

# MEDICAL ETHICS

FOR SELF-REGULATION OF MEDICAL PROFESSION AND PRACTICE

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## 1.

# Self-regulation of Medical Profession: Concept and History

### Doctors: Traders, Technicians or Professionals?

Are doctors traders, technicians or professionals? In our country, this question has become more relevant now than ever. With an overwhelming majority of doctors working in the for-profit, fee-for-service private sector, people who fall ill and seek medical care end up paying money on-the-spot for the doctor's service, as they would in a shop. Thus, buying medical care is a concrete, repeatedly experienced and often, unpleasant reality for a large majority. People's common sense is formed from the reality of daily life interaction. The perception of people about doctors being traders, therefore flows from the daily experience of cash transactions and fee-for-service. The unease felt by an average doctor, about the social image of their practice, is equally real. For doctors, through their education and training, and more so through their historical tradition, have been taught to believe that they are genuine professionals, working primarily not for trade but for the well-being of their patients. It is this teaching and tradition, in addition to the reality of dealing with the life and death of patients that have kept the doctors' self-image as professionals alive. This self-image also brings along the question of ethics in medical care, for a professional without ethics is again seen to be retreating to trade and commerce.

The term professional has in practice, been distorted beyond recognition by professionals themselves. In order to be real, the self-image of professionals must be reflected or translated into actual professional practice. A dichotomy between the concept of professional and the reality of professional practice is the greatest distortion, causing not just an ethical dilemma but also a problem of how an appropriate social image is to be.

The term profession is derived from the original Latin *profiteor*. This Latin original means confession, announcement, promise or making public statement of commitment. The dictionary meaning of the word is related to learned occupation and the religious belief. Thus, by all accounts, the meaning of highly learned and skilled go hand-in-hand with the statement of commitment which is as strong as, or even stronger than one's commitment to religion or belief. For the medical professional, this public commitment is to the welfare of patients and for improving health status of people. This medical morality, avowal, the public commitment has behind it a tradition of many centuries.

There is another development in the present day medicine, that of greater division of labour brought about by new specialities and super-specialities, and the invasion of medicine by the new medical technologies which have rendered the medical care highly technique and skill oriented. The doctors attached to sophisticated equipment or known as the best technician to perform certain types of operations have started dominating public imagination. This has changed the nature of practice by a section

of doctors. These doctors are called upon to merely perform an operation or procedure on a patient whom they meet first time on the operation table, and often such doctors play no role in post-operative care. This reduction of such doctors to mere efficient technicians runs counter to the image of healing profession where the doctor patient relationship is considered the most important. The doctor's work as professional is much greater than that of skilled technician in relation to the patient. The professional involves himself or herself in the entire healing process of the patient, though he or she might delegate a part of the work to other doctors or nursing professionals.

In the final analysis it is not the technical skill of the doctors but their public commitment of that is normally used as a reference point, a yardstick to judge the actions and practices of doctors. In the market and private sector dominated health care services, the doctors have three characteristics, all rolled into one. First, they are highly educated, scientific and skilled personnel. Second, they have a public commitment to serve the people, specifically to treat illnesses and to improve health status. And lastly, their service is traded or sold privately for money. All three, simultaneously, shape the economic and social role of doctors, and hence the social image of theirs. Interestingly, these characteristics of doctors and their medical practice are not new. They have history of many centuries. The social image, and the actual mode of medical practice have been determined by the social environment in which the medicine is practised, and the social responsibility exhibited by the profession as a group.

### **Medical Practice of Early Times**

Although the social organisation of health care in ancient and medieval times has not been studied in much detail, there is enough evidence to make some definite observations on the way medicine was practised and the kind of regulations exercised by the society. The agrarian economies and the kingdoms of that time did not have a formally constituted and separated health care service system. The latter was in fact a part of the economic organisation at the village and town level. Though few doctors were patronised by the rulers, the rest were integrated in the village economy, providing services like any other artisan and craftsman, and in return, they were supported by the society.

While practising medicine required knowledge and training gained from the family tradition or from other practitioners, the doctor was in many ways a self-contained artisan, collecting herbs and chemicals and compounding drugs to treat patients. Since the organised intervention of the state in ordering the medical practice was either non-existent or was only related to certain limited aspects, the trained physicians derived their authority as healer from the membership of their primitive associations and the reputation of their skills. In any case, the patient approaching a doctor did need a reassurance that the doctor had certain social standing, and this standing was gained from the authority and self-regulation of their associations. For instance, the Hippocratic Oath, now internationally known and recognised code of ethics, was a part of the adoption and initiation rites of the voluntary association or societies of

physicians of that time (Sigerist, 1934). The code was useful to the physician to build his reputation in the society. Similarly, the ancient Indian medical system of Ayurveda had well defined code of medical ethics, expounded in its ancient texts (Chattopadhyay, 1977: 21 and Sinha, 1983: 266).

What is important for our purpose, is to understand that these codes were purely voluntary codes, adopted within the specific social environment by the physicians to bring about self-regulation. And the same time, to assure the society that a physician governed by such a code would conduct himself in a manner which would be in the best interest of the patient and the society. Further, importantly, these codes were not part of any legal system of the state, and therefore the state had no responsibility to enforce it amongst the doctors.

These elaborate codes for self-regulations were thus, morally binding on doctors, and the morality of doctors was considered extremely important. This morality gave a social image and authority to doctors who in turn traded their services for a price in kind or cash. Naturally, the trading or charging fee for medical care by doctors is also an ancient phenomenon. The ethical code was, therefore, a regulator of the patient care as well as the trade in medical care.

Normally, the state refrained from interfering in this arrangement. However, there are instances when on certain aspects of trade and the negligence in care laws were made by the king or the state in order to protect and compensate people. The oldest known legal code for such purpose is the code of Hammurabi (300 BC), known as "The Judgement of Righteousness which Hammurabi, the Great King Set-up". This was a wide-ranging code for rights and duties of individuals and governed the family and property relations and the entire social life of the community (Sigerist, 1987: 386). It is also having instruction on how the patient who has suffered injury due to the medical intervention will be compensated, or rather the doctor will be punished. As compared to this code, the well known treatise on Indian state-craft, the Arthashastra of Kautilya (around 150 AD) laid great stress on the doctors providing information to patients, particularly when the medical intervention involved risk of injury. It also prescribed monetary compensation for the patient and in certain conditions, the punishment for doctors (Rangarajan, 1992). However, all such instances of law making in the old times covered only a small part of the doctor's conduct, the main body of the code of medical ethics was always left to the practitioners themselves to implement as a part of their moral duty.

### **Changes in Modern Times**

A radical restructuring of the health care took place in 18th and 19th century when the emergent nation states gradually reorganised the health care services at the national level. The advent of modern scientific medicine and the professionalisation of medicine made it possible for doctors to organise as a formidable organised force. The organised medicine first asserted itself in England for control over the entry of new doctors and then to have registration of practitioners so that the unqualified

"quacks" were weeded out of the medical practice. The doctors led a strong movement, lobbied in the parliament, gave evidence before parliamentary committees and inspired politicians to pass laws to give them monopoly over the medical care. (Waddington, 1984). In 1858, when the Medical Act creating General Medical Council was passed by the British parliament the medical profession attained a national and legal status. The Act gave monopoly to practice medicine by the registered doctors and gave power to the profession to lay down standards for admission and examination for new entrants.

Thus, it was only hundred and fifty years back that professionalised medicine consolidated itself as a group legally and thus formally recognised by the society. However, no society can give a blanket authority and monopoly power to professionals without demanding adequate safeguards in return. This made the code of ethics an important vehicle for both internal regulation and discipline expected of medical practitioners and for the safeguard of patient's and thus, society's interests. The legalisation of medical profession therefore went hand in hand with the legalisation of the internal regulation through the code of medical ethics. An ethical code which was hitherto a voluntary or moral guideline for medical practitioners, got converted at this juncture of history into a legal code for appropriate ethical conduct for doctors.

The legalisation of medical profession and the code of ethics in England gave rise to similar developments in other parts of the World. Within few decades, the Europe and North America adopted similar legislation, and in the early part of 20th century, the medical council acts were passed in various provinces of India, too.

### **Legal Framework of Professional Self-regulation in India**

The Bhore Committee report (1946) deliberates at length on the necessity of regulation the health care professional and various modes of doing so. The committee at the end recommended the strengthening of the professional regulatory mechanism fostered by the colonial government in the similar framework as the General Medical Council of the UK. However, there were differences within the committee on the extent to which the Professional should be allowed to self regulate. Interestingly, one member even placed on record a note of dissent by arguing that there should be stricter government control over the professional to bring their work in line with the development of health care services.

The post-independent revamping of the professional councils was an act to balance the contentions of two opposing views with regard to the self-regulatory functions of the medical councils. A substantial presence of government representatives as ex-officio members and nominated members has ensured that the professionals are put under some direct control of the government. In addition, as we will see later, certain aspects of their works do require governmental and or parliamentary sanction from time-to-time, including the fees to be charged for the registration of medical

practitioners. Thus, the onus of any failure in self-regulation cannot be laid exclusively on the profession, but the government also has its share in it.

### **Ethical code and principles**

The code of ethics for medical professionals adopted by the Indian parliament as a part of the Medical Council Act, governs the conduct of the medical professionals in their medical work, in their economic activity and with regards to their relationship with other professionals and the society at large.

Medical ethics, particularly those related to medical practice and societal responsibility, are essentially formulated on the basis of the justice theory developed by the moral philosophers. There are four principles, which form the fundamentals of justice theory as applied to the medical care. They are as follows:

- *Principle of non-maleficence:* It is also summed up in the axiom, first do no harm, or that the medical intervention should not cause harm to the patient seeking care.
- *Principle of beneficence:* This principle stipulates that the medical intervention not only should not harm, but should also be intended for the benefit of the patient.
- *Principle of autonomy:* This principle has developed to its fullest extent only in last quarter century and has replaced what was earlier called 'medical paternalism'. It is also in harmony with the liberal democratic ethos of individual liberty and choice. Essentially it means that the patient is an independent individual and any medical intervention should be done only after full information is given and the patient has expressly consented for such an intervention. This also gives the patient a right to make choice as to what kind of medical intervention is best suited for him or her.
- *Principle of justice:* This principle makes it clear that the doctors are responsible to the society and that they must follow the non-discriminatory way of medical practice.

