

The Indian Medical Council Regulations 2002: non-application of mind and spirit

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6.6 Human rights: The physician shall not aid or abet torture nor shall he be a party to either infliction of mental or physical trauma or concealment of torture inflicted by some other person or agency in clear violation of human rights.

This is the manner in which the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 (passed under Sections 20A and 33(m) of the Indian Medical Council Act, 1956), defines 'human rights'. No wonder, then, that the regulations fall terribly short of reflecting a human rights sensibility in its provisions. One would have hoped that the onslaught of HIV/AIDS in India in the last decade would have made the medical fraternity acutely aware of the need to address and uphold human rights while dealing with patients generally and people living with HIV/AIDS in particular. HIV/AIDS had just such an impact in the United States where the importance of consent before testing, confidentiality and non-discrimination were seen as essential components in effectively dealing with the epidemic. This had reverberations on the medical system in general, which saw great improvement in patients' rights and much greater accountability from physicians.

The Indian Medical Council (IMC) is clearly averse to this approach. This article attempts to highlight some of the failings of the new regulations and explain the golden opportunity that was lost due to an evidently insensitive and aimless approach adopted by the IMC.

The absence of consent

The concept of consent is so fundamental to our lives that it has been recognised under a variety of laws and ethical codes of practice. The decision to give consent is a choice we often make in our daily lives. The concept of consent derives from the seminal notion that every adult human being of sound mind has the right to decide what should be done to her/his body. This notion of autonomy is inherent to humans, and a violation of this autonomy is considered a serious wrong – in criminal law (where such a violation is described as assault and battery), in our Constitution which guarantees the right to life and liberty, and in common law regimes through judgments down the ages.

One would imagine that consent would be a core principle in the medical profession, where, due to the skill and knowledge possessed by a physician and the trust bestowed in her/him, a relationship of inequality develops that requires balance before a patient's body can be interfered with. It would therefore be required that patients be given information about procedures they need to undergo, so that they can make an informed choice about such treatment.

Shockingly, the new regulations virtually ignore this fundamental principle. Not only is the concept of consent

absent from the underlying tone of the regulations, it is only referred to in one clause ('7.16: *Before performing an operation the physician should obtain in writing the consent...*'). This clause is worded in such a manner that in essence it compromises on the principle of individual autonomy. Although it does mention that consent can be obtained from the patient himself, in the first instance it permits consent taken from the 'husband or wife'. This provision is possibly aimed at regulating proxy consent but then the language leaves much to be desired. The poor wording of this crucial clause reflects the lacklustre approach and non-application of mind of the drafters who obviously did not visualise the importance of consent. Instead the impression is given that consent can be obtained from the spouse without the necessity to obtain the same from the patient him/herself. An appropriate clause would have laid down the unequivocal requirement of consent in any medical procedure and then provided exceptions in various circumstances, such as in the case of unconscious patients or minors.

What of cases that do not deal with operative procedures? Is consent not required in such circumstances? This question is important considering that hospitals in India routinely conduct a variety of tests (including HIV tests) on patients at the time of admission irrespective of the treatment required.

It is even more disappointing to find the absence of the principle of consent anywhere else in the regulations. The regulations provide that pathology tests or any other diagnostic laboratory investigations require to '*...be done judiciously and not in a routine manner*.' This language is not protective enough that it imposes a duty on the healthcare worker to obtain consent. In the HIV/AIDS context particularly, where testing for sero-status is a key issue, this provision gives much leeway to the physician to insist on an HIV test without obtaining consent.

In another clause of the regulations, decisions to change treatment only require to be '*discussed/ explained*' to the patient. The consent of the patient finds no mention here either.

In the HIV/AIDS context, consent has been recognised as essential before testing in the National AIDS Prevention and Control Policy (NAPCP). Yet, it has been ignored in the IMC regulations.

