

CRISIS OF CREDIBILITY: THE TALE OF MEDICAL COUNCILS

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The debates succeeding the inclusion of medical services under the ambit of the Consumer Protection Act (CAP) have inevitably focussed public attention on the question of accountability of the medical system and the institutional framework within which it operates. The concern is not unnatural when we consider the professional's proximity to the delicate division between life and death, ill health and physical well being. Unlike other professionals, doctors and nurses tend to step into people's lives when they are vulnerable and to quit after making some attempt to restore health and hope in them. This is an idealised conception at best but one that clearly contributes to their appeal and heroism.

However, this image gets tarnished when it is contextualised in the everyday world of medical practice. An overwhelming majority of doctors (namely, practitioners of Allopathy, Homeopathy, Ayurveda, Unani and Siddha) are employed in an individual capacity in the profit-oriented private sector, the sick do not receive medical care without making an on-the-spot payment. So central are monetary transactions to the healing process, and so repeated is the experience of it, that doctors have begun to resemble traders in the public eye and the services they render are seen as commodities to be purchased for a price.

Accompanying this altered image are reports of medical negligence, malpractice and unethical practices that have increasingly made their way into the mainstream media. With aggrieved patients and/or their crusading relatives taking doctors through the orchestration of civil and criminal lawsuits, the unquestioned trust that once underpinned the doctor-patient relationship has all but disappeared.

It is at this juncture that CPA, which admits medical suits into the speedier realm of consumer courts, has made its appearance. Reactions to the judgement have been sharp and the defensive medical leadership has been unable to intelligibly counter the charges that have come up against them. It is obvious that the time for renewal has finally come, however vehemently it might be resisted.

Traditionally, the responsibility of regulating and disciplining the medical profession has been vested with the councils. Councils serve as gatekeepers between the state and the profession and between professionals and the public. They are facing a crisis of credibility at the moment. Since medical and nursing councils have not yet received the full attention of a sociological study in India, experiential accounts constitute the mainstay of conventional knowledge.

GENESIS OF MEDICAL COUNCIL

The facility of regulation of the medical profession, through the offices of a council, originated in the mid-nineteenth century in England. As recounted by Waddington (1984), the General Medical Council (GMC), which was constituted under the dictates of the Medical Act of 1858, was the outcome of a protracted struggle for radical reform in a profession deeply divided between the economically and politically powerful group of consultants and the relatively dis-enfranchised group of general practitioners. The Act served to uniformly bring all qualified medical practitioners under the governance of a single law and to elevate the organisation of the profession to the national level. More importantly, it provided legal monopoly to these practitioners over all other healers. In return, the profession implicitly assured potential patients quality of services. The vehicle through which this promise was sought to be lived out was a professional **Code of Ethics** to be enforced by the newly constituted council.

INDIAN MEDICAL COUNCIL

The medical profession in India followed the example set in England, like many practices in medicine and nursing. The early registration acts were legislated in Bombay, Bengal and Madras between 1912 and 1918. However, these were applicable only to practitioners of 'western' medicine (viz. Allopathy). The threat of non-recognition of Indian medical degrees by the GMC led to the creating of the Indian Medical Council in 1933. For such a council to be looked upon favourably by the British, it soon became obvious that its membership would have to be largely nominated and official. It was also evident that close association with indigenous practitioners would be incompatible with international recognition. Therefore, acts designed to cover practitioners of Ayurveda, Unani and Homeopathy were legislated separately some 20 years after the first provincial acts. The decision to have separate councils and nominees at the helm of affairs are historical precedents that have had a crucial bearing on the framework within which regulation of the medical profession takes place.

SEPARATE COUNCILS

Each system of medicine is governed by a separate council at the central and state levels. In Maharashtra, for instance, allopathic practitioners are governed by the Maharashtra Medical Council (MMC), homeopathic practitioners are affiliated to the Maharashtra Council of Homeopathy (MCH), practitioners of the Indian Systems (namely, Ashtang Ayurveda, Siddha, Unani and Tibb) fall under the purview of the Maharashtra Council of Indian Medicine (MCIM) and dentists are grouped under the Maharashtra State Dental Council (MSDC). The Maharashtra Nursing Council (MNC) and Maharashtra State Pharmacy Council (MSPC) are the bodies that regulate the para-medical professions.

Similarly, all councils continue, to this day, to have a substantial proportion of nominated members, many occupying positions of power in the state bureaucracy.

