MEDICAL ETHICS AND PROFESSIONAL SELF-REGULATION: SOME RECOMMENDATIONS

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In last one decade the health care professionals have been severely criticised both for being indifferent to their social responsibility and for not regulating themselves. As patients become more aware of their rights and the market in health care continues to operate without restraints exercised as a part of the self regulation, it is not difficult to foresee the emergence of new demands for imposing regulations on health care by the state. There is increasing evidence to suggest that, harassed by the rising cost of health care, the middle classes and the poor would welcome regulations. However, experience of the historical developed countries show that if such regulations are not accompanied by holistic planning to make health universally accessible to people, they invariably become self-defeating by encouraging the monster of private health insurance and the finance capital. The US is a classical example of having highest number of regulations over the health care market and yet, such regulations have neither brought down the cost of health care nor made consumers as well as providers happy. In fact, the increasing dominance of private insurance companies and corporations have encroached upon the professional independence of providers and done nothing to achieve the social goal of making health care universally accessible.

Thus, the health care providers in our country will soon be required to make a choice between external regulations and the genuine self-regulations in tune with their social responsibility and the goal of achieving health care ethics.

STRENGTH OF THE HEALTH SECTOR

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, adding together the infrastructure of PHCs, subcentres, CHCs, doctors and paramedics in the government sector, along with the health care facilities and human power available in the *private sector*, the strength increases by five *folds.* 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 who 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 even rational super-specialist tertiary care to those who medically need it. As scholars like Amartya Sen and Jean Dreze have argued that in the modern world with abundance of resources the hunger is intolerable and its persistence is not only a political issue but also ethical, one could likewise say that given our total health care resources, lack of access to *basic minimum health care* for a vast majority of our people is intolerable both politically and ethically.

ROLE OF PROFESSIONALS

The tendency to rely on trained professionals in the health system of the country has periodically been questioned by many people considering the current state of affairs in the health care services. That was a reason why in the 1970s, the community health and primary health care advocates sought to replace the professional model by arguing that lay individuals can be trained to take on certain of the medical interventions that are under the control of professionals. There was much appreciation when a government health system comprising 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 was also been considered as an affordable cheap option for the underdeveloped country like India. 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 deprofessionalisation, 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 the country.

There is basically nothing wrong in having a system, which has an appropriate combination of professional and para-professional workers. At philosophical plane, the emphasis on deprofessionalisation and putting health care in people's hand are very attractive. However, this attractive strategy needs to be contextualised, the roles of various providers clearly defined and the direction of future development of such system outlined. In the absence of such planning, such a system has many pitfalls at practical level, some of them have strong ethical dimension.

THE COMMUNITY HEALTH FIASCO

It is always nice to feel that health would be in people's hand and that the professionals would be divested of simpler and routinistic health care tasks. But articulation of such ideas without bringing public and private sector under a 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. It 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 of the orientation to community health during the last quarter century, 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.

NGO INITATIVES

How does one place the NGO experiments at deprofessionalised, 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 practical provision of health care, it gives an 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 deprofessionalisation 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-a-vis health care providers.

Having said this, there are some issue, 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 reorganisng and upgrading the rural referral support system Thus, essentially at the advocacy level, the NGOs have underemphasised the issue of redistributing health care institutions and professional humna power. What is ironic is that there is hardly any genuinely successful village health experiment. In the absence of such successful experiments there is no political and ethical justification for keeping the spot-light 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 practising 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 subcentre. 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.

NEED FOR A COMPREHENSIVE CODE

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, and losing sight of that makes the community health workers not only a self-defeating 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 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?

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 Primary Health Centre/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 D*ais*? 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 praraprofessionals 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 IN THE POLICY FRAMEWORK

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, 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. Just derailing them 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 preview 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 confirm to the needs of regulations, no good policy is likely to succeed.

STATE OF SELF-REGULATION

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

- who and what factors are responsible for this state of affairs?
- is there a possible strategy for reforming these professionals?
- or else, is the professional self-regulation neither desirable nor feasible in the present situation?

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 therefore, is a legal offence and invites serious penalties. 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 and the 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 two and half lakhs. There is of late, due to increasing competition in the medical market, some hue and cry being raised in the media about unqualified doctors and the government is coming under pressure to identify them and to weed them out. But 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, whether we are 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 scarcity for qualified and registered 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 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:

- 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.
- The way out from this situation, at the level of democratic self regulatory body of professionals, the Medical Councils, is to put reasonable restrictions and regulations on the location of doctors' medical practice.

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 compensation by paying appropriate tax.

- For the nursing professionals, the problem is different. Undoubtedly 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:

i.   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.

ii. The second method is conventional one, of increasing number of nursing schools and colleges .

▸ The Male Health Workers in the PHC network should also be made eligible to get registration with the nursing councils.

▸ The absence of organised continuing education programme not tagged to renewal of registration is a sure 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 the trainees and if necessary, supplemented by the government or the councils.

▸ The government and the NGOs need to combine their efforts to provide respectability and formal status to the paramedical professionals such as D*ais,* Community Health Workers and 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.

EFFECTIVENESS OF 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. 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. The finding of this basic uniformity in the limits upto which the profession could, or are interested in self-regulating themselves could also make one conclude that 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.

It is also absolutely essential that the councils are made financially autonomous and its staff are not appointed by the government. The other changes needed are:

a) Democratisation and transparency
These qualities should reflect in the functioning of the professional bodies. The best way to make the self-regulation successful is to make the functioning of the councils transparent and democratic.

b) People's Participation
In the professional councils, patients or people come into the picture only as complainants against doctors. There too they are completely at the mercy of the professionals sitting in the council to give them justice. Increasing the proportion of lay people in the council (at least 25% of all members) is absolutely essential. 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 complaints of patients on unethical conduct should be judged equally by the lay members as well as doctor members.

c) Interprofessional 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 very principle of self-regulation. This control of non-nursing people over the nursing council must be abolished forthwith. The rest of the issues should be in line with the recommendations made for the medical councils.

d) Revamping the Registration process

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. 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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