



NEPAL MEDICAL COUNCIL

Code of Ethics and Professional Conduct-2017

In exercise of the powers conferred by Nepal Medical Council Act (Third Amendment-2056 B.S), Section-33, Sub-Section-2, the Full House Meeting of Nepal Medical Council held on Chaitra 22, 2072 (March 14, 2016), unanimously recommended to amend the existing “Nepal Medical Council Code of Ethics 2002” after several rounds of discussions with the concerned subject-specialists, Legal experts, representatives of Universities, Academies Institutions, members of the professionals societies, Ministry of Health, Ministry of Law and Nepal Bar Council through one day “workshop on revising Code of Ethics for Doctors and to Formulate comprehensive Medical Law in Nepal” on December 30, 2016. Revised Code of Ethics and Professional Conduct-2017 was also unanimously passed from the Full House Meeting of Nepal Medical Council held on Falgun 2, 2073 (14th Feb, 2017) and also recommended to forward these recommendations to the Ministry of Health, Government of Nepal for the its approval. As per the same Act, Section and Sub-section-1 of Nepal Medical Council (Third amendment-2056 B.S.), the Ministry of Health, Government of Nepal sanctioned/approved the recommendations forwarded by Nepal Medical Council on and has made the following regulations.

1. Title:

- i. The regulations shall be titled as “Nepal Medical Council, Code of Ethics and Professional Conduct - 2017”.

2. Objective:

- ii. The objective of this is to formulate comprehensive and robust Code of Ethics that will guide the moral values of the medical professional.

3. Commencement:

- iii. It shall come into force immediately.



Nepal Medical Council

Medical Practitioner's Oath

The Nepal Medical Council has in accordance with the Nepal Medical Council Act 1964, passed a medical Code of Ethics & Professional Conduct 2017, which all doctors registered under it, are to abide by.

The code is as follows:

Oath:

The following oath should be read and agreed upon by the applicant at the time of registration:

1. I solemnly pledge myself to dedicate my life to the service of humanity.
2. Even under threat and duress I will not use my knowledge contrary to the norms of humanity.
3. I will maintain the utmost respect for human life right from the time of conception as per the laws of the land.
4. I will not allow consideration of age, sex, religion, nationality, ethnicity, politics, or social standing to intervene between my duty and my patient.
5. I will carry out my professional duties with conscience and dignity.
6. The health of my patient will be my first consideration.
7. I will respect the secrets of my patients confided in me.
8. I will give to my teachers the respect and gratitude that is their due.
9. I will maintain, by all means in my power, the honour and noble traditions of the medical profession.
10. I will maintain utmost rapport with my professional colleagues. I make these promises solemnly, freely and upon my honour.

Signature:.....

Name:.....

Date:.....

Reg. No:.....

In presence of,

Name of Registrar/Council Representative:.....

Signature:

Nepal Medical Council Regulations

(Related to Schedule No. 2)

Covenant Letter

I Dr. hereby solemnly swear that I will discharge my duties, as per Nepal Medical Council Act and Regulations. I hereby affirm my concurrence by signing this covenant letter that my actions may be taken against me under the prevailing act and regulation in case I act in defiance of and beyond Nepal Medical Council Act, Regulations and Code of Ethics and Professional Conduct 2017.

Signature:.....

Name:.....

Address:

Date:.....

नेपाल मेडिकल काउन्सिल

ने.मे.का. नियमावली २०२४

अनुसूची २

नियम (३) को उपनियम (३) खण्ड (घ) सँग सम्बन्धित

प्रतिज्ञापत्र

म डा. ले नेपाल मेडिकल काउन्सिल ऐन, नियम तथा विनियम एवं प्रचलित अन्य कानूनको अधिनमा रही चिकित्सकको हैसियतले आफूले पालन गर्नु पर्ने सबै काम र कर्तव्य ईमानदारी साथ पालना गर्ने प्रतिज्ञा गर्दै यो प्रतिज्ञापत्र प्रस्तुत गरेको छु । मैले नेपाल मेडिकल काउन्सिल ऐन, नियम, विनियम तथा पेशागत आचारण र अन्य प्रचलित कानूनले निर्दिष्ट गरेको चिकित्सकको काम, कर्तव्य र आचारसहिता विपरित काम गरे मा कानून बमोजिम कारवाही हुन मेरो मन्जुरी छ ।

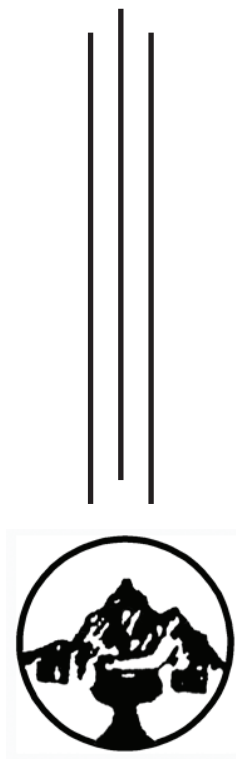
दस्तखत:.....

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Code of Ethics
&
Professional Conducts



Nepal Medical Council
Bansbari, Kathmandu
2017

Published by: Nepal Medical Council
Bansbari, Kathmandu

Copyright: Nepal Medical Council

Edition: First Edition 1992
Second Edition 2001
Third Edition 2002
Fourth Edition 2017

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1. Introduction

“A person may be a poor writer, a bad painter, or a bad actor but a man cannot and must not be a bad doctor.”

- Prof. M.P. Konchalovsky

Service to humanity is the prime objective of all medical professionals including doctors. This is why medical profession is considered a noble profession deserving high respect from the public as well as commanding self-controlled, ethical compliance by the doctors themselves, to maintain the nobleness of this profession. This Code of Ethics has been adopted by Nepal Medical Council (NMC) according to authority delegated by Section 7A (e) of NMC Act 2020 B.S. for regulating and bringing uniformity in professional conducts and ethical consideration for all registered doctors in Nepal.

This Code of Medical Ethics is a fundamental guide for all doctors and must be complied in course of their professional responsibility. This Code of Ethics is by no means exhaustive and will be updated periodically, and subsequent amendments will be published in the website of the Medical Council (www.nmc.org.np).

Violation of this Code or any recognized principles of medical profession will jeopardize quality health service delivery and patients' safety and thus such violations may render a registered medical practitioner liable to disciplinary proceedings.

In addition to this Code of Ethics, all medical practitioners should also familiarize themselves with and abide by all the medical laws, rules and regulations of Nepal.

The Nepal Medical Council is mandated to regulate medical profession within the country by the Nepal Medical Council Act. It is duty bound and responsible for setting the ethical standards of practice and the code of conduct for the medical professionals and ensuring all medical practitioners comply with ethical behaviour for safe and quality medical practice.

Acknowledging this responsibility, NMC shall also take steps towards disseminating this Code of Ethics and generating public awareness of the professional expectations and role of medical practitioners.

2. Definition of key terms and abbreviations

Council means Nepal Medical Council (NMC)

Medical practitioner means registered medical practitioner of Nepal whose name is listed in the registration book of Nepal Medical Council.

Professional misconduct means an act of a medical professional done in pursuit of his medical profession which is reasonably regarded as dishonourable and disgraceful by the professional brethren of good repute and competence.

Unless the context requires otherwise, words in the masculine gender include the feminine gender and words in the singular include the plural, and vice versa.

WMA: World Medical Association

DNR: Do Not Resuscitate

CPR: Cardiopulmonary Resuscitation

IEC: Institutional Ethical Committee

NHRC: Nepal Health Research Council

SOP: Standard Operating Procedures

3. General Principles of Medical Ethics

The purpose of medicine is to heal. In other words the purpose of medicine is to cure illnesses, stabilize a state of health when illnesses cannot be completely cured and always try to alleviate pain and discomfort. A medical practitioner should be a qualified person competent in practicing the art of scientific healing. S/he should always uphold the highest standards of medical professionalism, the highest standards of ethical conduct and place the interests of her/his patients above her/his own.

A. Foundation of Medical ethics

All medical practitioners are expected to comply with following fundamental principles of medical ethics in course of their professional practice:

- i. Principle of autonomy i.e. the mentally sound patient's rights to self-determination should be respected and it should be recognized. S/he has a right to make her/his own decisions and treatment choices.
- ii. Principle of beneficence i.e. treatments or procedures will be offered by medical practitioners only if they will potentially benefit the patient.
- iii. Principle of non-maleficence i.e. treatments or procedures will not be offered by medical practitioners if they will only harm the patient. As guiding principles any potentially harmful side effects of treatment should be minimized when possible and any treatments whose risks outweigh their potential benefits to the patient should not be offered.
- iv. Principle of justice i.e. scarce health resources should be fairly and equitably distributed according to medical needs and social needs without any prejudice or discrimination based on age, gender, sexual orientation, physical or mental disabilities, religious beliefs, employment or social status.

B. Accountability towards medical profession

The main aim of the medical profession is to render a service to humanity. A medical practitioner should work with utmost dedication and should always endeavour to stay updated on the latest medical advancements for the benefit of patients and medical fraternity. The medical practitioner should practice evidence based medicine and should encourage his colleagues to do the same.

C. Inappropriate advertisements

NMC (Nepal Medical Council) does not wish to hinder the ethical dissemination of relevant factual information about the services available at an institution or being provided by a medical practitioner. This information helps patients to make informed choice while seeking treatment and assists medical practitioners in advising their patients on the choice of specialist. The Council recognizes the duty the medical profession has in disseminating information about advances in medical science and therapeutics, provided that it is achieved in a moral, principled and honourable manner.

A medical practitioner is expected to make public (and inform the Council) the following information related to her/his practice:

- a. Starting of practice
- b. Change of type of practice
- c. Change of address
- d. Temporary absence from duty and temporary coverage of duties
- e. Resumption of another practice
- f. Succeeding to another practice

However, solicitation of patients directly or indirectly, by a medical practitioner or by groups of medical practitioners and organizations is unethical. Self-advertisement is not only incompatible with the principles of medical ethics but also could be misleading to the public. A medical practitioner successful at achieving publicity may not be the most appropriate medical practitioner for a patient to consult and also may raise illusionary hopes of cure in life threatening cases.

D. Gratuity and commissions

It is unethical to receive or offer any gratuity, commissions or bonuses in consideration of or in return for referring or recommending patient for prescribing medical and surgical treatments, investigations or consultations.

