

Personal integrity

One of the dominant themes discussed in medical ethics in India is that of personal integrity. It may also have the widest application. Indeed, this is the foundation of ethical guidelines ranging from the oaths of Hippocrates and Charaka to more current guidelines and codes. Medical education must inculcate values in students so that they understand that ethics is a part of their professional identity. However, ethical issues are barely touched upon in the course of medical education in India. IJME has tried to fill the gap created by the absence of India-specific educational material on ethics. This section contains pieces written by experienced practitioners and medical teachers, giving practical advice and laying down norms for good practice to the benefit of the medical student, medical practitioner and, eventually, the patient. They also look at variations of the physician-patient interaction and the various associated relationships, such as with the consultant, the referring physician, and the pharmaceutical industry.



Ethical problems in medical education

F E Udwadia

In this article a senior physician and medical teacher declares that medical education in India fails to equip the student with the necessary attributes and the breadth of vision “that transcends the mere acquisition of knowledge”. The problems start with the medical school entrance examination where high marks are no indication of intellectual ability. The system uses outmoded teaching methods that rarely teach ethical principles at the bedside. The writer is aghast at the culture of private coaching classes. There is something very wrong about paying fees for private tuitions. The practice invariably leads to other ethical lapses.

Ethics and morals

Medical ethics is merely one branch of general ethics, therefore it would be wrong to divorce ethics in medicine from the ethics of everyday life. Professor Dunstan gives a succinct but good definition of medical ethics – “obligations of a moral nature which govern the practice of medicine.” (1, 2) It is important to dwell briefly on this definition to understand the implications of ‘obligations of a moral nature’ and ‘the practice of medicine’. ‘Moral’ and ‘ethical’ are for practical purposes interchangeable words. The term ‘moral’ raises the practical issues of good and evil, of right and wrong, and of one’s obligations as a physician to choose the good or the right course. This is not always easy because one moral obligation may conflict with another different but equally righteous moral obligation in a given situation.

Morals have a basis either in religion, philosophy or socio-cultural traditions. Different concepts in religion, philosophy or in socio-cultural traditions will lead to differing moral principles. It can become increasingly difficult to establish an agreed ethical code in a number of situations where there is a wide variation in the moral

base (3). Even so, the absolute values of good and evil, right and wrong, and the belief in the sanctity of human life, are remarkably similar in all societies.

Medicine – a search for truth

Thus, the three basic, accepted, moral obligations in a doctor-patient relationship in all societies are, beneficence (and its companion-in-arms, non-maleficence), patient autonomy and justice. It is the judicious balance between these obligations that determines ethical decisions in a given clinical situation.

The practice of medicine, in a very broad philosophical sense, is a search for truth, and ethical and moral principles are in-built and inseparable within this search. In a more pragmatic sense, the practice of medicine is both an art and a science. The aspect of science in medicine is more easily understood. For example, it may constitute accurate, measurable observations that lead to a hypothesis, the truth of which is subsequently validated by relevant observations. The art in medicine is an immeasurable, indefinable quantum. It indeed approaches the realm of philosophy, which according to Bertrand Russell is the art of rational conjecture. It is no surprise that physicians have been some of the best philosophers through the ages, and have translated abstract theories of classic philosophy into practical philosophic or ethical action at the bedside.

Medical education and practice

The practice of medicine requires education, knowledge, and wisdom born of experience. It has to be taught and its path illuminated, so that the student who aspires to this practice is shown the way. It is the moral obligation and ethical responsibility of a civilisation or a society to ensure that this is done. The need to equip a physician with the right attributes and to inculcate a breadth of vision that transcends the mere acquisition of knowledge is even more imperative in a fast-changing, increasingly technology-oriented world. If this is neglected, the physician of today and tomorrow may do more harm than good and may well be a hazard to those he ministers to. It is unfortunate that this basic objective in medical education seems to be increasingly ignored in our country.