The professionals do face ethical dilemmas in day to day medical practice. These dilemmas are sought to be resolved, in a case to case basis, by weighing each principle as applicable to the situation.

The economic activity of the professionals is governed by restrictions to minimise the negative outcome of the monopoly control over the practice of medicine. This helps patients and at the same time creates good public image. In fact, historically, in the 19th and early 20th centuries, this aspect of the code was enforced with extra zeal, but not others, particularly the principle of autonomy. Accordingly, the medical professionals are prohibited from advertising their skills and services, the poaching of each other's patients, etc. However, in the last quarter century there has been increasing popular and professional pressure, created by the operation of market, to reduce controls exercised for maintenance of monopoly and due to increasing litigation, emphasise patient's autonomy.



### **Right to health care and medical ethics**

Apparently, medical ethics are normally viewed in terms of the doctor's role in patient care. This leaves out the a major problem of the people who are unable to approach the doctor due to financial constraints. This has happened simply because the basic conservatism of medical profession and the dominance of neo-liberal ideology in the way medicine has been practised. The four principles of ethics are as well applied to the way health care services are organised in a country as they do to the way medicine is practised. Such application of principles stipulate the following:

- (a) A health policy which deprives a strata of people the basic minimum health care is harmful.
- (b) The health policy must work for the enhancement of health status and access to health care by all people.
- (c) It is not the techno-managerial experts who should have paternalistic power to decide, but the ultimate power must be with people in deciding the way nation's health care is organised.
- (d) And lastly, according to the principle of justice and social responsibility of medical professionals, the medical professionals should be first people to demand and if necessary, agitate for the non-discriminatory universal basic minimum health care for all.

Unfortunately, the medical ethics, as applicable to the organisation of and access to health care; have not been paid sufficient attention, by the doctors as well as the society. One simple reason is that traditionally the medicine is practised in the market environment of the practitioner directly charging for the service. Indeed, in the Western Europe and in Canada when the society made attempts to reorganise health care keeping in mind the principle of universal and restricted market, the medical professionals were the first to protest against it. The society had to overcome this resistance of doctors in order to reorganise health care without fundamentally jeopardising the democratic ethos. These experiences of last half a century have emphasised that the ethical principles as applicable to the organisation of national health care services must be given prime importance.

In the underdeveloped country of ours, the way health care is organised has created condition for the gross violation of medical ethics. The principle of justice and non-discrimination are violated when a majority of people do not have access to basic minimum health care while those who can pay can avail of the high-tech, latest and expensive care. Indeed, any growth in medical care at the detriment of basic minimum health care for all people seriously compromises the fundamental principles of medical ethics. Similarly, the gross mal-distribution of doctors and underproduction of nursing human power is a gross failure in self regulation of medical and nursing profession, and the failure of the society to correct the situation. Further, the doctors and nurses are made to work in the health institutions that do not have adequate medicine, equipment and often trained human power, thus making it impossible for

them to practice ethically. It is really unfortunate that the professionals have simply laid the blame on government without using their professional strength to force the government to improve the situation.

Thus, conceptually, as well as in practice the medical ethics are not merely confined to the doctor patient relationship. They are equally, if not more, valid in understanding and changing the national organisation of health care services.

## **The Political Economy of Medical Malpractice**

The network of individuals and institutions which is responsible for delivering medical services to 846 million inhabitants of India has come in for ever increasing public scrutiny and censure. Stories of medical malpractice and negligence, once a rarity, have unfailingly made their way into the annals of mainstream media. These accounts have systematically eroded the trust on which the doctor-patient relationship was once founded. As costs of health and medical services escalate even as these become increasingly inaccessible, the need for reforms becomes self evident. How has this present situation come to be? What is the nature of the medical system that allows malpractice to thrive?

### **Character of the Medical System**

Medical services in India are provided by medical and para-medical practitioners in a variety of settings like hospitals, nursing homes, polyclinics, dispensaries and community-based health centres in the public and private (including the private voluntary) sector. The health industry in India is dominated by the private sector on the strength of its capacity to absorb trained practitioners as well as patients. Documentation of this fact has been growing since the last five years even as official figures do not record it. Therefore, one is compelled to go by estimates. One such estimate contends that the private sector employs more than 70% of the doctors in the country (Jesani and Anantharam 1993: 71). A related fact is the question of earnings and it has been found that the private sector has the capacity to generate significantly better salaries for practitioners than the government (Kansal 1992). In terms of utilisation too, the private sector takes care of 70% to 85% of all illness care in the country and this has been amply recorded by a wide spectrum of studies (Duggal and Amin 1989; NSSO 1987; George, Shah and Nandraj 1994). A comparison between state and private expenditure on health shows that the latter exceeds the former by nearly four to five times (Duggal and Amin 1989). Much of this expenditure in the private sector takes the form of user charges, which are borne by individual households.

The private sector is in fact built on and sustained by the purchasing power of people seeking some kind of medical care. Given the nature of development of the Indian economy, this is found in urban areas (including small towns) and in villages, which have the benefit of economic development. Not surprisingly, therefore, private facilities and services are skewed in their distribution.

The public health sector, which was exhorted to focus on the tiller of the soil in the first two decades of planning, is not immune from these tendencies either. For while this sector has shown commendable increases in the establishment of institutions and personnel, an urban bias and a proclivity towards areas with greater economic and

political weight cannot be ruled out. Rural health facilities in these areas are better endowed in terms of facilities, drug supply and personnel. This finding is borne out by research experience and studies (for example, Phadke et al, 1995). This maldistribution makes medical care services inaccessible for a large section.

While inaccessibility of the public sector is caused by their geographical location, skewed priorities as well as the insufficiency of facilities, equipment and drugs, inaccessibility of the private sector is engendered largely by economic considerations. Patients are required to pay user fees which veer between 7.64% (Duggal and Amin 1989) and 8.44% (George, Shah and Nandraj 1994) of the total consumption expenditure of the household. Furthermore, this proportion rises significantly across the different classes (*ibid.*). Information about indebtedness due to treatment in the private sector (especially for chronic illnesses like tuberculosis), comes to the surface in the research process. However, there appears to be no study to our knowledge that quantifies the process. Inaccessibility of medical services may not qualify as malpractice but the ethical problems that are created are enormous.

#### **Nature of the Medical Profession and Medical Practice**

The medical profession is comprised of a motley group of practitioners each subscribing to a different system of medicine. Allopaths constitute 43.3% of the profession, homeopaths 16% and practitioners of Indian systems of medicine (*viz.* Ashtang Ayurveda, Unani Tibb, Siddha) account for 35.7% of all trained medical personnel. Most of these professionals conduct private practice in urban areas and in an individual capacity. The urban concentration is particularly indicated for allopaths (72.8% of them were found in towns and cities as per the 1981 census) and to a lesser extent for practitioners of the Ayurveda and Unani (42.7% and 61.2% of whom were in urban areas during the 1981 census respectively). The tendency for trained medical personnel to practice in an individual capacity is borne out by a recent study of health resources in a district of Maharashtra (FRCH 1993). The study showed that over 91.5% of all qualified medical practitioners functioned as general practitioners with a basic degree.

The market forces govern the private sector, and breed competition. So the practitioners are forced to adapt and create room for them. One such response has been to specialise. Indeed, the numbers of students of Allopathy who have been seeking post graduate training have increasing, even if this trend is mitigated by practitioners of the other systems who are mostly content to remain in general practice (Phadke 1994). Related to this trend is the system of cut practice, which has become rampant in all cities. This is estimated to be 30-40% of the fees charged (Nandraj 1994: 1681).

Secondly, private doctors need to zealously guard the viability of their practice considering they need to invest towards its creation. One of the methods of doing so is to cultivate an appropriate clientele. In this connection, it is not surprising that private doctors do not always feel morally compelled, to treat patients suffering from

stigmatised diseases like leprosy. A study of 106 general practitioners in three slum areas of Bombay showed that about 20% felt worried about their practice being adversely affected by their treating leprosy patients in their clinics (Uplekar and Cash 1991).

Thirdly, medical practice in the private sector often results in expensive medical and surgical interventions, many of which are unnecessary. The Mangudkar committee in Maharashtra found that the proportion of caesarean sections in private hospitals was six times the proportion in government hospitals. Not only are fees drastically higher in private hospitals, the use of diagnostic investigations, often unnecessarily, are also substantially more. The penchant for injections which private doctors have routinely shown is another fact well documented by studies (Duggal and Amin 1989; George, Shah and Nandraj 1994). Studies have also brought to light significantly different prescription practices. One such study of the prescription practices in the treatment of tuberculosis showed that 100 doctors prescribed 80 different regimens, most of which were inappropriate and expensive (Uplekar and Shepard 1991).

This brings us to another feature that characterises many of the medical professionals we find today - their inability to keep up with the times with new scientific knowledge. Despite the continuing education programme conducted by medical associations, a bulk of the private practitioners, rely on sales representatives of pharmaceutical companies to keep them abreast with latest developments. This has an impact on their prescription practices as is borne out by an examination of 1944 prescriptions given by public sector doctors and 1638 prescriptions by private practitioners in an average district of Maharashtra (Phadke *et al* 1995). The study emphatically brought out the proportion of undesirable drugs prescribed was quite high for all types of doctors but significantly higher among private doctors (*ibid*: 22). On the whole the proportion of rational prescriptions was as low as 18.2% for all doctors, a proportion that was significantly higher among public sector doctors and in accordance with their education (*ibid*: 34). If this is the situation with regard to trained medical personnel, one can only imagine the worst about the medicine practised by people without proper qualifications.

