Aligning the International Code of Medical Ethics with the Indian Medical Ethical System: A Qualitative Analysis

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Abstract

Global medical ethics has consolidated around the World Medical Association's International Code of Medical Ethics (ICME), revised in 2022 to foreground patient autonomy, physician well-being, and equity and justice in health care. This qualitative study takes the Indian medical ethical system as its standpoint and asks how the 2022 ICME aligns with the normative commitments that have shaped Indian medical practice. Using a documentary and thematic analysis of the ICME, the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, and the ancient Charaka tradition, the paper traces three themes: the status of patient autonomy against a historically paternalistic doctor-patient relationship, the distributive meaning of justice under severe resource constraint, and the institutional capacity to translate written norms into practice. The analysis finds that the ICME's principles are broadly consonant with the aspirational language of Indian codes, yet the two systems diverge in emphasis and in the machinery available to enforce them. The paper argues that global codes gain moral force in India not by supplanting indigenous frameworks but by being read through them, and that a credible Indian standpoint requires attention to the gap between codified ethics and enacted ethics.

1. Introduction

Medical ethics is no longer a private professional courtesy; it has become a global normative project. The World Medical Association's International Code of Medical Ethics (ICME), substantially revised in 2022, sets out a canon of principles that national medical associations are expected to adopt and implement[1] . The revision was notable for what it added: explicit commitments to patient autonomy, the well-being of physicians themselves, and equity and justice in health care[2], alongside the enduring duties of competence, confidentiality, and non-maleficence[3]. Codes of this kind travel. When an international code is adopted into a national context, it meets a pre-existing normative landscape: local codes, professional cultures, legal frameworks, and ethical traditions that may rest on different assumptions about the doctor, the patient, and society. This

[1] Parsa-Parsi, R. W.. (2022). The International Code of Medical Ethics of the World Medical Association. JAMA. Available at: https://doi.org/10.1001/jama.2022.19697 (Accessed on 22 August, 2026)

[2] Archana K. (2026) A Critical Review of Right to Abortion of Adolescents and Reproductive Justice in India., GLS Law Journal. Available at: https://www.glslawjournal.in/index.php/glslawjournal/article/view/237 (Accessed: 7 July 2026)

[3] Parsa-Parsi, R. W., Gillon, R., & Wiesing, U.. (2024). The revised International Code of Medical Ethics: responses to some important questions. Journal of Medical Ethics. Available at: https://jme.bmj.com/content/50/3/179 (Accessed on 22 August, 2026)

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paper examines that encounter in India. It takes the Indian medical ethical system as its standpoint and asks a comparative question: to what extent does the ICME align with, extend, or strain against the norms that have shaped Indian medical practice?

The Indian standpoint matters for several reasons. India trains and deploys one of the largest physician workforces in the world, serves a population of extraordinary social, linguistic, and economic diversity, and operates under severe resource constraints that make abstract principles like justice immediately material. It also carries an unusually long ethical lineage: a codified medical ethics tradition that predates the Hippocratic corpus[4], expressed in the oaths and injunctions of the ancient Charaka Samhita Examining the ICME from this standpoint therefore illuminates how a global norm both converges with and diverges from a distinct national ethical tradition.

The paper proceeds in four moves. First, it sets out the methodological approach of qualitative document analysis. Second, it describes the normative structure of the 2022 ICME. Third, it reconstructs the Indian medical ethical system across its ancient, colonial-era, and contemporary regulatory layers. Fourth, it presents a thematic comparison across three axes: autonomy, justice, and the translation of ethics into practice. The discussion returns to the conceptual tension between universal ethical claims and culturally situated norms, and concludes with implications for how India, and the global community, might treat international codes.

2. Methodology

This study adopts a qualitative, documentary research design. Document analysis is a systematic procedure for reviewing and evaluating written texts, in which the researcher examines documents to elicit meaning, gain understanding, and develop empirical knowledge[5]. It is well suited to the present question, because the object of study is a set of normative texts rather than a population, and the research aim is interpretive: to understand how two ethical systems construe the physician's obligations.