Medical education all over the world involves selection for admission into medical schools, undergraduate study, postgraduate study and qualification, specialist training and research. I shall briefly consider the problems that plague each aspect of medical education in our country.

Admission to medical school

Entry into medical schools necessitates a selection from a large number of applicants. Universally this is attempted through results of a premedical examination in basic sciences relevant to medicine, and a personal interview of aspiring candidates. It is the height of absurdity that the average level of marks required for admission to medical school at the premedical entrance exam in Mumbai is over 95 per cent. One would have expected brilliance of an extraordinary character (amounting to genius) from these students.

Far from it, the standard at most is average and often pathetic. The fault obviously lies with the premedical education and the premedical exam. Surely a system of examination can be devised where the exceptional few would get more than 70 per cent, the very bright around 60 per cent and the average pass marks are around 50 per cent. A system of examination (as it exists today) where the difference of half or one mark decides admission into medical school, and where so many entrants to medical schools in Mumbai, mediocre though they may be, score near about 100 per cent, is not only absurd but morally and ethically unjustifiable. It needs drastic change and with a little effort this is possible. The system of examination again should not only be different, but should be patently fair. It should be so organised and conducted that allegations or leakage of papers and unfair marking practices are laid to rest once and for all.

Undergraduate medical education costs

Medical education as I see it today is confused in method, content and purpose. The old disciplines in medicine continue to expand taking up time and attention, only to be challenged by claims of newer disciplines, which have opened fresh vistas of knowledge. Good teaching involves a balance between what is old and trusted and what is new and changing. Medicine knows no frontiers. Even

so, the main thrust of undergraduate medical education in our medical schools should be oriented to the health problems and the people of our country. Yet the current trend is to lay greater stress on problems afflicting the West, and a passing or poor reference to diseases that ravage our communities. It is of ethical importance to teach medical students various aspects of community medicine, as only then are they aware of practical health problems that beset the people of this impoverished country. This of course does not mean that we should turn a blind eye to what goes on in medicine in the rest of the world. It only means that we structure our priorities in teaching and in health care correctly.

The method of teaching in our colleges leaves much to be desired. It is dull, dry, didactic and tabulated. It takes no cognisance of current views, current methods and techniques, and often does not utilise the more recent methods of imparting education as for example the use of slides, video recordings, student seminars, project work, clinico-pathological conferences, the use and study of key references that illuminate a subject or that excite interest and curiosity. Good teaching though concentrating on essentials must question dogma, must arouse and encourage an attitude of inquiry and a thirst for knowledge, and serve as stimulus for further study. Above all, a good teacher should use the patient as the chief source of education. The patient is the centre or the fulcrum on which medical education rests. It is wrong for a teacher to ignore this basic tenet. Ward rounds should be rounds where the patient speaks and instructs directly or indirectly, and the medical teacher with consummate art serves as the medium through which the patient instructs.

All teaching whenever possible should be imbued with an ethical slant. Ethics in medicine need not be taught in didactic lectures, but should be illustrated at every opportunity at the patient's bedside. Ethical principles are imbibed by example and precept, so that a good teacher besides teaching well will have a tremendous moral influence on his students.

It is thus both the form and content of teaching that needs to be revamped in all our medical schools. It is the moral and ethical obligation of the medical school that teachers discharge this responsibility to the best of their ability. The sadness of medical

education, to my mind, is the paucity of good teachers and good teaching in our colleges. This is ethically indefensible and is the fount of numerous unhealthy trends that beset the medical profession.

Costs

Medical teaching should always be the prerogative of medical schools and teaching hospitals. It is morally wrong to allow or to encourage medical teaching at a fantastic cost and price through tuitions or coaching classes outside teaching hospitals. What is even more ethically insufferable is the allegation that some of these expensive coaching classes are run by teachers currently employed in medical schools. It is one of the tenets of the Hippocratic Oath that the teacher will teach his students what he knows as a duty and not for a fee.