### **Nature of regulation**

It is perhaps ironical that while the medical sector - especially the private sector - has grown swiftly and in an unregulated manner, the institution of regulatory mechanisms has not come close to keeping pace with it. Today, barring some attempt at legislation in two - possibly three - states, there has been no serious attempt to ensure even the minimum quality of care in hospitals and nursing homes, mostly in the private sector. As a result most of these institutions remain unregistered. Whatever legislation that exist, is sketchy and beyond elaborating on the method of registering nursing homes, there are no indices to describe quality of care. All of this has created ideal conditions in which malpractice exists and thrives.

## **Regulation of the Medical Profession: The Scope of Legislation**

As the foregoing sections have made amply clear, the medical profession in India is a disparate group comprised of practitioners of Allopathy, Homeopathy and the Indian Systems of Medicine, namely, Ashtang Ayurveda, Siddha, or Unani Tibb. This group derives its legitimacy from an affiliation to medical councils, which are legally constituted and autonomous bodies. Councils are entrusted with an on-going responsibility of regulating and disciplining medical practitioners and medical practice.

In Maharashtra, allopathic medical practice and practitioners fall under the purview of the Maharashtra Medical Council (MMC). The Maharashtra Council of Indian Medicine (MCIM) governs the practice of ayurvedic, unani and siddha medicine. Homeopathic practitioners are grouped under the umbrella of the Maharashtra Council of Homeopathy (MCH) and dentists are affiliated to the Maharashtra State Dental Council (MSDC). To this list of councils could be added the Maharashtra Nursing Council (MNC) and the Maharashtra State Pharmacy Council which regulate the para-medical professions.

The creation of these councils and the scope of their regulatory functions is stipulated by legislation. Since health appears in the concurrent list of the Indian constitution, the acts enacted by the central government complement - and coexist with - those legislated by the states. Table 1, which provides a list of central and state level legislation bearing on the medical profession at the present moment, makes evident the fact that the medical (and nursing) councils are governed not by common legislation but by separately enacted acts. However, the acts are structurally similar and differences as might exist are merely in the matter of details.

Apart from councils, legal institutions like civil, criminal and consumer courts are also responsible, in some ways, for regulating the profession. However, unlike councils, courts are more sporadic in their interventions and serve only as channels of redressal for the lay public in the event of medical mishaps. They have the power to issue punitive sentences under the provisions of the Code of Criminal Procedure, 1973 and to determine monetary compensations under the law of Torts. The number of people who have begun to take irresponsible doctors to civil and criminal court has been growing in recent times. Their determination to do so, despite the prospect of boggling red-tapism, tedious court procedures and delayed judgements reveals an increasing disillusionment with the profession. However, the extent to which these problems will be alleviated by the recent inclusion of health services under the purview of consumer courts remains to be seen.

It is not our intention at this stage to deliberate on the functioning of courts nor indeed to wax eloquently on the merits of the Supreme Court ruling. What we hope to detail in this chapter is the scope of regulation of the medical profession by councils by an appraisal of their legally defined powers.

**Table 1**

<b>PROFESSIONAL BODY</b>	<b>LEGISLATION IN FORCE</b>
<b>Maharashtra Medical Council</b>	<ol style="list-style-type: none"> <li>1. Indian Medical Council Act 1956</li> <li>2. Indian Medical Council Rules 1957</li> <li>3. Maharashtra Medical Council Act 1965</li> <li>4. Maharashtra Medical Council Rules 1967</li> </ol>
<b>Maharashtra State Dental Council</b>	<ol style="list-style-type: none"> <li>1. Dentists Act 1948</li> <li>2. Bombay Dentist Rules 1951</li> <li>3. Maharashtra Dentists (Ethical Conduct) Rules 1965</li> </ol>
<b>Maharashtra Council of Indian Medicine</b>	<ol style="list-style-type: none"> <li>1. Maharashtra Medical Practitioners Act 1961</li> <li>2. Maharashtra Council of Indian Medicine Rules 1961</li> <li>3. The Indian Medical Degrees (Maharashtra Extension and Provision for Uniformity) Act 1961</li> <li>4. Maharashtra Medical Practitioners (Registration) Rules 1961</li> <li>5. The Maharashtra Medical Practitioners (Publications of Medical List) Rules 1966</li> <li>6. The Maharashtra Medical Practitioners (Enquiry into Misconduct) Rules 1966</li> <li>7. The Indian Medicine Central Council Act 1970</li> </ol>
<b>Maharashtra Council of Homeopathy</b>	<ol style="list-style-type: none"> <li>1. Indian Homeopathic and Biochemic Act</li> <li>2. The Bombay Homeopathic Practitioners Act 1959</li> <li>3. Bye-laws under Section 35 of the Bombay Homeopathic and Biochemic Practitioners Act 1959</li> <li>4. Maharashtra Homeopathic and Biochemic Practitioners Rules 1961</li> <li>5. Board and Court of Examiners of Homeopathic and Biochemic System of Medicine (Election) Rules 1961</li> <li>6. Board and Court of Examiners of Homeopathic and Biochemic System of Medicine (Executive Committee) Rules 1963</li> <li>7. Board and Court of Examiners of Homeopathic and Biochemic System of Medicine Rules 1965</li> <li>8. Homeopathy Central Council Act 1973</li> <li>9. Court of Examiners of Homeopathic and Biochemic System of Medicine. Bombay Examinations Revaluation of Answer books) Bye-laws 1985</li> <li>10. Court of Examiners of Homeopathic and Biochemic System of Medicine. Bombay Examinations (Admissions to, conduct of, appointment of examiners, paper setters, fees to be paid, etc.) Bye-laws 1987.</li> </ol>
<b>Maharashtra Nursing Council</b>	<ol style="list-style-type: none"> <li>1. Nursing Council Act 1947.</li> <li>2. The Maharashtra Nurses Act 1966</li> <li>3. The Maharashtra Nurses (Preparation of List) Rules 1970</li> <li>4. The Maharashtra Nursing Council Rules 1971.</li> <li>5. The Maharashtra Nursing Council Bye-Laws 1973.</li> </ol>

### **Scope of Legislation**

All legislation provides the councils with certain powers over medical education, registration and medical practice. Medical education is imparted in institutions

affiliated to universities. Ordinarily, a university is autonomous and grants degrees for courses that it recognises. These courses may be run by, private colleges affiliated to them. However, in medicine, it is not nearly enough for courses to be recognised by the University. The universities (or medical institutions) as well as the courses need to be approved by the councils. Only then do degrees attain any measure of legitimacy. Therefore, the acts and their concomitant rules specify guidelines and procedures by which institutions receive recognition as well as carry lists of approved degrees and teaching institutions.

Following the successful completion of medical education, students are entitled to become registered medical practitioners, in this connection, the acts entrust the councils with the responsibility of maintaining registers of practitioners. They outline the rights of registered practitioners as well as the nature in which their medical practice is to be regulated. Lastly, they provide details on the constitution and functioning of the councils as supervisory bodies. The acts for the nursing profession follow a similar pattern, too.

**CONSTITUTION OF CENTRAL AND STATE LEVEL COUNCILS:** All councils are comprised of selected and nominated members in varying proportions. Although ratios may vary, it is found that nominated members are substantial. Therefore, the mechanics of elections assume tremendous importance as they come in for special mention in all the acts and their concomitant rules.

Accordingly, elections in all the councils are conducted by postal ballot. The acts assign a pivotal role to the Registrar who functions as a Returning Officer. Any election dispute can be referred to the state government within 30 days of declaration of results.

**MEDICAL EDUCATION:** In order to be able to practice, medical students need to be equipped with recognised degrees from recognised universities. All the acts, especially those governing the central councils carry lists of approved qualifications and universities in three schedules. The first schedule is usually the main schedule with names of qualifications and universities or medical institutions in India which are recognised by the council. Of the remaining two, one lists down the qualifications that were offered in undivided India prior to 1947 or immediately after. This is designed essentially to include those persons who obtain medical qualifications from recognised universities in what are now known as Pakistan and Bangladesh.

The third schedule contains of recognised degrees offered by universities or medical institutions abroad, usually countries with which India has a scheme of reciprocity. The central councils are empowered to enter into direct negotiations with the Authority of foreign countries for the inclusion of additional degrees. In this matter, however, the council functions only in a recommendatory capacity, for it is with the central government that the final authority rests. The Nursing Council of India is the only notable exception to this restrictive clause in the acts.



These schedules are not rigid in their construction. they may be amended by the inclusion of new entries or removal of already existing ones. 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-à-vis universities and colleges.

When universities or medical institutions wish to get included in the main schedule, they approach the central or the state councils, which then constitute a team of inspectors, who visit them. The visiting team is guided by predetermined standards. The central councils are empowered to prescribe minimum standards of medical education essential in order to obtain recognition. Visiting teams are also guided by standards laid down regarding accommodation, equipment, staff and other facilities.

At the end of its visit, the team prepares a report of its observations and findings and this it is expected to submit to the council which in turn submits it to the government. The government takes the report under consideration and takes a final decision. Thus councils have only recommendatory powers in the matter of medical education.

this is particularly so in the matter of post graduate education. Here council's role is limited to merely guiding universities and advising them to conform to uniform standards.

**THE RIGHTS OF REGISTERED PRACTITIONERS:** Like medical education, the legitimacy of medical practice is guided by more than one consideration. Firstly, the qualification should be an approved one, mentioned in any one of the three schedules in the acts. Secondly, practitioner should have a valid registration under any of the state acts.

The rights that duly qualified and registered practitioners enjoy are mentioned in the central acts. These focus on four areas. First, the legitimate degrees entitle practitioners to hold office in institutions run by the government or local bodies and to all the posts, rights and powers under state or central laws by virtue of that employment. Second, to practice medicine in the state. Third, to sign or authenticate medical or fitness certificates required by the law. And lastly, to give evidence at an inquest or court of law under the Indian Evidence Act of 1872.

