Self-regulation or State Legislation: An Urgent Choice to Make

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"If you would take, you must first give, this is the beginning of intelligence"

—Lao Tzu

QUID AGIS–QUO VADIS

(Latin: "What are (we) doing – Where are (we) headed")

Award of an unprecedented *60 million-plus rupees' compensation* for medical negligence—this landmark judgment's[1] lesser-known parts are:

- "Doctors and senior doctors of high repute —made every *attempt to shift the blame to the other Doctors thereby tainting the medical profession.. unbecoming of a doctor* as renowned and revered as he is.."
- "It is pertinent for us to note the shifting of blames....which is a *shameful act on the dignity of medical profession...*"
- "...*Abhor the shifting of blames* by the senior doctor on the attending physician the appellant Dr... even though the Court held him guilty of negligence..."
- "...had *conducted with utmost callousness...* which led to her unfortunate demise".

While we all have debated at length on the decree's fairness and quantum of compensation, let us look at this decree from a Judge's perspective, who goes by a principle of "Preponderance of Probability"[2] in order to adjudicate civil matters. When doctors blame each other, especially in a court of law, the tone is set for the balance of probabilities tilting against the doctors and the resulting damages awarded include punitive damages (in addition to the pecuniary and non-pecuniary damages) also, which is awarded as a punishment in order to act as a deterrent in future, not only for the accused, but the fraternity at large, which is evident from this part of the same judgment:

"...we, therefore, hope and trust that this decision acts as a *deterrent and a reminder to those doctors, hospitals,* the nursing homes and other connected establishments who do not take their responsibility seriously..."

"...the *Central and the State Governments may consider enacting laws wherever there is absence of one* for effective functioning of the private Hospitals and Nursing Homes... [1]"

Consequentially, when the State or Judiciary, legislate or decree in their respective capacity, the unrest triggered within the medical fraternity results in instant reactions which may not exactly concur with the proposed intent of the State/Judiciary. On reacting to such legislations or decrees, as a fraternity (medical), we tend to get misled into inconclusive/conflictory discussions on the 'Letter of the Law',[3] not realizing that focusing on the Spirit of the Law, would eventually dictate its Letter, in the best interests of all the stakeholders, doctors included!

BASIC UNDERSTANDING

Let's get to the basics.

What is a Self-regulatory Organization?

The dictionary meaning is: A professional organization, unaffiliated with a Government, having certain, limited regulatory authority over members. An example is the American Dental Association, which has the ability to set standards and enforce discipline over dentists in the United States.[4]

The Regulatory Bodies

- *Statutory*: Medical Council of India (MCI) and the respective State Medical Councils.
- *Nonstatutory*: Associations like the Indian Medical Association (IMA), other speciality Associations like the API (Association of Physicians of India), IOA (Indian Orthopaedic Association), Indian Association of Dermatologists, Venereologists, and Leprologists (IADVL), Associations of Plastic Surgeons of India (APSI), etc.

While the nonstatutory bodies are free to have their own regulations, the statutory body, MCI is governed by the MCI Act, 1956.[5] Under this Act, we have the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002;[6] with the latest amendment in October, 2016.[7]

Self-regulation: As an Individual

For an individual, while the Statutory Code of Ethics details systematic self-regulation, it is very simple to Self-regulate—a basic outline could be:

- Smile and greet
- Speech—Soft and clear and document
- Stickler for basic protocols
- Sincere and professional approach
- Seek second opinion as needed
- Solve potential problems early—grievance redressal onsite
- Shun professional jousting
- Shun self-promotion
- Shun sponsorships, (e.g. Pharma)

Such self-regulatory norms of ethics and etiquette would be evident to the patient in practice—spoken (communication) and written (documentation). The relationship of Trust (*Fiduciary!*) thus built-up would be an effective way to avert a future Litigation (*Judiciary!*) or at least, mitigate it. In the event of a patient seeking to litigate frivolously, the etiquette and ethical conduct would be written all over the available records, be it, written, circumstantial or audiovisual, which would decide the course of litigation equitably.