The practice of coaching classes that claim to assure a successful exam result, and also perhaps ensure marks high enough to get good teaching resident posts, is not only unethical in principle, it is also fraught with numerous other unethical possibilities. There is always a probability, or at least a possibility, of a nexus between the coaching grades, distinctions and prizes at the university examinations. The tentacles of corruption and nepotism can further undermine a system that already leaves much to be desired. The standard of doctors would further fall, medicine as practised by these doctors would inevitably be even more oriented towards mere profit, and the profession would degenerate into a mercenary business where patient care may become secondary or even non-existent.

But then we must pause and ask ourselves: could these unethical eyesores (termed coaching classes) ever have come into existence in our city if teaching in our medical school was interesting, stimulating, instructive and comprehensive? Indifferent teachers and poor teaching in medical schools are ethically wrong and are undoubtedly factors responsible for the spawning of private coaching classes. This again illustrates a principle in medical ethics: one wrong often begets another and another so that we end up with a chain of wrongs.

Private medical colleges

Over the last two decades there has been a mushrooming of private medical colleges in our country, charging capitation fees of several lakhs of rupees. Should such colleges be permitted and even encouraged, or are these colleges unethical eyesores that make a mockery of medicine?

Private medical schools funded by trusts, foundations or even by individuals are not uncommon in other countries particularly in the United States. On principle there is nothing unethical in privately funded medical education, provided the following criteria are met:

- The *raison d'être* is altruistic and divorced from all profit motives.
- The college has the necessary infrastructure for good teaching, and has a hospital with sufficient number of beds to permit clinical study in all important disciplines of medicine.
- The college is well equipped and has qualified teachers in basic sciences and in clinical subjects with an acceptable student-teacher ratio.
- The funding and all sources of finance are transparently honest, and the fees charged are solely directed towards maintaining and improving medical education and facilities.
- There is accountability in the medical school's administration, and in all its other functions.
- The standard is on par with all other schools in the country.

There are very few schools that meet these standards. If, as is alleged, business ventures come in the guise of private medical schools, the standard of medicine would be deplorably poor and the practice of medicine an unmitigated disaster.

Examinations

There is even today a great deal of mistrust over the fairness of both undergraduate and postgraduate examinations. We read of favouritism, nepotism and even corruption. The degree of canker afflicting the honesty and propriety of examination results is impossible for an outsider to determine, but again it is the moral obligation of the universities to ensure that exams are fair and

impartial, on par with those conducted in teaching centres all over the world.

Postgraduate education

If undergraduate education is in the doldrums, postgraduate education is bound to suffer. Unfortunately, the majority of graduates, if they could, would elect to do their postgraduate studies and specialise. Freedom of choice needs to be tempered by ability, aptitude and resources. Ethically speaking it is preferable to have fewer but well-trained postgraduates and specialists rather than have a veritable army of postgraduates and specialists whose training by international standards leaves much to be desired. It is our ethical responsibility to ensure this is so. An inadequately trained specialist is an even greater danger to health than the poorly taught and trained general practitioner or community doctor. Such a specialist often practises in an uncritical workshop of technocracy, pays homage to and feeds the machine which benefits him, looks at his patients in a specialist frenzy but with blinkers, and loses the all important holistic approach to medicine.

It is ethically imperative that all invasive procedures, diagnostic or therapeutic, in specialist medicine should be taught and then supervised by peers in their respective fields. It is imperative, as in most countries in the world, that to independently qualify to do a potentially dangerous invasive procedure, a specialist needs to do and thereby practise a minimum acceptable number over a period of a year, and then continue to do so. This is sadly lacking in some specialties today and unquestionably contributes to iatrogenic morbidity and mortality.