The corpus comprised three principal documents. The first is the World Medical Association's International Code of Medical Ethics[6] as adopted in October 2022. The second is the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002, the operative professional code for registered medical practitioners in India[7]. The third is the Charaka tradition as represented in the ancient medical compendia, read here as the historical root of Indian medical

[4] Tung, T., & Jr., C. H. O.. (2000). Ethics in Surgery: Historical Perspective. JAMA Surgery. Available at: https://doi.org/10.1001/archsurg.135.1.10 (Accessed on 22 August, 2026)

[5] Paramasivan S, Davies P, Richards A, Wade J, Rooshenas L, Mills N, et al. (2021) What empirical research has been undertaken on the ethics of clinical research in India? A systematic scoping review and narrative synthesis. BMJ Global Health. 2021;6:e004729 Available at: https://doi.org/10.1136/bmjgh-2020-004729 (Accessed on 22 August, 2026)

[6] The World Medical Association's International Code of Medical Ethics

[7] Code of Medical Ethics Regulation, 2002; Government of India

ethics. Academic commentary on each text, identified through structured searches of the medical-ethics literature[8], provided interpretive context[9].

The analysis proceeded thematically. The author coded each document for statements bearing on three a priori themes: (a) the relationship between physician and patient, especially the balance of authority and autonomy; (b) the scope and meaning of justice and fairness in access to care; and (c) the mechanisms through which written norms are expected to translate into practice. The coding was iterative: themes were refined as the documents were re-read, and representative passages were retained to support each finding. This approach follows the established practice of thematic synthesis of documentary sources in qualitative health-policy research[10].

The study is entirely textual and involved no human participants, so it did not require institutional ethics approval. The limitations of the design are acknowledged in Section 7: a document analysis describes the normative content of codes, not their lived implementation, and the interpretation is shaped by the researcher's position as an external reader of the Indian context.

3. The International Code of Medical Ethics (ICME)

The ICME is the World Medical Association's statement of basic ethical principles for physicians worldwide[11] . Its 2022 revision restructured the code around duties to the patient, duties to other health professionals, duties to society, and duties as a member of the medical profession, and it is notable for the weight it places on patient autonomy, physician well-being, and equity and justice in health care[12].

Three features of the 2022 code bear directly on the comparison with India. First, the ICME[13] gives primacy to the health[14] and well-being of the patient, and it locates this commitment in a relationship of trust and respect for patient dignity, privacy, and autonomy. The code requires the physician to obtain informed consent, to respect the patient's decisions, and to maintain confidentiality. This is a decisive move toward a patient-centred, autonomy-respecting ethic.

Second, the ICME[15] expands the physician's moral horizon beyond the individual patient. It imposes duties to society, including the promotion of equitable access to health care[16] and the fair

[8] Parsa-Parsi, R. W., Gillon, R., & Wiesing, U.. (2024) Supra Note 3
[9] Parsa-Parsi, R. W.. (2022) Supra Note 1
[10] Paramasivan S, Davies P, Richards A, Wade J, Rooshenas L, Mills N, et al. (2021) Supra Note 4
[11] Parsa-Parsi, R. W.. (2022) Supra Note 1
[12] Parsa-Parsi, R. W., Gillon, R., & Wiesing, U.. (2024) Supra Note 3
[13] Supra Note 5
[14] Kumar. A, Augustim.A., (2023) For a Healthy Society its Laws Should Be Based on Morality: A Critical Study on Law & Morality., GLS Law Journal. Available at: https://glslawjournal.in/index.php/glslawjournal/article/view/78 (Accessed on 22 August, 2026)
[15] Supra Note 5
[16] Divya Telang. (2026) Women and Healthcare in India: A Socio-Legal Analysis of the Contraceptive Burden on Women., GLS Law Journal. Available at: https://www.glslawjournal.in/index.php/glslawjournal/article/view/205 (Accessed on 22 August, 2026)

stewardship of resources[17] . The 2022 revision explicitly incorporated equity and justice as core concerns, a departure from earlier editions that spoke primarily of duties to the patient[18].

