influenced by non-clinical considerations, including financial inducements, or institutional pressures. The insistence on repeat laboratory investigations or imaging solely because testing was performed elsewhere, or the rejection of valid reports from accredited centres without scientific justification, undermine both patient autonomy and professional integrity. In resource-constrained settings such as India, such practices also impose unnecessary financial and logistical burdens on patients, worsening inequities in access to care and denying justice [2].

The referral of patients to specific specialists or tertiary care centres raises parallel ethical issues. They may be grounded in demonstrable clinical outcomes, procedural expertise, infrastructure availability, and multidisciplinary capacity. Yet commission-driven or monopolistic referral networks distort clinical objectivity and erode public trust in the medical profession. The subtle normalisation of such practice risks placing individual or institutional financial interests above patient welfare.

An ethical middle ground is feasible and necessary. Physicians may appropriately recommend specific laboratories or diagnostic facilities, or specialists based on transparent, clinically justifiable criteria listed above. At the same time, patients must retain the right to choose their diagnostic provider and referral destination. Reports from accredited facilities should be assessed on merit rather than origin, and when diagnostic uncertainty exists, second opinions, or laboratory result verification should be preferred over automatic repetition [3].

Transparency is central to this balance. A clinician might ethically explain, "For this condition, I usually trust this laboratory or imaging centre because their standards and reporting accuracy are consistently high; however, you are free to choose any accredited facility." This preserves patient autonomy while allowing the physician to exercise informed professional judgement. This approach aligns with the foundational ethical principles of respect for autonomy, beneficence, and justice [2].

Regulatory frameworks in India explicitly prohibit fee splitting, referral commissions, and financial inducements from diagnostic laboratories, imaging centres, or hospitals. The National Medical Commission's ethics regulations underscore that professional decisions must be guided solely by patient interest and scientific considerations. Compliance with these standards is not merely a legal obligation but a moral imperative to safeguard the credibility of clinical decision-making and public trust in the profession [4].

Importantly, the solution to unethical referral practices cannot be reduced to individual moral rectitude alone. Systemic reforms are equally necessary. These include transparent disclosure of referral relationships, institutional policies that prohibit inducements, routine audit of referral patterns, accreditation-linked acceptance of laboratory and imaging reports, and regular patient education regarding their right to choose diagnostic and referral providers. Professional bodies and academic institutions must play a proactive role in reinforcing ethical norms and fostering a culture of accountability.

In conclusion, physician preferences in diagnostic laboratory, imaging, and referral practices are not intrinsically unethical when rooted in clinical quality and patient welfare. They become problematic when driven by financial or institutional interests that compromise transparency and autonomy. A balanced approach — anchored in merit-based assessment, open communication, respect for patient choice, and strict adherence to ethical regulations — offers a pragmatic pathway to reconcile clinical judgement with ethical responsibility.

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Conflict of Interest: None declared **Funding:** None

Acknowledgments: The author acknowledges the use of artificial intelligence-based language assistance (ChatGPT) for refinement and clarity. All intellectual content, interpretations, and the final decision remain the sole responsibility of the author.

To cite: Gupta DK. Diagnostic and laboratory referrals: Balancing clinical judgement, ethics, and patient autonomy. *Indian J Med Ethics.* 2026 Jul-Sep; 11(3) NS: 253-254. DOI: 10.20529/IJME.2026.018

Submission received: February 3, 2026

Submission accepted: March 5, 2026

Published online first: March 26, 2026

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From solidarity to isolation: Why do doctors distance themselves from colleagues accused of an offence?

SADANANDA BOLAR NAIK

A doctor in Madhya Pradesh was arrested when several children died, after consuming a toxin-contaminated cough syrup he had prescribed. The Indian Medical Association condemned the arrest, stating that the prescribing doctor

could not have known about the contamination [1]. Social media posts poured in from all quarters, including doctors, condemning the government for making the doctor a scapegoat to cover up their own inefficiency. But, when the police report filed in court, — opposing the doctor's bail application — charged him with taking a 10% commission from the manufacturer, the attitude of the doctors changed completely [2]. The medical fraternity disowned him overnight and declared him guilty before he was even tried on the charges. Imagine that he had been a politician or an individual belonging to an organisation. There would have been a plethora of statements like, "He is a victim of political vendetta", "We shall fight it to the end", and "We have full faith in the judiciary" … etc. This incident gives us an insight into the attitude of doctors as a group, which makes them take the moral high ground and judge their own colleague as an offender long before the person has been tried, rather than lend him support.

Medical professionals are supposed to act with compassion, empathy, and humanity. But, when one of their own colleagues is accused of medical negligence or misconduct, these inherent virtues go missing, long before a trial. Instead of expressing solidarity and empathy with their professional colleague in difficult times, they simply remain silent or judgmental, and some join the public in condemning the act without even verifying the facts. Is this the self-preservation instinct taking over wisdom and empathy and all the other noble virtues we talk about, day in and day out? Distancing themselves from controversy and preserving their own reputations becomes more important than seeking justice for their colleague. Though there may be no real negative feeling against the colleague, the fear of public backlash or damage to their own image — by aligning with the accused colleague — seems to force them to behave this way.

Another closely linked attitude known as "moral superiority bias" could be the stimulus. Here, the doctor feels that he/she would never have acted like the accused colleague, and this mental posture is quite comforting and helps the individual to believe in his own integrity, though it is an illusion. Unfortunately, the judgmental stance taken against the colleague is baseless and exposes a lack of understanding of the facts and the full context. A doctor is taught in the course of medical education to be "error free". As a result, every medical professional aspires to be an "error free doctor"; hence mistakes are stigmatised and not analysed transparently. This is connected to distancing oneself from a colleague accused of an offence, reflecting moral cowardice and disregard of the principle of "innocent until proven guilty". Offering support is consistent with justice and humanity. Sociologically, this "group moral distancing" allows the profession to protect its image by isolating the accused as an "exception", restoring public confidence at the cost of ethics, solidarity, and professional unity.

Consequences

Such distancing from peers has wide ranging implications for the medical profession and its practitioners. When doctors realise that their peers will abandon them in moments of crisis, they become guarded, defensive, and fearful. A climate of mistrust replaces collegial cooperation. Younger doctors internalise the message that vulnerability is dangerous, and empathy cannot be expected.

The way forward

The antidote to this problem lies in strengthening professional fraternity and cultivating moral courage. Medicine must rediscover its human core. Doctors must remember that empathy is not only for patients but also for their colleagues. Supporting a colleague does not mean defending malpractice. It means upholding dignity and justice until the truth is known. It means standing against mob judgment — whether by the media, patients, or peers — and affirming that every doctor deserves a fair hearing. The true test of professional integrity is not in celebrating the success of peers but in standing beside them when they stumble. A medical community that chooses empathy over judgment, fairness over fear, and solidarity over silence will not only protect its members but also strengthen the trust society places in it. For in the end, the nobility of medicine lies not merely in curing diseases but in embodying humanity — even towards its own.

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Conflict of Interest: None declared **Funding:** None

To cite: Naik SB. From solidarity to isolation: Why do doctors distance themselves from colleagues accused of an offence? *Indian J Med Ethics*. 2026 Jul-Sep; 11(3) NS: 254-255. DOI: 10.20529/IJME.2026.020

Submission received: November 10, 2025

Submission accepted: March 06, 2026

Published online first: March 30, 2026

Manuscript Editor: Olinda Timms

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