Reforming the Medical Council of India

The recent editorials by Dr George Thomas and Dr Sunil K Pandya in the *IJME* with respect to the functioning of the Medical Council of India (MCI) force us to think about how reforms can be introduced inthe MCI (1,2). Dr Pandya suggests that we would do well to learn a lesson from the General Medical Council (GMC) of the United Kingdom (UK). It is true that the MCI can learn from many aspects of the GMC reforms which were introduced in the 1980s, especially after the Bristol case[1] and the Shipman affair[2]. One of the most notable reforms introduced by the GMC was greater representation of lay members in its fitness-to-practice committee (3). At the moment, there are equal numbers of medical and lay members in the GMC. This suggests that the public has an equally important role as do physicians in regulating clinicians in the UK. In contrast, in the MCI, there is not a single representative of the public among the total of 89 members under different categories. As for the GMC, of its 12 members, half (ie six) are from among the public.

In addition, the GMC implemented a long-standing proposal for the revalidation of licensed doctors in 2012 (4). Revalidation,usually required every five years, is the process by which practising doctors must demonstrate their fitness to practise. During their annual appraisal and revalidation, doctors have to provide feedback from patients as one of the supporting pieces of information on their practice. It can be argued that compared to the MCI, the GMC is more accountable to the general public and its proceedings are more transparent. If the MCI introduced reforms on the lines of the GMC, it would reduce the monopoly of doctors and it would be easier to take disciplinary action against clinicians in case of violations. Moreover, it would help in strengthening the relationship between the public and doctors.

In sum, by making decision-making more transparent, changing the balance of interests in the MCI, and empowering citizens, some real progress can be made in reforming the MCI.

Acknowledgments

The letter is the part of a Wellcome Trust Studentship (grant number: WT087867MA) awarded to Shashank Tiwari at the Institute for Science and Society, School of Sociology and Social Policy, University of Nottingham, Nottingham (UK). The Trust is not responsible for views expressed in this letter. The author is grateful to Paul Martin, Sujatha Raman and Pranav Desai for support and guidance.

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Notes

1. The Bristol case was related to deaths of 29 babies and young children at the Bristol Royal Infirmary who had received complex cardiac surgery from 1985 to 1995.
2. The conviction of GP Harold Shipman for murdering several of his patients in 2000

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Life insurance and clinical trial participants

Are the informed consent forms of clinical trials silent on the rights and obligations of participants with respect to their life insurance policies?

Though life insurance in India has poor penetration, it has increased over the last couple of years after the entry of private insurance providers. When a person buys his life insurance, the insurance company carries out the process of underwriting which involves the risk profile assessment of the individual on the basis of information provided, including reports of medical investigations (if done). The policy documents of the majority of insurance providers state that a claim is not allowed in a case of suicide within one year of commencement, or revival, of the policy. In a parallel situation, assume that a person enters a drug trial leading to change in the risk profile. Do our informed consent documents inform insured persons about their rights and obligations? Should the participant inform the insurance company? Can his claim be rejected later if he dies because of the effects of a drug trial? The recently introduced compensation clause and its calculation mechanism may or may not be equivalent to the amount of insurance the individual might have taken (1, 2). Nowadays, due to various market forces, the usual online term plan offers insurance of Rs 1 crore or more at a relatively affordable premium.

Consider a second example, where an individual is part of a clinical trial and applies for an insurance policy. Has his risk profile changed? Is his premium going to be high? Or will he be denied an insurance policy? Is his premium going to be reduced after one year or so when he is out of the clinical trial? Who will compensate for the high premium? The most important issue is: what happens if his policy is declined? Probably after this, the participant will not be able to take any future polices as he needs to mention that earlier he had been denied a policy due to his involvement in a clinical trial and none of the companies will take the risk of providing him with life insurance. Are we going to compensate him for this?

Now consider a third scenario: the person may have been lucky enough to get the policy as he did not inform the insurance company about the clinical trial unintentionally, since the informed consent document is silent on this issue. What happens if the company becomes aware of the facts at the time of the claim, as it will ask for all previous medical records?

In a fourth scenario, a participant with very high insurance due to a terminal illness, like cancer for which no treatment is available, enters a clinical trial. If he dies, it may be difficult to prove he died due to illness during the clinical trial or due to a drug used in the clinical trial. What happens to his insurance policy?

In any of these cases, if the insurance company denies the claim, can family members approach the insurance ombudsman and hope to be considered? Should the insurer never deny any claim if the death occurs more than one year after the policy?

All these are grey areas. As a research community, we need to come forward and design a model informed consent which covers all these issues of importance to the trial participant for the protection and care of his family, in case of his unexpected death.

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Why Indian doctors are lethargic about active research

I happened to meet a journal editor at an IMA (Indian Medical Association) Conference who invited me to deliver a talk on my journey as a clinical researcher over the past three decades. I was delighted to share my experiences in research driven by patient needs, performed at resource-limited locations such as primary health centres, and without the help of any funding agency. I attended the two-day workshop consisting of routine monotonous lectures on research methodology. Many speakers emphasised the need to get funds and methods together; giving the impression that research is impossible without funds. My research of a lifetime bears testimony to the fact that original research driven by patient needs need not wait for research grants. One's sincerity as a clinician, keen observation, and dedicated work can overcome all the hurdles.

During the workshop, the editor who had invited me there would introduce me to the audience mentioning my publications in high impact journals like the *Lancet* and *BMJ*. The audience appeared very eager to interact with a speaker from abroad about the methods of procuring funds, receiving invitations to international conferences, and obtaining visas. However, I was shocked to notice the apathy of the same audience towards the actual process of research.

I wasn't so much surprised as utterly disappointed by the attendance of just seven to ten of the 70 registered delegates at my lecture. Not a single organiser, including my editor friend, was present. I still preferred to present my experiences in research to the delegates. There were no questions at the end. One of the private practitioners even remarked"Don't offer bananas to people who want oranges."

Finally, I was disheartened at the attitude of Indian doctors to research, their belief that research can only be done in large hospitals with world class laboratories, that funds are the driving factor behind research. But, perhaps, there lies the answer to these questions which had intrigued me since I became a doctor: Why did we have to wait for a Robert Koch to tell us what TB and cholera is caused by? Why did we need a Ronald Ross to tell us how malaria is transmitted?

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