EDITORIALS

Professional codes, dual loyalties and the spotlight on corruption

AMAR JESANI

Independent Researcher and Teacher (Bioethics, Public Health), 301, Prabhu Darshan, Swatantrya Sainik Nagar, Andheri (W) Mumbai 400 058, INDIA
E-mail: amar.jesani@gmail.com

The ugly but well known and hitherto cheerfully accepted phenomenon of corruption in the health system has once again come to haunt the healthcare professions in India. It is no accident of history that the birth of *The Indian Journal of Medical Ethics* was intimately connected to the brazen corruption evident in the Maharashtra Medical Council (MMC) elections in 1992 (1). But while health professionals associated with *IJME* understood corruption as a gross violation of ethics, mainstream doctors looked at it as a necessary evil, essential to survive in a highly competitive medical entrepreneurial environment. In the mind of the mainstream professional, corruption was not an ethical issue; in 1996, the publication, in this journal, of an essay by Chennai-based nephrologist M K Mani on corruption, presenting clear-cut evidence of the "cut practice" (2), made little impact.

In recent times, however, media interest has been captured by a series of events focusing on medical corruption. In 2013, Raigad-based physician H S Bawaskar filed a complaint with the MMC (3) with irrefutable documentary evidence that a diagnostic centre had offered him a "cut" or kickback to refer his patients to them. More recently the Kokilaben Dhirubhai Ambani Hospital in Mumbai apologised to the MMC for openly offering "cuts" to doctors for referring patients (4). In May this year, an Australian physician, David Berger, wrote in the *BMJ* on his own experiences of corruption while working in a charitable hospital in India (5). This was followed by a *BMJ* editorial in June giving a clarion call for a campaign against corruption in India (6); in an unusual but bold move, the *BMJ* declared its intention to get directly involved in this campaign. At the same time, there has been an outcry against corruption in the Medical Council of India (MCI) in relation to medical education (about which a lot has been written in *IJME*). Finally, the campaign to force the MCI to enforce a code of ethics on medical associations– and in case of violations by an association, to punish its office bearers– has continued unabated, with more doctors raising their voices on this subject than ever before.

Are these only episodic and temporary rumblings in the profession that will soon die down? Or do they represent some serious churning, propelled by ground level conflicts and restlessness in a section of the profession and the public that are unlikely to disappear without effecting some change? I believe that these are early signs of more serious upheavals in coming times. It is unusual for a hospital controlled by the most powerful corporate house in the country to apologise to a state medical council, especially when the council itself declares that it does not have any power over the hospital. For that matter, in a time of hyper-patriotism, it is unusual for the media to appreciate a foreign journal's indictment of the system and its resolve to directly involve itself in an international campaign against corruption in the Indian medical system.

A shift in perceptions and social arrangements

Despite widespread experience of corruption, there is very little empirical evidence collected by researchers in India on corruption. This makes it difficult to assess whether corruption has increased or decreased in recent times. But there is no doubt that it is now more visible than ever. The increased visibility of corruption is aided by the reports of scams and scandals; this has much to do with anti-corruption political activism at the wider level in last few years. In the field of healthcare, even in the absence of hard evidence, I may point to two major shifts – in the public perception and in social arrangements – that could be responsible for the current welcome turmoil and that in the medium term may sustain this turmoil for effecting change.

It is important for corruption to be perceived differently if we are to understand its perniciousness and view it as a challenge to overcome rather than something to which we must "adjust".

People's perception of the healthcare system in the last three decades has been marked by a growing disillusionment with publicly provided care and a paradoxical attraction to the seductive trap of private healthcare.The decade-long experience of the Health Missions (rural and urban) – with the state doling out money to the private sector for social health insurance and activists trying to conduct community monitoring – has helped bridge the gap in perceptions of corruption in public and private systems. It is now difficult to get popular support for the argument that corruption will be overcome by the market, rather than by the government's regulatory intervention.

Another important visible change is the increasing realisation among a section of health professionals that it is difficult to pursue

ethical medical practice and also have a secure economic status and physical security and preserve one's reputation. Palliative measures such as a law to protect health professionals against violence from angry patients are ineffectual; the real malady remains – an increasing erosion of trust. At the same time, the excessive concentration of services in areas that facilitate the market leave the physician no option but to resort to supplier-induced demand – which in an unregulated market is closely linked with corruption. This means resorting to various types of fee-splitting or "cut" practice; unnecessary and harmful investigations, prescriptions and interventions; silence on the misdeeds of one's colleagues, and the overall need to deceive patients at every step. Such cheating is easily possible when patients have blind faith or trust in doctors, or are ignorant or tolerant of such practices. The consequences of loss of trust in the doctor-patient relationship, manifested in violence, litigation and bad media reports, are felt the most by the frontline providers, particularly by new doctors entering the healthcare market.

