Medical Self-Regulation: A study of Maharashtra

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Medical Self-Regulation
A Study of Maharashtra

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The 25 state medical councils and the apex body, the Medical Council of India, were set up to regulate practitioners registered with them. However, the self-regulatory bodies themselves often made news by getting mired in corrupt activities. Taking the case of the Maharashtra Medical Council as an illustration, this article discusses how it emerged from the controversies surrounding it and also looks at how it can better its functioning.

stablished in 1934 under the Indian Medical Council Act, 1933 the Medical Council of India (mci) is the apex medical self-regulatory body in India. Besides the mci there are 25 state medical councils and together with similar councils for dental and non-allopathic practitioners these work as primarily independent and quasi-judicial bodies; these councils are constituted by representatives from the respective state governments and elected members from the profession.

However, the performances of most of these bodies have not been satisfactory (George 2011). The 13th report of the Parliamentary Committee on Subordinate Legislation highlighted the need for reforming the mci Act as a response to the changing environment in healthcare in India. It stressed the need to focus on issues related to renewal of medical registration, continuing medical education, advertisements of healthcare services and practitioners, heightening patients’ awareness on excess fees, unnecessary tests and on the process of accrediting medical colleges (Jesani 1996). Keeping in mind the dearth of research on the functioning of medical self-regulatory bodies in India, along with the emphatic need to make them more accessible and transparent to the larger community, this article would provide a map of the field with particular reference to the Maharashtra Medical Council (mmc). We choose to focus on this case because bearing a history of controversies and steep challenges, it has successfully overcome most of the hurdles and has been trying to implement and mainstream certain positive changes in health regulation in Maharashtra.

The Beginnings
Set up in 1965 as a statutory body (MMC Act 1965), the MMC designed its missions to primarily focus on maintaining an updated register of allopathic practitioners, developing a code of ethics for its registered practitioners, attending to the complaints filed by users of the medical service and taking necessary disciplinary actions against the doctors found guilty, and inspecting and accrediting medical colleges across the state. As per the Act, first elections for the council members were to be held every five years. However, after a term expired in 1990 no elections were held for two years. The matter was brought to the attention of the Supreme Court and it ordered an election at the earliest and which took place in 1992.

Severe malpractices were reported to have vitiated the election process (Kamath 1993). The consumer rights group Forum for Medical Ethics Society (FMES) filed a case in the high court (hc) which alleged that candidates who had contested the elections had collected blank ballot papers1 from voters and filled it up as suited their needs. It was also reported that votes were cast in the names of deceased members and there was horse trading of votes after they were collected (Kamath 1993; Nagral 2011). The hc did not respond for the next five years and the next elections were due in 1992. However, this time around the hc appointed observers (on the request of the fmes) who witnessed all the proceedings. However, similar events occurred. Based on the report the observers submitted to the court, the hc declared the elections results null and void. Based on recommendations coming in from other independent organisations including the fmes, the hc also demanded that the inherently faulty system of the postal ballot be replaced by the direct secret ballot (Kamath 1993). In the light of these events, the Council did not get constituted in 1998, and things hung in a limbo for a decade. During this period registration was carried out by a sole administrator who was appointed by the government.

The next elections were conducted in 2009 and for the first time in India a secret direct ballot voting was used by the mmc. Nine members were elected from the registered medical practitioners in the state while another nine members were to be nominated by the government from various government bodies.

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However, the nominations did not take place until 2011 which resulted in the MMC being non-functional even after the elections. Eventually, the government notified the list of nominated members in March 2011 as a result of a petition by the Indian Medical Association (IMA).

**Council’s Activities**

With the MMC back in place, the daunting task of handling cases and registrations pending for more than a decade loomed large. In 2011 there was a backlog of around 450 cases (Andhale 2011) while between 10 to 20 cases were added every month (Latker 2012). A special ethics committee for speedy redressal of complaints was set up in 2012 (Mascarenhas 2012). However, there has been no official announcement by the MMC about the number of cases it has dispensed thus far.