4. Duties of medical practitioner

A. Towards patient

A Medical practitioner is not bound to treat each and every patient asking for his services except in emergencies, but s/he should be ready to respond to the calls of the sick and injured, upholding the honour and integrity of medical profession. If the situation is an emergency meaning that any delay in treatment would result in increased morbidity and mortality, treatment should be started and consent should be obtained from the patient or the family to continue treatment once the patient is stable.

i. Informed Consent

Informed consent is the fundamental ethical and legal cornerstone of the doctor-patient relationship. For an informed consent to be valid, the patient has to be given

1. Adequate information regarding nature of illness,
2. Potential benefits and risks, side effects and harms of available treatment options,
3. Their alternatives, their consequences and complications, and
4. The consequences of no treatment which enable the patients to exercise their right to self-decision.

Such informed consent is required to be recorded in writing by the treating medical practitioner. A general informed consent taken during admission of a patient in hospital does not serve to address all the diagnostic and treatment procedures that will need to be undertaken. New informed consent in writing has to be taken before each and every invasive procedures and before any new treatments or for any additional treatments within the originally consented original treatment plan when these additional treatments carry significant risks, are going to be painful and invasive, or will have significant consequences on short or long term prognosis and quality of life. Informed consent should once again be clearly document in writing in the patient's medical record.

In the following situations the process of informed consent and decision-making regarding treatment options should be discussed with patient's family/primary caretaker:

- If the patient is a minor, who is less than 16 years of age, informed consent has to be taken from her/his parents or guardian or legal guardian.
- If the patient has mental illness or any impairment of mental soundness, informed consent has to be taken from his next of kin who knows the patient as a person, her/his values and treatment goals and can make decisions in the patient's interests by placing the patient's interests before her/his own. To be mentally sound with respect to treatment, patients must be able to understand the information given to them about their illness and treatment options and to appreciate the consequences of any choices/decisions they make with respect to treatments. If a patient is not mentally sound, consent should be obtained from her/his family

A mentally sound patient has the right to refuse to consent to treatment, provided that he is able to exercise his judgment freely. The refusal should be respected and clearly documented. However, in case of Hunger strike, medical practitioner may intervene and provide lifesaving treatment to the striker without her/his consent if the striker becomes unconscious or his ability of fair judgment is compromised due to physiological changes brought by starvation. The treatment of such striker should be done according to the World Medical Association's Declaration on Hunger Strikers .

In case of implied consent, where the behaviour of the patient implies willingness to undergo examination, e.g. patient extending his arm for a blood sample to be taken, a written informed consent may not be necessary. However, this does not mean that the medical practitioner has no obligation to explain to the patient, the reason for the tests, the potential differential diagnosis and/or the patient's actual ailment and subsequent potential modalities of treatment.

The medical practitioner must inform the patient about their ailment, the method of administration, potential adverse effects, warning signs of problems and contraindication of any prescribed medicines, signs of deterioration and how these should be addressed, what to do if an emergency arises when appropriate in view of the illness and proposed treatment and when to follow

up next with the medical practitioner, irrespective of the number of patients waiting for treatment and irrespective of being busy/not having much time. This is a standard of care and a fundamental ethical obligation that must be met by all medical practitioners

An intimate examination of a patient should be conducted in the presence of a chaperone. If the patient requests to be examined without a chaperone, the request should be recorded in medical records.

ii. Alcohol and drugs

A medical practitioner should completely restrict himself from consuming alcohol, smoking cigarette or taking intoxicating drug in the work place. S/he should not attend patient under the influence of alcohol and intoxicating drugs.

iii. Medico-legal cases

Examination of medico-legal cases such as victim or suspect of sexual offences, physical assault, autopsy examination, age estimation etc., should be carried out by trained or expert medical practitioners.

iv. Proper communication with patients/patient family

Any communication between a patient and her/his medical practitioner should be viewed as private and confidential and should not be shared publicly. Information may be shared between medical practitioners involved in the patient's care only if such information is relevant to the care being provided. Medical practitioner should allow the patient to express and communicate their grievances unreservedly to avoid mistrust and conflict between doctor and patient. In case of any conflicts, the medical practitioners should try to understand the cause of the conflict and seek to resolve it by sincere and honest communication with the patient/and/or patient family.

v. Personal relationship with patient or patient's family members

A medical practitioner should not be involved in any emotional or sexual relationships with patient or patient's family members or relatives while continuing doctor-patient relationship.

vi. Termination of doctor-patient relationship

Except in situations wherein it is in the best interest of the patient for such medical care to be provided by another medical practitioner, no medical practitioner should deny continuing treatment and terminate doctor patient relationship. In particular, it is professional misconduct to terminate the relationship and should not be terminated on grounds of age, gender, religion, political beliefs, physical or mental disabilities, sexual orientation or social status. However, the medical practitioner may terminate the relationship in the following situations:

- a. Loss of trust between the medical practitioner and the patient,
- b. Where the treatment requested is beyond the competence of the medical practitioner or the treatment is considered futile by the treating medical practitioner,
- c. Refusal to pay the fee for service (unless in an emergency situation in which case the medical practitioner must continue to treat until the emergency is resolved),
- d. Noncompliance with the recommended treatment after reasonable attempts have been made to understand and fix the reasons for noncompliance),
- e. Exerting undue pressure to prescribe unnecessary drugs,
- f. Forcing to do an immoral act in her/his favour,
- g. When medical practitioner is unwell or unfit to practice in which case notice should be provided as soon as possible to patients and a referral to another practitioner should be made if at all possible.

vii. Medical records

A medical practitioner should maintain or demand to maintain confidential medical records of her/his patients' history, physical findings, investigations, treatment, and clinical progress in both private and government settings. It may be handwritten, printed, or electronically generated. Special medical records in the form of audio and visual recording can also be maintained.

- Medical practitioners should keep and maintain such confidential medical records in a safe location for at least 5 years from the date of last visit of the patient.
- Medical practitioners should be able to provide such medical records upon the request of patient, in response to a judicial order, or from the order of Nepal Medical Council or any other authorized body.

viii. Patient confidentiality

A medical practitioner should maintain the secrecy and confidentiality of a patient's information and all data obtained in course of investigation and treatment. Such information should not be disclosed to a third party without prior consent of the patient except in case of necessity to disclose such confidentiality for protecting the larger public interest or where disclosure is necessary to avoid serious harm to the patient or other persons, or when disclosure is required by law.

ix. Dissemination of false or misleading information

A medical practitioner providing any information to the public through media or to his patients must comply with the principles of accuracy and objectivity. Such information must not be exaggerated or misleading, unjustified, aimed at financially exploiting any patient(s) or promoting commercial medical and health related products and services, and nor should it ever be disparaging to other medical practitioners.

x. Abuse of trust of patient

A medical practitioner should not take undue advantage of her/his patient's trust to promote and sell medical products or health benefit substances, as such activity can lead to unnecessary increments in the cost of treatment to patient.

No attempt should be made to put undue pressure and coercion on patients or patients' family, exploiting her/his lack of knowledge to pursue any particular modality of treatment or to force participation in research projects. S/he also should not offer guarantees to cure disease and should not involve in the contract of 'no cure no cost'.

xi. Information about cost of treatment

- Tentative consultation, investigation and procedural fees should be made known to patients before the treatment begins. It is against the code of ethics to defer the disclosure of cost of treatment until the later course of treatment. An exhibit of notice of cost is desirable to be kept for demonstration at medical practitioner's place of practice.
- For those patients who cannot afford services, a medical practitioner can try to help them by advocating for free beds or, if available asking for charitable donations.

xii. Respect of religion

A medical practitioner should aspire at serving humanity above all religious beliefs. However, the religious faith of patients should always be respected. Any discrimination on the basis of religious beliefs is unethical and will be considered unprofessional conduct.

xiii. Care of the terminally ill patient

- Where death is imminent, the medical practitioner should make sure that the patient dies with dignity and with as little pain and suffering as possible.
- Euthanasia, the act of painless killing of a patient suffering from an incurable and painful disease, is not legalized in Nepal and hence no medical practitioner should practice it. However, administration of narcotics and sedatives titrated to alleviate pain and distress in a dying patient is not euthanasia but is palliative care which should be provided and clearly documented in the medical record.
- In the terminally ill patient "Do Not Resuscitate" or "DNR" does not mean Do Not Treat. It actually signifies refusal of administration of "Cardio Pulmonary Resuscitation (CPR)" in case of sudden cardiac arrest. Hence all the required treatment should be continued as usual except the CPR.
- If a patient is terminally ill, medical practitioners need to consider whether treatments will offer any benefit to the patient at all or if, in the patient's situation they will only cause harm. If a treatment will not work, if it will only prolong death, if it will increase suffering and make death more painful, the treatment is futile and should not be offered. This

includes CPR and life support. To offer treatments that are not aimed at alleviating pain and discomfort in other words treatments that are not palliative in these situations would fall outside the medical standard of care.

- If it becomes clear when caring for a terminally ill patient that the treatment isn't working and that any treatment that is not palliative in nature is futile, e.g., terminally ill patient admitted in ICU with ventilator support, medical practitioners should discuss the situation empathically with the patient's family as soon as possible regarding discontinuation of life supportive measures keeping in mind the best interest of the patient.

B. Towards medical profession

i. Honour of the profession

A Medical practitioner while practicing should act in a manner that her/his activities contribute towards upholding the nobleness, dignity and honor of medical profession to the highest standard.

ii. Membership in medical societies

For the advancement of her/his career, a medical practitioner is encouraged to affiliate and actively participate in medical societies. Medical practitioners' linkage to such societies is believed to consolidate efforts to uplift the profession and help each other to remain updated with new innovations and medical advancements within their field of practice.

iii. Safeguard of the medical profession

Medical practitioners should not practice improper delegation of authority or employ unqualified persons or unregistered medical practitioners to attend, treat or perform any diagnostic or therapeutic procedures upon patients. It is the duty of registered medical practitioner to report any illegal practice of unregistered medical practitioners to the concerned authority.

iv. Exposure of unethical conduct

Medical practitioner should report to the Nepal Medical Council without fear, about incompetent, corrupt, and dishonest members and their unethical conduct.

v. Fitness to practice

- Physical and mental fitness of reasonable degree is expected in each medical practitioner. In case of a medical practitioner being carrier of serious infectious disease such as HIV, Hepatitis B and C or Tuberculosis, flus and other epidemics he/she must take necessary steps to prevent the spread of such infection to her/his patients and colleagues, should immediately seek appropriate investigation and treatment and should inform the concerned authority.

