout this article, references to the 2002 Regulations and related MCI provisions are to be interpreted as the equivalent authority of the NMC.

UNIVERSAL PRINCIPLES OF MEDICAL ETHICS

Universal medical ethics represent the guiding moral principles of physicians all over the world, regardless of nationality or culture. They are a moral compass that harmonizes both international (WMA) and national (Indian) codes of ethics. These principles have been distilled from classical bioethics and have been enshrined in charters like the Hippocratic Oath, Declaration of Geneva, Declaration of Helsinki, and contemporary regulatory codes.

Autonomy

Definition: The patient's right to make autonomous decisions about their own body and health.

Application: Doctors must respect informed voluntary consent, facilitate shared decision-making, and respect treatment refusals.

Example: Both WMA Code (principles 15–18) and Indian Code (Reg. 2.1–2.5) require informed consent for medical interventions and respect for patient choices.

Beneficence

Definition: Duty to act in the patient's best interest and maximize well-being and welfare.

Application: Medical treatment must strive to do the best with the least harm.

Example: Giving precedence to life-saving treatment in emergencies is an expression of beneficence, as emphasized in WMA principle 1 and Indian Regulation 2.1.

Non-Maleficence

Definition: "Do no harm" — refrain from doing anything that might injure the patient unnecessarily.

Application: Doctors must weigh risks carefully and avoid iatrogenic harm.

Example: Refraining from untested procedures or harmful interventions concords with both WMA principle 14 and Indian Regulation 2.1–2.5.

Justice

Definition: Equitable and fair treatment of patients, including equal access to care and distribution of limited resources.

Application: Physicians are not allowed to discriminate on the basis of age, gender, religion, ethnicity, or social status.

Example: WMA principle 2 and Indian Regulations place special stress on non-discrimination and equitable delivery of service.

Confidentiality

Definition: Protecting privacy of patient data and maintaining trust.

Application: Ethical management of medical records, secure communication, and informed disclosure are necessary.

Example: WMA principle 22 and Indian Regulations 2.3–2.5 mandate strict confidentiality.

Professionalism and Integrity

Definition: Maintaining honesty, accountability, competence, and ethical practice in all professional matters.

Application: Physicians shall not have conflicts of interest, exploitation, or misconduct.

Example: Both codes stress reporting unethical peers and ongoing professional development.

Respect for Human Rights and Dignity

Definition: Affirmation of inherent worth of every human being and respect for vulnerable groups.

Application: Ethical care should be delivered without coercion, abuse, or discrimination.

Example: WMA principle 10 forbids torture; Indian Regulation 2.5 underlines ethical obligation to every patient.

Accountability and Transparency

Definition: Accountability for decision-making, actions, and outcomes; open disclosure to patients and authorities.

Application: Proper documentation, reporting mistakes, and rationalizing clinical decisions.

Example: Both WMA and Indian codes require documentation and reporting obligations of professionals.

COMPARATIVE ANALYSIS OF THE INTERNATIONAL AND INDIAN CODE OF MEDICAL ETHICS

Medical ethics are the cornerstone of professional behavior in medicine, directing physicians in their responsibility to the patient, colleagues, and society. The World Medical Association (WMA) has drawn up the International Code of Medical Ethics (ICoME), a global ethic for medical practice. India's ethical framework, as outlined by the National Medical Commission (NMC), is specific to the legal, cultural, and societal environment of India.

Foundational Principles:

International Code of Medical Ethics (ICoME):

The ICME prioritizes the physician's fundamental commitment to advance the health and well-being of patients as individuals through the provision of competent, timely, and empathetic care in good medical practice and professionalism. It highlights the commitment to support the health and well-being of populations and society at large, including future generations. The

code requires doctors to deliver care with respect for the highest value of human life and human dignity, and for the patient's autonomy and rights.

Indian Code of Medical Ethics (NMC):

The NMC code of conduct is closely followed by the ICoME and focuses on responsibilities to patients, colleagues, and society. It reinforces compassion and respect in the delivery of care, patient confidentiality, and no discrimination. The Indian code also emphasizes the need for ongoing medical education and the observance of legal and ethical principles within the country.

Informed Consent:

ICoME:

The ICoME requires doctors to seek informed consent from patients prior to any medical procedure, making patients thoroughly understand the procedures, risks, and benefits. The principle supports the patient's autonomy and right to make informed choices regarding their health.