Third, the ICME recognizes the physician as a moral subject in their own right. It addresses physician well-being, continuing professional development, and the physician's obligations to colleagues, students, and the profession. The physician is positioned not merely as a servant of the patient but as a member of a profession with internal duties and legitimate claims to support[19].

In sum, the 2022 ICME is a comprehensive, principle-rich document that combines patient-centred duties with social duties and professional self-regard. It is these three commitments, autonomy, equity, and the professionalism of physicians, that the Indian system must be measured against.

4. The Indian Medical Ethical System

Any honest account of the Indian medical ethical system must begin before the modern state. The Charaka Samhita, among the earliest medical compendia of the subcontinent, contains a professional oath that bound the physician to treat the sick with compassion, to serve the poor and the helpless, to avoid harming the patient, and to keep the secrets of the household[20]. The tradition predates the Hippocratic oath and expresses a commitment to beneficence and confidentiality that echoes across later codes. Its emphasis falls on the physician's character and on a duty of care that is inclusive of the poor, an orientation that has deep resonance in contemporary debates about equity.

The modern regulatory layer is the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002[21]. Drafted under the Indian Medical Council Act, the code binds registered medical practitioners to maintain good medical practice, uphold the dignity of the profession, and serve humanity. Its structure is heavily disciplinary and conduct-oriented: substantial portions address the physician's obligations to colleagues and the profession, restrictions on advertising and the solicitation of patients, and the maintenance of medical records[22]. The 2002 code is, in important ways, a code of etiquette as much as of ethics, concerned with the internal ordering of the profession and with protecting the professional standing of physicians.

The Indian system also operates within a plural medical landscape. Alongside allopathic medicine governed by the Medical Council regulations, India recognizes systems under the AYUSH framework, including Ayurveda, yoga, Unani, Siddha, and homoeopathy, each with its own training

[17] Parsa-Parsi, R. W.. (2022) Supra Note 1
[18] Parsa-Parsi, R. W., Gillon, R., & Wiesing, U.. (2024) Supra Note 3
[19] Ibid
[20] Tung, T., & Jr., C. H. O.. (2000) Supra Note 3
[21] Supra Note 6
[22] Tiwari, S. S., & Desai, P. N.. (2018). Unproven Stem Cell Therapies in India: Regulatory Challenges and Proposed Paths Forward. Cell Stem Cell. Available at:https://doi.org/10.1016/j.stem.2018.10.007 (Accessed on 22 August, 2026)

and registration pathways[23]. This plurality means that the Indian medical ethical system is not a single code but a web of traditions and regulatory instruments, within which the 2002 code governs the allopathic profession that is the direct counterpart to the ICME.

Two features distinguish the Indian system from the ICME. First, the Indian code[24] is more explicitly paternalistic in tone than the ICME: it emphasizes the physician's responsibility to act in the patient's best interests and to maintain the patient's confidence, but it does not foreground patient autonomy or shared decision-making with the same insistence. Second, the Indian code is primarily a disciplinary instrument of the profession, concerned with professional conduct and etiquette, whereas the ICME is a statement of ethical principle directed at the physician's obligations to patient, society, and self[25]. These differences set the stage for the thematic comparison[26].

5. Comparative Thematic Analysis

5.1 Autonomy and the doctor-patient relationship

The most pronounced divergence between the two systems lies in the treatment of patient autonomy. The ICME[27] places patient autonomy at the centre of the physician-patient relationship, requiring informed consent, respect for patient decisions, and a partnership between physician[28] and patient. The Indian code[29], by contrast, is built around the physician's responsibility to act for the patient's welfare, and its language of service and dutiful care leans toward a benevolent-paternalist model rather than an autonomy-based one.