Research

The last, yet important, aspect of medical education is research. There are undoubtedly some who are born to research rather than patient care. Research again should be on subjects of topical interest. There is indeed great scope for clinical research in our country because of the wealth of clinical material we possess. There is also an equally tremendous scope for epidemiological research – an aspect of disease that is shrouded in ignorance. Is it morally justified to allocate sparse funds for research on some aspect of disease

which has already been researched upon a hundred times over? This has more often than not become the rule rather than the exception in our country. It is important for the concerned authorities to realise that one good research publication is superior to a hundred research papers that repeat what has been said many times over. Integrity in research has deteriorated the world over; the motto “Publish or perish” is the sword of Damocles hanging over the researcher’s head. He compromises on scientific standards, on truth, on honesty, and often also on his ethical approach to methods employed to further his research.

In summary, ethics should relate not only to the practice of medicine but to all facets of medical education. Only then will the practice of medicine flower and flourish as it should. That “there is something rotten in the kingdom of Denmark” is obvious in relation both to the practice of medicine and to medical education. I shall not dissect the cause of this canker except to state that it is due to a sharp, progressive fall of values all over the world, more so in our country. When one loses one’s sense of values, when the value system is corrupt, the edifice this system supports and embellishes crumbles and disintegrates. One cannot expect the profession of medicine in all its varied aspects to remain a bastion of virtue and probity when it is surrounded by a sea of filth and corruption. The bastion slowly and surely is bound to be eroded and may well be submerged beneath this sea.

References

1. Dunstan CR, Dunstan GR. *The artifice of ethics*. London: SCM Press; 1974.
2. Dunstan GR. In: Duncan AS, Dunstan GR, Welbourn RB editors. *Dictionary of medical ethics*. London: Darton Longman and Todd; 1981
3. Johnson AG: *Pathways in medical ethics*. London: Edwin Arnold; 1990.
4. Russell B: *The art of philosophising*. Totowa, NJ: Helix Books; 1974.

Published in: Volume 5, Number 2, April-June 1997



Medical ethics: relationships between doctors

R F Chinoy

A lot has been written on appropriate ethical behaviour in the doctor-patient relationship. But doctors are never taught how to interact with their colleagues. The writer here describes the many ways this has not been accomplished as well as ways in which ethical interaction between doctors can be encouraged. She also describes ethical norms governing various other relationships such as between doctors in different specialties and between general physician and consultant. Norms for inter-professional relationships affect not only relationships between professionals but also the treatment of patients. The profession is both a fraternity of equals and a hierarchical group based on self-interest. The writer uses the guidelines of the Medical Council of India to elaborate on the different tensions in inter-professional relationships.

A code of conduct for inter-professional behaviour is, in all professions, an important element of organising the profession. Such a code faces challenges from within, from professionals unwilling to follow norms of conduct. It also faces challenges from without, as professionals face pressure from patients, unqualified practitioners and the demands of the market.

Introduction

Over the four-and-a-half-year span of medical training, students are extensively grilled on how to diagnose diseases and treat patients. The rules of conduct, which should guide his behaviour when interacting with his own professional colleagues, are hardly ever touched upon in the medical curriculum. These rules and laws actually offer a framework within which the future doctor can act. Many students and practitioners are genuinely surprised to know

that rules actually exist. Some know that some sort of ethical conduct is expected of them, but are not very clear on the subject. This essay is an attempt at starting a discussion on the ethics of relationships between doctors.

Forms of professional relationship

The doctor has to play many roles in his professional life. He is both student and teacher during different periods of his career, a patient himself when ill, or a doctor to another professional colleague. More pertinently, throughout his career, he has to regularly interact with colleagues in his speciality and those in different branches of medicine. The forms of professional relationship between two doctors may thus be summarised as follows:

- between student and teacher;
- between doctors (including specialists) in the same discipline;
- between general practitioner (GP) and consultant;
- between two doctors in differing specialities and
- between the doctor and his doctor-patient.

