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Medical Council of India vs. Government Oversight: Can Self-Regulation Prevent Medical Malpractice?

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ABSTRACT

This essay examines the continuing debate between self-regulation and hierarchical regulation in high-risk sectors, with particular reference to the healthcare system in India. It traces the transition from the Medical Council of India (MCI) to the National Medical Commission (NMC) in order to assess whether self-regulation can genuinely prevent medical malpractice. The MCI, originally created to allow medical professionals to oversee their own conduct, ultimately failed on account of corruption and insufficient accountability, leading to its supersession. The NMC was established to put in place a better-organised regulatory framework, yet it has encountered difficulties of its own, including bureaucratic inefficiency and concerns about over-regulation. By comparing the two regulatory approaches, the paper identifies their respective advantages and drawbacks. Self-regulation offers professionals greater freedom and flexibility but is prone to conflicts of interest and weak enforcement. Hierarchical regulation, by contrast, secures uniform standards and external supervision but may stifle innovation through bureaucratic process. The paper concludes that a balanced regulatory system is essential if professional ethics are to be upheld while public safety is secured.

Keywords: *Self-regulation mechanisms, hierarchical regulatory frameworks, Medical Council of India, National Medical Commission, healthcare governance*

I. INTRODUCTION

The debate between self-regulation and hierarchical regulation poses an important challenge for high-risk industries, where the need for public safety often conflicts with the desire for professional independence. Self-regulation allows experts to oversee their own conduct, providing flexibility and specialised management, but it also raises questions about who is answerable for accountability. Hierarchical regulation, administered by outside agencies, offers uniform standards and enforcement, but it can produce bureaucratic delay and resistance from professionals.

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India's healthcare system is a striking example of this regulatory dilemma. The shift from the Medical Council of India (MCI) to the National Medical Commission (NMC) marks a key change in regulatory strategy, from predominantly self-regulation to a more strongly hierarchical system. The change came in response to allegations of corruption, concerns about quality, and a growing loss of public confidence in the capacity of the medical profession to regulate itself effectively.

This essay assesses which regulatory system is more effective at reducing medical malpractice by exploring the advantages and disadvantages of both approaches as they have been applied in India. The findings matter not only for healthcare but also for other high-risk sectors such as aviation, finance, and nuclear energy, where regulatory failure can be catastrophic. By examining the transition from the MCI to the NMC, the essay contributes to the wider discussion about designing regulatory frameworks that balance expert knowledge with public accountability where lives are at stake.

II. LEGAL AND THEORETICAL FRAMEWORK

Self-regulation and hierarchical regulation are two distinct approaches to governance in the professions. Self-regulation rests on the idea of subsidiarity, which gives professionals the power to create, monitor, and enforce their own standards. From a legal standpoint, this approach assumes that those with specialised expertise are best placed to set the relevant norms and to identify breaches of them.[1] Hierarchical regulation, by contrast, reflects a more positivist conception of law, in which the state directly supervises activity through established bodies vested with statutory enforcement powers.

In Indian administrative law, self-regulation is supported by the framework of delegated legislation, under which Parliament permits professional bodies to make rules through enabling statutes. The Indian Medical Council Act, 1956, which authorised medical professionals to govern medical education and practice, is an example.[2] Hierarchical regulation, on the other hand, derives from the distribution of legislative power in the Seventh Schedule, which places public health in the State List and medical education and the medical profession in the Concurrent List, enabling the legislature to intervene directly through statutory bodies that represent a wider range of interests.[3]

[1] Julia Black, *Decentring Regulation: Understanding the Role of Regulation and Self-Regulation in a 'Post-Regulatory' World*, 54 CURRENT LEGAL PROBS. 103, 115–17 (2001), https://doi.org/10.1093/clp/54.1.103.
[2] Indian Medical Council Act, No. 102 of 1956, INDIA CODE (1956).
[3] INDIA CONST. sch. VII, list II, entry 6; list III, entries 25, 26.

The Constitution of India lays down the essential legal framework for healthcare regulation through several provisions: Article 21 guarantees the right to life, Article 41 recognises the right to public assistance in cases of sickness,[4] and Article 47 imposes on the State a duty to improve public health.[5] These provisions frame healthcare regulation as a matter of fundamental rights and directive principles, and call for regulatory systems that uphold the constitutional entitlements of citizens.