This textual difference corresponds to a documented pattern in Indian clinical practice. Empirical work on the doctor-patient relationship in India finds that it retains a strong shade of paternalism, particularly in marginalized communities where educational and economic disadvantage reinforces deference to the clinician. The physician-patient dynamic in such settings is marked by a power imbalance, and patients often expect the physician to decide for them. The ICME's autonomy-centred ideal therefore describes an aspiration that Indian practice has only partially adopted.

Yet the contrast is not a simple opposition between autonomy and its absence. The paternalism of the Indian code is inseparable from a beneficence that the ICME also endorses, and the practical

[23] Thirthalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., Hankey, A., Wang, G., Gangadhar, B. N., Nie, J.-B., & Nichter, M.. (2016). Traditional, complementary, and alternative medicine approaches to mental health care and psychological wellbeing in India and China. The Lancet Psychiatry. Available at: https://doi.org/10.1016/S2215-0366(16)30025-6 (Accessed on 22 August, 2026)
[24] Supra Note 6
[25] Parsa-Parsi, R. W.. (2022) Supra Note 1
[26] Parsa-Parsi, R. W., Gillon, R., & Wiesing, U.. (2024) Supra Note 3
[27] Supra Note 5
[28] Parsa-Parsi, R. W., Gillon, R., & Wiesing, U.. (2024) Supra Note 3
[29] Supra Note 6

question is how the two commitments are weighed when they conflict. The ICME resolves this tension in favour of autonomy; the Indian tradition has historically resolved it in favour of beneficence exercised by the physician[30]. A credible Indian standpoint would not dismiss autonomy but would ask how shared decision-making can be realised in a setting where patients both defer to and deeply trust their doctors.

5.2 Justice and the meaning of equity

Both systems affirm a duty of justice, but they mean different things by it. The ICME's[31] commitment to equity and justice is framed as a duty to promote equitable access to health care and to steward resources fairly, a universalist claim that the physician must serve the health of society as well as the individual[32]. The Indian tradition, in the Charaka oath, expresses a duty to serve the poor and the helpless, an inclusive beneficence that treats care for the disadvantaged as a defining obligation of the physician[33].

Under conditions of severe resource scarcity, justice ceases to be a distant principle and becomes a daily allocation problem. Indian physicians practise in a system where the gap between need and resources is wide, where public and private sectors coexist, and where the burden of non-communicable disease is rising against limited primary-care capacity[34]. In this context, the ICME's principle of fair resource stewardship offers a framework, but the Indian system must translate it into concrete allocation decisions that the ICME does not specify. The ancient duty to serve the poor provides a moral anchor that the technical language of the ICME does not always supply.

5.3 From codified ethics to enacted ethics

The third theme concerns the machinery by which written norms become lived practice. The ICME is a statement of principle; it depends for its effect on adoption by national associations and on the ethical formation of individual physicians[35]. The Indian code[36], by contrast, is a regulation with disciplinary teeth: it is enforced through state medical councils that can censure or strike off practitioners who breach professional conduct[37].

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[30] Tung, T., & Jr., C. H. O.. (2000) Supra Note 3
[31] Parsa-Parsi, R. W., Gillon, R., & Wiesing, U.. (2024) Supra Note 3
[32] Parsa-Parsi, R. W.. (2022) Supra Note 1
[33] Tung, T., & Jr., C. H. O.. (2000) Supra Note 3
[34] Thirthalli, J., Zhou, L., Kumar, K., Gao, J., Vaid, H., Liu, H., Hankey, A., Wang, G., Gangadhar, B. N., Nie, J.-B., & Nichter, M.. (2016) Supra Note 20.
[35] Parsa-Parsi, R. W., Gillon, R., & Wiesing, U.. (2024) Supra Note 3
[36] Supra Note 6
[37] Tiwari, S. S., & Desai, P. N.(2018) Supra Note 19.