If a medical practitioner comes to know about any medical practitioner continuing practice in spite of being infected with communicable disease without having informed the Council, he/she should report to the Medical Council about such unethical practice.

However, the status and rights of an infected medical practitioner as an employee should be safeguarded and restriction or modification, if any, will be determined on a case-by-case basis.

- **Impaired mental state or psychiatric illness:**
If a medical practitioner's mental soundness is impaired as a result of psychiatric disorders or substance abuse (e.g. alcohol and other psycho active substances), s/he should not attend and treat patients and should seek treatment immediately. In such state, her/his insight and judgment may be compromised which may affect his competence and pose serious threat to patient's welfare. If her/his colleague comes to know about the condition, then the colleague may attempt to counsel or encourage the impaired colleague to seek treatment and to refrain from patient care. However, if the impaired medical practitioner does not respond to collegial approach, it is the duty of every medical practitioner to report such persons to appropriate authority so that they do not harm the patient.

vi. Health education activities

- It is appropriate for a medical practitioner to take part in health/medical education activities. However, he must not use such activities for promotion of his practice or to canvass for patients. Any information provided should be objectively verifiable and presented in a balanced manner, without exaggeration of the positive aspects or omission of significant negative aspects.
- A medical practitioner should take reasonable steps to ensure that the published or broadcasted material, either by their contents or the manner they are referred to, do not give the impression that the audience is being encouraged to seek consultation or treatment from him or organizations with which he is associated. He should also take reasonable steps to ensure that the materials are not used directly or indirectly for the commercial promotion of any health related products or services. Failure to do so will be considered a conflict of interest and unethical conduct.
- Information given to the public should be authoritative, appropriate and in accordance with general experience. It should be factual, lucid and expressed in simple terms. It should not arouse unnecessary public concern or personal distress, or generate unrealistic expectations. Medical practitioners must not give the impression that they, or the institutions with which they are associated, have unique or special skills or solutions to health problems if this is not true. Information should not be presented in such a way that it furthers the professional interests of the medical practitioners concerned, or attracts patients to their care.

vii. Specialist title

- Only medical practitioners on the Specialist Register are recognized as specialist, and can use the title of “specialist”. Medical practitioners who are not on the specialist register cannot claim to identify themselves as specialists.
- A nonspecialist is not allowed to set up a dedicated specialist practice and publicize as such. However, providing a generalist care or a lifesaving treatment in a community setting or when delegated by Government is a duty of every registered medical practitioner.
- A medical practitioner should not practice beyond the scope of her/his speciality.

- If there is a doubt about the specialist or the training of the specialist medical practitioner, the question of speciality will be judged by the ethical committee of the council which will involve peer group and the respective professional society to make a final decision about the appropriate action.
- Involvement of a medical practitioner during her/his residency, fellowship (MD, MS, DM, MCh), in private practice or practice at any other hospital not attached to his primary program is highly unethical and will be liable for disciplinary action.
- Medical practitioners who have completed a speciality training program and academic studies but have failed the specialist exam of the Nepal Medical Council should not be allowed to work as a specialist.

viii. Complementary/alternative treatment modalities

If a medical practitioner has acquired necessary training and qualification regarding the complementary and alternative treatment modalities then only s/he can practice such treatment modalities.

ix. Organ transplant and organ donation

- Medical practitioners should exercise the principles and the provisions of the Human Organ Transplant Act 2055 amended on 2072.

x. Scientifically assisted reproduction, abortion and related technology

- Medical practitioners who perform any human reproductive technology procedure or conduct research on human embryos should ensure that they comply with relevant guidelines issued by the World Medical Association on Assisted Reproductive Technology.
- Medical practitioners performing termination of pregnancy must follow Muluki Aen, 11th amendment and safe abortion service protocol (2060).
- Prenatal screening for common congenital, genetic and chromosomal disorders can be offered as part of antenatal care. However, the pregnant woman has the right to decline such prenatal screening.
- Prenatal diagnostic procedures are for the detection and confirmation of fetal diseases. The medical practitioner should ensure that the

recommended procedure is reasonably safe and will provide reliable results. S/he should also balance the risks and benefits of the procedure, and advise the pregnant woman accordingly. The procedure should be performed by appropriately trained specialists following informed consent of the pregnant woman.

- The interest of both the pregnant woman and her fetus should be taken into consideration before undertaking any prenatal intervention.
- Sex identification in utero for social or cultural reasons is a violation of the Code of Ethics and is a punishable crime under Nepal legislation.

C. Towards professional colleagues and their families

i. Disparagement of other medical practitioners

- It is unethical for a medical practitioner to make unwarranted defamatory or slanderous comments, which either directly or by implication, undermines trust in the professional competence or integrity of another medical practitioner. This is considered a violation of the Code and unprofessional conduct.

However, when medical practitioners are summoned to express their views about a colleague's professional practice, honest comment is entirely acceptable, provided that it is carefully considered and can be justified, offered in good faith and intended to promote the best interests of the patient.

ii. Regarding fee to colleagues and their family members

It is not mandatory for a medical practitioner not to charge fee to another medical practitioner or her/his immediate family members for rendering professional services. But the medical practitioner should consider it a pleasure and privilege to render such services to their professional colleagues and their immediate family members free of charge as far as possible.

iii. Improper intra-professional relationship

A medical practitioner should not use her/his professional position to coerce other health professionals, colleagues or students for unethical professional or personal benefits and exploitation.

D. In consultation

A treating medical practitioner should not hesitate to seek second opinion from colleagues when necessary. During consultation the medical practitioner should not have the feeling of rivalry, envy or insincerity; instead s/he should have due respect towards the treating medical practitioner and should not make any remarks which would impair the confidence between the treating medical practitioner and patient. Moreover, the consulting medical practitioner should not take over the case but should discuss with the treating medical practitioner the treatment approach, keeping in mind the best interest of the patient.

Consultation or asking for any other diagnostic investigation should be done judiciously, when requested by the patient or family and not in a routine manner.

Medical practitioners representing the patient/patient's family should be permitted to discuss the matter with the treating medical practitioner and can discuss the treatment modalities.

E. Towards society

Medical practitioners, as good citizens and possessing special training, should disseminate health advice and information on public health issues. S/he should partake in enforcing the sanitary/public health laws and regulations of the country and protect the interests of humanity.

Medical practitioners should also contribute towards protecting and promoting health of the public by taking measures to prevent spread of epidemic and communicable disease by educating the public or notifying the notifiable disease to the health authority. In an epidemic medical practitioner should not abandon his duty for fear of contracting the disease himself. In epidemics or when treating contagious diseases, the medical practitioner has the right to expect to be provided by the healthcare facility with the protective measures to minimize the risk to her/his own personal health when treating affected patients.

Medical practitioner should recognize and promote the practice of paramedical services such as pharmacy and nursing as professions and should seek their cooperation wherever required.

F. While prescribing medicine

i. Rational prescription and labelling of dispensed medicines

- Every medical practitioner should prescribe medicine to a patient only if and when the drug treatment is necessary for patient's benefit. Proper explanation should be made in plain language, and patient and/or patient family should be explained about the dose, route of administration and duration of treatment. Likewise, potential adverse effects of the medicines and the need for follow up should also be discussed. It is highly important that such prescriptions be written in capital letters or printed or written in entirely legible handwriting.
- The medical practitioner should sign the prescription and should also mention her/his name and Nepal Medical Council Registration Number. Failure to sign and mention her/his name and Nepal Medical Council registration number is a professional misconduct.
- A medical practitioner should not run a pharmacy for dispensing drugs prescribed by other medical practitioners.
- A medical practitioner who also dispenses medicine (prescribed by himself) to her/his patients has the personal responsibility to ensure that the drugs are dispensed strictly in accordance with the prescription, are not outdated/expired and are properly labelled before they are handed over to the patients. The medical practitioner should establish suitable procedures for ensuring that drugs are properly labelled and dispensed.
- Medicines should be prescribed in generic name as far as possible.

ii. Supply of scheduled drugs

- Medical practitioners are advised to acquaint themselves with the Guidelines on Proper Prescription and Dispensing of scheduled Drugs.
- A medical practitioner should not prescribe or supply drugs with the potential for addiction or dependence unless it is absolutely indicated.

iii. Physician's sample drugs

- Medical practitioner can receive physician's sample drugs from drug companies for the benefit of the patient and not for resale. Reselling such medications is considered professional misconduct.

G. Improper financial transactions

- A medical practitioner shall not offer to, or accept from, any person or organization (including pharmaceuticals, medical equipment manufacturers, diagnostic laboratories, hospitals, nursing homes, health centres, beauty centres or similar institutions) any financial or other inducement (including free or subsidized consulting premises or secretarial support) for referral of patients, for consultation, investigation or treatment.
- If a medical practitioner has any interest in commercial organizations (including but not limited to organizations providing health care or pharmaceutical or biomedical companies) or products, he must not allow such interest to affect the way he prescribes for, treats or refers patients.
- Sponsorship for conference or other academic activities should be through proper channels rather than being individualized and the ultimate benefit of such sponsorship (from pharmaceuticals companies, medical goods manufacturers) should be directed towards the patient benefit. Full disclosure of such endorsement should be made to the institutions/ department. However, the Council has the right to seek clarification and medical practitioner is obliged to produce all documents as and when required by the council.
- Medical practitioner should not accept monetary or other gifts or service from pharmaceuticals or other companies for individual or familial purpose in individual capacity under any pretext.
- Medical practitioners can accept gifts which are restricted to medical appliances and books that contribute towards patients' benefit.
- Funding for medical research grant can be received with prior disclosure and approval from IEC of each hospital and or NHRC.

H. Regarding New medical treatment and procedures

- Medical practitioners in public institutions or in the private sector may judiciously apply new methods of treatment for appropriate patients under appropriate circumstances. Innovative ideas, approved new appliances, diagnostic procedures and medications are to be encouraged. Nevertheless, the medical practitioner must be cautious that the new innovations benefits the patient and their human rights and dignity are not compromised.