Principles governing the relationship between doctors

It is necessary to clear a general misconception that medicine and ethics are two independent and divergent subjects, or that ethics is merely an adjunct to medical activity. The two are irrevocably harnessed together, and this marriage has been recognised since before the days of Charaka, Susruta and Hippocrates. After all, medical ethics are those obligations of a moral nature which govern the practice of medicine (1). In turn, the practice of medicine, in any field, in any discipline, has been succinctly described as “a long, continuous sequence of ethical moments.” (2)

The set of moral principles that must guide members of the medical profession in their dealings with each other is termed medical etiquette. The basis of a good relationship between doctors lies in mutual respect and understanding. A feeling of loyal camaraderie is essential, not only for the sake of the profession but also for the welfare of patients.

Rules or codes of medical ethics are good templates to work on. In this essay, only those comments and rules that apply specifically

to the relationship between doctors will be covered. On this matter, the Medical Council of India declared the following clauses in its code of medical ethics:

- I will give to my teachers the respect and gratitude which is their due.
- I will maintain by all means in my power, the honour and noble traditions of the medical profession.
- My colleagues will be my brothers. (3)

In the same vein, the International Code of Ethics states the following:

- A doctor ought to behave towards his colleagues as he would have them behave towards him.
- A doctor must not entice patients away from his colleagues. (3)

Some rules are clear and precise. However, there is scope for debate and controversy in many of the complex situations of our modern competitive lifestyle. Some of these controversial areas will be dealt with individually, with frequent references to the Indian code of medical ethics. Situations as they exist today will be touched upon and attempts to achieve the ideal will be suggested.

Student and teacher

One of the tenets of the Hippocratic Oath states that it is a physician's duty to teach his students all he knows, freely and without thought for remuneration. At an undergraduate level, the physician (and I use this term in the broad sense which encompasses doctors in all disciplines of medicine) is teaching his future colleagues.

The onus of guiding and shaping a young mind should never be taken lightly. As stated by Dr F Udwadia, "Good teaching, though concentrating on essentials, must question dogma, must arouse and encourage an attitude of inquiry and a thirst for knowledge and serve as a stimulus for further study. Above all, teaching must be imbued with an ethical slant." (4) The professionally sound and ethically upright teacher is in the best position to appear as a role model for his impressionable pupils.

The ideal is sometimes very far from reality. Full-time teachers are often dull, uninteresting and are themselves bored with the monotony of their teaching careers. That they are underpaid and

live in relatively modest conditions as compared to those of their colleagues in private practice does nothing to improve their psyche. The cream of the medical profession is often enticed into making their way to foreign shores, or to the more lucrative avenue of private practice. Teaching jobs are often manned by professionals who start working as a stop-gap arrangement and then just carry on, with very few being truly motivated to take on the vocation of being a teacher. Many teachers view their work as just another job. Many of the truly gifted teachers may not be motivated enough to take on the job because of its limited returns. Some of these same full-time teachers resort to coaching classes to boost their income. This is unethical and is a source of corruption with all the undercurrents of nepotism and misconduct. Students at the undergraduate level are striving not just for the 'pass class'. They know, and the teacher knows, that marks matter tremendously for entrance into the postgraduate training programme. One does not require much imagination to understand the implications of coaching classes run by potential examiners or by influential staff members.

The government has got to realise that teachers at all levels (and this definitely includes school teachers), are in the best position to mould young minds. In order to recruit good and gifted teachers, it is necessary to provide them with salaries and amenities that are realistic and at least on par with the earnings of those in practice.

For those already in the teaching profession, it is imperative to see that high standards of teaching are maintained and improved upon with constant seminars and workshops for teachers. Teaching aids, computers, internet facilities and availability of the latest journals and literature on the subject are not just a luxury but a necessity in the fast changing world of medicine.

At the postgraduate level, it is the duty of the teacher to train the young doctor so that he learns to perform according to accepted international standards.