The central acts provide for punitive action against persons usurping the rights of medical practitioners with the legitimate means (i.e. without recognised qualifications). Accordingly, the Indian Medical Council Act, 1956, mentions imprisonment for a period of one year. The Indian Medicine Central Council Act of 1970 and the Homeopathy Central Council Act of 1973 stipulate imprisonment for a period of one year or a fine of Rs. 1000 or both. The Dentists Act mentions a fine of Rs. 500 on first conviction and imprisonment for six months and a fine of Rs. 1000 for subsequent convictions. However, this conviction has to be by a criminal court. The councils simply do not have the power to penalise unqualified practitioners.

**DESIGNING CODES OF ETHICS:** The acts enjoin the councils to prescribe standards of professional conduct and etiquette through the design of a code of ethics. This serves two purposes. Firstly, it provides practitioners with some professional guidelines when they start practice and secondly, the code sets the standard against which the nature and content of professional misconduct can be ascertained.

The codes of ethics of the different branches of medicine follow a pattern. The areas covered include the duties and obligations of practitioners towards patients, duties towards other practitioners and duties towards the public. The content of unethical practices are also listed out.

**THE DISCIPLINING OF MEMBERS:** All the state level councils are vested with the responsibility of disciplining registered practitioners and in doing so are empowered with the status of civil courts while holding inquiries. Thus, they can enforce the attendance of any person and examine him/her under oath and compel the production and submission of documents, and issue commissions for examination of witnesses.

What is meant by the term misconduct has been spelt out in the state acts: conviction by a criminal court for an offence involving moral turpitude, conduct which in the opinion of the council is infamous in relation to its code of ethics and conviction under the Army Act, 1950. The last mentioned is absent in the act for practitioners of the Indian Systems of medicine and for nurses.

Disciplinary action may take place either through a *suo moto* action on part of the councils or in response to complaints from aggrieved patients. These have to be written and duly signed. Complaints are first submitted to the Registrar who can ask for additional information if so needed. This is then forwarded to the Executive Committee which goes through the particulars of the case, seeks legal counsel if necessary, makes its report and submits it to the council for consideration and a decision.

Upon receiving the papers, the council can direct the registrar either to call for additional information or to file and put away the papers if it feels that there is no *prima facie* case. In information and explanation are ordered, it either exonerates the medical practitioner if his/her explanation is deemed to be satisfactory or directs that a regular enquiry be held.

According to the acts and their rules, inquiries are unnecessary if the practitioner has been convicted by a criminal court of an offence involving moral turpitude, or if he/she is convicted under the Army Act, 1950 for a cognisable offence. 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 an inquiry is felt to be essential, the council is required to serve notice on the charged practitioner with details of the charges levelled against him/her 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.

At the inquiry a legal practitioner may assist the council. Similarly, the complainant and the practitioner under trial are also allowed legal representation. In addition to this, the council may appoint an “assessor” who is usually an advocate for advice on the matters of law. Inquiries can be conducted in the same fashion as courts with witnesses to whom members of the council and the Assessor can put questions. After the hearing, the council is required to deliberate on the case and abide by the majority verdict.

Punishments meted out include a letter of warning, a temporary suspension or at worse de-registration. Once a practitioner’s name is deleted from the state list, it is automatically removed from the central list as well. For redress, the de-registered practitioner is allowed to approach the central government, who decides the appeal in consultation with the central council in question and the decision of the central government will be binding on the state government and the authorities maintaining the state list.

#### **Concluding Note**

Medical Councils are not really autonomous bodies when you consider their relative incapacitation vis-à-vis the powers assigned to the state. Firstly, the composition of the councils necessarily brings in a number of nominated and ex-officio members who occupy various government positions. Secondly, all decisions need necessarily to receive state sanction. For example, even the design of a code of ethics requires the sanction of the Governor. Thirdly, all councils are financed by the government, which cuts at the very base of any pretension of autonomy.

## The Functioning of Councils

Councils are charged with the regulation of the medical profession in the public interest. In exchange for protection and privilege in the market over all other healers, the profession has effectively assured the state that the members of the public would get satisfactory treatment. Councils are gatekeepers between the state and the profession and between professionals and the public. To what extent have the medical and nursing councils been able to enforce accountability among professionals? How do they utilise the powers vested in them? What obstacles do they face in their day-to-day functioning? In order to be informed about these questions, we conducted a brief round up of the councils located in the western Indian state of Maharashtra. The chapter that you are about to read presents the method adopted and experiences gleaned from such an exercise.

### Note on Method

The methodology that guided us was an uncomplicated one: a discussion based appraisal at one point in time. The registrars of the four medical councils and the lone nursing council were approached with a letter of introduction and a request for an appointment with the President. The letter stated the intent and scope of our research together with a list of requests, which covered nine areas.

1. Copies of all official publications to date
2. Present and past rules and procedures on the recognition of medical and nursing schools and colleges, their inspection, recognition of degrees, etc.
3. Rules and procedures related to the maintenance of the register - removal of names who have expired, migrated or changed residence, etc.
4. Information on the number of complaints of unethical conduct during the last five years and the results
5. Number of *suo moto* actions taken by the council(s) against erring practitioners and results of such actions
6. Action taken against practitioners working without proper registration or without a recognised degree
7. Financial and administrative problems faced by the councils and representations in this regard to the government
8. Information about suggestions for amendments in the law and its rules by the council(s) to the government
9. Ethical positions of the council(s) on issues like sex determination, organ transplantation, hysterectomies on mentally handicapped women, etc.

Our success in eliciting information from each of the councils hinged on our ability to get interviews with its key persons: the President and the Registrar. The fact that the Registrar holds an important position in the Council is amply evident from a review

of their duties and functions. Registrars are effectively the real gatekeepers regulating the access of registered practitioners and the lay public to the councils.

However, the task of meeting them and acquainting them with the research under way was not easy and the reason for this is simple enough. They were not always available. This was particularly true of the MSDC where the Registrar remained elusive during six visits over three weeks. Similarly, the Registrar of the MCIM was also not available on two separate occasions. When Registrars were unavailable during the first visit, they were visited again or contacted on the phone. We were, sometimes helped during subsequent visits by secretaries or office clerks who set up appointments for us with the Registrar. This was the case in the MCIM.

The second task of getting appointments with the president and/or vice-president leave alone getting them to talk proved to be a greater challenge than we envisioned. This was the case with the MMC and MNC. At the MMC, the Registrar first gave us an appointment with the vice-president, who usually made a weekly appearance at the office, after making thorough inquiries about the credentials of organisation. When we showed up at the appointed hour, we were politely but firmly put down. Apparently, it was a decision taken in a previous council meeting that none of the office bearers - save the President - would deal with journalists and activists. Unfortunately, the President who resides in Pune was not easy to contact. In the end, he could not be contacted at all.

At the MNC, on the other hand, a mere phone call to the Registrar first gave us the names and phone numbers of the president and vice-president. As it turned out, the President of the MNC was the vice-president of the MMC! When we met him at the MMC, he promised to give us “full co-operation” saying that while he was not at liberty to opine on matters related to the MMC, he would tell us whatever we wanted to know about the MNC. Indeed, he even said that he would show us how a council *should* be run. To get him to back up this boast in any substantial manner was, however, impossible. He first dodged us by claiming to be too busy. After calling up several times, we decided to ignore him and seek information from the Registrar. Again we were stonewalled. In fact, the Registrar, who has always been forthcoming in the past, was unwilling to talk and referred us right back to the President. This game of *Ping-Pong* went on for some time, in the midst of which the Registrar went on leave and the person officiating in his absence said that she was not at liberty to talk. She admitted that she was only acting on the instructions of the President who was expecting some kind of written assurance that we would not “misuse the information” that came our way!! By then, we had neither the time nor the patience to humour their extraordinary requests and so, like the MMC, the MNC allowed us no insights into their functioning.

This convoluted tale is intended to show up these councils for what they are - secretive and defensive and it is in this light that the MMC and the MNC have incriminated themselves by their reticence. This is not altogether surprising when you

consider the fact that in recent times, the MMC has come in for increasing criticism from the press as well as health and consumer activists. Our association with these socially conscious groups did not go unnoticed and the interview that should have come our way was denied to us.

On reflection, the responsiveness of councils to our research agenda appear to bear some relationship to their status. This is why the ones that had little to lose by an interview were more inviting, at times dispensing with some of the usual formalities to accommodate us. That is why the Registrar of the MCIM not only spent a considerable amount of time in conversation but also offered to keep us posted with latest developments. At the MCH too, the President and vice-president who happened to visit the council on the day of our first visit, made time for an interview without prior appointment.

It is obvious that councils - especially the dominant councils - are neither transparent nor readily accessible to the lay public. Information on certain subjects like inquiries conducted in the past and *suo moto* cases is virtually impossible to elicit. Specifics are never divulged; what one is served instead are broad guidelines about the procedures.

#### **Functioning of the state council for Allopathic Practitioners**

Although the councils for allopathic practitioners govern less than half the total number of registered practitioners in the country, they are more dominant than all the other councils put together. Much of the reason for this goes back into colonial history. Yet, the credibility of this body has taken a severe beating in recent times as stories in the mainstream press have focussed increasingly on their apathy and arrogance. These attitudes are visibly apparent when controversies come to the fore.

For example, one of the newspaper reports focused on the fact that the Medical Council of India had failed to examine the ethical aspects of sex determination tests which were responsible for a high rate of female feticide (Katyal 1995: 7). The Central Committee on Sex Determination in fact noted that the need for legislation on the issue of sex determination would, perhaps, not have arisen had the medical councils taken note of this controversy. And taken timely steps to lay down wholesome principles for the guidance of the profession, in keeping with the interests and demands of society (quoted by Ravindra 1995: 13). Similarly, the MMC was reported to have taken no serious note of complaints from elected representatives during the kidney transplantation racket (Marpakwar 1995: 1-3). For all these reasons, fellow professionals and consumer activists feel that the MMC has “lost credibility” (Bal 1995: 8).

