HANDBOOK ON MEDICAL ETHICS

Law, ethics and Medical Councils: evolution of their relationships

Medicine: trade or profession?

In the past few years, Indian doctors have often been asked this question. In the present context of commercialised medical practice, there is a strong public feeling that doctors have become traders. Doctors, on the other hand, have reacted in a contradictory manner. Some have found the label 'trader' offensive and refuse to participate in any debate on the subject. Others have, at least implicitly, accepted that a large part of present day medical practice is nothing but trading by qualified as well as non-qualified medical technicians. Such doctors have, when cornered, attempted such defenses as, 'We are a part of society. Since it is heavily commercialised, why blame us?' The Indian professional can now lay claim to just two major characteristics: first, unlike a lay trader, the professional is highly educated, qualified and skilled; second, he does work for maximising income.

Some time back, in a small town where two of my friends practice medicine, one as general practitioner (GP) and another as a consultant, I had. an interesting experience. My GP friend had referred a patient to my consultant friend. The patient called up the GP after visiting the consultant to complain that the consultant had charged an abnormally high fee. The GP turned around and lamented on how rapidly standards were deteriorating. 'See, our idealist friend has become a professional. ' This was meant to be a criticism, an expression of disapproval and shows how a term which once gave a sense of pride to doctors has changed its connotation in the minds of doctors themselves.

Nevertheless, there is a sense of unease amongst most doctors when they are called traders instead of professionals.

The word profession is derived from the original Latin *profiteor* which conveys a meaning of making a public statement of commitment, promise, announcement or confession. When one refers to a dictionary, one finds that the term is restricted to learned occupations and religions. A profession is not merely an occupation of highly learned and skilled technicians. It also includes a strong and inseparable moral commitment made publicly. In medicine, this avowal of morality has behind it a tradition of many centuries. This is the reason why in the present completely commercialised environment there is inevitable tension between the traders in medical practice and those committed to giving primacy to healing the sick. That is also why even in an environment dominated by market ideology, it is not simply the wealth of doctor which gives him or her social and moral authority. A substantial part, if not almost all of that authority is derived from the public perception of the extent to which the doctor follows the ethical traditions of medicine. Ethics has become a force both within and outside the medical profession, shaping its contours and the behaviour of its practitioners.

The professionalisation of medicine ensured separation of overt trading practices from the activities of the medical professional. Earlier, the doctor, while healing the sick, was also compounding drugs and selling them to the patient at a price. This custom endures in some parts of the world. In most countries, compounding and/or selling drugs is no longer considered to be a part of the activities of the modern medical man. It has been entrusted to the chemists who evolved from the apothecaries. The apothecaries formed a 'lower' class of doctors: less educated and less skilled, who sold drugs directly to patients.

In our country this separation of doctors from chemists is ordered by law. Whenever doctors or hospitals have tried to store drugs for sale to patients, the chemists have protested against this infringement over their occupational territory. Similarly, another trading practice - 'fee splitting', or 'cut practice' - is also considered outside the realm of professional medical practice. This is why the profession as a whole is reluctant to admit its existence in public despite the existence of widespread cut practice in our country.

Place of *ethics in the medical profession*

The practice of medicine has a special characteristic not found in so pronounced a manner in other occupations. Doctors deal directly, and at the time when person is most vulnerable, with the immediate issues of life and death, health and illness. The patient is heavily dependent upon the technical knowledge and integrity of the doctor. The doctor thus has an unique involve-

We present a series of essays on **various aspects of** medical ethics which, taken together, might form **a handbook on the** subject. We shall print these on a four-page centrefold which **can be pulled out and filed for** reference. These **pages are being given** separate, sequential centrefold **numbers.**

ment with the patient, but this relationship, between doctor and patient, is not balanced. The patient's attitude is a complex of trust (which comes from perceived competence and integrity of doctor) and, paradoxically, also that of distrust which comes from the state of uncertainty and vulnerability.

This ambivalence in doctor-patient relationship is addressed by medical ethics, which tries to guarantee the patient that the doctor will not abuse his dominance in the relationship. Thus, medical ethics is essentially a regulatory mechanism that makes the doctor commit publicly that though medical practice is the source of his living, he will strive to the utmost for the benefit of the patient and not be driven by lust for mere personal aggrandisement.

This basic understanding of medical ethics pervades history, both in its modern period of professionalised medicine and in pre-modern medical practice. The professionalisation of medicine only elaborated the scope and role of medical ethics in the practice of medicine. In order to wipe out all traces of 'trading' from the minds and acts of doctors and to reassure patients, pioneers advancing medical ethics took great pains to severely restrict internal competition, poaching of patients, fee splitting and other practices that are commonplace in the- world of commerce but have no role in medicine.

