

## EDITORIALS

# The functioning of the Medical Council of India analysed by the Parliamentary Standing Committee of Health and Family Welfare

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On March 8, 2016, the 92nd report on the functioning of the Medical Council of India (MCI) (1) was placed before both Houses of Parliament by Professor Ram Gopal Yadav, Chairman of the Parliamentary Standing Committee of Health and Family Welfare.

The committee examined the role and functioning of the MCI and obtained a background note on it from the Ministry of Health and Family Welfare, Government of India. The Ministry informed the Parliamentary Committee that it had set up a group of experts to study the Indian Medical Act of 1956, had obtained its report in February 2015 but that it "was under consideration of the Ministry". There is no explanation of why it took the Ministry over a year to complete its "consideration" and make changes for the better.

The committee noted that primary health care centres showed a worsening of vacant positions of doctors. Dr Devi Shetty, former member of the Board of Governors of the MCI stated, "I am not really that concerned about medical education but I am very concerned about the impact it has on the lives of common people..." (1:11) He did not find the effect of substandard medical education on these very common people important.

The representative of the Indian Medical Association made some astounding statements. Here is an example: "In India even a general practitioner sees 500-1000 patients daily." (1: p13) The unspoken assertion about the number of patients seen by individual specialists would then be truly mindboggling. Since an average doctor works for eight hours on each of six days, the available time is 2,880 minutes. Even at 500 patients, the time per patient is about 6 minutes. This time is barely adequate to obtain a cursory history, leave alone examine the patient!

The representative of the MCI could not tell the Parliamentary Committee the number of doctors registered with it who were actually practising in India and how many had emigrated. It merely stated that the process to collect such data had been undertaken. The Parliamentary Committee concluded in bold letters: "**the Indian Medical Register is not a live database and contains names of doctors who may have passed away or retired from active practice, by now, as well as those with a permanent address outside India and that there is no mechanism in place for filtering out such cases... the MCI has been unresponsive to health system needs (of the country)...**" (1: p 85)

The Parliamentary Committee noted that the MCI has 102 members of whom 35 are nominated and 67 elected and that central and state governments have nominated doctors from corporate private hospitals to represent themselves in the current MCI. Currently, there are 412 medical colleges in the country of which 217 (53%) are from the private sector. This is a damning statement in a country committed to "health for all" and in which the vast majority cannot afford private education and healthcare. The Parliamentary Committee recorded expert opinion that "MCI as presently elected has been mired in multiple controversies and corruption and what is of greater concern is it has failed to address the needs of the health system in the country. The MCI as presently constituted is not accountable or transparent in its functioning."

In its conclusions to this section of the report, the Parliamentary Committee once again notes in bold print: "...**The Medical Council of India, when tested on the above touchstone, has repeatedly been found short of fulfilling its mandated responsibilities... the MCI, as presently elected, neither represents professional excellence nor its ethos. The current composition of the Council reflects that more than half of the members are either from corporate hospitals or in private practice. The Committee is surprised to note that even doctors nominated under Sections 3(1) (a) and 3(1) (e) to represent the State Governments and the Central Government have been nominated from corporate private hospitals which are**

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**not only highly commercialised and provide care at exorbitant cost but have also been found to be violating value frameworks...the current composition of the MCI is biased against larger public health goals and public interest...**"(1:p 87-8)

As regards the constitution of the MCI, the Parliamentary Committee made this recommendation: **"The Committee, accordingly, recommends that the regulatory framework of medical education and practice should be comprised of professionals of the highest standards of repute and integrity, appointed through a rigorous and independent selection process. This process must be transparent...Committee is of the considered view that the composition of the MCI is opaque and skewed and diversity needs to be brought into this because having only medical doctors in the Council is not an enabling factor for ensuring reforms in medical education and practice..."** (1:p 89)

The Parliamentary Committee advocated opening membership of the MCI to public health experts, social scientists, health economists, health NGOs, legal experts, quality assurance experts and patient advocacy groups. There is an urgent need to restructure the composition of MCI. The Parliamentary Committee agreed with the recommendation of the Roy Choudhary Committee that no member of the MCI can hold this office for more than two terms.

Among other topics, the Parliamentary Committee's report considered

*Capitation fee and common entry examinations:* It recommended a national common entrance test and a common exit test for all medical colleges, including those charging capitation fees to ensure that the quality and competence of every doctor is guaranteed and standardised.

*Fees charged by private medical colleges:* The Parliamentary Committee recommended uniformity of fees across the country among the public and private sector medical colleges, with strict enforcement of the fee structure.

*Postgraduate medical education:* "The present MCI system of oversight of PG medical education does not at any stage evaluate the teaching and learning process or have any benchmarks for quality... The Committee is, therefore, convinced that an overhaul of the whole system is required, and accordingly, recommends that the PG medical education system should be restructured in such a way that training is assessed by the quality of the product and not by the infrastructure and a robust system be put in place for evaluation of skills and competencies."