In the short discussion that follows, the functioning of the MMC will be described on the basis of secondary information - published letters and filed reports. We are being forced to rely on this method since we do not have the benefit of an interview.

THE COUNCIL ELECTIONS: The MMC, which governs registered allopathic practitioners in Maharashtra, is constituted of the Director of Health Services, the Director of Medical Education and Research, five nominees of the state government (of whom at least four are practitioners), one elected member from each of the universities with medical faculties in the state, one elected representative of the College of Physicians and Surgeons, Bombay and finally, nine elected representatives of all registered members on the rolls. The term of office of this group does not exceed five years.

In 1992, elections to the MMC took place after a gap of 10 years. The process by which, the nine members were elected from among registered practitioners, was closely monitored by the Forum for Medical Ethics. Its report at the end of the exercise was shocking since it brought to light massive rigging and the indifference of the profession itself to the electoral process.

ROLE IN REGISTRATION OF PRACTITIONERS: The MMC has failed to maintain an updated register. The limitation of this was most vividly seen in the case of the last elections. This fact is also noticed in strictly academic ventures. A study to map out health resources in a district in Maharashtra was founded on a number of lists, not least of which were those provided by the medical councils. The experience of the team involved showed that the MMC could offer in 19.. a list compiled way back in 19...

ROLE IN ENFORCING DISCIPLINE AMONG MEMBERS: Much of the insights into the functioning of the MMC has come from the experiences of the Bombay group of the Medico Friend Circle. From this we can conclude that the performance of the councils vis-à-vis disciplining professionals is no better. There have been few instances of doctors being penalised for negligence or for violating the code of ethics. The MMC has been unable to produce a record of action taken against erring doctors, even when forced to do so in the past (Jesani and Nandraj 1994:26).

### **Functioning of the state council for Dentists**

The office of the MSDC is contained within a small room in a complex of offices belonging to the MMC. In the space that is left after all the cupboards have been positioned, the files and papers piled one over the other, there is just enough space for two table, a bench and a few chairs.

The characteristic feature of the council is its size: a staff of two to assist a registrar and a population of 6,505 practitioners, are not what one calls large. Further, unlike other councils, the MSDC is marked by an attitude of boredom, indifference even. The Registrar, who is a retired ex-government employee, is rarely in the office. He has either been summoned by the President (who heads the Department of Orthodontia in the Government College) or simply on leave. The President *never* visits the Council office according to the Registrar and the clerk. Also, council meetings never take place in the office due to the lack of space: large meetings like the annual council meeting or meetings of the Executive Committee are conducted in

the government dental college. This is why the impression that greets a lay visitor is one of inactivity -- a somewhat dispirited council.

When we finally met the elusive registrar, we were pleasantly surprised, by his co-operation and his relatively open attitude. Indeed, the wariness that typifies the other council in the vicinity had not yet set in. This can be explained by the fact that he is a relative newcomer, having been in the council for a mere six months. We also discovered that there were no takers for the post of Registrar due to poor pay scales. Previously, the post was entrusted an employee of the Directorate of Health Services, who was unable to devote much time to council affairs. So a retiring colleague was persuaded to take up the job for the opportunity it gave to *keep busy* (rather than *earn a regular income*).

The MSDC is a fairly impoverished council if the registrar's off-the-record conversation is anything to go by. According to him, the council has an annual budgetary outlay of Rs. 1,00,000 but an annual expenditure of Rs. 1,50,000. Previously a grant from the state government kept the council afloat. Now that the grant has ceased to be, the council whose major source of revenue is registration fees, is required to scrimp so as to regularly pay the salaries to its two employees - a peon and a clerk. Representations to be allowed to increase registration fees to the central council and to the state government have so far been unheeded. As a result, the Registrar is beset with a general feeling of futility and powerlessness.

**ELECTIONS TO THE COUNCIL:** The MSDC is comprised of 13 members including representatives from among registered practitioners, a representative of the Medical Council, three members nominated by the state government and the Chief Minister of the state. The additional members are the heads of dental colleges as ex-officio members. However, much of these provisions are a matter of academic interest since the existing council has been in existence since 1984. An election has not been held since the council lacks the financial backing and since there does not appear to be any of the motivation so necessary to organise one.

**ROLE IN MEDICAL EDUCATION:** The council's role in inspecting medical colleges with a view to accessing its subscription to standards laid down by the Central Council is minimal. Apart from serving as some kind of *via media*, the appointment of inspection teams essentially falls under the purview of the Dental Council of India. At present, the colleges recognised for conducting courses number six. Three of these are government-run - the ones at Nagpur, Aurangabad and Bombay - one is municipal-run - Nair Hospital in Bombay - and two are privately owned and run - V. D. Patel College in Sangli and *Bharatiya Vidya Peeth* in Pune. During our visit to the council, some of the students from a privately run (but so far unrecognised) college in one of the districts of the state visited the Council to find out whether there were any information about the current status of their college. The Registrar referred them to the council in Delhi.



Unlike colleges conducting courses in Ayurveda and Unani, there are no grant-in-aid dental colleges. The Registrar said that it was more viable for non-government initiatives be privately-run since it created room for endowments in the form of donations.

**ROLE IN REGISTRATION OF PRACTITIONERS:** At present, much of the going work of the state council focuses on registering practitioners. The MSDC levies an initial registration fee - a paltry sum of Rs.100 – which, is followed up by an even smaller annual renewal fee of Rs.15. If practitioners fail to pay up, the council dispatches stern warnings along with a late fee charge of Rs.10. The Registrar believes - and rightly so - that these sums are far too small.

Since the council accepts renewal fees annually, the register is updated constantly. The onus of informing the council about migration or death of practitioners lies with the respective practitioners and their families.

Unlike other councils, the MSDC does not have a printed list of practitioner registered with it. The reason is simple - finances. What it does maintain, however, is a file copy with duplicates.

**ROLE IN ENFORCING DISCIPLINE AMONG MEMBERS:** The Council does not have the capacity to actively regulate practitioners. A code of ethics is given to practitioners on registration with the expectation that it will guide them through their careers.

In case of complaints, the Council takes on the task of processing these. Firstly, it is the Registrar who whets the complaint and judges its seriousness in terms of how life threatening it was). The complaint is then passed on to the Executive committee for a wider discussion and then on to the entire council. If it is felt that the case demands it, the council appoints a third person to go into details of the case including the interview of witnesses.

The Registrar does not know the total number of the cases brought up before the Council in the last five years. 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. In any case, the Registrar holds the belief that none of the complaints coming before the Council are serious. This is a subjective opinion given the Registrar relatively recent tenure of service and the unrelated nature of his previous employment. Therefore, how competent the Registrar is (from a technical point of view) to judge each complaint as it comes is a matter of doubt.

### **Functioning of the state council for Indian Systems of Medicine**

The MCIM, which is there to govern the 28,000-odd registered practitioners of what are known as the Indian Systems of Medicine, namely, Ashtang Ayurveda, Siddha, Unani and Tibb is housed on the uppermost floor of one of the early buildings of South Bombay. The council office looks weary with age but exudes a certain charm.

The Registrar says that the offices have not been painted for very long and no one (except himself) seems to be interested in sprucing its appearance.

An experienced, dynamic and politically savvy registrar with a staff of six friendly, responsive and obliging people runs the MCIM. An air of informality pervades despite the presence of “secretaries” and “appointments”. The Council is also characterised by a certain absence of activity - the only people who drop in are the occasional student wishing to get registered and acquaintances of the Registrar asking for favours. It is not always easy to find the Registrar in his office because he is frequently expected to put in an appearance at the *Mantralaya* where the Deputy Secretary, Medical Education is seated.

Of all the councils, the MCIM was the most open and the reason for this could be the fact that it has so little to lose. The council also shared, in my opinion, the greatest willingness to self-regulate.

CONSTITUTION OF THE COUNCIL: The motivation to self-regulate through the facility of a council sounds ironical when you consider the fact that no council exists at the present moment. What existed until 1982 were the Board and Faculty of Ayurvedic and Unani Medicine in accordance with the requirement of the 1961 Act. The former concerned itself with the medical practice of registered practitioners while the latter was focused on the question of medical education. The amendment in 1982 stipulated the dissolution of the Board and Faculty and the institution of a council with 19 members in its place. The council was to have included the Director of Ayurved, five nominees of the state government (of whom two are practitioners of Ashtang Ayurved or Siddha and two are practitioners of Unani or Unani Tibb), nine elected representatives of registered practitioners (five of whose names appear in Part I of the Register and four of whose names appear in Part II), two members elected by the Heads or Principals of recognised institutions from amongst themselves and, finally, two members elected by teachers (other than principles or Heads) of recognised institutions from amongst themselves. Until the formation of such a council, the Administrator was expected to assume and retain all powers. In doing so, the act has legitimised the situation that exists today.

It is 13 years since this radical restructuring and there is still no council in sight, despite periodic representation by the Registrar to the State Government in this regard. What exists instead is the authority of the Administrator even though the persons who have occupied this seat have changed with unfailing regularity.

According to the Act, the Administrator should be the Director of Ayurved, a technical person employed at the Directorate. However, due to a number of political manoeuvrings (which are irrelevant to the present discussion), the post has been handed over to the Deputy Secretary of the Department of Medical Education as an additional responsibility. This is accompanied by the monetary benefit of an augmented monthly wage. Despite this, the current Deputy Secretary and her

predecessors have reportedly not visited the MCIM offices, much less noticed its peeling paint!

The Registrar feels strongly about the necessity of a council. When we met him, he was particularly buoyed with the expectation that the time for such a long-standing demand might have finally come. The reason being that this time it was not he who was raising the demand, but a group of agitating students and teachers who felt threatened by an impending government decision to bring a group of students of “electro-pathology”, who had so far been denied registration under homeopathic and allopathic councils, under the umbrella of the MCIM. There were serious doubts about the scientific rational kernel of the system and of its legitimacy as a separate “system” of medicine. The Registrar was absolutely against the inclusion of students of electro-pathology even as the government seemed bent on legitimising the course in these privately funded and run colleges. Here the absence of autonomous council was being felt deeply.

