

‘I strongly believe in the need for PCPNDT and the safe abortion activists to come together’



Dr. Amar Jesani is one of the founders of the Forum for Medical Ethics Society and had initiated the Indian Journal of Medical Ethics. He is an independent consultant, researcher and teacher in bioethics and public health. Girls Count had a tête-à-tête with him on gender-biased sex selection, medical ethics and the regulations. Excerpts:

Girls Count: What has been your experience in fighting against gender-biased sex selection?

Dr. Amar Jesani (Dr. Jesani): I have been involved in the campaign against gender bias in medical practice and healthcare in general and the campaign against pre-conception and ante-natal sex determination of foetus in particular for more than three decades now. My experience says that healthcare is not immune from gender bias; it is strongly influenced by patriarchal norms from outside and the entrenched gender roles and norms from within.

The role played by healthcare system in sex determination is only one manifestation of the gender bias, and it is more in debate due to its overt overlap with the other extreme biases against girls and women in society such as violence against girls and women, female infanticide, neglect of girl child, dowry and wife burning/killing, etc. There are other manifestations too, which are equally bad, such as unnecessary hysterectomies, denial of abortion rights to women, callousness in the provision of contraception—its worst manifestation was seen recently with the death of women in a camp for tubectomies; and so on. Although the health system has a large number of women workforce—nurses, ANMs, ASHAs, angandwadi workers as well as doctors—gender bias is still continuing in the healthcare system.

Girls Count: How do you see the role of ethics in medical profession and sex selection?

Dr. Jesani: Ethics is important in all walks of life and in all professions. The issue of ethics came to the fore

in our profession simply because medical professionals are relatively in a more powerful position compared to their clients. This is primarily because of their specialised knowledge and skills and control over the services; and also because of the needs and vulnerabilities of the clients/users/patients. This situation gets accentuated in healthcare because the patients are often unwell and in dire need of curatives. They are not able to take informed decision about the best medical solution for themselves. As a consequence, they often delegate decision-making to the providers, who, if not free from the influence of for-profit industry, have the potential to exploit and harm. This is an important reason why unnecessary investigations, medications and surgeries fuel the supplier induced demand, which is not in the interest of patients and is unfair.

The ethics or realisation of the ethics could help both in policy and law making. Further providers will refrain from alliances with the for-profit industry, and give the best interest of the users of the services the exclusive priority. The legal regulation on sex determination, therefore, emerged from the need to translate ethics and human rights of non-discrimination into a law, and thus give an unambiguous message from the society to the healthcare system and professionals that “gender discrimination is unethical”.

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Girls Count: The Medical Council of India (MCI) has a prescribed written code of ethics. But it has not taken cognizance of malpractices like sex selection. Why is it so?

Dr. Jesani: The statement that the MCI has not taken cognizance of unethical sex determination is not true. What can be argued, however, is that the MCI was very late in taking cognizance? In 1984 when the movement against sex determination and pre-selection started in India, the activists had approached the Maharashtra Medical Council (MMC) to declare it unethical. But the MMC, and also the MCI at that time did not do anything. Even when the Maharashtra Act was passed in 1989 and the national Act in 1994, the MCI still did not strongly send out a message that it was unethical. However in 2002, when the MCI's Code of Medical Ethics Regulation was revamped, MCI unambiguously declared it as a malpractice. Section 1.9 listed the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act in the list of laws they cannot evade; and in Section 7.6 declared it as a professional misconduct.

However, delay in implementation like it was seen in the case of the PCPNDT Act, is a problem. There are at least two important reasons for delay in implementation of the Code of Medical Ethics. First, ethics in medical education and practice, and healthcare in general, are grossly neglected. The private control, profit-oriented market and powers of the healthcare industry over the profession and the system have rendered the observance of medical ethics the least priority. Besides, there are credible allegations against the MCI and the state Medical Councils that they are controlled by the vested interest groups, their elections are routinely rigged and there is rampant corruption. So unless the regulators are reformed, there is little hope for the implementation of the ethics. This scenario is in some ways similar to the scenario in the regulatory system for the PCPNDT Act.

Second, due to the intervention and pressure from the PCPNDT activists, in some places, the implementation of those regulations has improved. But the PCPNDT activists did not give serious notice to the Medical Councils for building pressure for the implementation

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of the Code of Medical Ethics, 2002. Wherever some efforts are made, we find that the Councils were forced to respond and take some action, howsoever inadequate they may be. So there is a need for the activists to use the regulatory platform of the Medical Councils in addition to the PCPNT regulatory framework.

Girls Count: As far as sex selection is concerned, “loyalty” towards the co-professionals is getting confused with loyalty towards the profession. What is your opinion?