NMC:

Likewise, the NMC mandates that doctors elicit informed consent from patients. Indian guidelines lay down that consent should be voluntary, informed, and recorded. They also discuss cases in which consent is implied, like in emergency situations, yet still focus on patient autonomy.

Confidentiality

ICoME

The ICoME upholds the confidentiality of patients, providing information only with the patient's agreement or when there is an imminent risk of harm to the patient or third parties. This is a key principle to uphold trust in the physician-patient relationship.

The NMC's codes of practice reflect this, placing stress on the duty of doctors to respect patient confidentiality. They also stipulate when disclosure may be allowed, namely where compulsory

by law or where there is a public health hazard.

Professionalism and Integrity

ICoME:

The ICoME emphasizes the need for doctors to exhibit professionalism and integrity, having no conflicts of interest and making sure that their actions maintain the dignity of the profession. It promotes ongoing professional development and abiding by ethical principles.

NMC:

The NMC's code of conduct also emphasizes professionalism and integrity. It specifies certain responsibilities towards colleagues and the profession, such as the duty to report untoward behavior and to cooperate in the furtherance of medical knowledge.

Disciplinary Actions and Accountability

ICoME:

Although the ICoME gives ethical directives, it exists mainly as a guidance document. Implementation of its principles rests on the shoulders of national medical associations and regulatory authorities. The WMA urges doctors to uphold these ethical standards but lacks the direct power to exact sanctions.

NMC:

The NMC, however, has the legal power to impose ethical standards in India. It can discipline medical professionals who fail to abide by ethical guidelines, either by suspending or taking them off the medical register. This regulatory function ensures responsibility and compliance with ethical standards in the nation.

Both the International Code of Medical Ethics and the Indian Code of Medical Ethics are based on the same set of fundamental principles, including patient autonomy, informed consent, confidentiality, professionalism, and accountability. The Indian code, however, contains more specified guidelines specific to the legal and cultural environment of India, with the added clout to apply such standards. Appreciating and incorporating these moral principles are important

for medical practitioners to deal with the intricacies of patient care and maintain the integrity of the medical profession.

MEDICAL ETHICS IN OTHER COUNTRIES

Medical ethics, though rooted in universal human values, manifests differently across national contexts depending on legal systems, cultural norms, and healthcare frameworks. While the World Medical Association's International Code of Medical Ethics provides a unifying foundation, countries like the United States, United Kingdom, Canada, and Japan have developed their own national codes that reflect distinctive ethical priorities and regulatory mechanisms.

United States – The AMA Code of Medical Ethics

The American Medical Association adopted its Code of Medical Ethics in 1847, making it among the world's earliest comprehensive ethical codes[22] It emphasizes patient autonomy, confidentiality, non-maleficence, and justice. The AMA Code outlines physicians' responsibilities to their patients, society, and profession. It provides interpretive opinions on subjects relating to modern issues like end-of-life decisions, telemedicine, and genetic research.

Ethical regulation in the US is mostly professional and institutional, rather than statutory. State medical boards and hospital ethics committees feature prominently in enforcing ethical behavior. In comparison with India, where the NMC's code of ethics has legal backing, the AMA system relies more on professional discipline and peer accountability.[23]

United Kingdom – The GMC's "Good Medical Practice"

In the United Kingdom, medical ethics is regulated by the General Medical Council through the landmark publication known as Good Medical Practice.[24] This code outlines core duties such as maintaining patient trust, acting with integrity, respecting patient autonomy, and ensuring effective communication. Legally, the GMC code carries legal weight in that it is a

[22] American Medical Association, AMA Code of Medical Ethics, 2023, available at https://code-medical-ethics.ama-assn.org/ (last visited Oct. 22, 2025).
[23] Federation of State Medical Boards, Guide to Medical Regulation in the United States, 2020, available at https://www.fsmb.org/ (last visited Oct. 22, 2025).
[24] General Medical Council, Good Medical Practice, 2024, available at https://www.gmc-uk.org/ethical-guidance/good-medical-practice (last visited Oct. 22, 2025).

prerequisite for medical registration. Ethically, the U.K. system places greater emphasis on accountability and transparency. Disciplinary action, including suspension or erasure from the medical register, may result from ethical violations. The Bolam Test, established in Bolam v. Friern Hospital Management Committee (1957), continues to guide the standard of care by requiring conformity to a responsible body of medical opinion.[25]

Canada – The CMA Code of Ethics and Professionalism

The CMA developed its first Code of Ethics in 1868, which has evolved into the CMA Code of Ethics and Professionalism (2018).[26] In this code, traditional ethical principles are combined with a strong emphasis on equity, social justice, and Indigenous health rights. It encourages shared decision-making between physicians and patients and reflects Canada's multicultural ethos and rights-based legal system.