The consequence is an asymmetry. The ICME is richer in principle but thinner in enforcement; the Indian code is comparatively thin in ethical principle but richer in disciplinary mechanism. This asymmetry helps explain why written convergence between the two systems, both can agree that physicians must be competent, honest, and committed to the patient, does not translate automatically into convergent practice. The gap between codified ethics and enacted ethics is where the real work of alignment lies[38].

Empirical research on the ethics of clinical research in India illustrates the stakes. A systematic scoping review found that the Indian literature is heavily weighted toward knowledge assessments of ethics among students and professionals, with far less work on the actual informed-consent process and on equity and justice in practice[39]. The presence of a code does not guarantee its enactment; the gap requires institutional attention, training, and accountability[40].

6. Discussion

The comparison yields a more nuanced conclusion than either a celebratory convergence or a stark opposition. At the level of stated principle, the ICME and the Indian medical ethical system overlap substantially. Both require competence, confidentiality, fidelity to the patient, and a duty of care that reaches the disadvantaged. The 2022 ICME's attention to equity resonates with the ancient Indian injunction to serve the poor, and its recognition of the physician as a professional subject echoes the Indian code's[41] concern for professional dignity.

The divergence is one of emphasis and mechanism. The ICME elevates autonomy; the Indian tradition has weighted beneficence. The ICME frames justice as equitable access; the Indian system must live justice under scarcity. The ICME relies on principled persuasion; the Indian code relies on professional discipline. These are differences in degree and in institutional form, not in the deepest commitments of either tradition.

This finding speaks to a familiar tension in bioethics between universal ethical claims and culturally situated norms. A purely universalist reading of the ICME risks imposing a model of the physician-patient relationship that does not fit the Indian setting; a purely relativist reading risks abandoning the critical leverage that a global standard provides. The Indian standpoint suggests a middle path: the ICME is most persuasive and most useful when it is read through the indigenous ethical tradition, as a provocation to clarify what Indian medicine already values rather than as a replacement for it.

[38] Paramasivan S, Davies P, Richards A, Wade J, Rooshenas L, Mills N, et al. (2021) Supra Note 4.
[39] Paramasivan S, Davies P, Richards A, Wade J, Rooshenas L, Mills N, et al. (2021) Supra Note 4.
[40] Tiwari, S. S., & Desai, P. N.(2018) Supra Note 19.
[41] Supra Note 6

The practical implication is that alignment between the ICME and the Indian system should proceed at the level of ethical formation and institutional practice, not merely at the level of codified text. Curricula that teach shared decision-making in a context of patient deference, investment in the informed-consent process, and accountability mechanisms[42] that translates professional norms into enacted care would narrow the gap that this analysis identifies. Global codes such as the ICME can support this work, but they cannot do it on their own.

7. Conclusion and Limitations

This qualitative document analysis has examined the 2022 International Code of Medical Ethics from the standpoint of the Indian medical ethical system. It finds broad convergence at the level of principle, a divergence in emphasis on autonomy and beneficence, a divergence in the meaning of justice under scarcity, and a marked asymmetry in enforcement machinery. The conclusion is that the ICME and the Indian system are aligned in their deepest values but divided in emphasis and in the institutional capacity to enact those values. A credible Indian standpoint reads the ICME through the indigenous tradition, and directs the resulting moral energy toward the gap between codified and enacted ethics.

Several limitations qualify these findings. The study examines normative texts, not clinical practice; documentary analysis cannot establish how physicians actually behave. The interpretation is informed by the researcher's external position relative to the Indian context, and the analysis of a living plural system is necessarily selective. Future research could extend the comparison empirically, for example by interviewing Indian physicians about how they weigh autonomy and beneficence, or by examining how the 2002 code and its successors are applied in disciplinary practice. Such work would test the gap between codified and enacted ethics that this paper identifies as the central challenge of alignment.

[42] Paramasivan S, Davies P, Richards A, Wade J, Rooshenas L, Mills N, et al. (2021) Supra Note 4