To assess how effective a regulatory system is, several legal criteria must be applied: constitutional adherence (consistency with fundamental rights), procedural fairness (transparent processes for decision-making),[6] substantive justice (real remedies for the victims of malpractice),[7] institutional integrity (safeguards against corruption),[8] and proportionality (equilibrium between professional freedom and public safety).[9] These criteria offer a comprehensive legal framework for evaluating whether self-regulation or hierarchical control better fulfils the constitutional obligation to safeguard public health while respecting professional expertise.

III. Legal analysis of the MCI framework

The Indian Medical Council Act, 1956 led to the formation of the Medical Council of India (MCI) and conferred on it significant legal authority to supervise medical education and practice throughout the country. Under the Act, the MCI was charged with ensuring the quality of medical education, recognising medical degrees, registering practitioners, and regulating their conduct. This arrangement established the MCI as the centrepiece of a self-regulatory model, in which practitioners monitored one another through elected representatives, ideally combining expertise with accountability within the profession.

Initially, the courts supported the MCI's authority. In *Dr. Mukhtiar Chand v. State of Punjab* (1998),[10] the Supreme Court treated enrolment under the 1956 Act as the sole gateway to practising modern medicine, so that practitioners of the Indian systems of medicine could not cross over into allopathic practice. Likewise, in *Manohar Lal Sharma v. Medical Council of India* (2013),[11] the Court upheld the MCI's refusal to renew a college's permission to admit students on account of faculty and infrastructure deficiencies, affirming that the statutory

[4] India Const. art. 41.
[5] India Const. art. 47.
[6] *S.P. Gupta v. Union of India*, AIR 1982 SC 149 (India).
[7] *V. Krishnakumar v. State of Tamil Nadu*, (2015) 9 SCC 388 (India).
[8] *Vineet Narain v. Union of India*, (1998) 1 SCC 226 (India).
[9] *Modern Dental College & Research Centre v. State of Madhya Pradesh*, (2016) 7 SCC 353 (India).
[10] *Dr. Mukhtiar Chand v. State of Punjab*, (1998) 7 SCC 579 (India).
[11] *Manohar Lal Sharma v. Medical Council of India*, (2013) 10 SCC 60 (India).

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minimum standards it set could not be diluted. Nevertheless, as signs of systemic failure became apparent, judicial and parliamentary confidence in the body weakened.

A pivotal point came in March 2016, when the Department-related Parliamentary Standing Committee on Health and Family Welfare, in its 92nd Report, found that the MCI had repeatedly failed on all of its mandates, describing an elected body dominated by private interests, opaque in its approval of medical colleges, and almost inert in disciplining errant practitioners.[12] Within weeks, in *Modern Dental College and Research Centre v. State of Madhya Pradesh* (2016), a Constitution Bench of the Supreme Court took note of these findings and directed the Union Government to constitute an Oversight Committee, headed by former Chief Justice R.M. Lodha, to supervise all statutory functions of the MCI until new legislation was enacted.[13] It was the most severe judicial censure the regulator had received.

The foundation for the MCI's supersession was thus laid by parliamentary review and judicial decision together. The Standing Committee's report characterised the MCI's performance as a failure of its statutory duties.[14] When the Lodha Committee's one-year term expired, the Supreme Court on 18 July 2017 reconstituted the Oversight Committee under Dr. V.K. Paul to continue supervising the MCI.[15] The sequence culminated in the Indian Medical Council (Amendment) Ordinance, 2018, which superseded the MCI and vested its powers in a Board of Governors, opening the door to comprehensive reform.[16]

A closer critique exposes significant legal shortcomings in the self-regulatory system: an absence of robust checks and balances, insufficient representation of the public interest, opaque decision-making, weak enforcement against negligent practitioners, and structural vulnerability to regulatory capture. The MCI's composition, drawn almost entirely from medical professionals with little outside oversight, fostered a situation in which institutional interests routinely took precedence over public benefit, calling into question the effectiveness of self-regulation in a sector fraught with risk.

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[12] DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE ON HEALTH AND FAMILY WELFARE, *92nd Report on the Functioning of the Medical Council of India* (Mar. 8, 2016).
[13] *Modern Dental College*, *supra* note 9.
[14] DEPARTMENT-RELATED PARLIAMENTARY STANDING COMMITTEE ON HEALTH AND FAMILY WELFARE, *supra* note 12, at 20.
[15] NATIONAL MEDICAL COMMISSION, *Hon'ble Supreme Court Mandated Oversight Committee on MCI* (orders of the Supreme Court dated May 2, 2016 and July 18, 2017), https://www.nmc.org.in/honble-supreme-court-mandated-oversight-committee-on-mci/ (last visited Sept. 6, 2026).
[16] Indian Medical Council (Amendment) Ordinance, 2018, No. 8 of 2018, GAZETTE OF INDIA, pt. II sec. 1 (Sept. 26, 2018) (India), https://prsindia.org/billtrack/the-indian-medical-council-amendment-ordinance-2018.