While the articulated ethical conduct is important, it is the "unarticulated premise"[8] of a physician's diligent time spent with the patient (which arises naturally when considering the patient as a kin) which

determines the standard of care in the patient's mind and also in the adjudicator's mind, should the patient litigate. One such example is the case[9] (Kamalesh versus Dr Ajit Roy, State Commission of West Bengal, 2000) where a doctor shifted a patient with respiratory distress (who eventually expired) by his car and not by an ambulance, was held not guilty; because the Judge felt that "all possible treatment was given to the patient," apparently biased by the diligent time he spent with the patient.

This apparent "**unarticulated premise**" of time with the patient, possibly helped in acquitting the doctors in another case[10] (Ganga Ram Hospital versus DP Bhandari), where the allegation of negligence was that the patient died for not shifting the patient to the intensive care unit (ICU), higher/scan centre.

More specifically, it is interesting to note that the *four - Judge* bench of the *High Court* that adjudicated this case, took cognizance of the fact that "*as many as 140 visits were made by the paramedical staff and 25 visits by the doctors to the patient's room during 57 hours, the period when his condition required to be kept under constant watch and there was regular monitoring of his pulse, urine, blood pressure, respiratory functions, etc. Taking into account all the facts and circumstances disclosed by the materials available on record, we find ourselves unable to uphold the finding recorded by the State Commission that there was negligence on the part of the hospital in not transferring the patient to the ICU,*" rather than the details of technicalities of treatment or delay.

"A mind all logic is like a knife all blade. It makes the hand bleed that uses it."

—Rabindranath Tagore

Applying Tagore's wisdom to this aforementioned scenario, self-regulatory norms like **diligent time** with the patient could provide a **humane** "**handle**" to the "mind all logic", thus **protecting** the **patient (during treatment)** and the **doctor (during litigation)** from the "knife all blade" (of only logic and letter of law). Due diligence taking precedence over shifting to an ICU—not only helped overrule the order by the State Commission, but could provide the insight to answer the contemporary question of relevance of physical presence of an ICU/ventilator, when adjudicating on alleged negligence.

Self-regulation: As a Fraternity

Sustained violation of ethical practices and failure of the Statutory Regulatory body to impose deterrent disciplinary action on the violators, forces the State/Judiciary to step in and impose Legislative and Judicial restrictions on the accused. Thereafter, violation of ethics would be viewed as violation of law with floodgates open and an exponential rise of litigation follows; to the tune of 400% in a decade, according to a legal resource, Manupatra.[11]

This is when, as a fraternity, we need to stand up to the challenge and strategize, to seek a solution, rather than blaming the State/Judiciary. In this context, it is worth recalling Justice DK Jain, retired Supreme Court Judge and the then President, NCDRC (National Consumer Disputes Redressal Commission), quoting at a National Medicolegal Conclave, Chennai, September, 2017: "I have a lurking fear in my mind that I might give a wrong judgment against doctors, going by western standards. I want you (doctors) to help me with what is appropriate for our set-up and infrastructure."

We need to believe that we are the best at seeking a rational solution going by our training at medical school. A similar understanding

on the lines on Etiology/Pathophysiology/Management/Prophylaxis, could help us show the way.

Such an understanding on the lines on Management Studies is the well-known SWOT (*Strengths*, *Weaknesses*, *Opportunities*, and *Threats*) analysis.[12]

As a fraternity, a *sample* of our listing could be:

- *Strengths*: Ability for hard work, empathy, knowledge, analytical thinking to conquer disease.
- *Weaknesses*: Lack of uniformity/consensus on consent/treatment/grievance redressal, silence of the ethical majority, unethical practices with absence of structured deterrents, deficient knowledge of medical jurisprudence.
- *Opportunities*: Digital Revolution, vacuum in the areas of Clinical Practice Guidelines (CPG), costing of treatment—our forte, quick redressal, Government's inability to handle the rising cost of healthcare, Judiciary's burden of huge pendency of cases.[13]
- *Threats*: Rise in Patient-Doctor trust deficit, "Draconian" state legislations,[14] insurance companies dictating protocols and pricing,[15] unprofessional advertisements by both 'professionals' and nonprofessionals ('quacks'), corporate culture with entrepreneurs imposing 'targets',[16] Violence against healthcare staff/establishments.