Dr. Jesani: The loyalty to co-professionals is a phenomenon found in almost all professions, albeit it is visible more clearly and perniciously in the medical profession in India. And it is visible not only in the sex determination issue, but also in all aspects of unethical practices and malpractices. For instance, the patients or his/her relatives would find it difficult or almost impossible to get doctors to testify as independent expert witnesses in the courts or in regulatory proceedings. That means there is unhealthy solidarity within the profession, and it is being reinforced by the way the healthcare system is structured in India.

The Medical Council, like other professional Councils or bodies, is structured around the concept of professional self-regulations, in which the doctors elected and appointed to the Council regulate the profession. Thus, the Council combines the role of maintaining the quality of practitioners with the role of disciplining the professionals violating professional ethics. In the context of unhealthy professional solidarity such a combination of roles has been found to be inadequate. That was the reason why the General Medical Council (GMC) of the UK, on which model the MCI was shaped in India both during colonial times and post-independence days, was forced to separate the disciplining role from it and hand it over to the Medical Practitioners Tribunal Service (MPTS) headed by a legal expert and the committee of doctors and non-doctors.

From the experience of so many decades of the functioning of Medical Councils in India, it is clear that the disciplinary arm of the Councils need to be headed by non-doctors and the committee should have non-doctor members, who are more sensitive to the complaints of the patients. This is a reform that the activists need to spearhead in the future. Unless something like that is brought in, the current situation in the best scenario may at the most improve a bit, but the problems will remain.

Girls Count: Rather than being PCPNDT compliant, service providers choose to take the other route of refusing or not providing anomaly scans and legal abortion services. Do you think this stand is a tactics to avoid the pressure to curb sex selection practices?

Dr. Jesani: Those in position of power do not like to be regulated in any way in India. So when regulations are brought in under public pressure, there are efforts to discredit those. Denial of services rather than compliance to regulation is the method used for discrediting regulations everywhere, and it is also being seen in the medical profession; though the consequences of such denial could be extremely harmful to the patients. Not only that, even the regulators often work in tandem with the regulated, and they deliberately use the regulatory power to falsely harass those who are ethical and committed to patient care. This only adds to the disgrace of regulations.

On the issue of the legal abortion services, I strongly believe that the PCPNDT activists are to be blamed. The fight against the gender discretionary use of sex determination was used by some PCPNDT activists to generally discredit the abortion services. They often gave out messages which termed all abortions as “killings” and “murders”, thus playing in the hands of the moral brigade of the society opposing the abortions. The use of term like, “foeticide” was problematic. And so were images that conveyed similar meanings. Their misguided advocacy forced such terms into the policy and legal documents too. Involving religious groups when most of the religions of the world do not support women the right to abort was another misguided advocacy. As a consequence, one right of women (discriminatory sex determination) was inadvertently juxtaposed against another right of women (the right to abortion), thus leading to schism between the PCPNDT activists and the activists fighting for safe abortion services. The vested interests groups in the profession used this situation to their advantage.

I, therefore, strongly believe that there is a need for PCPNDT and the safe abortion activists to come together and devise joint strategies for their work, and ensure that they strengthen the movement for women’s empowerment; and do not work at the cross-purpose to

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give space or excuses to vested interests in denying any reproductive right to women.

Girls Count: How can we develop service providers as stakeholders on the issue of sex selection and how best we can communicate on this issue with them?

Dr. Jesani: This is another important issue which has been neglected in this movement. While the dominant representatives of the medical profession have often protected the current state of affairs, the profession is not made up of only unethical doctors. In fact, a large number of doctors like to practice ethically, provided the society ensures that ethical practice will be appreciated and protected from unhealthy competition and unethical practitioners. This is the reason why this movement needs to reach out to those members of the profession who are not vocal, but committed to the welfare of their patients and clients. Such members of the profession need to be protected and empowered so that they can boldly support the movement. This indeed is a difficult task, but no task in the healthcare field is easy to achieve, as is evident from the modest achievement of laws like the PCPNDT in the last two decades.

Girls Count: How long will the ‘regulation’ on sex selection take to become effective? Do you think adhering to medical ethics could be a solution to the problem?

Dr. Jesani: There is no one solution to eradicate gender bias in medical practice and healthcare; and for that matter in the society. The struggle against discriminatory “sex selection” is only one aspect of the struggle against gender bias. Its success would ultimately help reduce gender bias. At the same time, reduction in gender bias will reduce this practice. The PCPNDT activists therefore ought not to concentrate merely on the implementation of the law and the demographic change in sex ratios, but while doing so, they also need to expand their perspective to fight against gender bias. Narrow and reductionist approach may result in inadvertent or misguided reinforcement of some other kind of gender bias as was seen in the past on legal abortions.

Additionally, the questions that you asked were all on healthcare and its regulations, so I have not spoken about how to combine these strategies in healthcare with the strategies for struggle against gender bias in society, which actually constitute the demand side. However, they are also important and need to be brought in the struggle.