The Canadian model articulates human rights and diversity concerns more explicitly as part of its ethical framework, in comparison to India. Furthermore, the TCPS 2 steers research ethics in a manner that makes sure respect for human dignity, welfare, and justice are protected in biomedical research involving humans.[27]

Japan - Ethics Founded on Harmony and Obligation

Japanese medical ethics reflect Confucian values that stress societal harmony, respect, and duty to others rather than individual autonomy. The Japan Medical Association promotes a professional code that blends traditional values with international norms.[28] Current medical decision-making is guided by the importance of societal harmony, family decision-making, and respect for elders.

Most ethical challenges in Japan occur in areas of informed consent and decisions about end-of-life care, in which cultural expectations of family involvement sometimes override individual patient autonomy. Nevertheless, Japan adheres to global declarations such as the WMA Declaration of Helsinki, reflecting a balance between cultural traditions and universal

[25] Bolam v. Friern Hospital Management Committee, (1957) 1 WLR 582 (QBD).
[26] Canadian Medical Association, CMA Code of Ethics and Professionalism, 2018, available at https://www.cma.ca/cma-code-ethics-and-professionalism (last visited Oct. 22, 2025).
[27] Government of Canada, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2), 2022, available at https://ethics.gc.ca/ (last visited Oct. 22, 2025).
[28] Japan Medical Association, Code of Ethics, 2016, available at https://www.med.or.jp/english/ (last visited Oct. 22, 2025).

ethical norms.[29] Comparative Insights While there is a commitment to basic ethical principles by all countries, their approaches vary in the way of enforcement and cultural emphasis. The U.S. model is largely based on autonomy and institutional oversight; the U.K. system interlinks professional accountability within a legal framework; Canada stresses the elements of inclusivity and human rights; and Japan blends ethics with social duty and collective responsibility. In contrast, India's position presents a hybrid of global ethics and local realities through combining statutory enforceability with professional self-regulation in the NMC Regulations, 2023.[30]

EMERGING ISSUES IN MEDICAL ETHICS

Telemedicine and Digital Health

The growth of telemedicine has revolutionized conventional models of healthcare provision. It allows patients to receive medical services over the internet, overcoming geographical and logistical challenges and enhancing health equity.[31] But this technological advancement also invites critical ethical questions about informed consent, confidentiality of patients, quality of care, and professional accountability. Ensuring that online visits are on par with face-to-face care is crucial to preserving patients' and physicians' trust.

Moreover, doctors also need to adhere to legal and regulatory models such as proper documentation, licensure, and maintaining the scope of practice. There are also fears of possible misdiagnosis, failure to perform physical examination, and violation of data privacy. With the rise of digital health, there is also a need to strengthen ethical guidelines in order to respond to the challenges it poses without affecting the quality of treatment.

Artificial Intelligence in Medicine

Artificial Intelligence (AI) is increasingly being applied in diagnostic imaging, predictive analytics, and clinical decision support systems. While enhancing efficiency and accuracy, AI

[29] World Medical Association, Declaration of Helsinki – Ethical Principles for Medical Research Involving Human Subjects, 2013, available at https://www.wma.net/policies-post/wma-declaration-of-helsinki/ (last visited Oct. 22, 2025).
[30] National Medical Commission, Registered Medical Practitioner (Professional Conduct) Regulations, 2023, available at https://www.nmc.org.in/rules-regulations/code-of-medical-ethics-regulations-2002/ (last visited Oct. 22, 2025).
[31] World Health Organization, Telemedicine: Opportunities and Developments in Member States. Report on the Second Global Survey on eHealth, 1st ed., CAB Direct Ltd., Geneva, 2010.

introduces ethical considerations regarding transparency, bias, accountability, and informed consent[32]. Doctors have to ensure that AI applications are employed as aids to, rather than substitutes for, human clinical judgment. Explainability and traceability of algorithmic decisions are imperative in order to preserve patient trust.