IV. Legal transition to the NMC

The National Medical Commission Act, 2019 emerged from a lengthy and contentious legislative process that stretched over nearly three years from the first draft bill of 2016. Even before the MCI was superseded, the Government introduced the National Medical Commission Bill in the Lok Sabha in December 2017;[17] it lapsed with the Sixteenth Lok Sabha and was reintroduced and passed in August 2019. Almost immediately, the transition was met with constitutional challenge. In a petition brought by the Indian Medical Association, the petitioners contended that the Act infringed Article 19(1)(g) by imposing undue governmental constraints on the right of medical practitioners to carry on their profession.[18] The petition was entertained, but no stay of the Act's implementation was granted, reflecting Parliament's authority to regulate healthcare in the public interest.

The statutory structure of the NMC signals a major shift towards a more hierarchical form of regulation. The Act creates four autonomous boards functioning under the Commission's overall supervision: the Under-Graduate Medical Education Board, the Post-Graduate Medical Education Board, the Medical Assessment and Rating Board, and the Ethics and Medical Registration Board.[19] Unlike the MCI's largely elected composition, the NMC comprises appointed members, including government representatives, which curtails the profession's exclusive control.

A comparative reading of the two statutes reveals important differences in accountability mechanisms. The 1956 Act contained no provision for periodic reporting on the regulator's performance, whereas the NMC Act requires the Commission to prepare an annual report that the Central Government must lay before each House of Parliament.[20] The NMC Act also introduces notable innovations absent from the earlier law: section 15 establishes a common National Exit Test as the basis for licensure,[21] section 14(3) provides for common counselling for admissions,[22] and section 26(1)(f) empowers the Medical Assessment and Rating Board to impose graded sanctions, from warnings and monetary penalties to stoppage of admissions, on institutions that fail to maintain minimum standards,[23] addressing the corruption in college approvals that flourished under the MCI regime.

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[17] National Medical Commission Bill, 2017, Bill No. 279 of 2017, as introduced in Lok Sabha (Dec. 29, 2017) (India), https://prsindia.org/billtrack/the-national-medical-commission-bill-2017.
[18] *Indian Medical Association v. Union of India*, W.P. (C) No. 1231 of 2019 (SC Oct. 15, 2019) (India).
[19] National Medical Commission Act, No. 30 of 2019, India Code (2019), § 16.
[20] *Id.* § 44(2)–(3).
[21] *Id.* § 15.
[22] *Id.* § 14(3).
[23] *Id.* § 26(1)(f).

Litigation over the reach of central regulation has centred on federalism. In *Tamil Nadu Medical Officers Association v. Union of India* (2020),[24] a Constitution Bench upheld the States' competence under Entry 25 of the Concurrent List to provide a separate channel of postgraduate admission for in-service doctors, against the central regulator's regulations, while reaffirming that the coordination and determination of standards remains a Union matter under Entry 66 of the Union List. The judiciary has thus largely backed the goal of national standardisation while continuing to recognise the concerns of the States.

To address the bureaucratic delay commonly associated with hierarchical structures, the Act includes procedural safeguards: section 28(3) requires the Medical Assessment and Rating Board to approve or disapprove a scheme for a new medical college within six months,[25] the proviso to that sub-section requires that an applicant be given an opportunity to rectify defects before a scheme is disapproved,[26] and sections 28(5), 28(6) and 30(3) to (4) create a two-tier appellate ladder for aggrieved institutions and practitioners.[27] These measures are intended to blunt the standard criticism of hierarchical regulation, namely procedural delay, while preserving centralised oversight. The initial rollout, however, has revealed some tension between thoroughness of regulation and administrative speed, raising the question of how hierarchical authority and operational efficiency are to be balanced.