*Merger of DNB and MD/MS programmes:* Deploring the two parallel systems of postgraduate certification (University and NBE), the committee recommended that the current system of PG medical education should be restructured taking the best of both systems that is, all India common entrance exam for all seats and common exit evaluation for all candidates as practiced by DNB and the training and evaluation processes of the university based system into one national qualification. There should be only one regulatory body for postgraduate medical education and the training should be made more robust.

Chapter IX deals with regulation of professional conduct of doctors. I reproduce the Parliamentary Committee's recommendations in bold (as in the original document):

**"The Committee observes that the oversight of professional conduct is the most important function of the MCI. However, the MCI has been completely passive on the ethics dimension which is evident from the fact that between 1963–2009, just 109 doctors have been blacklisted by the Ethics Committee of the MCI... Due to crass commercialization of the health sector, many unprincipled doctors and private sector hospitals have lost their moral compass and overcharge or subject their hapless patients to unnecessary surgeries and diagnostic procedures. The instance of unethical practice continues to grow due to which respect for the profession has dwindled and distrust replaced the high status the doctor once enjoyed in society. What is of greater concern to the Committee is that the medical profession has not been transparent in dealing with complaints. It is a matter of surprise that despite the worst kind of gross unethical practices happening by way of ghost faculty, fake patients and hired instruments and substantial amount of money (not white, of course) reportedly changing hands at the time of inspections, there is little proactive action on the part of the MCI to deal with this malady..."** (1:p 102)

**"The Committee notes that the Ethics Committee of the MCI presently consists entirely of medical doctors and is thus a self-regulatory body. But all over the world, it has now been realized that the medical profession (or any profession for that matter) tends to protect its own flock. The Committee, therefore, recommends that the new Board of Medical Ethics should also have non-doctor lay members from different fields..."**

**"The Committee, therefore, recommends that the new Board of Medical Ethics should be mandated to develop standards and norms of professional conduct and codes of ethics for medical practice not only for individual doctors, but also for institutions of health service delivery, i.e., hospitals, clinics, nursing homes, rehabilitation centres, associations..."** (1: p 103)

**“The Committee is astonished to note that the MCI has notified on 1st February, 2016 an amendment to clause 6.8 of the Regulations, deleting the words ‘and professional association of doctors’ and exempt professional association of doctors from the ambit of MCI Code of Ethics Regulations, 2002. The Committee observes that exempting professional association of doctors from the ambit of Ethics Regulations is nothing short of legitimizing doctors’ associations indulging in unethical and corrupt practices by way of receiving gifts in cash or kind under any pretext from the pharma industry or allied health industry. The Committee agrees with the view point of public health activists that ‘an action that is ethically impermissible for an individual doctor cannot become permissible if a group of doctors carry out the same action in the name of an association.’ The Committee could not uncover any rational reason as to why the MCI has taken such a retrograde decision. It seems that the MCI has become captive to private commercial interests, rather than its integrity in public interest...”**(1:p104)

**“The Committee also finds it intriguing that instead of intervening to thwart attempt of MCI at subverting the system, the Ministry has meekly surrendered to MCI...”**(1:p105)

Chapter XII discusses corruption in the MCI. The Parliamentary Committee noted, “On being asked about the kinds of corruption that is happening in the MCI, the President, MCI during evidence before the Committee admitted that corruption was there when there was sanctioning of medical colleges, or increasing or decreasing seats (emphasis added). The Committee has also been informed that the private medical colleges arrange ghost faculty and patients during inspections by MCI and no action is taken for the irregularity. The Committee has also been given to understand that MCI is proactive in taking action on flimsy grounds against Government Medical Colleges which are 100% better...”(1:p 75)

“On being asked about the steps taken by the Ministry to tackle corruption in the MCI which has been there for the past 20–25 years, the Health Secretary during evidence submitted that the entire IMC act was under review. He also informed that the MCI Act as it exists today does not empower the Government to take action even in proven corruption charges. However, in the IMC (Amendment) Bill 2013, there is a provision that if there are proven charges then the Member can be removed. Such a provision was in the 2010 Ordinance also during the Board of Governor’s time...”(1: p 75)

In its conclusions to this chapter, the Committee notes in bold print: **“The Committee is shocked to find that compromised individuals have been able to make it to the MCI, but the Ministry is not empowered to remove or sanction a Member of the Council even if he has been proved corrupt. In a day and age when the need for sturdy systems and enhanced transparency based regimes are being increasingly emphasized, such state of affairs indicate that the MCI has not evolved with the times. Such state of affairs are also symptomatic of the rot within and point to a deep systemic malice. Otherwise how could it happen that the MCI, which has laid down elaborate duties and responsibilities of the ‘Physician’ under the MCI Code of Ethics Regulations, 2002, could have at its very top a person who was arrested on charges of corruption in 2010. The former Union Health Minister, who must have an insider’s view of the functioning of the MCI, making scathing comments about corruption in the MCI, speaks volumes of the decay in the MCI and is an eye-opener on the need for urgent reforms in the structure and functioning of MCI...”**(1: p 76)