The earlier social arrangement between the healthcare profession and its institutions (hospitals, diagnostic centres, etc, often owned by doctors) provided scope to each for enrichment at the expense of patients and the public health system. Indeed, they complemented each other in their business practices. This arrangement is under stress with the increasing power of corporate hospitals, health insurance providers and pharmaceutical companies, wherein collaboration is often marred by increased competition and takeover attempts.The advent of corporate medicine in the last three decades has increased not only the cost of healthcare but also the segmentation and inequity within the mainstream allopathic profession and the hospital industry. This is in addition to the earlier segmentation, which was primarily between allopathic and non-allopathic (or AYUSH) doctors. For long, the former could maintain a semblance of consensus amongst themselves by according second-class status to the latter, and using them as whipping dogs for all the ills of "quackery" in medical practice. This complexity in segmentation, and the inequities within the profession, needs systematic research. However, what is heartening for the time being is that segmentation and inequities in the allopathic profession are eroding collaboration and the consensus that was built around it.

Professional power and dual loyalties

This agreement to collaborate has for long ensured that the code of medical ethics and the regulatory powers of medical councils were rarely used against those who violated them. The new code of medical ethics promulgated in 2002 (7) had more specific stringent standards of conduct for doctors and for the first time explicitly named many corrupt practices (eg "rebates and commissions", absence from duty at rural health centres, etc) as misconduct. In December 2009, the MCI added Section 6.8 to the code of ethics bringing, under regulation, the relationship of doctors and medical associations with "the pharmaceutical and allied health sector industry" (7). One may say that codes are only as good as the political will to implement them. But when there are contending forces within the profession, such codes can come in handy in the effort to revive the regulatory structures for their implementation. As recent events show, a section of the profession is able to use the code to demand accountability from regulatory medical councils to act against the corruption of the healthcare industry establishment and its power over the profession.

On February 18, 2014, the executive committee of the new MCI decided to exempt medical associations from the purview of its ethics committee. In other words, the MCI exempted them from the observance of the code of ethics, particularly, section 6.8 which prohibited them from taking financial support from the pharmaceutical and allied healthcare industries. This triggered off protest, and *IJME* has actively participated in this campaign (8). Here the issue is relatively simple because the code of ethics, which is legally binding, specifically mentions medical associations as well as individual doctors in this prohibition. However, medical councils have constantly expressed their inability to make medical establishments (hospitals, diagnostic centres etc) accountable for violating ethics and indulging in corrupt practices. Even the MMC, which received an apology from the Kokilaben Dhirubhai Ambani Hospital for offering cuts to doctors, has stated that it does not have the power to punish medical institutions.

While punishing an institution may require a different authority, or the vesting of additional power in the medical councils, it would be difficult to argue that medical councils do not have the power to identify and punish doctors involved in designing and implementing unethical policies in medical institutions. Can doctors acting as administrators of a medical establishment claim that the ethics of the profession do not apply to decisions they take as administrators? In other words, can doctors who function under the authority of others (companies, employers, military/prison authorities, etc) be allowed to give primacy to the interests of their authorities or employers over the interests of patients and professional ethics? Such doctors do suffer from dual loyalties. But they cannot be permitted to resolve ethical conflicts arising from these dual loyalties to the detriment of patients, people and the code of medical ethics. There are several precedents in history, but there is one current case from South Africa where the international principle of giving primacy to ethics and human rights over obedience to authority is being reiterated. This principle has universal applicability. The case is that of Wouter Basson (often described by the local media as "Dr Death"), tried by the Health Professions Council of South Africa (HPCSA).

Dr Basson, a cardiologist, was the head of South Africa's secret chemical and biological warfare project called Project Coast[1] during the Apartheid era in the 1980s. He was suspended from his military post in 1999, but a court trial that lasted from 1999 to 2002 acquitted him of 67 charges, including criminal charges of causing death, or murder. But the health profession in South

Africa considered that this acquittal did not exonerate him from his ethical obligations. In 2006, the HPCSA's Professional Conduct Committee started its own ethics investigation and trial. After seven years of deliberations, on December 18, 2013 it pronounced him guilty of unprofessional conduct. His sentencing is awaited – in fact the delay in sentencing has triggered off protests in the profession (9).