The general approach would be to capitalise on our strengths, using the opportunities and *thus,* progressively strengthening the weaknesses and neutralizing the threats, the nitty-gritty of which can be handled in purposefully structured brain-storming workshops/think-tanks. If we opt to be more advanced/positive in our approach, we could seek to apply the management concept of Appreciative Inquiry,[17] rather than SWOT.

While an in-depth analysis/solution for each of the issues is beyond the scope of this chapter, it suffices to mention here, that solutions are being sought using certain principles like:

- Seeking 'Win-all' solutions
- Employing digital tools like Aadhaar, etc
- Arriving at consensus on CPG, *for practice*
- Structuring protocols for imposing disciplinary action, *upon breach*

In this manner, we are in the process of proposing/implementing solutions/mechanisms like:

- Medical Tribunal to supplant 'Consumer Forum'
- "Beti-Aadhaar" to supplant PC-PNDT Act
- Aadhaar in helping Emergent care
- ABCDE of formulation of CPG (Clinical Practice Guidelines) – **A**pproval-consent/**B**asic Protocols/**C**linical Pathways/**D**uties of Doctor-Patient/**E**thical Guidelines
- Constituting a Patient Grievance Redressal Cell.[18]

Rather than resisting change, we could *propose better change,* in keeping with the aforementioned principles, and, *"make an offer that cannot be refused"!!*

On this note, it would be pertinent to acknowledge MCI's to-be-notified Guidelines on Constitution of peer group which would judge the professional as medical incompetence of a doctor which would be applicable at the medical trial jurisdiction.[19] This could be the foundation for a Medical Tribunal! It would be commendable if the MCI could act positively on the Parliamentary Standing Committee[20] report too, which could possibly deter the State from imposing the proposed National Medical Commission Bill and also the Judiciary from acting *suo moto,* such as, appointing an Oversight Committee[21] and lambasting the MCI: "In March 2016, a

Parliamentary Standing Committee (PSC) on health and family planning tabled its report in Parliament suggesting restructuring Medical Council of India in order to improve healthcare and medical education in our country. Shortly thereafter, endorsing the said PSC report, the Supreme Court has used its rare and extraordinary powers under the constitution (under Article 142) to set-up three members committee, headed by a former Chief Justice of India, to oversee the functioning of the Medical Council of India (MCI) for at least a year. In the Judgment the Supreme Court said "Unethical practices Medical professionals indulge in unethical practices conducting unnecessary diagnostics tests and surgical procedures in order to extract money from hapless patients, the judgment said. The challenges facing medical education of the 21st Century are truly gigantic…Game changer reforms of transformational nature are therefore the need of the hour and they need to be carried out urgently and immediately".

CONCLUSION

While it is relatively easy to self-regulate and be safe at an individual level, we could seek to pitch in collectively to self-regulate as a fraternity in the little capacity that we can, so as to mitigate the trust-deficit and thus practice in peace and counteract objectively, should the patient litigate. Ethical Practice, even if it is in contravention of the Law in a given instance, the Law (its Letter) would amend itself to suit its Spirit.

How Portia successfully invoked the Spirit of the Law to fight its Letter to save Antonio from Shylock's wicked demand for 'the pound of flesh', is worth recalling from Shakespeare's *Merchant of Venice!*

Likewise, we could replicate the unmatched success, we, as a fraternity have hitherto achieved (as evidenced by the rise in life expectancy from 32 years in 1947[22] to 69.09 years in 2018),[23] in the process of Self-regulation too, particularly, way beyond mitigating litigation.

Self-regulation could revive the *Dream* of the traditional/ancestral image of the Indian Physician—

"Vaidyo Narayano Harihi" (translating as, Doctor is equal to God)!

To 'dare to' dream of such a possibility, we could invoke *Dr APJ Abdul Kalam sir's* wisdom

"Dream is not that which you see in sleep, but something that does not let you sleep!"

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