The 19th century saw the development of elaborate measures towards this goal in the Western medical world. Doctor-to-doctor relationship was regulated. This paid huge dividends to the medical profession. It helped the profession by wiping out 'external' competition from quacks, midwives and others and consolidated its monopoly over medical practice. Stress was then laid on the doctor-patient relationship. The integration of the democratic principle of patients' rights in the explicit ethical framework followed.

It was only in the 20th century, under the pressure exerted by the creation of national health services in the European world, the involvement of the legal profession in ensuring a better deal for patients and malpractice litigation that greater public accountability by the medical profession became mandatory. This led to the elaboration of patient's rights as an autonomous individual in the codes of medical ethics. Interestingly, the issues of the doctor's competence, systematic and periodic peer review of his health and medical knowledge as criteria for judging fitness to practice were elaborated only in last quarter of this century.

There is nothing to suggest that historically, ethics governing medical practice are unchanging and form fixed categories. Although ethics seem to be emanating from moral principles, giving an impression that the moral doctor is ethical, in fact both morality and moral principles are found to be ever evolving, consequently changing material relationships between the medical profession and society in general; and between doctor and patient and doctor and doctor in particular. The concrete shape of ethics in medicine is embedded in the contemporary, material, social reality rather than in any abstract moral philosophy or moral principles. The relationship between law and ethics is indicative of the changing reality at any given time and is a good guide for analysis of trends.

Self-regulation of medical practice

The concept of self-regulation is strongest in the medical profession. The only other profession which, perhaps, could boast of more autonomy and greater self regulation is the priestly community and those involved in the work of religion and theology. Self-regulation implies a voluntary and internal regulatory mechanism within the profession, irrespective of whether such controls are demanded by law or others outside the profession.

This concept can be traced to ancient times. The traditions set up by Caraka, Susruta in India, Hippocrates in Greece and other medical sages elsewhere are examples of this concept in practice. The oaths named after them and the obligations they enforced from their pupils were not legal documents. Rather, they exerted authority on the basis of the relationship between teacher and student and the examples offered by the teachers, gaining a sanctity that few laws can match. The extremely high standards they set prompted the acceptance of these oaths by subsequent professionals in medicine right up to the present as the basis for medical ethics. In our own time, these moral codes are used during the initiation of neophytes into the profession and for self-regulation by medical practitioners belonging to private, voluntary associations. They provide moral foundations for self-regulation and a justification for the autonomy of the medical profession.

This autonomy provides doctors great flexibility in their work. It permits improvisations and innovations, without which the science and art of medicine cannot progress. It also gives them the authority to determine reasonable standards of practice based on acceptable scientific practice at any given period. Autonomy is, however, a double-edged tool. The monopoly of medical practice can allow and has, in fact, permitted many

members of the profession to deviate from its social obligations, Using its control over medical education, such monopoly can make and has made the entry of individuals in the profession so difficult that there is a gross short supply of doctors to society or ensure that there is a perpetuation of dynasties within the profession. Autonomy can and has led to more power to doctors in relation to patients and abuse of such powers. The pursuit for profit and high income can and has led to the neglect of healing objective. These and many other ills that go with irresponsible autonomy make it mandatory that professional groups prove their responsibility by strict self-regulation and disciplinary action against erring members. They must show society that the freedom and latitude awarded to them are not misused. The implicit existence of self-regulation is not sufficient. Self-regulatory mechanisms must have sufficient transparency before they can gain credibility in the public eye.

Law and medical ethics

Frank Grad, a professor of law, in his article entitled 'Medical Ethics and the Law' in *Annals of the American Academy of Political and Social Science'*, commented: 'It is part of our folklore that once we were a free people, with physicians, lawyers and others carrying on their professions free from burdensome regulations, exercising their best professional and ethical judgments, responsible only to themselves and to their peers, in accordance with norms expressed in codes of professional societies in which they were free and voluntary members. Historical facts do not match folklore. Physicians have been a regulated profession for quite some time. Indeed, the practice of medicine was one of the earliest fields in the United States to be subjected to licensure and to regulatory controls concerning education and training and elements of personal and ethical fitness.'