Compromising confidentiality

Like consent, the principle of confidentiality is sacrosanct in legal and human rights discourse. It should be sacrosanct in any sensible public health strategy too. Again, it is HIV/AIDS that has highlighted the importance of maintaining confidentiality in order for stigma and discrimination to be tackled, and for the effective control of the epidemic. Not only have privacy and confidentiality been recognised as key human rights, but their maintenance is a key component of an effective public health system. After all, would anyone

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access the services of a physician if it was known that the information shared in the visit would be divulged outside the doctor-patient relationship? If people stopped accessing physicians how would society be able to grapple with health crises that had disappeared underground? It has, therefore, been established that confidentiality is crucial in any effective public health system. However, the IMC regulations fall short of protecting confidentiality in a precise and satisfactory manner.

In dealing with issues such as the maintenance of medical records, surely the patient should be guaranteed confidentiality. However, the regulations fail in providing this. On the contrary, without any controls being prescribed to maintain patient confidentiality, the regulations provide that medical records shall be issued if any request for them is made ‘...by the patients/ authorised attendant or legal authorities involved...’. This means that those other than the patient concerned could have access to information that should be private between doctor and patient, without any clarity on the grounds under which such information can be shared.

The regulations even provide that a physician should ‘...ensure himself that the patient, his relatives or his responsible friends have such knowledge of the patient’s condition as will serve the best interests of the patient and the family.’ This predicates that a physician actually has a right to breach confidentiality to a wide spectrum of people and clearly without consulting the party most concerned and whose right is at stake – namely, the patient. Surely this goes against all norms of medical practice as reflected in law and ethics.

The regulations then provide specific grounds under which a physician can disclose ‘the secrets of a patient that have been learnt in the exercise of his/her profession...’. These include disclosure under orders of a court of law, in cases of a notifiable disease and ‘in circumstances where there is a serious and identified risk to a specific person and/or community’. This appears to be an attempt by the IMC to factor in the ratio of a leading judgment on medical confidentiality – *Tarasoff v Regents of the University of California* (17 Cal 3d 425) which was cited in the Indian Supreme Court’s judgment in *Mr. X v Hospital Z* (1998) 8 SCC 296 (wherein the Supreme Court of India suspended the right of HIV-positive people to marry). Unfortunately the IMC appears to have got the framework laid down by the American court a little wrong. The court in the case of *Tarasoff* sought to delicately balance the need to maintain confidentiality against the need for disclosure in very specific circumstances. Essentially it said that if a physician found that an *identifiable third party* was *foreseeably endangered* due to the conduct of the patient then the physician had a duty to warn the third party. Clearly then, disclosure has to be to a *specific* third party and cannot be made generally. The regulations, however, conveniently permit the physician to violate confidentiality in cases of risk to a *community*, thereby permitting public disclosure. It is hard to imagine the citizenry accessing the services of a healthcare professional who follows the framework set out in the regulations.

(It is important here to note that in the case of *Mr. X v Hospital Z* the Supreme Court of India did not require a physician to divulge the HIV-positive status of a patient to his/her spouse. It, however, held that if a physician made such a disclosure, s/he would not be liable.)

Conclusion

The regulations also fail to put sufficient onus on the private health sector to treat all patients. In the absence of anti-discrimination laws to protect patients in the private sector (against which the constitutional remedy of equality cannot be used), private practitioners are left free to discriminate, as they rampantly do against HIV-positive people in India. Following another Supreme Court judgment [*Parmanand Kataria v Union of India* (1989) 4 SCC 286], the regulations provide that even private healthcare must treat a patient in emergency cases. But this cannot improve the situation sufficiently. In order for the healthcare system in India to reclaim its position as a key *service* provider, members of the healthcare system must understand the importance of patients’ human rights and assist in their realisation. If this understanding of human rights remains only ‘the right against torture’, and does not consider issues such as consent and confidentiality within its framework, then the healthcare system will have failed in its fundamental duty to improve the health of the community it serves.