Medical practitioners should be well trained before applying any new method of treatments, skills and innovations. S/he should clearly explain to the patient that the treatment is new and that the risks and benefits may not be entirely known.

Clinical research

- The practice of good clinical research should follow the principles of good clinical practice set out in the guidelines of Nepal Health Research Council.
- Fraudulent practice of clinical research or reporting false results for the purpose of self-enrichment/self-grandiosity constitutes professional misconduct.

5. Violation of Code of Ethics

Advertising is against the code of ethics except in the manner set out below: A medical practitioner, whether in private or public service, may provide information about his professional services to the public only in the following ways:

A. Signboards

Signboards include any signs and notices exhibited by a medical practitioner to identify his practice to the public.

Medical practitioners in group practice may exhibit either their own individual signboards or a shared signboard. Both individual and shared signboards should comply with the requirements set out as below.

Signboards should not be decorated. Illumination is allowed only to the extent required to enable the contents to be read. Blinking lights are not allowed.

A signboard and a visiting card may carry only the following information:

- Name of the medical practitioner with the prefix Dr. and any academic designations
- Name of the practice
- Quotable qualifications approved by the Council in the approved abbreviation forms
- Specialist title approved by the Council
- Nepal Medical Council registration number
- Name and logo of the medical institution(s) with which the medical practitioner is associated
- Consultation hours
- Indication of the location of the practice in the building
- A medical practitioner should not allow his name to appear on any signboard which carries merchandise or service promotion. He should not allow the placement of his signboard to be associated with other signboards

B. Announcements in mass media

Announcement of commencements of practice or altered conditions of practice (e.g. change of address, partnership etc.) are permissible but such announcements should be completed within four weeks of commencement or changed conditions of practice.

C. Practice websites

- A medical practitioner may publish his professional service information in either his practice website or the website of medical practice group.
- The website may carry only the service information which is permitted by the council.
- Medical practitioner should not post her/his medical activities in social medias (like Facebook) with an intent of procuring patients or with a sense of self-grandiosity as it is against the code of medical ethics.

D. Unsolicited visits or telephone calls

- Medical practitioners' services may not be promoted by means of unsolicited visits, telephone calls, fax, e-mails or leaflets or persons acting on their behalf.

E. Practice in association with unqualified persons

- A medical practitioner should not be associated with a unqualified person in providing any therapeutic treatment for patients. If a medical practitioner has information about any person practicing medicine unlawfully, information has to be submitted to the Council for necessary action, which the council shall keep confidential to safeguard the personal security of such complainant medical practitioner.
- It is misconduct for a medical practitioner to issue any medical experience related certificates to enable a nonregistered/unqualified health professional to a qualified health professional.

F. False or misleading certificates and similar documents

- Medical practitioners are required to issue reports and certificates for a variety of purposes (e.g. insurance claim forms, payment receipts, medical reports, vaccination certificates, sick leave certificates) on the basis of the truth of the contents.
- Medical practitioners are expected to exercise care in issuing certificates and similar documents, and should not include in them statements which they have not taken appropriate steps to verify.
- A sick leave certificate can only be issued after proper medical consultation of the patient by the medical practitioner. The date of consultation and the date of issue must be truly stated in the certificate, including a certificate recommending retrospective sick leave.
- Any medical practitioner who in his professional capacity gives any certificate or similar document containing statements which are untrue, misleading or otherwise improper, renders himself liable to disciplinary proceedings. The signing of blank certificates is prohibited by the Council.
- Medical practitioners must not issue more than one original receipt for the same payment.

G. Duty to report

A medical practitioner who has been convicted in or outside Nepal of an offence punishable by imprisonment or has been the subject of adverse finding in disciplinary proceedings by other professional regulatory bodies is required to report the matter to the Council within 28 days from arrival to Nepal or the adverse disciplinary finding, even if the matter is under appeal. Failure to report within the specified time will in itself be a ground for disciplinary action. In case of doubt the matter should be reported.

H. Conflict of interest

- No medical practitioner shall obtain secondary professional or personal gain through her/his political affiliations. Such actions will be considered a violation of the Code.
- No medical practitioner should allow her/his political affiliation to unduly influence her/his clinical practice. Such actions will be considered a violation of the Code.

- No medical practitioner shall obtain secondary gain, either professional or personal through her/his affiliations with pharmaceutical or medical equipment companies. Such actions will be considered a violation of the Code.

6. Special ethical issues

If any new special context arises creating ethical medical dilemmas, Standard Operating Procedures (SOP) shall be made and shall proceed further accordingly.

7. Detection methods of misconduct

Council holds the right to actively detect and investigate the event if it feels there is violation of Code of Ethics or if brought into the notice of Council by any of the following means:

- Complain by the victim and by any person
- Telephone/E-mail complaints
- Newspaper/Television/Radio
- Information and order form various government authorities
- Complains from various associations/societies

8. Method of investigation

All investigations modality will be in accordance with the Nepal Medical Council by laws 2024 annex 23 .

9. Disciplinary actions and punishments

Violation of the Code of Ethics and Professional Conduct

In the exercise of its legal authority, the Council shall not only provide a forum of redress for the aggrieved public, but also seeks to protect the public and patient against medical negligence, medical malpractices and other professional misconducts. The maintenance of a high standard of professional conduct is necessary to ensure public trust in the nobleness, competency and integrity of the medical profession.

According to the seriousness of the violation of Code of Medical Ethics, medical practitioners shall receive punishment ranging from a notice of attention, warning, probation (not be allowed to work independently/ should work under supervision), suspension and/or permanent removal from Council's registration. Suspension/permanent deletion of the name shall be published widely in national newspapers and on the Council website. It shall be held serious professional misconduct for a person to practice medicine in a state of her/his name being removed from the Nepal Medical Council's Register. The detailed procedures shall be as prescribed by the Council.

10. Disqualification from medical practice

- Registration of any medical practitioner convicted by court for an offence involving moral turpitude shall *ipso facto* be cancelled and such person shall not be eligible for medical practice.
- A particularly serious view will likely be taken in respect of offences involving dishonesty (e.g. obtaining money or goods by deception, forgery, fraud, and theft), indecent behaviour or violence.
- Offences which may affect a medical practitioner's fitness to practice (e.g. alcohol or drug related offences) will also be of particular concern to the Council.

11. Role of ethical committee

Role of the Ethics Committee

Ethics committee shall be responsible for identification, detection, investigation and bringing the issue within the context of Nepal Medical Council.

It shall also look into cases of medical malpractice and medical negligence. The detailed complain and investigation procedure including right to appeal shall be as prescribed.

12. Erasure of name from medical register

Nepal Medical Council holds the right to erase the name of medical practitioners depending upon the gravity and frequency of the violation of code of ethics or medical negligence along with any offences involving moral turpitude.

The council can order the erasure of name of medical practitioner from the medical register. The erasure remains effective unless the medical practitioner's application is accepted for restoration of name to the medical register.

13. Application for restoration of registration

Application for restoration of registration can be made at any time after two years from the date of erasure. The Professional Conduct and Health Committee will analyse every application on its merits and may recommend unconditional or conditional restoration or extend the period for another one year. In case of unsuccessful application, a further period of at least 12 months must elapse before a further application can be made.

14. Appeal against erasure

If a medical practitioner's registration is erased from the medical register for whatsoever reason, s/he has the right to appeal to the court against it.

Appendix A

Code of Medical Ethics and declarations

WMA Declaration of Geneva

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968 and the 35th World Medical Assembly, Venice, Italy, October 1983 and the 46th WMA General Assembly, Stockholm, Sweden, September 1994 and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006

AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:

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 PRACTISE 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;

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.

WMA Declaration of Lisbon on the Rights of the Patient

Adopted by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981 and amended by the 47th WMA General Assembly, Bali, Indonesia, September 1995 and editorially revised by the 171st WMA Council Session, Santiago, Chile, October 2005 and reaffirmed by the 200th WMA Council Session, Oslo, Norway, April 2015

PREAMBLE

The relationship between physicians, their patients and broader society has undergone significant changes in recent times. While a physician should always act according to her/his conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice. The following Declaration represents some of the principal rights of the patient that the medical profession endorses and promotes. Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them.

PRINCIPLES

- i. Right to medical care of good quality
 - a. Every person is entitled without discrimination to appropriate medical care.
 - b. Every patient has the right to be cared for by a physician whom he/she knows to be free to make clinical and ethical judgements without any outside interference.

- c. The patient shall always be treated in accordance with her/his best interests. The treatment applied shall be in accordance with generally approved medical principles.
 - d. Quality assurance should always be a part of health care. Physicians, in particular, should accept responsibility for being guardians of the quality of medical services.
 - e. In circumstances where a choice must be made between potential patients for a particular treatment that is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination.
 - f. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.
- ii. Right to freedom of choice
- a. The patient has the right to choose freely and change her/his physician and hospital or health service institution, regardless of whether they are based in the private or public sector.
 - b. The patient has the right to ask for the opinion of another physician at any stage.
- iii. Right to self-determination
- a. The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform the patient of the consequences of her/his decisions.
 - b. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make her/his decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.
 - c. The patient has the right to refuse to participate in research or the teaching of medicine.

iv. The unconscious patient

- a. If the patient is unconscious or otherwise unable to express her/his will, informed consent must be obtained whenever possible, from a legally entitled representative.
- b. If a legally entitled representative is not available, but a medical intervention is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient's previous firm expression or conviction that he/she would refuse consent to the intervention in that situation.
- c. However, physicians should always try to save the life of a patient unconscious due to a suicide attempt.

v. The legally incompetent patient

- a. If a patient is a minor or otherwise legally incompetent, the consent of a legally entitled representative is required in some jurisdictions. Nevertheless the patient must be involved in the decision-making to the fullest extent allowed by her/his capacity.
- b. If the legally incompetent patient can make rational decisions, her/his decisions must be respected, and he/she has the right to forbid the disclosure of information to her/his legally entitled representative.
- c. If the patient's legally entitled representative, or a person authorized by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution. In case of emergency, the physician will act in the patient's best interest.

vi. Procedures against the patient's will

Diagnostic procedures or treatment against the patient's will can be carried out only in exceptional cases, if specifically permitted by law and conforming to the principles of medical ethics.

vii. Right to information

- a. The patient has the right to receive information about himself/herself recorded in any of her/his medical records, and to be fully informed about her/his health status including the medical facts about her/his condition. However, confidential information in the patient's records about a third party should not be given to the patient without the consent of that third

- party.
- b. Exceptionally, information may be withheld from the patient when there is good reason to believe that this information would create a serious hazard to her/his life or health.
- c. Information should be given in a way appropriate to the patient's culture and in such a way that the patient can understand.
- d. The patient has the right not to be informed on her/his explicit request, unless required for the protection of another person's life.
- e. The patient has the right to choose who, if anyone, should be informed on her/his behalf.

viii. Right to confidentiality

- a. All identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind must be kept confidential, even after death. Exceptionally, descendants may have a right of access to information that would inform them of their health risks.
- b. Confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other health care providers only on a strictly "need to know" basis unless the patient has given explicit consent.
- c. All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of its storage. Human substances from which identifiable data can be derived must be likewise protected.

ix. Right to Health Education

Every person has the right to health education that will assist him/her in making informed choices about personal health and about the available health services. The education should include information about healthy lifestyles and about methods of prevention and early detection of illnesses. The personal responsibility of everybody for her/his own health should be stressed. Physicians have an obligation to participate actively in educational efforts.

x. Right to dignity

- a. The patient's dignity and right to privacy shall be respected at all times in medical care and teaching, as shall her/his culture and values.