It is true that absolute autonomy and moral self-regulation are nothing but folklore in the modern context. Historically, doctors, themselves, have fought bitterly against established medical vested interests and other political powers to persuade society to promulgate laws for registration (licensure) of doctors and control over medical education. The 18th and 19th centuries were marked by the struggle of doctors to get legal recognition of their autonomy and self regulation. This of course was necessitated by the emergent socio-political order based on private property, liberal democracy, industrialisation and formation of nation states. Within medicine, the monopoly of a small learned group to be harbingers of medical knowledge was challenged by the emergence of scientific medicine. These factors created historic changes in the Western world, originating in England, for changing from informal, voluntary autonomy to formal and legal autonomy and organised self-regulation by such bodies as the General Medical Council.

The current larger framework of autonomy and self-regulation within which the medical profession is governed is also a legal framework. There are two broad aspects which distinguish medical self regulation from that by the law.

Within the legal framework, Medical Councils have been given sufficient powers to regulate members of the profession. Professionals on these Councils can carry out their regulatory function using their 'scientific' and 'moral' expertise. The morality of ethics, with strong roots in the Hippocratic tradition, has therefore helped shape modern codes of ethics. The scientific expertise has, of course, helped in shaping the medical training and the standards of medical care. (While such regulations are formulated under legally created Medical Councils, voluntary professional associations have played and must continue to exert a very important role.)

The profession is also given power to implement regulations formulated by itself. The profession, thus, not only decides the details of its regulatory mechanism, but uses its own members to implement it. Here, to use an example, the liberal democratic principle of separating functions of legislation/executive and judiciary is waived in favour of providing autonomy to the profession.

It is normally accepted as a rule that ethics is something more than law. The formulation of various aspects of ethical code is based on ethical principles which are in many ways different from legal principles. Ethics govern conduct. Principles based on it thus delve into fine aspects of the conduct of doctors. Ethics and its principles also come into play to resolve recurrent ethical dilemmas in medical practice. As the occurrence of a particular dilemma increases and as its resolution in a certain manner gains general acceptance within the profession, it gets integrated into the code itself. This creates a dynamic mode which makes the ethical code progressively more elaborate. Laws are circumscribed. Their elaboration by the judiciary is also greatly limited. Since the profession acts as law maker as well as its implementing agency, its elaboration is wider.

The point of ethics being more comprehensive than the law has a practical implication on medical malpractice and judicial remedies available against it. Legal recog-

nition of medical malpractice is confined to violation of a specific law, criminal nature of malpractice and admissibility for compensation. For instance, compensation can be sought only if harm and loss are demonstrated. Whilst malpractice not resulting in loss and harm does not qualify for compensation, such malpractice can still qualify as unethical conduct inviting penalty on the doctor.

There is another interesting relationship between the law and ethics. Since autonomy and self regulation are not merely ethical principles but are backed by law, the self regulatory code has legal value and significance. Once specific clauses are accepted by the profession as part of a self-governing code, they acquire legal validity. Aggrieved patients can haul up professionals erring against such clauses before the court of law. Medical Councils in our country, and, to a lesser extent even in the countries of their origin (Western Europe) have shown inadequate efficiency in the stringent implementation of self-regulation by doctors. Patients and public organisations have ample scope under the law for making them respect their legal obligations.

A lesson for the medical profession

Professor Grad's statement (quoted above) also highlights an emerging trend that can only be ignored by the medical profession at its peril. Failure of doctors to put their house in order must, inevitably, bring in its wake regulatory mechanisms imposed by society on the profession in the form or legal and other restrictions. Such impositions are likely to be beyond amendment by the profession. If, then, the profession is to safeguard its autonomy it must remain true to the principles of ethics and maintain total transparency in its dealings with patients in particular and the public at large.

References and further reading

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XVIII 'Annual meet of Medico-Friends Circle (MFC), December 27-29, 1995, Yatri Nivas, Sevagram, Wardha, Maharashtra

Theme: Ethics in health care.

MFC invites all interested individuals, groups, organisations and institutions to participate. If you'd like to help in the planning of this meeting, please join our adhoc organising committee. We invite background papers, articles, reports, notes and case studies on any topic relevant to the theme of the meet.

We propose to discuss, among other issues, the following:

- the making and implementation of health policies
- population control and family planning, research on and use of various contraceptives
- disaster management (as in Bhopal, Latur)
- experiments, innovations in low cost primary health care delivery by non-governmental-organisations (NGO)
- technology, end stage disease, organ transplantation
- mental health care
- AIDS
- cost of health care and doctors' fees
- any other relevant topic.

'During this meet a creche-cum-camp for children will be organised on all three days. Participants are encouraged to bring their children along.

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