**ROLE IN MEDICAL EDUCATION:** There are at present in government colleges, 14 aided colleges and 17 unaided colleges for the teaching of ayurveda. The number of Unani colleges, are four, of which three are aided and one unaided. The number of non-aided colleges, have been increasing at an alarming rate in the recent past. It is from the point of view of these private colleges that the absence of the council is ‘godsend’. These colleges with reportedly non-existent facilities get recognition through their connections with politicians. According to the Registrar, these elected representatives instruct the Deputy Secretary to “inspect the college and come back with a favourable report.” Since the Deputy Secretary is a state government employee s/he cannot but oblige. Thus, the absence of a medical council gives a boost to the politician-private college nexus which, in turn, results in the production of practitioners with indifferent training.

Given his redundant role in the process of recognising medical institutions and universities, such information does not routinely come the Registrar’s way and he does not really bother to seek updates from the state secretariat. So the activists currently undertaken by the MCIM is focused exclusively on registration of new graduates and maintenance of the register.

Thirdly, there is no authority to counter the state government under whose control they have fallen and lastly, there is no scope for reforms within the existing structure of the profession.

**REGISTRATION OF MEMBERS:** Member practitioners pay a one-time registration fee of Rs.500. This absence of the concept of renewals saves the Registrar and his staff much of the drudgery that beset the activity of registration in other councils. In fact, the Registrar for precisely this reason initiated this practice. However, every five years the register is updated through the mechanism of a mailed questionnaire.

Details in the intervening years are identified in the process. Migrants from other states are expected to register themselves with the MCIM. The registration of practitioners who formally apply for a transfer from another state is deferred until the Registrar receives a written reply to his query from his counterpart there.

In order to safeguard against forgery, the Registrar takes care to sign certificates with a special pen, which is not widely available.

Like all the other acts, the Maharashtra Medical Practitioners Act of 1961 provides the state council with no powers over unqualified practitioners. However, around 1985, the Registrar had mooted the idea of vigilance committees in a decentralised fashion - to identify and report such practitioners. These committees were constituted of nominated members like local practitioners, etc. However, the idea did not last beyond two months for a number of operational reasons.

**ROLE IN DISCIPLINING MEMBERS:** The MCIM plays no role in disciplining members and this is not really surprising given the fact that no council exists at the present moment. With the non-existence of a state council, a vital avenue for redress in the event of medical malpractice has ceased to be. According to the Registrar, the number of complaints have, drastically declined due to the absence of a council. As a result, during the last five years, only two complaints were lodged.

#### **Functioning of the council for Practitioners of Homeopathy**

The MCH has a staff of more than 10 persons in various clerical positions and bustles with bureaucratic formalities. Peons and clerks walk in and out of rooms delivering and collecting files. The Registrar functions behind a closed door. Your arrival is announced before hand by a peon. The languages spoken predominantly are Hindi and Marathi unlike the other councils, which entertain English.

The information presented here was gathered during the course of a single day. A visit in the morning to drop off an introductory letter and seek an appointment with the President revealed that the President and vice-president, who reside outside Bombay, were due to visit the Council later that day. So waiting for four to five hours seemed to be only thing to do.

During that time, the Registrar did not personally attend to even one of the queries that had been put up in the letter. Instead, he directed me to one of the office clerks for whatever clarifications I might need. This gentleman provided only the most perfunctory of responses. "As per the rules" seemed to be his patent line even though we were not given the opportunity to learn what these rules might be. A request for copies of official publications was first treated positively. However, the Registrar who maintained that they did not have copies of all publications and it was not possible for them or us to have them photocopied, later turned this down. They did, however, have copies of the syllabus and Minimum Standards of Education Regulations, 1983, both Central Council Publications, which they sold at twice the printed cost.

By contrast, the President and vice-president who were not expecting to be interviewed were amenable and the brief interview that took place was before an audience of five Principals of Colleges in the State. The group appeared to adopt a paternalistic attitude towards the interview and interviewer. By the time, the interview took place, it was close to 5.30 p.m., some six hours after my arrival in the morning and a general feeling of weariness from spending time doing nothing marred what could have been a good interview.

**CONSTITUTION OF THE COUNCIL:** The Council consisting of 11 members was constituted as recently as 1992. According to the Bombay Homeopathic Practitioners Act of 1959, these members should comprise of the Deputy Director of Homeopathy (in an ex-officio capacity), four state government nominees with special or practical knowledge of Homeopathy, three elected representatives from among registered practitioners, one member elected by the Principals or Heads of recognised homeopathic institutions, two members elected by teachers in recognised institutions (other than the Heads or Principals). The term of office is to be five years.

Before 1992, an Administrator took on the responsibility of running the council. The President and vice-president do not reside and practice in Bombay (in fact, only two members are residents of Bombay). They visit the office once a month.

**ROLE IN MEDICAL EDUCATION:** At present, the Council's role in regulating medical education consists of inspections to ascertain that minimum standards as laid down by the Central Council are met. The President and vice-president believe that they are not faced with the problem of other councils like the allopathic or ayurvedic councils in that privately-run colleges provide dubious courses. They do not appear to see any extraordinary problem in the matter of medical education beyond what can be addressed by procedures enlisted in the Act.

**ROLE IN DISCIPLINING MEMBERS:** According to the President and vice-president, an average number of five to six complaints get lodged a year. The Council reviews them and refer them to the police as they deem fit. The Council cannot control medical practice in anything but a passive manner.

The heads of the Council endorse cross practice and feel that the Act should make provisions to that effect. The justification that they offer is compelling in some ways. According to them, since the proportion of homeopaths in rural areas far exceeds the proportion of allopaths, since they are often the only practitioners for miles around, it is better that to allow homeopaths to provide some level of primary care instead of being sticklers and turning patients away.

However, the Council feels that their proposed amendments are not taken seriously. Only two out of 28 amendments submitted over the years have been accepted. One long standing demand is for legitimacy for cross practice. The President and vice-

president also feel that there should be one Council. According to them, the basic training in all the systems of medicine is virtually the same save the aspect of therapeutics. Therefore, there should be one kind of training for all medical practitioners with specialisation in homeopathy, allopathy or Indian systems of medicine.

### **Concluding Note**

Medical councils and the legislation under which they are constituted cover only those practitioners who are part of the organised profession by virtue of their registration. 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. For although practitioners without medical training or legitimate degrees could be dragged into criminal suits, such a phenomenon occurs rarely or not at all.

Even registered practitioners are all but officially cast out of the regulatory mechanism of the councils. Mostly, this regulation is passive. There appears to be no evidence of suo moto inquiries and the major form of disciplining is in response to written complaints. Even if complaints are put through the orchestrations of full-fledged inquiries, 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 of the profession than as regulatory bodies which enforce some social accountability in the profession. Some activists have labelled them as “irresponsible trade unions” whose self-interest overrides public interest (Ravindra 1995: 13). Other reporters wager that they (especially the MMC) have become “virtually defunct” (Marpakwar 1995: 1-3).

Perhaps the councils can take consolation from the fact that this critique does not apply to them alone. The General Medical Council (GMC) which grew out of the Medical Act of 1858 in the U.K. has been similarly indicted. A doctoral dissertation, published as a book, examines the GMC's performance from its inception in 1858 until as recently as 1990 (Smith 1994). This is a monumental study enabled by whatever transparency exists and the availability of data. Despite that, the author states in his introduction, the task was no mean one. He was denied access to the non-public activities of the council for a good deal of its activities are carried on in private like the preliminary screening of cases, the operation of health jurisdiction and the quasi-disciplinary jurisdiction of the Overseas Committee and Registration Committee. As a result, the study is based on the public sittings of the disciplinary committee and the material reported in the GMC's minutes as well as the medical and lay press (*ibid*: 17). So the secrecy surrounding the medical councils in India, which are in every way patterned on the GMC, is not unusual.

While the GMC has some transparency, the minutes of council meetings in India are kept in strict confidence. So too are the proceedings of inquiries. This wilfully

precludes the possibility of a more in-depth study of the functioning of councils. This is why a study like the one in the U.K. is of great value. According to the study, between November 23, 1858 and December 31, 1990, the number of individual practitioners who were involved in public disciplinary proceedings conducted by the council was 2015 while the number of charges that were dealt with was 2316 (ibid: 97). So for a time period spanning 132 years, an average of 15 doctors were tried on disciplinary charges every year. Alcohol offences constituted 13.44% of 2849 cases indexed from the GMC documents. Sexual offences constituted 12.14%, financial offences 11.58%, certification 9.62%, drug offences 9.9%, neglect 7.79%, attracting patients 8.7%, unregistered practice 6.74%, covering/delegation 5.41%, abortion 3.55%, drug prescription 3.12%, offences against the person 3.33%, un-stated/other 2.81%, false registration 1.02%, lastly, breach of confidence/consent 0.85%. Interestingly, the charges against nearly one-fourth (specifically 22.5%) of the 2849 cases tried in public by the GMC were not proved, while the rest were penalised.

An analysis of all the complaints filed in one year shows that out of 949 complaints received by the GMC, only 147 (ie.15.5%) complaints were sent to the Preliminary Proceedings Committee (PPC). The PPC scrutinises complaints in private and on declaring them suitable for a full public hearing, refers them to the Professional Conduct Committee. In contrast, most cases were either awaiting screening (218 cases or 22.75%), were referred to the NHS (168 or 17.7%), were let off without action (355 or 37.4%), were withdrawn (10 or 1.05%) or disposed off with a letter of advice (51 or 5.37%). Thus, only a small proportion of complaints, are actually heard in public and practitioners were protected from a great deal of adverse publicity.