- b. The patient is entitled to relief of her/his suffering according to the current state of knowledge.
- c. The patient is entitled to humane terminal care and to be provided with all available assistance in making dying as dignified and comfortable as possible.

xi. Right to religious assistance

The patient has the right to receive or to decline spiritual and moral comfort including the help of a minister of her/his chosen religion.

WMA Resolution on Combating HIV/AIDS

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006 and rescinded by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

MINDFUL that the WMA Statement on HIV/AIDS and the Medical Profession was adopted at the 57th WMA General Assembly in Pilanesberg, Republic of South Africa, on 14 October 2006; and

RECOGNIZING the alarming statistic from UNAIDS that some 37-38 million people worldwide are infected with HIV, with the number increasing daily, and that 60% percent of them live in sub-Saharan Africa; and

NOTING that there exist evidence-based methods for preventing the spread of the infection and also for life-prolonging treatment; therefore

The WMA urges governments to work closely with health professionals and their representative organizations to identify and implement the critical steps to ensure

1. that all efforts are made to prevent the spread of HIV/AIDS;
2. that the diagnosis, counselling and treatment of patients for HIV/AIDS is undertaken only by appropriately trained physicians and other healthcare personnel, according to established evidence-based principles;
3. that patients be given accurate, relevant and comprehensive information to enable them to make informed decisions about their health care treatment; and
4. that barriers preventing people from coming forward for testing and

treatment be identified and eliminated.

The WMA calls on National Medical Associations to use this resolution in their advocacy efforts to their governments, their patients and the public.

WMA Statement on HIV/AIDS and the Medical Profession

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006

INTRODUCTION

HIV/AIDS is a global pandemic that has created unprecedented challenges for physicians and health infrastructures. In addition to representing a staggering public health crisis, HIV/AIDS is also fundamentally a human rights issue. Many factors drive the spread of the disease, such as poverty, homelessness, illiteracy, prostitution, human trafficking, stigma, discrimination and gender-based inequality. Efforts to tackle the disease are constrained by the lack of human and financial resources available in health care systems. These social, economic, legal and human rights factors affect not only the public health dimension of HIV/AIDS but also individual physicians/health workers and patients, their decisions and relationships.

DISCRIMINATION

- xii. Unfair discrimination against HIV/AIDS patients by physicians must be eliminated completely from the practice of medicine.
- e. All persons infected or affected by HIV/AIDS are entitled to adequate prevention, support, treatment and care with compassion and respect for human dignity.
- f. A physician may not ethically refuse to treat a patient whose condition is within his or her current realm of competence, solely because the patient is seropositive.
- g. National Medical Associations should work with governments, patient groups and relevant national and international organizations to ensure that national health policies clearly and explicitly prohibit discrimination against people infected with or affected by HIV/AIDS.

APPROPRIATE / COMPETENT MEDICAL CARE

1. Patients with HIV/AIDS must be provided with competent and appropriate medical care at all stages of the disease.
2. A physician who is not able to provide the care and services required by patients with HIV/AIDS should make an appropriate referral to those physicians or facilities that are equipped to provide such services. Unless or until the referral can be accomplished, the physician must care for the patient to the best of his or her ability.
3. Physicians and other appropriate bodies should ensure that patients have accurate information regarding means of transmission of HIV/AIDS and strategies to protect themselves against infection. Proactive measures should be taken to ensure that all members of the population, and at-risk groups in particular, are educated to this effect.
4. With reference to those patients who are found to be seropositive, physicians must be able to effectively counsel them regarding: (a) responsible behaviour to prevent the spread of the disease; (b) strategies for their own health protection; and (c) the necessity of alerting sexual and needle-sharing contacts, past and present, as well as other relevant contacts (such as medical and dental personnel) regarding their possible infection.
5. Physicians must recognize that many people still believe HIV/AIDS to be an automatic and immediate death sentence and therefore will not seek testing. Physicians must ensure that patients have accurate information regarding the treatment options available to them. Patients should understand the potential of antiretroviral treatment (ART) to improve not only their medical condition but also the quality of their lives. Effective ART can greatly extend the period of time that patients are able to lead healthy productive lives, functioning socially and in the workplace and maintaining their independence. HIV/AIDS is increasingly looked upon as a manageable chronic condition.
6. While strongly advocating ART as the best course of action for HIV/AIDS patients, physicians must also ensure that their patients are fully and accurately informed about all aspects of ART, including potential toxicity and side effects. Physicians must also counsel patients honestly about the possibility of failure of first line ART, and the subsequent options should failure occur. The importance of adhering to the regimens and thereby reducing the risk of failure should be emphasized.

7. Physicians should be aware that misinformation regarding the negative aspects of ART has created resistance toward treatment by patients in some areas. Where misinformation is being spread about ART, physicians and medical associations must make it an immediate priority to publicly challenge the source of the misinformation and to work with the HIV/AIDS community to counteract the negative effects of the misinformation.
8. Physicians should encourage the involvement of support networks to assist patients in adhering to ART regimens. With the patient's consent, counselling and training should be available to family members to assist them in providing family based care. Physicians must recognize families and other support networks as crucial partners in adherence strategies and, in many places, the only means to adequately expand the care system so that patients receive the required attention.
9. Physicians must be aware of the discriminatory attitudes toward HIV/AIDS that are prevalent in society and local culture. Because physicians are the first, and sometimes the only, people who are informed of their patients' HIV status, physicians should be able to counsel them about their basic social and legal rights and responsibilities or should refer them to counsellors who specialize in the rights of persons living with HIV/AIDS.

TESTING

1. Mandatory testing for HIV must be required of: donated blood and blood fractions collected for donation or to be used in the manufacture of blood products; organs and other tissues intended for transplantation; and semen or ova collected for assisted reproduction procedures.
2. Mandatory HIV testing of an individual against his or her will is a violation of medical ethics and human rights. Exceptions to this rule may be made only in the most extreme cases and should be subject to review by an ethics panel or to judicial review.
3. Physicians must clearly explain the purpose of an HIV test, the reasons it is recommended and the implications of a positive test result. Before a test is administered, the physician should have an action plan in place in case of a positive test result. Informed consent must be obtained from the patient prior to testing.

4. While certain groups are labelled “high risk”, anyone who has had unprotected sex should be considered at some risk. Physicians must become increasingly proactive about recommending testing to patients, based on a mutual understanding of the level of risk and the potential to benefit from testing. Pregnant women should routinely be offered testing.
5. Counselling and voluntary anonymous testing for HIV should be available to all persons who request it, along with adequate post-testing support mechanisms.

PROTECTION FROM HIV IN THE HEALTH CARE ENVIRONMENT

1. Physicians and all health care workers have the right to a safe work environment. Especially in developing countries, the problem of occupational exposure to HIV has contributed to high attrition rates of the health labour force. In some cases, employees become infected with HIV, and in other cases fear of infection causes health care workers to leave their jobs voluntarily. Fear of infection among health workers can also lead to refusal to treat HIV/AIDS patients. Likewise, patients have the right to be protected to the greatest degree possible from transmission of HIV from health professionals and in health care institutions.
 - a. Proper infection control procedures and universal precautions consistent with the most current national or international standards, as appropriate, should be implemented in all health care facilities. This includes procedures for the use of preventive ART for health professionals who have been exposed to HIV.
 - b. If the appropriate safeguards for protecting physicians or patients against infection are not in place, physicians and National Medical Associations should take action to correct the situation.
 - c. Physicians who are infected with HIV should not engage in any activity that creates a risk of transmission of the disease to others. In the context of possible exposure to HIV, the activity in which the physician wishes to engage will be the determining factor. Whether or not an activity is acceptable should be determined by a panel or committee of health care workers with specific expertise in infectious diseases.
 - d. In the provision of medical care, if a risk of transmission of an infectious disease from a physician to a patient exists, disclosure of that risk to patients is not enough; patients are entitled to expect that their physicians

- will not increase their exposure to the risk of contracting an infectious disease.
- e. If no risk exists, disclosure of the physician's medical condition to his or her patients will serve no rational purpose.