At present, clinics are held often at erratic intervals and the science of medicine is elaborated upon. Ethical issues may be touched upon in passing, but ethical dilemmas are rarely the subject of detailed discussion. More often than not, the teachers themselves scoff at and ridicule the behaviour and practice of their own contemporaries.

To exercise restraint and maintain the dignity of their profession is something which many teachers themselves need to learn. Students are shrewd and discerning and can easily read between the lines when such comments are made. The effect of snide remarks on their minds is usually the exact opposite of what the teacher hoped to achieve.

Conducting coaching classes at the postgraduate level too is unethical and opens up immense possibilities for corruption and exploitation (3).

At an interpersonal level, sharing of knowledge and dissemination of scientific information are very necessary in our profession. For the advancement of his profession and for his own sake, a physician would do well to affiliate himself with medical societies and scientific meetings and contribute his time, energy and means so that these societies may represent and uphold the ideals of the profession. There is no age bar to the process of learning and it does not matter whom one learns from. It should not be surprising that one day the student may indeed be teaching his own professor in the course of conferences, seminars and workshops. The physician who feels he knows it all and has seen it all is dangerous. Sooner or later he is going to harm some of his patients because of his inability to keep up with the times and learn about recent advances and techniques.

Professional services of physicians to each other

A physician should consider it a privilege to render service to his colleagues and their immediate dependants. The Indian code of ethics urges a physician to “cheerfully render professional services to his physician-colleagues and their immediate family members without seeking monetary compensation.” However, there is no rule that a physician should not charge another colleague for his services (3). When called from a distance to attend to, or advise, a colleague he should be reimbursed for travelling and other incidental expenses. Unfortunately, many doctors who themselves require specialised or professional help from their colleagues cheat on them by seeking free treatment for themselves, their families and also for friends and distant relatives. This is unfair to the treating colleague, who gives of his best without receiving compensation

for his time and efforts. In this context, the terms ‘immediate family’ and ‘dependants’ require definition. The immediate family consists of parents, spouse and children. Dependants include non-earning members of the family dependent upon the doctor for their survival.

Duties of the physician profession at large

Doctors may criticise one another, but only face to face and in complete confidence. To criticise a colleague in front of a patient is both damning and dangerous and can never be justified.

It is equally important that the utmost care and tact be maintained when listening to patients complaining about how they have been treated or handled by other doctors. A patient who dislikes or develops a grouse against a doctor based on some real or imagined mistake can be extremely disparaging and indiscreet in his manner of speech. The mature doctor would do well to refrain from listening to this tirade against a colleague. If, however, he cannot restrain the agitated patient, he must studiously refrain from making any comment that could possibly be construed as acceptance of the patient’s criticism. Professional loyalty demands understanding and mutual respect for your colleagues.

On the other hand, a doctor is urged to expose incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession without fear or favour as these are against the best interests of patients. The accused doctor may be an alcoholic or a drug addict or a debauched person. Such matters may have to be considered by medical tribunals or by specially appointed ethics committees if they are not already sub judice. This cannot be considered as licence for witch hunting or slander. The responsibility is grave but must be followed through with courage and honesty.

Ethics of employment obtaining assistance of non-medical men

In the matter of employment of personnel who would be required to render professional skill and discretion, the physician is morally obliged to recruit qualified attendants who are registered and enlisted under the law in force at that time. Those who are deficient in character or education should not be allowed to attend, treat or

perform operations upon patients, as this is dangerous to public health. By enlisting non-medical men for medical tasks, the physician denies his colleagues jobs and, at the same time, does a grave disservice to his patients. If, however, the clinician does employ assistants to help him, the ultimate responsibility in the event of any mishap rests solely with the doctor.