No legislation for AI In healthcare currently exists in India, which has raised liability concerns in case of errors, misuse of data, or harm to patients.[33] Global guidelines highlight that AI deployments in health should be human-centered, evidence-based, and ethically governed. Following these principles can ensure the ethical application of AI in medicine.

Genome Editing and Genetic Engineering

Genetic engineering tools like CRISPR-Cas9 have opened new avenues in the treatment of hereditary diseases. These tools make it possible to edit genes with high precision to correct mutations and enhance patient outcomes.[34] But they raise important ethical concerns about germline modification, possible misuse for non-therapeutic enhancements, and long-term societal effects. The possibility of exacerbating inequality through access to cutting-edge genetic therapies is a concern.

Ethical models highlight the ideals of justice, non-maleficence, and informed consent. WHO and NHGRI promote clear governance, international cooperation, and public involvement to avoid unethical uses.[35] Balancing scientific innovation and ethical duty is key to this growing field of medical ethics.

Reproductive Ethics and Surrogacy

Reproductive technologies such as surrogacy have deep ethical and legal controversies. In India, commercial surrogacy is banned under the Surrogacy (Regulation) Act, 2021, but altruistic surrogacy is only allowed to shield women from exploitation.[36] Ethical dilemmas

[32] WHO, Ethics and Governance of Artificial Intelligence for Health, 2021, available at https://www.who.int/publications/i/item/9789240029200 (last visited Oct. 22, 2025).
[33] NITI Aayog, Responsible AI for All: 2021 Strategy Paper, available at https://www.niti.gov.in/ (last visited Oct. 22, 2025).
[34] NHGRI, "What are the Ethical Concerns of Genome Editing?", available at https://www.genome.gov/about-genomics/policy-issues/Genome-Editing/ethical-concerns (last visited Oct. 22, 2025).
[35] PMC, Ethical Perspectives of Therapeutic Human Genome Editing From Islamic Bioethics, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9793437/ (last visited Oct. 22, 2025).
[36] Surrogacy (Regulation) Act, 2021, India Code, available at https://www.indiacode.nic.in/bitstream/123456789/17046/1/A2021-47.pdf (last visited Oct. 22, 2025).

come up in issues of informed consent, rights of parents, and rights of surrogate mothers.[37]

Internationally, the practice remains controversial owing to cultural, legal, and religious variations. The main ethical issues include commodification of the human body, reproductive autonomy, and access to reproductive technologies on fair terms.[38] These questions need definite legal articulations and ethical frameworks to safeguard the interests of all parties.

End-of-Life Choices and Euthanasia

End-of-life care provokes concerns regarding patient autonomy, dignity, and the moral obligation to save life. Though numerous nations permit assisted dying with robust safeguards, India only allows passive euthanasia in the Common Cause v. Union of India (2018) decision.[39] The ruling establishes the patient's right to renounce life-support treatment via advance directives.

Balancing the principles of beneficence and autonomy is one of the central challenges. Ethical guidance needs to ensure that end-of-life choices are respectful to patient rights, free from coercion, and offer access to palliative care.[40] With advancing medical technology, ethical controversies are set to escalate, necessitating unmistakable legal and professional guidelines.

Climate Change and Environmental Ethics

Climate change poses significant risks to public health, including vector-borne disease expansion, heat stress, and illness related to air pollution.[41] Medical ethics increasingly accepts healthcare professionals' obligations to promote environmental sustainability.[42]

Ethical models place a strong focus on justice and solidarity because climate effects

[37] N. Narayan et al., "The Surrogacy (Regulation) Act, 2021," Cureus, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10199460/ (last visited Oct. 22, 2025).
[38] PMC, The Surrogacy (Regulation) Act, 2021: A Critique, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC9816354/ (last visited Oct. 22, 2025).
[39] Common Cause v. Union of India, (2018) 5 SCC 1 (India).
[40] WHO, Integrating Palliative Care and Symptom Relief into Primary Health Care, 2018, available at https://www.who.int/publications/i/item/integrating-palliative-care-and-symptom-relief-into-primary-health-care (last visited Oct. 22, 2025).
[41] WHO, Climate Change and Health, Fact Sheet, 2023, available at https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health (last visited Oct. 22, 2025).
[42] Lancet Countdown, Tracking Progress on Health and Climate Change 2022 Report, available at https://www.lancetcountdown.org/ (last visited Oct. 22, 2025).

disproportionately impact vulnerable populations.[43] Physicians are urged to advance sustainable healthcare practices, lower carbon footprints, and become involved in policy advocacy to reduce health effects related to environmental deterioration.