## CONCLUSIONS AND RECOMMENDATIONS

### **Professional Vs Community model:**

Before we conclude on the manner in which the medical and nursing professions are functioning and the way they should be revitalised, we need to perhaps discuss the issue of professionalisation. The tendency to rely on trained professionals to build up the health system of the country has periodically been questioned by people who subscribe to the community health approach. Indeed, the “professional model” which guided the planning process until the 1970s, was replaced by what authors like Maru (1985) term the “populist model”. The thinking at the time was that lay individuals could be trained to take on certain of the medical interventions that are under the control of professionals. The committees constituted in 1974 and 1975 - the Kartar Singh and Srivastava Committees - must have taken cognisance of the “success” of several of the experiments of voluntary organisations with community workers. A health system comprised of professional and para-professional workers (Auxiliary nurses or Female health workers, Male health workers and Village health guides) was designed for rural areas with graded spheres of competence. This strategy has also been considered an affordable cheap option for an underdeveloped country like ours. It was and is assumed that the professionals necessarily mystify health information to maintain their control over medical practice and power over patients. Demystification of medicine and de-professionalisation, therefore, constitute an essential strategy for placing “health in people’s hands” and to build a culturally suitable and financially affordable health care services in any underdeveloped country. The talent of professionals is, of course, to be conserved by divesting them of the more simpler and routine tasks (e.g. First aid, immunisation, primary curative care, etc.).

There is basically nothing wrong in having a system, which has an appropriate combination of professional and paraprofessional workers. It appears to be not simply “populist” but also practically attractive for an underdeveloped country, and at a philosophical plane, by emphasising de-professionalisation and putting health care in “people’s hand” is very attractive proposition. However, this attractive strategy has many pitfalls at practical level, some of them have strong ethical dimension.

It is always nice to feel that health would be in people’s hand and that the professionals would be divested of simpler and routine health care tasks. But articulation of such ideas without bringing public and private sector under uniform purview of a national plan aimed at universal and equitable access to health care would inevitably mean leaving the professional and private sectors untouched and unregulated. An isolated emphasis on community approach only obscures the need for reform in the *entire* health care sector. If the community approach is applied and considered valid only for the public and voluntary sectors, it by default or design allows the professionals to flourish without self-regulation as well as external control.



In the market economy, such isolated emphasis on the community health fails to generate genuine demand for the services of community health workers, preserves privileges of the professionals and ironically, instead of making health care cheap and affordable, increases the overall cost of health care. This has been the actual outcome the last quarter century's orientation to community health, not only in India, but in most of the countries which tried to implement it only in the public and a part of the voluntary sectors.

The health care sector in India, though underdeveloped in comparison to the developed countries, is not as underdeveloped for our modest needs as it is made out to be. The argument of underdevelopment is absolutely justified when made for the size and utilisation of health care in public sector and for the proportion of health care expenditure financed by the state. But when the health care sector is considered in totality, one finds it to be reasonably developed to meet all basic health care needs of people.

Simply put, if one only counts PHCs, sub-centres, CHCs, doctors and paramedics in the government sector, etc, then the health care sector is indeed very poorly developed. However, when one also adds the health care facilities and human power available in the *private sector*, the count seems to increase *five fold*. Similarly, when one narrowly looks at the allopathic doctors only, the doctor population ratio appears to be shamefully low. But when the exercise is carried out, by counting properly qualified doctors of all systems of medicine, the ratio comes down three-fold. Lastly, the health care expenditure of the country is not one percent of GNP that government alone spends, but with the inclusion of what people spend from their pockets (private health care expenditure), it jumps to five to six percent of GNP.

In essence though we do not have great abundance of health care resources (like developed countries which waste more than use), it is still abundant enough to provide for *basic minimum health care* needs of our people. And also abundant enough to provide for rational super-specialist tertiary care to those who medically need it. Just as in the modern world with abundance of resources the hunger is intolerable and its persistence is not only a political but also an ethical issue; the lack of access to *basic minimum health care* for a vast majority of our people is intolerable both politically and ethically. A health policy, which does not quantify *basic minimum health care* that could universally be made available to all and does not give it as a justiciable right, violates the fundamental principles of medical and health care ethics.

How does one place the NGO experiments at de-professionalised, demystified and cheap health care in the framework of ethics? Simply put, the voluntary work is voluntary initiative to meet an immediate situation. It has dual strength. Firstly by making real and practical provision of health care, it gives entitlement to primary health care to the people the NGO serve. The NGO by no stretch of imagination can provide people the right to the primary health care delivered by it, though. Secondly,

its experiments in de-professionalisation and demystification are extremely useful not only as futuristic exploration but also, at practical and political level, for empowering people at micro level to have rational information on health and to have more power vis-à-vis health care providers.

Having said this, there are some issues, which should make the NGOs uneasy at ethical plane. The NGOs have somehow popularised the village health worker more than the quality and efficiency of their referral health care centre. As a consequence, at the health policy level, the struggle is waged more for the continuance of village health workers rather than reorganising and upgrading the rural referral support system. Thus, essentially at the advocacy level, the NGOs have under-emphasised the issue of redistributing health care institutions and professional human power. What is ironic is that there is hardly any genuinely successful village health experiment with as inefficient and resource deprived sub-centres, PHCs and CHCs as they exist in our country. In the absence of such successful experiments, there is no political and ethical justification for keeping the spotlight on the village health workers.

Further, the demand for a community health worker for 1000 population has certain problems from political and ethical correctness. We have about a million properly qualified registered doctors of all systems of medicine and additional quarter to half million unqualified but practicing doctors in the country. That defines a ratio of one doctor for eight to nine hundred persons. Then, is it ethical only to demand one community health worker for 1000 people, primarily for rural areas, and not to make as strong, if not stronger, demand of one doctor for 1000 people or one doctor for every sub-centre? More so when the strongest advocates of community health workers have been doctors who have chosen to work among or focus on the rural people.

Another ethical problem at advocacy level relates to the status of nurses. We all know that the number of qualified nurses is shamefully low, so much so that an overwhelming number of private hospitals and nursing homes do not employ any qualified nurse, and the doctor nurse ratio is not only inverted, but much more than inverted. There hasn't been strong and consistent demand from the voluntary sector and community health advocates on this issue.

The ethical issues raised for the NGOs are obviously as well applicable to the health policy in general. If we have given any impression that we do not appreciate the usefulness and conceptually higher standing of community health workers, let us dispel it again, for we are highly appreciative and supportive of that move. But in the modern health care system, it is essential that they have adequate professional support in order to succeed. Losing sight of this need makes the community health workers not only a self-defeating or temporary exercise, but also leaves out the task of essential reforms in the professional health workers from the policy framework.

Before we move to other issues, it is necessary to say that some place or status should be found for community and para-professional health workers. Are ethics only for professionalised doctors, dentists and nurses? Or, are they also for community health workers and other para-professionals (e.g. male multi purpose workers)? If so, what are they and how are they exercised? Since these paraprofessionals are for all practical purposes supposed to work as primary health care providers, their framework of ethics need to be formulated. Their ethics cannot be left to the government and NGOs, the former forcing them to insert IUDs without properly selecting cases simply because the target pressure is too intense, and the latter expecting them to undertake more and more skilled health care work.

Between the ANM (female health workers) and male multipurpose workers (male health workers) in the PHC/sub-centre system, the dichotomy is glaring. Firstly, when by training, qualification and work-wise both workers are similar, there is no justification for the ANMs to be part of the nursing cadre (hence registered with nursing council) and the male workers not a part of any such cadre. There appears to be a highly sexist undertone in this arrangement, that male workers cannot be part of the nursing cadre but being female paramedics, the ANMs are appropriate to be nurses. Secondly, being part of the nursing councils, the ANMs are governed by the code of nursing ethics, but for male workers at the same level, there is no code!

Does the community approach envisage real progressive upgradation of education and skills of paraprofessionals like community health workers and *dais*? We believe it does. In that case, how far is it ethically justified, to envisage future as static, and thus they always remain what they are? In other words, isn't it necessary that these paraprofessionals are formally accepted as a part of health care delivery system, and thus registered in their own right with their own code of ethics governing their conduct?

### **Professional self-regulation**

Once we accept that the health care professionals are here to stay, they are in large quantity and they are needed for health care services then; irrespective of whether we adopt and implement an exclusively community model, an exclusively Western professional model or a mix of both, we have no choice at the policy level but to pay serious attention to them. Only condemning or ignoring them, as our policy documents and others have often done will take us nowhere. On the contrary, the last quarter of century of keeping them away from the purview of health policy has damaged anything progressive in those policies. In fact, unless the professionals are, through a well planned democratic strategy, provided a place they rationally deserve in the health care and at the same time made to conform to the needs of regulations, no good policy is likely to succeed.

Our experience and research clearly show that the professional self-regulatory bodies of medical (all systems), dental and nursing professions do not self-regulate these professionals, even within the framework of their own ethical codes. Worst still, after interacting with them it is clear that the present leadership of the health care

professionals have no interest or incentive to self-regulate themselves. In conclusion, the questions we have to answer are: (1) who and what factors, are responsible for this state of affairs?, (2) is there a possible strategy for reforming these professionals?, (3) or else, is the professional self-regulation neither desirable nor feasible in the present situation? We will make an attempt to answer these questions (not in the same order) and develop a framework for recommendations.

### **Weeding out unqualified practitioners:**

The laws which legitimise the monopoly status of properly qualified professionals of all system and all variety, invariably say that unless one has registration with the relevant council, one is not allowed to practice that branch of medical system. To practice without registration is, therefore, a legal offence and invites serious penalty. And in order to get registration, there is an absolute need to have qualification as prescribed by the councils.