V. COMPARATIVE LEGAL ANALYSIS

The enforcement mechanisms of the MCI and NMC regimes differ markedly in both organisation and effectiveness. The MCI relied chiefly on professional ethics committees with limited investigative capacity and no clear statutory scale of sanctions beyond removal from the register.[28] The NMC Act, by contrast, provides a range of penalties: monetary penalties on practitioners found guilty of professional or ethical misconduct, graded sanctions on institutions, and imprisonment of up to one year or a fine of up to five lakh rupees for unauthorised practice, producing a stronger enforcement regime with clearer legal consequences.[29]

An examination of the case law shows that the standards applied in medical malpractice cases are still evolving. During the MCI era, *Jacob Mathew v. State of Punjab* (2005)[30] entrenched the

[24] *Tamil Nadu Medical Officers Ass'n v. Union of India*, (2021) 6 SCC 568 (India).
[25] National Medical Commission Act, No. 30 of 2019, § 28(3).
[26] *Id.* § 28(3), proviso.
[27] *Id.* §§ 28(5)–(6), 30(3)–(4).
[28] Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, regs. 8.1–8.7 (India).
[29] National Medical Commission Act, No. 30 of 2019, §§ 26(1)(f), 30(2), 34(2).
[30] *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1 (India).

Bolam standard, under which negligence is judged against accepted professional practice, and *Balram Prasad v. Kunal Saha* (2013)[31] demonstrated the civil consequences of that standard by awarding the largest compensation then recorded in an Indian medical negligence claim. Whether the NMC framework will move the courts towards a more patient-centred allocation of the burden of proof in routine procedures remains to be seen; no decision of the Supreme Court since 2019 has yet displaced the Bolam-based standard.

The roles of stakeholders have also changed significantly. The MCI system allowed patients only limited participation in disciplinary matters, whereas the NMC Act channels complaints of professional or ethical misconduct to the State Medical Councils and, where none exists, to the Ethics and Medical Registration Board, with a statutory right of hearing and a two-tier appeal.[32] This marks a notable shift from a system centred on professionals to one that gives the public a defined place in the disciplinary process.

From a legal standpoint, the remedies available to patients have widened. The MCI offered mainly administrative remedies through its internal machinery, whereas the NMC framework establishes a layered system that combines administrative penalties with a statutory appellate ladder, although compensation for the victims of negligence still lies with the consumer fora and the civil courts rather than with the regulator itself.

Judicial standards of liability have progressed in parallel, with courts increasingly treating the strengthened statutory framework as a reason for closer scrutiny of medical standards and greater institutional accountability.

VI. Creating a balanced regulatory framework: a hybrid model for healthcare governance

A successful hybrid regulatory system for Indian healthcare will require specific amendments to the NMC Act. First, section 4 of the Act should be revised to alter the composition of the Commission so as to guarantee balanced representation of healthcare experts, government nominees, and members of civil society, in keeping with the constitutional commitment to participatory governance. Second, a two-tier accountability system is proposed. Under it, routine professional standards would be assessed by Professional Standards Committees, while a separate Public Oversight Panel would handle complaints and broader systemic problems.

In designing any hybrid model, it is essential to balance the State's duty to safeguard public health under Article 47 against the professional freedom of individuals recognised in Article

[31] *Balram Prasad v. Kunal Saha*, (2014) 1 SCC 384 (India).
[32] National Medical Commission Act, No. 30 of 2019, § 30(2)–(4).

19(1)(g). That balance can be achieved through legal structures that separate technical standards, which depend on professional knowledge, from ethical standards, which are subject to wider supervision. A specialised healthcare tribunal composed of judges, medical experts, and public health specialists would supply the judicial oversight needed for fair and informed decision-making in this field.

VII. CONCLUSION

This examination of the MCI and NMC regulatory systems highlights the essential tension between professional independence and public accountability in the governance of healthcare. It shows that neither self-governance alone nor total control from above is sufficient to address the intricate problems involved in preventing medical malpractice. Effective healthcare oversight requires a suitable compromise between the skills of professionals and supervision from outside, reflecting the constitutional reasoning of *Modern Dental College v. State of Madhya Pradesh*.[33]

The proposed changes include new legislation to create a mixed regulatory framework with levels of oversight graded by risk, enhanced protection for healthcare providers consistent with public safety, and continuing adjustment of the regulatory settlement. These proposals resonate with the Supreme Court's insistence on balanced and proportionate regulation in *Cellular Operators Association of India v. TRAI*.[34]

Further legal research should investigate practical methods for measuring regulatory effectiveness, compare hybrid systems in other jurisdictions, and establish specific constitutional criteria for judging reforms in healthcare regulation.

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[33] *Modern Dental College*, *supra* note 9, ¶¶ 60–63.
[34] *Cellular Operators Ass'n of India v. Telecom Regulatory Auth. of India*, (2016) 7 SCC 703, ¶¶ 38–42 (India).