## Ethics in medical practice, Mumbai, November 30, 1997

*The Forum for Medical Ethics Society and the Indian Medical Association held a seminar on ethics in medical practice. Extracts from the seminar proceedings:*

Dr Sunil K Pandya spoke on the relevance of the Hippocratic oath and code of medical ethics today, and suggested specific modifications appropriate to our culture, and modern-day medicine. In the discussion that followed, Dr Anil Pilgaonkar asked who would implement the oath. Dr Parmar stated that IMA office bearers did not observe these ethics, a charge denied by Dr Medhekar. Dr Sambargi felt that such efforts would not work unless ethics were inculcated from one's childhood.

Regarding the need to develop a code for India, Dr Santosh Karmakar suggested that we could adapt from the revised codes of the WHO and other international organisations

Dr S Y Medhekar spoke on standards for pathology laboratories. Pathology laboratories were once manned by MCI-registered doctors accountable to the MCI. However, medical developments, economic change and a DMLT course to train technicians to work under laboratory pathologists have led to a mushrooming of laboratories unregistered with any professional body, which promote overinvestigation, uneven quality and corrupt practices.

The fear is that no one is responsible for false results from DMLT-run labs. DMLT technicians should therefore not be allowed to start their own labs. Also, hospital-based labs charge more, and on an irrational sliding scale.

In the discussion, Dr Kapadia said that DMLTs are not supposed to set up their own labs. Dr Borges also said that MDs are not necessarily the most qualified professionals to run certain specialised investigations

Dr Sambargi said that laboratories like other private health services are essentially business propositions, and payment policies are based on this fact. Dr Borges said that even doctors -- not just pathologists -- have a range of charges. Dr Shelat responded that patients do not choose more expensive beds; they are compelled to do so by the hospital. Dr M J Shah added that the mandatory free beds in private hospitals are always blocked by private patients.

Dr Borges mentioned that a national board for pathology labs will soon make accreditation mandatory. Dr Bhalerao mentioned a voluntary service at Vellore and- also suggested that MD pathology courses take into account findings of gaps in current training.

Dr Chowdhary said that pathology reports from big hospitals are not always accurate. Dr Sanjay Nagral said that the profession should also be willing to be scrutinised for the standardisation called for in pathology labs. Dr Ruparel said medical students should be trained in "auditing" and "setting standards".

The afternoon's panel discussion concerned the doctor-patient relationship. Speakers were Hozie Kapadia (HK), M J Shah (MJS), RA Bhalerao (RAB), V C Talvalkar (VCT), A J Shelat (AJS), Anita Borges (AB) and Harshad Ghulam (HG).

About the criteria guiding the decision to ask for a referral (HK), while the only criterion is the good of the patient (AJS), the CPA leads us to ask for a second opinion anyway, leaving the decision up to the patient (RAB). For the essence of the problem is the breakdown of the relationship with the family physician (AB). Most patients have simple problems diagnosable by GPs (AJS). Family practice also saves resources, a fact now recognised the world over (S Karmakar). Yet GPs are given second preference, remembered only when there is a late-night emergency or a death (MJS). In this new scene, consultants have become glorified GPs (MJS). Many consultants do not even inform the family GP about the patient's management (HK).

Some suggested that doctors should be open about the cut practice (Y Lokhandwalla and RAB). Others felt that legitimising the prac[illegible]nc[illegible] that money, not the patient's interests, is primary (AB). The cut practice was started by consultants, not GPs (S Y Medhekar).

While some argued for a formal referral protocol, others opposed it in today's corrupt climate (GP). Also, all patients treated in a hospital must get a proper discharge summary (VCT).

Some felt doctors should refer only to those registered with the medical council (SYM). Others noted that this was already an MMC requirement; it is more important that patients get a brief summary of their case management, enabling them to consult whoever they chose (AB and RAB). The question of regulating such varied medical practices was a social problem (Upadhyay).

Should doctors charge their colleagues? Some felt they should take only the cost incurred for investigations (RAB). They should be honoured to be chosen by a knowledgeable colleague (AB). Others argued that it made more sense to subsidise poor patients than well-off doctors (SKP, J Taskar). Yet others argued that the two were not mutually exclusive, and were done on different principles.

Other points: doctors should consider the opportunity cost of free consultation (VS); charge since the bill is picked up by medical insurance companies (MJS) [opposed by those who felt we would go the American way (VJ)]; free service isn't of the same quality; family doctors accompanying patients to a consultant could charge for their time (SYM).

One response: the discussion indicated that doctors functioned as traders in a market economy, they should then be expected to be treated as such. From an ethical point of view, doctors have a clear responsiblity: to treat the poor, and to correct the maldistribution of services which encourage unethical behaviour (AJesani).

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