Dental council elections

After the CPA has been made applicable to doctors there has been a lot of debate on the effectiveness of the functioning of medical and dental councils. In this regard, it would be interesting to know how the dental council has being functioning.

The 6,601 qualified dental surgeons (BDS) registered with the Maharashtra State Dental Council have an opportunity to elect a representative on the Dental Council of India. Elections are meant to be held every five years under Section 3A of the Dentist Act, 1948.

The elections, recently held after a gap of 21 years (the incumbent has been there for the last 26 years), were announced only in the Maharashtra government gazette notification. While this *may* be technically correct, it does not allow for true participation by members. For example, even the vice-president of MSDC, Dr SG Damle, dean Nair dental college, was not aware of such a notification!

A dental surgeon from Sangli filed his nomination and was elected. The executive committee of the Indian Dental Association, Mumbai branch,were surprised at the manner in which the elections were conducted, and are trying to find out whether a representativecan still be elected who truly represents dental surgeons in Maharashtra.

***J G Kulkarni and EC members of the IDA*, Mumbai branch, Mumbai**

Assessment of disability

Thank you for publishing the review by Dr. S'anjay Nagral of the book on assessment of disabilities.

Dr. Nagral has raised a doubt on the legality of assessment of disablement as per the criteria given in this book. The Workmen's Compensation Act of 1923, in its section 4-1-C-(ii), has clearly explained that the disabilities not covered by Schedule I given in the Act are to be considered as per the assessment of the doctor.

Schedule I covers amputations, disablements due to total deafness and so on. It does not cover disablements due to other diseases or orthopaedic complications which are not amputations. For such disablements, section 4-1-C-(ii) clearly states that the doctor's assessment is legally valid.

The explanation provided for this section further states that while assessing disablement not given in Schedule I, qualified medical practitioners should have due regard for Schedule I. This is understandable.

Total amputation of the thumb warrants 30% disability in Schedule I. In case of deformity of the thumb following an accident, the assessing doctor will have to bear in mind this limit of 30% for total amputation. If deformity is associated with loss of strength, restriction of movement or other factors that make the thumb useless, a maximum disability of 30% can be granted.

As long as Schedule I is respected and as long as there is a rational basis for assessing disability, legality is not in doubt. In the book under review, we have discussed Schedule I and have tried to provide a rational basis for assessment.

***Vijay Kanhere*, Mumbai**

Reference

Nagral Sanjay:. Review of Impairments, disabilities and their assessment. Issues *in Medical Ethics* 1997;5: 101

Doctor-doctor ethics

In reference to your article on the ethical relationship between doctors, I would like to make some comments:

Regarding the professional services physicians provide to each other, the fact is that when a doctor approaches a specialist for himself or his family, the specialist assumes he must treat his colleague free of charge or at a reduced charge. Either incorrect or substandard treatment is given as a result. The fees may be recovered indirectly (or through the hospital's 'cut') by ordering unnecessary hospitalisation, even in the ICCU, or other procedures. Perhaps physicians would be wise to conceal their professional identity when seeking medical services.

Regarding the ethical question of the "duty of a physician to the profession at large to expose incompetent, corrupt, dishonest, unethical conduct on the part of members of the profession without fear or favour as these are against the best interests of the patient," how many of us have done anything towards this goal — either singly or collectively, through medical associations, through *Issues in Medical Ethics*, a medical journal, or any other means?

The medical councils are meant to do exactly this, in the case of all doctors registered with them. Instead, members of these medical councils shield doctors against accusations of obvious medical negligence. Decisions are taken, and cases are closed unilaterally, without conducting a proper enquiry or giving the complainant an opportunity to present the matters personally before the council.

Specialists play with the lives of unsuspecting patients by admitting them into hospitals where the registered medical officer is not an allopath, a situation created by hospitals mainly to save a few thousand rupees for the services of qualified doctors. Physicians issue false affidavits to shield their colleagues even in cases of deaths caused by clear-cut medical negligence.

Patients witness 'non-ethics' at all levels of the medical profession. When a doctor becomes a patient there exists no relationship between doctors.

***H.R. Parmar*, Mumbai**

Reference

Chinoy, RF , Medical ethics: relationship between doctor and patient. Issues *in Medical Ethics, 1997; 5:*