The arguments put forward by Dr Basson and his legal counsel (10) were that whatever he did was in the context of war and conflict; he was under military instructions and acted as a soldier and not as a doctor; that the ethics of military doctors are different; and that the chemical and other material for warfare produced by him was not used on his own patients– in other words, he did not have a doctor-patient relationship with those who might have suffered.

The HPCSA rejected all these arguments. It stated that medical ethics are important at all times, in war as well as during peace; individual medical doctors are responsible for their actions even when under orders by superior authorities, including superior medical authorities; doctors, whether inside or outside the military, are bound by the same set of medical ethics; and the absence of a doctor-patient relationship with the victim is not sufficient to absolve doctors of the consequences of their actions, as they have an additional obligation to society at large.

This decision of the HPCSA reiterates the universal principle. Thus, it reminds medical regulators all over the world not to allow doctors who indulge in unethical practices at the behest of their industrial or government employers to escape the regulatory powers of ethics. Medical councils in India ought to act against doctors who assist healthcare companies and governments in corrupt and unethical practices, rather than express their helplessness for not having direct legal regulatory powers over healthcare institutions.

Beyond actions within the profession

I cannot elaborate here on all that needs to be done to eliminate corruption from the system. Corruption is, indeed, only a symptom of an iniquitous and unregulated system dominated by business interests. Radical change in such systems would need the intervention of the very large numbers of people who suffer not only because of corruption but also because of the lack of free universal access to quality healthcare. The extent to which those inside the profession who struggle for reform are able to build an alliance with people at large would determine the sustenance of the present turmoil and its extension for larger systemic changes.

Note

[1] For more information on Project Coast, see: http://en.wikipedia.org/wiki/Wouter_Basson [cited 2014 Jun 23]

References

1. Kamath MS. Elections: The true story. *Med Ethics*. 1993 Aug-Oct; 1(1): 1-3.
2. Mani MK. Our watchdog sleeps, and will not be awakened. *Issues Med Ethics.* 1996 Oct-Dec 4(4):105-7.
3. Bawaskar HS. The medical trade. *Indian J Med Ethics*.2013 Oct-Dec;10(4):278.
4. Andhale S, Pal S. Kokilaben hospital in the dock over cut practice. *DNA* [Internet]. 2014 Jun 25[cited 2014 Jul 2]. Available from: http://epaper.dnaindia.com/story.aspx?edorsup=Sup&ed_code=820009&ed_page=3&boxid=38970&id=66509&ed_date=06/25/2014
5. Berger D. Corruption ruins the doctor-patient relationship in India. *BMJ* [Internet]. 2014 May 8 [cited 2014 Jul 2]; 348:g3169. Available from: http://www.bmj.com/content/348/bmj.g3169.full.pdf+html
6. Jain A, Nundy S, Abbasi K. Corruption: medicine's dirty open secret. *BMJ* [Internet]. 2014 Jun 25 [cited 2014 Jul 2];348:g4184. Available from: http://www.bmj.com/content/348/bmj.g4184.full.pdf+html
7. Medical Council of India. Code of Ethics Regulations, 2002 (Amended up to December 2010). MCI: New Delhi [Internet]; 2002 Mar 11. [cited 2014 Jul 2] Available from: http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx
8. Shukla A, Jesani A, Dabade G, Kaul S. A letter to the union minister of health. *Indian J Med Ethics* [Internet]. 2014 Mar 12 [cited 2014 Jul 2]. Available from: http://ijme.in/index.php/ijme/article/view/1616/4387
9. Malan M. How long do we have to wait for Dr Death to be punished? *Mail & Guardian* [Internet]. 2014 Jun 20 [cited 2014 Jul 2]. Available from: http://mg.co.za/print/2014-06-19-how-long-do-we-have-to-wait-for-dr-death-to-be-punished
10. Mapumulo Z. Why health council found Wouter Basson guilty of unprofessional conduct. *City Press* [Internet]. 2013 Dec 18 [cited 2014 Jul 2]. Available from: http://www.citypress.co.za/news/health-council-found-wouter-basson-guilty-unprofessional-conduct/