PROTECTING PATIENT PRIVACY AND ISSUES RELATED TO NOTIFICATION

1. Fear of stigma and discrimination is a driving force behind the spread of HIV/AIDS. The social and economic repercussions of being identified as infected can be devastating and can include violence, rejection by family and community members, loss of housing and loss of employment, to name only a few. Normalizing the presence of HIV/AIDS in society through public education is the only way to reduce discriminatory attitudes and practices. Until that can be universally achieved, or a cure is developed, potentially infected individuals will refuse testing to avoid these consequences. The result of individuals not knowing their HIV status is not only disastrous on a personal level in terms of not receiving treatment, but may also lead to high rates of avoidable transmission of the disease. Fear of unauthorized disclosure of information also provides a disincentive to participate in HIV/AIDS research and generally thwarts the efficacy of prevention programs. Lack of confidence in protection of personal medical information regarding HIV status is a threat to public health globally and a core factor in the continued spread of HIV/AIDS. At the same time, in certain circumstances, the right to privacy must be balanced with the right of partners (sexual and injection drug) of persons with HIV/AIDS to be informed of their potential infection. Failure to inform partners not only violates their rights but also leads to the same health problems of avoidable transmission and delay in treatment.
2. All standard ethical principles and duties related to confidentiality and protection of patients' health information, as articulated in the WMA Declaration of Lisbon on the Rights of the Patient, apply equally in the context of HIV/AIDS. In addition, National Medical Associations and physicians should take note of the special circumstances and obligations (outlined below) associated with the treatment of HIV/AIDS patients.
 - a. National Medical Associations and physicians must, as a matter of priority, ensure that HIV/AIDS public education, prevention and counselling programs contain explicit information related to protection

- of patient information as a matter not only of medical ethics but of their human right to privacy.
- b. Special safeguards are required when HIV/AIDS care involves a physically dispersed care team that includes home-based service providers, family members, counsellors, case workers or others who require medical information to provide comprehensive care and assist in adherence to treatment regimens. In addition to implementing protection mechanisms regarding transfer of information, ethics training regarding patient privacy should be given to all team members.
 - c. Physicians must make all efforts to convince HIV/AIDS patients to take action to notify all partners (sexual and/or injection drug) about their exposure and potential infection. Physicians must be competent to counsel patients about the options for notifying partners.

These options should include:

- notification of the partner(s) by the patient. In this case, the patient should receive counselling regarding the information that must be provided to the partner and strategies for delivering it with sensitivity and in a manner that is easily understood. A timetable for notification should be established and the physician should follow-up with the patient to ensure that notification has occurred.
 - notification of the partner(s) by a third party. In this case, the third party must make every effort to protect the identity of the patient.
- d. When all strategies to convince the patient to take such action have been exhausted, and if the physician knows the identity of the patient's partner(s), the physician is compelled, either by law or by moral obligation, to take action to notify the partner(s) of their potential infection. Depending on the system in place, the physician will either notify directly the person at risk or report the information to a designated authority responsible for notification. In cases where a physician must disclose the information regarding exposure, the physician must:
 - inform the patient of his or her intentions,
 - to the extent possible, ensure that the identity of the patient is protected,
 - take the appropriate measures to protect the safety of the patient, especially in the case of a female patient vulnerable to domestic violence.

- e. Regardless of whether it is the patient, the physician or a third party who undertakes notification, the person learning of his or her potential infection should be offered support and assistance in order to access testing and treatment.
- f. National Medical Associations should develop guidelines to assist physicians in decision-making related to notification. These guidelines should help physicians understand the legal requirements and consequences of notification decisions as well as the medical, psychological, social and ethical considerations.
- g. National Medical Associations should work with governments to ensure that physicians who carry out their ethical obligation to notify individuals at risk, and who take precautions to protect the identity of their patient, are afforded adequate legal protection.

MEDICAL EDUCATION

1. National Medical Associations should assist in ensuring that there is training and education of physicians in the most current prevention strategies and medical treatments available for all stages of HIV/AIDS, including prevention and support.
2. National Medical Associations should insist upon, and assist with when possible, the education of physicians in the relevant psychological, legal, cultural and social dimensions of HIV/AIDS.
3. National Medical Associations should fully support the efforts of physicians wishing to concentrate their expertise in HIV/AIDS care, even where HIV/AIDS is not recognized as an official specialty or sub-specialty within the medical education system.
4. The WMA encourages its National Medical Associations to promote the inclusion of designated, comprehensive courses on HIV/AIDS in undergraduate and postgraduate medical education programs, as well as continuing medical education

WMA Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment

Adopted by the 29th World Medical Assembly, Tokyo, Japan, October 1975
Editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005 and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006. Revised by the 67th WMA General Assembly, Taipei, Taiwan, October 2016

PREAMBLE

It is the privilege of the physician to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, and to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use is to be made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

DECLARATION

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.
2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment or to diminish the ability of the victim to resist such treatment.
3. When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information.

- A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities.
4. As stated in WMA Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment and as an exception to professional confidentiality, physicians have the ethical obligation to report abuses, where possible with the subject's consent, but in certain circumstances where the victim is unable to express him/herself freely, without explicit consent.
 5. The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals.
 6. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.
 7. A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose.
 8. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially, as stated in WMA *Declaration of Malta on Hunger Strikers*. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.
 9. Recalling the *Declaration of Hamburg concerning Support for Medical Doctors Refusing to Participate in, or to Condone, the Use of Torture or Other Forms of Cruel, Inhuman or Degrading Treatment*, the World Medical Association supports, and encourages the international community, the National Medical Associations and fellow physicians to support, the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.

10. The World Medical Association calls on National Medical Associations to encourage physicians to continue their professional development training and education in human rights.

WMA Statement on Assisted Reproductive Technologies

Adopted by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006

PREAMBLE

1. Assisted reproductive technology encompasses a wide range of techniques designed primarily to aid couples unable to conceive without medical assistance. Since the birth of the first so-called ‘test-tube baby’ in 1978, more than 1.5 million children worldwide have been born following IVF treatment.
2. The term ‘assisted reproductive technology’ includes techniques such as in-vitro fertilisation (IVF) and intra-cytoplasmic sperm injection (ICSI). It can be defined as including all treatments that include medical and scientific manipulation of human gametes and embryos in order to produce a term pregnancy. Although some legislatures have considered artificial insemination, whether using donor semen or semen from the patient’s partner, as different, many of the issues about regulation in relation to obtaining, storing, using and disposing of gametes and embryos are closely interlinked. In this statement treatments such as artificial insemination are excluded.
3. Assisted reproductive technologies raise profound moral issues. Views and beliefs about the moral status of the embryo, which are central to much of the debate in this area, vary both within and among countries. Assisted conception is also regulated differently in various countries. Whilst consensus can be reached on some issues, there remain fundamental differences of opinion that cannot be resolved. This statement identifies areas of agreement and also highlights those matters on which agreement cannot be reached. Physicians faced with such situations should comply with applicable laws and regulations as well as the ethical requirements and professional standards established by their National Medical Association and other appropriate organisations in the community.

4. Physicians involved in providing assisted reproductive technologies should always consider their ethical responsibilities towards any child who may be born as a result of the treatment. If there is evidence that a future child would be exposed to serious harm, treatment should not be provided.
5. As with all other medical procedures, physicians also have an ethical obligation to limit their practice to areas in which they have relevant expertise and experience and to respect the rights of patients. These rights include that of personal bodily integrity and freedom from coercion. In practice this means that valid or real consent is required as with other medical procedures; the validity of such consent is dependent upon the adequacy of the information offered to the patient and their freedom to make a decision, including freedom from coercion or other pressures to decide in a particular way.
6. Assisted conception differs from the treatment of illness in that the inability to become a parent without medical intervention is not always regarded as an illness. While it may have profound psychosocial, and thus medical, consequences, it is not in itself life limiting. It is, however, a significant cause of major psychological illness and its treatment is clearly medical.
7. Obtaining informed consent from those considering undertaking treatment must include consideration of the alternatives, including accepting childlessness or pursuing adoption, the risks associated with the various techniques, and the possibility of failure. In many jurisdictions the process of obtaining consent must follow a process of information giving and the offer of counselling and might also include a formal assessment of the patient in terms of the welfare of the potential child.
8. Patients seeking assisted reproductive technologies are entitled to the same level of confidentiality and privacy as for any other medical treatment.
9. Assisted reproductive technology always involves handling and manipulation of human gametes and embryos. Different individuals regard this with different levels of concern but there is general agreement that these special concerns should be met by specific safeguards to protect from abuse. In some jurisdictions all centres handling such materials require a licence and must demonstrate compliance with high normative standards.

SUCCESS OF THE TECHNIQUES

1. The success of different techniques may differ widely from centre to centre. Physicians have an obligation to give realistic information about success rates to potential patients. If their success rates are widely different from the current norm they should disclose this fact to patients. They also have an obligation to consider the reasons for this as they might relate to poor practice, and if so, to correct their deficiencies.

MULTIPLE PREGNANCIES

1. Replacement of more than one embryo may raise the likelihood of at least one embryo implanting. This is offset by the increased risk, especially of premature labour, in multiple pregnancies. The risk of twin pregnancies, while higher than that of singleton pregnancies, is considered acceptable by most people. Practitioners should follow professional guidance on the maximum number of embryos to be transferred per treatment cycle. If multiple pregnancies occur, selective termination might be considered on medical grounds to increase the chances of the pregnancy proceeding to term where this is compatible with the national law and code of ethics.

DONATION

1. Some patients are unable to produce usable gametes. They require ova or sperm from donors. Donation should follow counselling and be carefully controlled to avoid abuses, including coercion of potential donors. It is inappropriate to offer money or benefits in kind (for example free or lower cost treatment cycles) to encourage donation but donors may be reimbursed for reasonable expenses.
2. Where a child is born following donation, families should be encouraged to be open with him/her about this, irrespective of whether domestic law entitles the child to information about the donor. Keeping secrets within families is difficult and can be harmful to children if information about donor conception is disclosed inadvertently and without appropriate support.

PRE-IMPLANTATION GENETIC DIAGNOSIS (PGD)

1. Pre-implantation genetic diagnosis (PGD) may be performed on early embryos to search for the presence of genetic or chromosomal abnormalities, especially those associated with severe illness and very premature death and for other reasons, including identifying those embryos most likely to implant successfully in women who have had multiple spontaneous abortions. Embryos carrying the abnormality are discarded; only embryos with apparently normal genetic and chromosomal complements are implanted.
2. Neither this powerful technique nor simpler means should be used for trivial reasons such as sex selection for reasons of gender preference. The WMA holds that physicians should only be involved with sex selection where it is used to avoid a serious sex-chromosome related condition such as Duchenne's Muscular Dystrophy.
3. PGD can also be combined with HLA matching to select embryos on the basis that stem cells from the resulting child's umbilical cord blood could be used to treat a seriously ill sibling. Views on the acceptability of this practice vary and physicians should follow national laws and local ethical and professional standards if confronted with such requests.

