

## 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 in the 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<sup>1</sup> and the Shipman affair<sup>2</sup>. 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.

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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

### References

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3. Stacey M. The General Medical Council and professional self-regulation. In: Gladstone D (editor). *Regulating doctors*. Institute for the Study of Civil Society, London. Great Britain: St Edmundsbury Press; 2000:28–39.
4. General Medical Council (GMC). An introduction to revalidation [Internet] [cited 2014 Dec 18]. Available from: <http://www.gmc-uk.org/doctors/9627.asp>

## 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 policies 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?