Data Privacy and Cybersecurity

With the digitalization of medical records, safeguarding patient information is an important ethical issue. Unauthorized access, hacking, and misuse of data can seriously undermine patient trust.[44] Physicians and institutions have a responsibility to use strong security controls, gain informed consent, and be transparent.[45]

India's Digital Personal Data Protection Act, 2023 creates a legal framework for the protection of health data.[46] Globally, GDPR outlines strict privacy and accountability standards. Ethical data handling to maintain patient autonomy and confidentiality is becoming a priority in the rapidly digitalizing world.

Pharmaceutical Industry and Conflict of Interest

Interactions between doctors and the pharmaceutical industry have the potential to advance medical progress but may also generate conflicts of interest.[47] Moral implications arise where commercial rewards bias clinical judgment, compromising patient benefit and professional credibility.[48]

Indian regulations forbid doctors from receiving gifts or incentives from drug companies.[49] Global standards such as those adopted by the World Medical Association stress transparency and disclosure in order to preserve public confidence in the medical profession.

[43] UNEP, Sustainable Health Care Systems, available at https://www.unep.org/ (last visited Oct. 22, 2025).
[44] WHO, Global Strategy on Digital Health 2020–2025, available at https://www.who.int/publications/i/item/9789240020924 (last visited Oct. 22, 2025).
[45] Ministry of Electronics & IT, Digital Personal Data Protection Act, 2023, available at https://www.meity.gov.in/ (last visited Oct. 22, 2025).
[46] GDPR, General Data Protection Regulation, EU Official Journal, available at https://gdpr-info.eu/ (last visited Oct. 22, 2025).
[47] WMA, Statement on Conflict of Interest, available at https://www.wma.net/policies-post/wma-statement-on-conflict-of-interest/ (last visited Oct. 22, 2025).
[48] WHO, Ethical Criteria for Medicinal Drug Promotion, 1988, available at https://apps.who.int/iris/handle/10665/38125 (last visited Oct. 22, 2025).
[49] MCI, Code of Ethics Regulations, 2002, available at https://www.nmc.org.in/ (last visited Oct. 22, 2025).

JUDICIAL APPROACH

Indian Medical Association v. V.P. Shantha and others [50](1996)

The case was rooted in several complaints of medical negligence in private hospitals. The central legal issue was whether services provided by medical practitioners would come within the ambit of the definition of "service" of the Consumer Protection Act, 1986. The medical associations argued that the medical profession was a noble one and could not be dealt with on a commercial basis.

The Supreme Court ruled that medical care are "services" under the Consumer Protection Act, with the exception of when provided free of charge. This ruling enhanced accountability and patient protection, strengthening ethical standards of diligence, competence, and patient autonomy.

Mr. 'X' v. Hospital 'Z' [51](1998)

A patient was HIV positive, and the hospital revealed his status to a third party, causing his marriage to be cancelled and his privacy being breached. The patient claimed that the revelation breached doctor–patient confidentiality.

The Supreme Court ruled that confidentiality may be violated when the non-disclosure is sufficiently serious to jeopardize other people. The case established the ethical limit between patient confidentiality and public health protection, offering a balance between individual rights and public safety.

Malay Kumar Ganguly v. Dr. Sukumar Mukherjee[52] (2010)

The case was that of a patient named Anuradha Saha, who succumbed to a rare skin condition known as Toxic Epidermal Necrolysis (TEN) following treatment by several physicians. Her husband, Dr. Malay Kumar Ganguly, a physician settled in the US, brought the case against the physicians and the hospital on charges of medical negligence.

[50] AIR 1996 SC 550.
[51] (1998) 8 SCC 296.
[52] AIR 2010 SC 1162.

The Supreme Court of India held the doctors and the hospital liable for medical negligence and ordered a compensation of ₹6.08 crores (about $1 million then), which is one of the highest compensations for medical negligence in Indian legal history. The case laid down some key principles related to:

The level of care required by medical professionals.

The responsibility of hospitals for the negligence of their doctors.

The calculation of compensation in medical negligence cases.

Common Cause v. Union of India[53] (2018)

A PIL was moved by the NGO Common Cause requesting legal approval for passive euthanasia and living wills for patients who were terminally ill.