USE OF SPARE GAMETES AND EMBRYOS AND DISPOSAL OF UNUSED GAMETES AND EMBRYOS

1. In most cases, assisted conception results in the production of gametes and embryos that will not be used to treat those from whom they are procured. Such so-called spare gametes and embryos may be stored, cryo-preserved for future use, donated to other patients or disposed of. One alternative to disposal, in countries that permit embryo research, is donation to a research facility. The available options must be explained clearly and precisely to individuals before donations are made or retrievals performed.

SURROGACY

1. Where a woman is unable, for medical reasons, to carry a child to term, surrogacy may be used to overcome childlessness, unless prohibited by national law or the ethical rules of the National Medical Association or other relevant organisation. Where surrogacy is practised, great care must be taken to protect the interests of all parties involved.

RESEARCH

1. Physicians should promote the importance of research using tissues obtained during assisted conception procedures. Because of the special status of the material being used, research on human gametes and especially on human embryos is, in many jurisdictions, specifically regulated. Physicians have an ethical duty to comply with such regulation and to help inform public debate and understanding of the issues.
2. Due to the special nature of human embryos, research should be carefully controlled and should be limited to areas in which the use of alternative materials will not provide an adequate alternative.
3. Views, and legislation, differ on whether embryos may be created specifically for, or in the course of, research. Physicians should act in accordance with national legislation and local ethical advice.

CELL NUCLEAR REPLACEMENT

1. The WMA opposes the use of cell nuclear replacement with the aim of cloning human beings.
2. Cell nuclear replacement may also be used to develop embryonic stem cells for research and ultimately, it is hoped, for therapy for many serious diseases. Views on the acceptability of such research differ and physicians wishing to participate in such research should ensure that they are acting in accordance with national laws and local ethical guidance.

RECOMMENDATIONS

1. Assisted reproductive technology is a dynamic, rapidly developing field of medical practice. Developments should be subject to careful ethical consideration alongside the scientific monitoring.
2. Human gametes and embryos are accorded a special status. Their use, including for research, donation to others and disposal, should be carefully explained to potential donors and subject to local regulation.
3. Embryo research should only be carried out if local law and ethical standards permit it and should be limited to areas where the use of alternative materials or computer modelling does not provide an adequate alternative.
4. Physicians should follow professional guidance on the maximum number of embryos to transfer in any treatment cycle.
5. It is inappropriate to offer money or benefits in kind (for example free or lower cost treatment cycles) to encourage donation but donors may be reimbursed for reasonable expenses
6. Families using donated embryos or gametes should be encouraged and supported to be open with the child about this.
7. Sex selection should only be carried out to avoid serious, including life threatening, medical conditions.
8. Physicians have an important role in ensuring that public debate about the possibilities of assisted conception, and the limits to be applied to its practice, is informed.
9. Physicians should comply with national legislation and should demonstrate compliance with high normative standards.

WMA Declaration of Malta on Hunger Strikers

Adopted by the 43rd World Medical Assembly, St. Julians, Malta, November 1991 and editorially revised by the 44th World Medical Assembly, Marbella, Spain, September 1992 and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006

PREAMBLE

1. Hunger strikes occur in various contexts but they mainly give rise to dilemmas in settings where people are detained (prisons, jails and immigration detention centres). They are often a form of protest by

people who lack other ways of making their demands known. In refusing nutrition for a significant period, they usually hope to obtain certain goals by inflicting negative publicity on the authorities. Short-term or feigned food refusals rarely raise ethical problems. Genuine and prolonged fasting risks death or permanent damage for hunger strikers and can create a conflict of values for physicians. Hunger strikers usually do not wish to die but some may be prepared to do so to achieve their aims. Physicians need to ascertain the individual's true intention, especially in collective strikes or situations where peer pressure may be a factor. An ethical dilemma arises when hunger strikers who have apparently issued clear instructions not to be resuscitated reach a stage of cognitive impairment. The principle of beneficence urges physicians to resuscitate them but respect for individual autonomy restrains physicians from intervening when a valid and informed refusal has been made. An added difficulty arises in custodial settings because it is not always clear whether the hunger striker's advance instructions were made voluntarily and with appropriate information about the consequences. These guidelines and the background paper address such difficult situations.

PRINCIPLES

1. Duty to act ethically. All physicians are bound by medical ethics in their professional contact with vulnerable people, even when not providing therapy. Whatever their role, physicians must try to prevent coercion or maltreatment of detainees and must protest if it occurs.
2. Respect for autonomy. Physicians should respect individuals' autonomy. This can involve difficult assessments as hunger strikers' true wishes may not be as clear as they appear. Any decisions lack moral force if made involuntarily by use of threats, peer pressure or coercion. Hunger strikers should not be forcibly given treatment they refuse. Forced feeding contrary to an informed and voluntary refusal is unjustifiable. Artificial feeding with the hunger striker's explicit or implied consent is ethically acceptable.
3. 'Benefit' and 'harm'. Physicians must exercise their skills and knowledge to benefit those they treat. This is the concept of 'beneficence', which is complemented by that of 'non-maleficence' or *primum non nocere*. These two concepts need to be in balance. 'Benefit' includes respecting individuals' wishes as well as promoting their welfare. Avoiding 'harm'

means not only minimising damage to health but also not forcing treatment upon competent people nor coercing them to stop fasting. Beneficence does not necessarily involve prolonging life at all costs, irrespective of other values.

4. **Balancing dual loyalties.** Physicians attending hunger strikers can experience a conflict between their loyalty to the employing authority (such as prison management) and their loyalty to patients. Physicians with dual loyalties are bound by the same ethical principles as other physicians, that is to say that their primary obligation is to the individual patient.
5. **Clinical independence.** Physicians must remain objective in their assessments and not allow third parties to influence their medical judgement. They must not allow themselves to be pressured to breach ethical principles, such as intervening medically for non-clinical reasons.
6. **Confidentiality.** The duty of confidentiality is important in building trust but it is not absolute. It can be overridden if non-disclosure seriously harms others. As with other patients, hunger strikers' confidentiality should be respected unless they agree to disclosure or unless information sharing is necessary to prevent serious harm. If individuals agree, their relatives and legal advisers should be kept informed of the situation.
7. **Gaining trust.** Fostering trust between physicians and hunger strikers is often the key to achieving a resolution that both respects the rights of the hunger strikers and minimises harm to them. Gaining trust can create opportunities to resolve difficult situations. Trust is dependent upon physicians providing accurate advice and being frank with hunger strikers about the limitations of what they can and cannot do, including where they cannot guarantee confidentiality.

GUIDELINES FOR THE MANAGEMENT OF HUNGER STRIKERS

1. **Physicians must assess individuals' mental capacity.** This involves verifying that an individual intending to fast does not have a mental impairment that would seriously undermine the person's ability to make health care decisions. Individuals with seriously impaired mental capacity cannot be considered to be hunger strikers. They need to be given treatment for their mental health problems rather than allowed to fast in a manner that risks their health.

2. As early as possible, physicians should acquire a detailed and accurate medical history of the person who is intending to fast. The medical implications of any existing conditions should be explained to the individual. Physicians should verify that hunger strikers understand the potential health consequences of fasting and forewarn them in plain language of the disadvantages. Physicians should also explain how damage to health can be minimised or delayed by, for example, increasing fluid intake. Since the person's decisions regarding a hunger strike can be momentous, ensuring full patient understanding of the medical consequences of fasting is critical. Consistent with best practices for informed consent in health care, the physician should ensure that the patient understands the information conveyed by asking the patient to repeat back what they understand.
3. A thorough examination of the hunger striker should be made at the start of the fast. Management of future symptoms, including those unconnected to the fast, should be discussed with hunger strikers. Also, the person's values and wishes regarding medical treatment in the event of a prolonged fast should be noted.
4. Sometimes hunger strikers accept an intravenous saline solution transfusion or other forms of medical treatment. A refusal to accept certain interventions must not prejudice any other aspect of the medical care, such as treatment of infections or of pain.
5. Physicians should talk to hunger strikers in privacy and out of earshot of all other people, including other detainees. Clear communication is essential and, where necessary, interpreters unconnected to the detaining authorities should be available and they too must respect confidentiality.
6. Physicians need to satisfy themselves that food or treatment refusal is the individual's voluntary choice. Hunger strikers should be protected from coercion. Physicians can often help to achieve this and should be aware that coercion may come from the peer group, the authorities or others, such as family members. Physicians or other health care personnel may not apply undue pressure of any sort on the hunger striker to suspend the strike. Treatment or care of the hunger striker must not be conditional upon suspension of the hunger strike.
7. If a physician is unable for reasons of conscience to abide by a hunger striker's refusal of treatment or artificial feeding, the physician should make this clear at the outset and refer the hunger striker to another

- physician who is willing to abide by the hunger striker's refusal.
8. Continuing communication between physician and hunger strikers is critical. Physicians should ascertain on a daily basis whether individuals wish to continue a hunger strike and what they want to be done when they are no longer able to communicate meaningfully. These findings must be appropriately recorded.
 9. When a physician takes over the case, the hunger striker may have already lost mental capacity so that there is no opportunity to discuss the individual's wishes regarding medical intervention to preserve life. Consideration needs to be given to any advance instructions made by the hunger striker. Advance refusals of treatment demand respect if they reflect the voluntary wish of the individual when competent. In custodial settings, the possibility of advance instructions having been made under pressure needs to be considered. Where physicians have serious doubts about the individual's intention, any instructions must be treated with great caution. If well informed and voluntarily made, however, advance instructions can only generally be overridden if they become invalid because the situation in which the decision was made has changed radically since the individual lost competence.
 10. If no discussion with the individual is possible and no advance instructions exist, physicians have to act in what they judge to be the person's best interests. This means considering the hunger strikers' previously expressed wishes, their personal and cultural values as well as their physical health. In the absence of any evidence of hunger strikers' former wishes, physicians should decide whether or not to provide feeding, without interference from third parties.
 11. Physicians may consider it justifiable to go against advance instructions refusing treatment because, for example, the refusal is thought to have been made under duress. If, after resuscitation and having regained their mental faculties, hunger strikers continue to reiterate their intention to fast, that decision should be respected. It is ethical to allow a determined hunger striker to die in dignity rather than submit that person to repeated interventions against his or her will.
 12. Artificial feeding can be ethically appropriate if competent hunger strikers agree to it. It can also be acceptable if incompetent individuals have left no unpressured advance instructions refusing it.