INTERACTIONS WITH THE COUNCIL

It becomes apparent, even with the most cursory interaction, that councils are inaccessible bodies. The real gatekeepers between the lay public and the councils are the Registrars. However, the task of meeting them and acquainting them with the ongoing research work was not easy. The reason for this is simple enough. Registrars are not easily found. This was particularly true of the MSDC where the Registrar remained elusive during our six visits over three weeks. Even if they are found, researchers are confronted with wariness, distrust and even active non-cooperation. This was also the case with the MMC and MNC. Therefore, inaccessible personnel and inaccessible information make councils remote and difficult to study.

Although councils are separate entities, they are not impervious to inter-professional dominance. We discovered this in the case of the MNC since its President is actually the Vice-President of the MNC also.

LEGAL STATUS OF COUNCILS

Councils are legally constituted bodies. Legislation defines the scope and limits of their functioning. Since health appears on the concurrent list of the Indian Constitution, the acts enacted by the central government complement and coexist with those legislated by the state. Legislation empowers councils to control the entry and exit of practitioners. This automatically brings into the picture, three major spheres of authority; medical education, registration and medical practice.

MEDICAL EDUCATION

For medical education to be considered legitimate, universities (or medical institutions) and the courses offered by them need to be approved by the councils. All the acts, especially those governing the central councils, carry a list of approved qualifications and the universities in three schedules. These schedules

are not rigid but are open to new additions and removals. How this can be done has been mentioned in the acts and it appears as if the central and state level councils have dual responsibility vis-avis universities and colleges.

Interestingly, councils have only recommendatory powers in the matter of medical education; the ultimate decision on recognition rests with the state and central governments. This is particularly so in the matter of post graduate education where the council's role is restricted to that of an adviser.

This is a limited role, to say the least, but one that is compounded in the case of the MCIM, which is a council only in name. It is 13 years since a radical restructuring was in sight, despite periodic representations by the Registrar to the state government.

In the recent past, the number of non-aided Ayurvedic and Unani colleges in the state have been increasing at an alarming rate for reasons that are not hard to see. According to the Registrar, private colleges with less than optimum facility get recognition through their political connections. Thus, the absence of a medical council has allowed the political-private college nexus to thrive, which has, in turn, produced doctors with indifferent training.

REGISTRATION PROCESS

After successfully completing a recognised degree in a recognised institution, new entrants into the profession are registered with councils. Councils comply with legally ordained registration systems, which show no uniformity. The MSDC, for example, levies an initial fee of Rs. 100 and follows it up with an annual renewal fee of Rs. 15 while the MCIM accepts a one-time payment of Rs. 500 and follows it up with mailed questionnaires once every five years. These differences have no apparent rational basis and revisions in the law do not come easily. The rupee value has been diminishing consistently and resultant loss of what could be a useful source of revenue has created permanent dependence on the state for monetary support. The cash strapped MSDC, is a case in point, which barely manages to pay its two employees and run its very modest establishment.

An activity that routinely engages almost all-clerical employees of the councils is the updating of the register. The maintenance of a credible register is problematic; although renewals are automatic upon payment of the renewal fee, deletion of members who may have expired or migrated does not routinely take place. Practitioners tend to be lax about re-registering themselves in the state to which they have migrated. As a result, registers are not always reflective of the geographical location of practitioners, which becomes crucial during elections.

Elections to councils take place by postal ballot with the register serving as the electoral list and the Registrar serving as the Returning Officer. The non-deletion of deceased or departed members from the register creates room for bogus voting.

The Council are expected to publish their registers every year. This does not happen in practice. The reason revolves around the inadequacy of funds. The only councils that have attempted to publish their register (with all the inherent inconsistencies) have been the MCH and MMC, largely due to their somewhat recent elections.

RIGHT TO PRACTICE

The right to practice medicine, to hold office in institutions run by the government or local bodies, to sign or authenticate medical or fitness certificates and to give evidence at inquests or courts of law comes automatically to all duly qualified and registered professionals. To safeguard these rights, the central acts make provisions for punitive action against unqualified persons usurping them. However, this conviction has to be by a criminal court.

This is ironic since it runs contrary to their monopolistic intent.

A SILENT CODE

All acts enjoin upon the councils to prescribe standards of professional conduct and etiquette through the design of a code of ethics. This serves two purposes; it provides practitioners with professional guidelines and secondly, it sets the standards against which the nature and content of professional misconduct can be ascertained. However, the code of ethics remains, by and large, an unimplemented document. What is interesting is that even this document needs to be ratified by the Governor.