A Supreme Court Constitution Bench acknowledged the right to die with dignity and permitted passive euthanasia subject to stringent safeguards. The judgment boosted patient autonomy and dignity, aligning Indian medical ethics with international human rights standards.

Mohini Jain v. State of Karnataka[54] (1992)

The case questioned the capitation fee system of private medical colleges that restricted access to medical education for economically disadvantaged students.

The Supreme Court enunciated the right to education as an integral part of the right to life under Article 21. The verdict emphasized the ethical responsibility of the State to provide fair access to healthcare and medical education, connecting social justice with medical ethics.

Jacob Mathew v. State of Punjab[55] (2005)

A patient had passed away as a result of oxygen deficiency in the hospital. The physician was charged with criminal negligence. The issue was the requirement for criminal liability for medical negligence.

[53] (2018) 5 SCC 1.
[54] AIR 1992 SC 1858.
[55] (2005) 6 SCC 1.

The Supreme Court ruled that criminal prosecution of physicians is only legitimate for gross neglect, and not for simple mistakes in judgment. This landmark ruling struck a balance between ethical responsibility and professional defense so that medical professionals receive just treatment.

Aruna Shanbaug v. Union of India[56] (2011)

Aruna Shanbaug, a nurse, was in a persistent vegetative state for more than 40 years following an attack. A petition asked for leave to withdraw life support.

The Supreme Court acknowledged passive euthanasia under limited conditions but not in her case. The ruling opened the doors to ethical considerations relating to end-of-life care, patient dignity, and withholding treatment.

Airedale NHS Trust v. Bland (1993)[57] (UK):

Anthony Bland was left in a permanent vegetative state following the Hillsborough disaster. Physicians asked for consent to remove life support, causing ethical and legal controversy.

The House of Lords authorized the withdrawal of treatment, deciding that maintaining it had no therapeutic value. The case became an international precedent regarding end-of-life decisions and was later referred to in Indian euthanasia judgments.

SUGGESTIONS

Enhancing Legal Consciousness of Physicians

Physicians must be provided with regular refresher courses on Indian and International Codes of Medical Ethics, patient rights, and latest judicial pronouncements. This will check violation of ethics and promote adherence to international standards.

Standardization of Ethical Codes

Though the WMA International Code offers 40 principles, India needs to develop a more elaborative, practical framework of implementation for hospitals and clinics to eliminate

[56] (2011) 4 SCC 454.
[57] (1993) AC 789 (HL).

subjective meanings.

Increased Emphasis on Informed Consent and Patient Autonomy

Rights of patients to information, voluntary consent, and the capacity to decide need to be given greater importance. Hospitals should implement formal consent protocols as per international best practices.

Incorporation of Bioethics in Medical Education

Educating medical students in bioethics, end-of-life care, and advancing technologies ensures that new professionals will be equipped to address ethical issues responsibly.

Addressing Emerging Ethical Challenges

Ethical principles should specifically deal with matters such as telemedicine, artificial intelligence in healthcare, genetic screening, and the commercialization of medicine. These need transparent guidelines to weigh innovation against patient rights.

Monitoring and Accountability Mechanisms

Set up independent ethics committees at hospitals and regulatory authorities to hear grievances, impose compliance, and issue guidance in difficult ethical dilemmas.

Public Awareness and Patient Empowerment

Patients need to be taught about their rights, the ethical duties of physicians, and how to report unethical practice. This can be aided by awareness campaigns and online materials.

CONCLUSION

Comparative study of International and Indian Codes of Medical Ethics identifies that, notwithstanding variations in legal systems and cultural backgrounds, both codes abide by the basic tenets of beneficence, non-maleficence, autonomy, justice, and confidentiality. Indian case laws, including IMA v. V.P. Shantha, Aruna Shanbaug v. UOI, and Common Cause v. UOI, illustrate the working of these ethical principles in actual medical and judicial contexts, bringing into sharp focus the trade-offs among patient rights, professional duty, and societal

interests. While the International Code offers a common model, local refinement through the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 provides context-relevant direction to health professionals. Emergent issues such as technological progress, commercialism, and decision-making at the end of life require ongoing ethical training, legal education, and rigorous mechanisms of accountability. Finally, blending universal ethics with localized culture enhances confidence, professionalism, and quality of care in medicine, protecting the well-being and dignity of patients and facilitating ethically informed decisions by physicians.

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