Yet, it is well known that the unqualified and unregistered professionals do practice in our country. And their number is not insignificant. Similarly, in the strange absence of any medical law regulating the qualification of staff, minimum physical standards and minimum quality of care in the private sector health care institutions, a large number of unqualified and unregistered women are employed as nurses. Their estimated number would be anywhere between one lakh to a quarter million. While, of late, due to increasing competition in the medical market, there is some hue and cry being published in the media about such doctors and the government is coming under pressure to identify them and to weed them out, there is hardly even a murmur about such nurses, more so from the doctors who are responsible for employing unqualified and unregistered nurses. This is a double standard applied by doctors, and it also puts the doctors in the bad light of morality and ethics.

At policy level the pertinent ethical point is, are we ethically justified in stopping all those unqualified and unregistered doctors and nurses from pursuing their occupation? No doubt their practice does constitute a public health danger and it is duty of the government to look after the safety of people. However, there is another side of the story. A big proportion of such unqualified and unregistered doctors, practise in the under-served rural areas about nurses, as we explained, there is a real dearth of qualified and registered nurses. When our laws do not put any limit or regulation on where doctors could locate their practice and the policy makers are unconcerned about training enough number of nurses or retraining the practising but untrained nurses, is it ethically correct to stop such people from practising and thus, taking away the minimum little service, perhaps albeit substandard, that our under-served people are getting? Secondly, in the absence of any well organised continuing medical, dental and nursing education programme, the renewal of registration with council being a ritualistic formality (not tagged to the quantum of continuing education credit), and the presence of tolerated but rampant cross system and irrational medical practices, a significant proportion of properly qualified and registered professionals themselves pose some health risk for patients. Thus, if ethics

demand that we should use our yardstick uniformly, there is a real dilemma in actually implementing what our laws for professionals stipulate.

The conclusion and recommendations from the discussion on this subject are obvious. They may be specified as follows:

(1) The presence of unqualified and unregistered medical practitioners in the situation of abundantly available registered practitioners is highly unethical. However, to stop the unregistered one from practising without making available better replacement would only compound the ethical dilemma.

(2) The way out from this dilemma, at the level of democratic self-regulatory body of professionals, the Medical Councils, is to put reasonable democratic restrictions and regulations on the location of doctors' medical practice. They are indeed not undemocratic as such restrictions have been exercised in many other fields. Thus, for location of medical practice, the district if not the block or tehsil, should be the geographic registration unit, and the total number of doctors who can practice in that geographic location should be based on a desirable doctor patient ratio. This physical location method should be supplemented by incentives for locating the practice in the rural areas and disincentives for doing so in the urban areas within the given geographic unit. If this measure for redistributing doctors sound too bureaucratic and inviting direct control, one may still provide enabling right to doctors to locate their practice even in the already saturated geographic unit, but at a higher, flat and direct tax rate, the collection of which could supplement the health budget. This concession would not completely "take away" doctors right of locating practice in the place of their choice even after the area has the stipulated number of doctors, but in doing so they would be harming the larger societal interest for which they would regularly pay substantially high amount of tax as a compensation to the health care budget.

(3) For the nursing professionals, the problem is different. Undoubtedly their number is far less than required, and the ethical dilemma is related to their less number. A continuation of this situation is indeed forcing the medical providers and institutions to resort to unethical acts of employing unqualified nurses. This situation must be remedied. There are two ways, both can be implemented simultaneously: (a) Women who are working for a specified (say 3 or 5 years) as nurses in the hospitals or nursing homes and have acquired skills in the process, could be asked, within a specified period, to take a very short training for working as auxiliary nurse in the nursing home and on successful completion of the training, provided registration. This would ensure that these super-exploited women are not made jobless, and they will be able to assert themselves as trained personnel to demand better wages and working conditions. (b) The second method is conventional one, of increasing number of nursing schools and colleges and the intake of females and males for nursing training.

(4) The male health workers in the PHC network should also be made eligible to get registration with the nursing councils.

(5) The absence of organised continuing education programme not tagged to renewal of registration is a surest way of lowering competency and ethical standards of all professionals. Thus, a minimum amount of continuing education credit for renewal must be made compulsory. The education on ethics must also be made inseparable part of such programme and credits. For its organisation, a large number of institutions across the country (the IMA must not have monopoly over it) must be accredited by the councils, and their training standards must be supervised with the same rigour as the standards of the medical colleges. Such efforts could be financed by the fees charged from participants of the sessions of continuing education and if necessary, supplemented by the government or the councils.

(7) The government and the NGOs need to combine their efforts to provide respectability and formal status to the paramedical professionals such as *dais*, community health workers and any others. Two measures need discussion: (a) to formulate their ethical standards, and (b) to register them as paraprofessionals. Both suggestions are controversial and debatable. However, at the same time it is ethically undesirable to keep these workers floating in the legal and ethical vacuum.

#### **Functioning of the Councils**

The ultimate responsibility of the malfunctioning or non-functioning of our professional self-regulatory bodies, the councils, is of course of the professionals themselves. If ethics demand that the professions should self-regulate, by being so callous and indifferent to the functioning of these self-regulatory bodies the professionals have violated the promise given to the society for self-regulation, and hence their own ethics. Significantly, while the professionals in India have made a bigger mess of their self-regulation and ethics, the professionals elsewhere have also created their own mess of self-regulation and ethics. The finding of this basic uniformity in the limits up to which the profession could, or are interested in self-regulating themselves could also make one conclude that given the vested interest of the professionals in escaping societal regulations in the name of self-regulation, it would be better to do away with the self-regulation altogether. This would, of course, be going from one extreme to another, and in relation to health care, such extremes may not be as useful. The experiences in other countries where professional autonomy and self-regulations were completely abolished are not so encouraging.

In any case, the present councils are only partially autonomous. In the national and state level professional councils, there is a significant presence of and control by government bureaucrats sitting as *ex officio* members and others as nominated members. Thus, with its presence in the councils, the government cannot absolve itself of partial responsibility for the failure of self-regulation. Interestingly, in last so many decades of their participation in the councils, there are very few instances of the government representatives and nominees ever asserting their presence to put the house of councils in order. On the other hand, there are also instances when the government policies have actually acted as measures for commercialisation of

medical education. The case of establishing private medical colleges, often with the participation of prominent politicians and the bureaucrats either turning blind eye or even helping in the process, are well known. Interestingly, a section of medical professionals have strongly opposed establishment of private medical colleges, so much so that the resident doctors have resorted to the extreme measures of strike. It has also happened that the medical councils have resisted such moves, refused to recognise such colleges, but at the end given in to the governmental, politician's and bureaucratic pressure.

Further, the councils are heavily dependent on the government to finance its work. The successive governments have taken no measures to increase the revenue of councils either by increasing registration and renewal fees, or the fines charged from defaulting members. Additionally, the registrars of these councils are government appointees, and one visit to council would make it clear that since most of the council members are practicing doctors and never present on daily basis at the council office, the registrar wields great power over its functioning.

Thus, the best way would be either to make the council completely autonomous by withdrawing all ex officio members and government nominees, or if they are going to be there, then to use strict guidelines for the selection of nominated members. Just as the courts have asked the government to make public its guidelines and if there is none, then to formulate one, for the national titles awarded by it, similarly it is time for us to demand detailed guidelines for the selection of nominated members. These guidelines must be publicly debated before they are adopted and they should be strictly adhered to.

As mentioned earlier, it is absolutely essential that the councils are made financially autonomous, and its staff not appointed by the government. The other changes needed include:

*(a) Democratisation of professional councils and transparency in their work:* The best way to make the self-regulation successful is to make the functioning of the councils transparent and democratic. However, it is indeed unfortunate that the transparency in the functioning of medical council is not achieved even in the developed countries. That is the reason why there is a real dearth of studies on the functioning of medical councils all over the world. The work of councils is shrouded in mystery, the minutes of its meetings are not made public and much of the disciplinary proceedings are not open to other registered doctors, let alone the public. In such a situation, there is neither genuine democracy possible nor the self-regulation. That is also one of the reasons why critics often found self-regulation only an euphemism for undemocratic monopoly control. We feel that the work of councils should be made completely open to the public and professional scrutiny.

The elections to the councils need to be properly streamlined. The present system of postal ballot has invariably led to corruption and electoral malpractice. There is a need to either plug the loopholes in the postal ballot system or to adopt the secret ballot system at the district level.

*(b) Rights of people/patients in the self-regulatory framework:* In the professional councils, patients or people come into the picture only as complainants against doctors for the professional misconduct. There too they are completely at the mercy of the professionals sitting in the council to get a semblance of justice. Thus, increasing proportion of lay people in the council (at least 25% of all members) is absolutely essential. As in the case of nominated doctors to the council, the guidelines for selecting such nominated members must be drawn up, publicly discussed, adopted and adhered to. The unethical conduct, the chief realm of council's disciplinary work, does not need medical acumen to judge. The unethical conduct is a codified social and medical behavioural issue, less of a technical medical issue. Hence, the lay members as well as doctor members should judge the complaints of patients on unethical conduct equally.

*(c) Inter-professional controls:* This is a serious issue when we look at the nursing councils. The control of doctors, besides bureaucrats and others, is so tight over the nursing councils that the nurses have hardly any autonomy. This is basically against the principle of self-regulation. This control of non-nursing people over the nursing council must be abolished forthwith. The rest of the issues, elections, presence of lay members should be in line with the recommendations made for the medical councils.

*(d) Changes in registration and decentralisation of certain functions:* There is enough evidence to show that the registers of professionals are very badly maintained, the weeding out of members who died, migrated etc has not been properly done. This needs immediate correction. Especially about the members dying, there must be a proper reporting system to the councils. Secondly, the state as a geographical unit for the council is too large to be amenable to the common people. Even if the state as a unit is persisted with, the district or region level arrangement needs to be made for registration, changes in address etc and for filing complaints and disciplinary procedure. Presently, the patients from the distant parts of the state are hardly in a position to fight their complaints in the medical councils.

*(e) Strengthening of disciplinary functions:* The councils must be duty bound to complete action on the complaints within a specified time limit. All complaints must be fully heard in public.

Of course, this is not an exhaustive list of recommendations. However, they would be useful for making a beginning for improving self-regulation.





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