It has mandated that all registered practitioners should renew their registrations every five years. Towards facilitating this process it has initiated an online registration portal. Continuing Medical Education (CME) has been mandated by the MCI as an essential criterion for renewing registrations with a minimum of 30 credit hours per five years in accordance with the 2002 central government gazette notification.

Using its powers as a quasi-judicial body, the MMC has started to take action against erring doctors; in 2011 it suspended five doctors for carrying out sex determination and sex-selective termination of pregnancy under the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act (PCPNDT) (Shukla 2011). In 2012 it issued show cause notices to 14 doctors who were found guilty and convicted under various provisions of the PCPNDT Act (Isalkar 2012). In 2013, it suspended three Mumbai doctors for violating the PCPNDT Act including a gynaecologist and two other doctors who own the hospital where this gynaecologist worked (Vora 2013).

**New Challenges**

A major challenge for the MMC is the organisation of the CME programmes: given that earning CME credit hours is compulsory, the absence of relevant CME programmes for all the sub-specialties of medicine haunts a lot of practitioners. This leads to a common situation where a practitioner might have to attend a workshop/conference that is in no way related to his/her area of specialisation. Another problem pertains to accessing the workshops/conferences which are usually always held in the cities. Often those in rural postings or practising in remote locations need to take leave and travel long distances, arrange for accommodation in the city and finally attend a workshop not related to their specialisation. Recommendations have been made that official leave be granted to doctors who are government employees for attending such courses/workshops apart from their time and expenses being reimbursed (Sohoni 2011).

On the international front, the move is now from CME which includes only updating medical knowledge to Continuing Professional Development (CPD) which involves a broader set of skills such as information technology, audit, management and team building (Peck et al 2000). The effectiveness of a system of evaluation based only on credit hours is also being debated (Grant and Stanton 1998). Alternative methods of learning that are grounded in self-accreditation, reflection and everyday practice such as regular reading of journals, case discussions and visiting other departments are being advocated (Boulay 2000). It would be worth considering how similar practices can be adopted by state councils in India to best suit particular local needs and contexts.

Another challenging area is complaint redressal. Currently, the MMC does not...
deal with anonymous complaints. Arguably, this might work to the disadvantage of several patients who would not want to take the risk of revealing their identity even before they can be sure that their complaint will be acted upon. Also, filing a complaint with the MMC is not easy. To begin with, even though there is plenty of information about registration for doctors, there is no information available on the website about the process of filing a complaint. An example could be taken from the General Medical Council, Britain which has elaborate modules on the process and even interactive resources on the website to help people understand all about filing a complaint. It is obvious that while the General Medical Council is user-oriented, the slant of the obvious that while the General Medical Council in the UK and some state medical boards in the us have representation of lay members (Vries et al 2009). Furthermore, the present change in the MMC was brought about by default and not as a result of conscious reflection on the issue of representation. The relative role of the state, the public and the profession in medical regulation has always been controversial (Crues and Crues 2005), and a public debate is needed on how to configure a balance in India. Finally, towards improving the ethical standard of medical practice as a whole, the MMC would do good to set in place its own code of ethics.

Conclusion

The MMC has overcome administrative hurdles and been prompt in resuming and initiating important functions since its reinstitution in May 2011. Nevertheless, it can significantly improve the practice of some core functions and expand its scope of activities. Some of the changes suggested above will require amendments in the MMC Act (1965) itself. In order to actualise these reforms, further empirical and comparative research will be required. However in presenting these preliminary observations we hope to break the long silence on the state of medical self-regulation in the country.

References


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1 In the postal ballot system, blank ballot papers were mailed to the voters who were supposed to write the name of their preferred candidate and after putting their signatures on the designated places on the paper and on the covering envelope, post it back to the Returning Officer. On the designated day, the Returning Officer was expected to open the envelopes and count the votes in the presence of all the contestants or their representatives.