Discussing the autonomy of the MCI and the government claim that it cannot remove a corrupt member, the Parliamentary Committee reiterated in bold print: **“The Committee is all for professional autonomy, but autonomy sans accountability tends to degenerate into autocracy and therefore cannot be acceptable. The MCI is funded by the Government and therefore the Government must have the leverage to enforce accountability in the MCI. Since the real cause of the problem is systemic and cannot be fixed without setting the system right, the Committee recommends that the Ministry should take expeditious action to amend the statute or enact a new legislation in a manner that it comprises within its ambit accountability provisions as well and empowers the Government with legal authority to intervene in matters of corruption...”**(1: p 77)

**“The Committee takes note of the admission of the President of MCI that corruption is there when there is sanctioning of medical colleges or increasing or decreasing of medical seats. However, the Committee finds the inaction of the MCI enigmatic in this matter. If the MCI is aware of the fact that denial of recognition of a medical college or grant of seats and then its permission/enhancement or reduction leads to corruption, then the Committee wonders why it has failed to put in place a framework or system which can plug these loopholes...”**(1: p 77)

**“The Committee wonders to find that certain persons were appointed as Advisors to the President in transgression of law and the Joint Secretary in the Ministry of Health and Family Welfare vide his letter dated the 4th March, 2014 had to write to the President to cancel ‘all such appointments which were not authorized by the Act.’ The Committee takes serious note of such flouting of law and would like the matter to be thoroughly probed and an action taken report furnished to the Committee within three months from the presentation of this Report.”**(1: p 77-8)

In its summary the Parliamentary Committee finds fault with the government and the MCI.

**“Due to massive failures of the MCI and lack of initiatives on the part of the Government in unleashing reforms, there is total system failure due to which the medical education system is fast sliding downwards and quality has been hugely side-lined in the context of increasing commercialization of medical education and practice. The situation has gone far beyond the point where incremental tweaking of the existing system or piecemeal approach can give the contemplated dividends...”(1:p 82)**

The Parliamentary Committee has performed a difficult task commendably. Its recommendations are reasoned and rational. Their implementation should go a long way in cleaning the Augean stable that the MCI currently represents.

### **Is optimism justified?**

Alas! I have my reservations. Recommendations of earlier committees, when found unpalatable by the government or when conflicting with vested interests of those in power have been rendered ineffective by the simple measures of either shelving them or, worse, referring them to yet another committee for study and recommendations.

A government that could transfer Mr Keshav Desiraju in order to facilitate Dr Ketan Desai's entry into the MCI through the backdoor of a recommendation by a pliant university in Ahmedabad, and which could accept the replacement of Dr Ketan Desai by someone else from the same state does not generate confidence.

I sincerely hope I am wrong and that these recommendations will be implemented *in toto*.

### **Reference**

1. Department-related Parliamentary Standing Committee on Health and Family Welfare. 92nd report on the functioning of Medical Council of India. New Delhi: MoHFW; 2016 Mar 8 [cited 2016 April 8]. Available from: <http://twofourinsight.com/wp-content/uploads/2016/03/20160308-RAJYA-SABH...>

## The Chennai floods of 2015 and the health system response

**RAKHAL GAITONDE, VIJAYAPRASAD GOPICHANDRAN**

### **Introduction**

The Chennai floods of 2015 were a calamity of unexpected proportions(1). The impact on the lives of the poor has been immense. Thousands needed to abandon their already precarious dwellings on the banks of the Adyar River, and other low-lying areas for temporary shelters. The differential experience and impact of disasters on different segments of the population helps understand the dynamics of sociopolitical structures and supports.

The disaster was recognised as being largely manmade. It has been reported that one of the important water reservoirs of Chennai, the Chembarambakkam reservoir was opened up during incessant rains without adequate warning, which contributed to the massive deluge(2). Unplanned urban development, illegal constructions, and corrupt practices of permitting development projects without environmental impact assessment have all also contributed to the making of this disaster. There is an urgent need to envisage a role for the health system (as part of all other public systems) towards a more sustainable and resilient future.

This editorial focuses on the health system response to the Chennai floods. It takes anecdotes and experiences of the authors and others whom the authors have worked with during the floods and tries to analyse the successes and drawbacks of the health system response. It argues the case for an effective and responsive health system, which is highlighted in the face of disasters as an ethical imperative.

### **Ethical framework of analysis**

Public health systems have an ethical obligation to protect and promote the health of populations and minimise health risks through equitable, transparent, responsive, proportional, accountable and sustainable actions. However, in the recent Chennai

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