13. Forcible feeding is never ethically acceptable. Even if intended to benefit, feeding accompanied by threats, coercion, force or use of physical restraints is a form of inhuman and degrading treatment. Equally unacceptable is the forced feeding of some detainees in order to intimidate or coerce other hunger strikers to stop fasting.

WMA Statement on the Use of Computer in Medicine

Based on Resolution adopted by the 27th World Medical Assembly, Munich Federal Republic of Germany, October 1973 and amended by the 35th World Medical Assembly Venice, Italy, October 1983 and rescinded at the WMA General Assembly, Pilanesberg, South Africa, 2006

The WORLD MEDICAL ASSOCIATION, having taken note of the great advances and advantages resulting from the use of computers and electronic data processing in the field of health, especially in patient care and epidemiology, makes the following recommendations:

1. National medical associations should take all possible steps to insure the privacy, the security and confidentiality of information on their patients;
2. It is not a breach of confidentiality to release or transfer confidential health care information required for the purpose of conducting scientific research, management audits, financial audits, program evaluations, or similar studies, provided the information released does not identify, directly or indirectly, any individual patient in any report of such research, audit or evaluation, or otherwise disclosed patient identities in any manner;
3. National medical associations should oppose any effort to enact legislation on electronic data processing which could endanger or undermine the right of the patient to privacy, security and confidentiality. Effective safeguards against unauthorized use or retransmission of social security numbers and other personal information must be assured before such information enters the computer;
4. Medical data banks should never be linked to other central data banks.

WMA Statement on the Ethics of Telemedicine

Adopted by the 58th WMA General Assembly, Copenhagen, Denmark, October 2007

DEFINITION

Telemedicine is the practice of medicine over a distance, in which interventions, diagnostic and treatment decisions and recommendations are based on data, documents and other information transmitted through telecommunication systems.

PREAMBLE

The development and implementation of information and communication technology are creating new modalities for providing care for patients. These enabling tools offer different ways of practising medicine. The adoption of telemedicine is justified because of its speed and its capacity to reach patients with limited access to medical assistance, in addition to its power to improve health care.

Physicians must respect the following ethical guidelines when practising telemedicine.

PRINCIPLES

Patient-physician Relationship and Confidentiality

The patient-physician relationship should be based on a personal encounter and sufficient knowledge of the patient's personal history. Telemedicine should be employed primarily in situations in which a physician cannot be physically present within a safe and acceptable time period.

The patient-physician relationship must be based on mutual trust and respect. It is therefore essential that the physician and patient be able to identify each other reliably when telemedicine is employed.

Ideally, telemedicine should be employed only in cases in which a prior in-person relationship exists between the patient and the physician involved in arranging or providing the telemedicine service.

The physician must aim to ensure that patient confidentiality and data integrity are not compromised. Data obtained during a telemedical consultation must be secured through encryption and other security precautions must be taken to prevent access by unauthorized persons.

Responsibilities of the Physician

A physician whose advice is sought through the use of telemedicine should keep a detailed record of the advice he/she delivers as well as the information he/she received and on which the advice was based.

It is the obligation of the physician to ensure that the patient and the health professionals or family members caring for the patient are able to use the necessary telecommunication system and necessary instruments. The physician must seek to ensure that the patient has understood the advice and treatment suggestions given and that the continuity of care is guaranteed.

The physician asking for another physician's advice or second opinion remains responsible for treatment and other decisions and recommendations given to the patient.

A physician should be aware of and respect the special difficulties and uncertainties that may arise when he/she is in contact with the patient through means of tele-communication. A physician must be prepared to recommend direct patient-doctor contact when he/she feels that the situation calls for it.

Quality of Care

Quality assessment measures must be used regularly to ensure the best possible diagnostic and treatment practices in telemedicine.

The possibilities and weaknesses of telemedicine in emergencies must be acknowledged. If it is necessary to use telemedicine in an emergency situation, the advice and treatment suggestions are influenced by the level of threat to the patient and the know-how and capacity of the persons who are with the patient.

RECOMMENDATION

The WMA and National Medical Associations should encourage the development of national legislation and international agreements on subjects related to the practise of telemedicine, such as e-prescribing, physician registration, liability and the legal status of electronic medical records.

Appendix B

Duties of medical practitioners in general

A medical practitioner SHALL

- Always exercise her/his independent professional judgment and maintain the highest standards of professional conduct.
- Respect a competent patient's right to accept or refuse treatment.
- Not allow her/his judgment to be influenced by personal profit or unfair discrimination.
- Be dedicated to providing component medical service in full professional and moral independence, with compassion and respect for human dignity.
- Deal honestly with patients and colleagues, and report to the appropriate authorities those medical practitioners, who practice unethically or incompetently or who engage in fraud or deception.
- Not receive any financial benefits or other incentives solely for referring patients or prescribing specific products.
- Respect the rights and preferences of patients, colleagues, and other health professionals.
- Recognize her/his important role in educating the while using due caution in divulging discoveries or new techniques or treatment through nonprofessional channels.
- Certify only that which he/she has personally verified.
- Strive to use health care resources in the best way to benefit patients and their community.
- Seek appropriate care and attention if he/she suffers from mental or physical illness.
- Not engage in any kind of torture afflictions.
- Respect the local and national codes of ethics.

Duties of medical practitioners to patients

A Medical practitioner SHALL

- Always bear in mind the obligation to respect human life.
- Act in the patient's best interest when providing medical care.
- Owe her/his patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the medical practitioner's capacity, he/she should consult with or refer to another medical practitioner who has the necessary ability.
- Respect a patient's right to confidentiality and privacy. It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality.
- Give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care.
- Provide honest and clear explanation of diagnosis, prognosis and obtain informed consent for any treatments being offered in attempts to cure, stabilize illness and alleviate pain and discomfort.
- In situations when he/she is acting for a third party, ensure that the patient has full knowledge of that situation.
- Not enter into a sexual relationship with her/his current patient or into any other abusive or exploitative relationship.

Duties of medical practitioners to colleagues

A Medical practitioner SHALL

- Behave towards colleagues as he/she would have them behave towards him/her.
- NOT undermine the patient-medical practitioner relationship of colleagues in order to attract patients.
- When medically necessary, communicate with colleagues who are involved in the care of the same patient. This communication should respect patient confidentiality and be confined to necessary information.

Appendix C

Guidelines on proper prescription and dispensing of dangerous drug

Prescribing and dispensing of dangerous drugs should be guided by “Aushadhi Ain, 2035 (1982/83AD)”

Appendix D

Few examples of violation of code which are punishable:

- Failure to assess mental soundness/capacity and take informed consent
- Failure to treat in an emergency
- Failure to maintain medical records
- Breach of confidentiality
- Terminating doctor-patient relationship unjustly
- Disparagement of other medical practitioners
- Obtaining personal gains from improper financial transactions with pharmaceutical or medical equipment companies
- Failure of proper communication with patient
- Abuse of alcohol or drug while on duty
- Extracting excess fees from patients
- Working with unqualified or unauthorized person
- Taking commission while referring patient, investigation and while prescribing drugs and equipment.
- Treating a patient in private clinics or nursing homes by medical practitioner during duty hours away from primarily employed hospitals.
- Medical practitioners pursuing higher education and simultaneously practicing in other places away from her/his studying institution.
- Practicing medicine without fitness to practice
- Practicing beyond level of competency
- Improper personal relationship with patient, patient’s family members or relatives and juniors misusing her/his dominant status
- Disseminating misleading information to public
- Irrational drug prescription
- Practicing complementary and alternative medicine without being qualified
- Issuing false certificate
- Exerting undue pressure or creating situation to compel a patient admitted at government hospital to visit private clinic or nursing home.

Appendix E

List of various declarations and acts

- WMA Declaration of Geneva
- WMA Declaration of Lisbon on the Rights of the Patient
- WMA Resolution on Combating HIV/AIDS
- WMA Statement on HIV/AIDS and the Medical Profession
- WMA Declaration of Tokyo, Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment
- WMA Statement on Assisted Reproductive Technologies
- WMA Declaration of Malta on Hunger Strikers
- WMA Statement on the Use of Computer in Medicine
- WMA Statement on the Ethics of Telemedicine
- Safe Abortion Service Procedure 2060 B.S. (सुरक्षित गर्भपतन सेवा प्रक्रिया २०६०)
- Narcotic Drugs (Control) Act, 2033 (1976), Drug Act and Regulation 2035 B.S. (1978), Civil Penal Court (Muluki Ain - 1962/64)
- Nepal Health Research Council Act 2047 B.S.
- Human Organ Transplant Act 2055 B.S.

Appendix F

List of contributors during the workshop in alphabetical order

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1	Dr. Aarati Shah	National Academy of Medical Sciences
2	Dr. Abdul Sami Khan	National Medical College
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8	Dr. Anil K. Jha	Nepal Medical College
9	Mr. Anil Neupane	Swasthya Khabar Patrika
10	Ms. Anita Lama	Nepal Medical Council
11	Dr. Anjan Rizal	Nepal Medical College
12	Dr. Anjani Kumar Jha	B. P. Koirala Memorial Cancer Hospital
13	Ms. Apsara Pandey	Nursing Association of Nepal
14	Dr. Arjun Karki	Grande International Hospital
15	Dr. Asha Singh	Nepal Police Hospital
16	Dr. B. D. Chataut	Former DG, MOH
17	Dr. B. R. Poudel	Devdaha Medical College
18	Dr. Bal Man Singh Karki	KIST Medical College
19	Dr. Bhagawan Koirala	Institute of Medicine, TUTH
20	Mr. Bharat Damala	Nepal Medical Council
21	Dr. Bharat Raj Acharya	Devdaha Medical College
22	Dr. Bhupendra Basnet	National Academy of Medical Sciences
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24	Dr. Bibhu Pradhan	Institute of Medicine, TUTH
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27	Mr. Bishnu Aryal	Republica
28	Dr. Bishnu D. Paudel	National Academy of Medical Sciences

29	Dr.	Bishnu P. Sharma	Patan Academy of Health Sciences
30	Mr.	Borna Bdr. Karki	Press Council
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37	Dr.	Dharma Subedi	Janaki Medical College
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54	Dr.	Hemang Dixit	Kathmandu Medical College
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61	Dr.	Jyoti Sharma	Institute of Medicine, TUTH
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