DISCIPLINARY ACTIONS

All councils at the state level are empowered to discipline the erring practitioners on their rolls and their inquiries enjoy the status of civil courts. This is the most dynamic aspect of their regulatory role. They cannot only enforce court attendance and examination under oath but can also compel the production and submission of documents, and issue summons for examination of witnesses. Disciplinary action may take place either through suo moto action instituted by the councils or in response to complaints from aggrieved patients. These have to be written and duly signed.

According to the acts and their rules, inquiries are unnecessary if the practitioner has been convicted by a criminal court or under the Army Act of 1950. In cases like these, the President is required to place before the council a copy of the judgement whereupon the council decides the punishment to be meted out.

In case of inquiry is felt to be essential, the council is required to serve a notice on the charged practitioner with details of the charges and copies of all relevant documents. The practitioner is asked to furnish a written statement. All inquiries are held in camera where the onus of proof rests with the complainant.

It is here that council's task can be daunting. People who have approached councils for redress find themselves pitched against powerful lobbies, antagonistic court procedures, delayed judgements or summary dismissals. In a recent case filed in the MMC, the complainant maintained that the hearing of the case was conducted without reference to the medical records of the case. Not only that, he found that his statements had been altered to favour the accused doctors. Similar sentiments have been expressed by other also in the media.

Even the more obliging councils do not ordinarily divulge specific information about the charges made in each of the complaints coming to them and the suo moto action they have taken.

How many cases do councils handle in a year? How many have they had to deal with during the last five years? The Registrar of the MSDC, who has only recently been appointed, did not know the answer to this. However, discussions with the peon and clerk who have been there for a longer time revealed that an average of one case per year would have come up since 1990. The MCIM received two cases during the last five years. The MCH reported average five to six complaints per year.

On the whole, councils as disciplining bodies, are neither accessible to the lay public not tough on fellow professionals. They appear to lack the dynamic leadership that is willing and capable of bringing ethical issues into the core of everyday practice. Their apathy is evident though their silence on many of the burning issues of the day.

LIMITATIONS OF LAW

Medical Councils are not really autonomous bodies. Further, councils and the legislation under which they are constituted cover only those practitioners who are part of the organised profession. Unqualified practitioners-quacks, as they are commonly called-are untouched by the law. This group includes not just unqualified doctors but nurses and other auxiliary workers too. Therefore, the laws are restrictive in their scope.

AN EYEWASH

However, when councils are asked about their disciplinary roles, they become notoriously tightlipped. Health groups like the Medico Friend Circle (Bombay Group) maintains that, in the past, the MMC has failed to produce a record of action taken against erring doctors, even when forced to do so.

Whatever regulations take place is passive. Even if complaints are put through the orchestrations of full-ledged inquiries, sufficient information on this not available though, they rarely result in the enforcement of punitive measures. The in-camera proceedings rule out the possibility of public censure and de-registration rarely takes place. Therefore, the councils function more as guild bodies protecting the self-interest than as regulatory bodies which enforce some social accountability in the profession. Some activists have labeled them as 'irresponsible trade unions' whose self-interest overrides public interest, others say they have become 'virtually defunct'.

No matter how defunct councils may be, it is clear that we need them. The limitation of having no council is painfully evident in the case of the MCIM. However, the need for a radical overhauling of the entire system is evident. If councils are to become credible entities they need to clean up their encrusted image.

NEED FOR REVAMPING

Council needs to become more transparent and accessible to the public. The possibility of lay representation in the constitution of the council and a drastic reduction (if not total abolition) of state nominees and ex-officio members could be actively considered.

The existence of separate councils a divisive climate within which regulations take place. Issues on the cutting edge – for example, mishaps arising out of cross-practice, tend to get passed on from one council to another and unnecessarily delayed.

This argument finds some support among the office bearers of the Homeopathic council who additionally feel that there should be a common course for all medical students. According to them since the basic training in all the systems of medicine is virtually the same (save the aspect of therapeutics), there should be a common course with specialisations in Homeopathy, Allopathy or the Indian Systems of Medicine. They also endorse cross practice especially in rural areas where allopathic practitioners are not easy to find. However, they maintain that amendments proposed by them have never been taken seriously; only two out of 28 amendments submitted over the years have been accepted.

The possibility of decentralisation of councils from the state to the district level also needs to be considered. This will make the task of maintaining a credible and a more manageable register. Information gathered at the district level can then be fed into the state register.

The system of automatic renewal of registration needs to be contingent upon performance or a accumulation of credit in a Continuing Medical Education Programme. Secondly, the registration fees need to be rationalised in order to raise sufficient revenue from within the profession. This will reduce their dependence on state support.

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