A doctor asked whether he could utilise the services of a clinical laboratory which was not being operated under the supervision of a qualified pathologist but was run by a science graduate who had no medical qualifications. The reply of the Maharashtra Medical Council was as follows: "The medical practitioner should not cooperate with the clinical laboratory conducted by a BSc who neither has medical qualifications nor works under the supervision of a medical man. Such a person, by himself, is not competent to assess the results obtained and as he is not directly under the control of the medical council, a report submitted by him, if incorrect, will reflect upon the medical practitioner who acts on the report." (3)

The burgeoning home industry of small laboratories run by laboratory technicians or by mere science students or less is on the rise. There are, at present no curbs on this sort of activity. The truth is that they prosper and multiply because they are patronised by members of our own profession who find such laboratories cheaper than those run by professionally qualified pathologists and microbiologists. The danger to patients from this selfish measure can be considerable. In addition, injustice is done to our own qualified colleagues.

There is also a proliferation of diagnostic and imaging centres which are run as businesses, manned by smart but ill-qualified personnel. The public may not be in a position to understand the threats this may pose to their health. It is necessary for our profession and the medical councils to take cognisance of these centres and force them to run with some form of a licence under the guidance and direction of a fully qualified doctor. They, too, along with the pathology and microbiology laboratories, must be subject to reviews and surprise checks similar to those for blood banks.

The practice of doctors running drug shops, dispensing drugs and appliances prescribed by other physicians also needs correction. This is the prerogative of the qualified pharmacist. A physician

should not run a shop for the sale of medicine or for dispensing prescriptions prescribed by doctors other than himself, or for sale of medical or surgical appliances. This does not mean he cannot prescribe or supply drugs, remedies or appliances for his own patients, so long as there is no exploitation of the patient.

Advertising

The physician who sets up practice and announces his presence with an unusually large signboard is probably not breaking the law, but he is certainly acting unethically. A doctor's signboard cannot have the status of a glossy hoarding. Both signboard and the doctor's prescription pad should proclaim nothing more than the physician's name, qualifications, titles and speciality. It is improper to affix a signboard on a chemist's shop or in places where he does not reside or work.

Advertising lowers the dignity of the profession and entices or lures patients on the basis of glamour rather than competence.

The Maharashtra Medical Council is aware of the growing menace of doctors who seek self-glorification and who market themselves in newspapers, magazines and on television. Doctors, surgeons and many quacks have been known to make tall claims of successful and fantastic surgeries, guaranteed cures for obesity, cancer, AIDS and other diseases. Such individuals cannot wait for their work to speak for itself. Instead, they indulge in talk shows, consultancy columns in newspapers and advertisements of their arrivals and departures in various cities.

The Maharashtra Medical Council is now taking cognisance of doctors who advertise for various drugs, toothpaste products or remedies on TV and is also proceeding against doctors who place huge advertisements in newspapers for slimming programmes and other quick money-making programmes. Self promotion in any form is a punishable offence under the rules laid down by the Medical Council of India and the state councils. These also bar doctors from publishing their photographs.

Unless the councils force the medical profession to realise that such conduct will debar doctors from medical practice, this cheap exhibition is likely to worsen.

A physician cannot claim to be a specialist unless he has put in a number of years of study and experience in the speciality, or has the appropriate university qualification. Once he becomes a specialist, he cannot and should not work outside his specialty even for his friends. The ramifications of this statement are far reaching. Cross practice of allopathy and other disciplines of medicine like homeopathy, unani or ayurvedic medicine is wrong and it behoves the clinician to restrict his practice to the discipline he is specifically trained for. Dabbling in other sciences is unethical and potentially dangerous. On a similar note, the anaesthetist, for instance, should not do general practice. Nor should the neurosurgeon dabble in conditions that fall within the domain of the neurologist. There is, however, scope for debate on this issue when considering physicians who practise in rural areas, where they are forced to offer services on many fronts because of the non-availability of qualified or specialist help. The rules have to be viewed in the context of the circumstances and the intentions of the physician.

An institution run by a clinician for a particular purpose, such as a maternity home or sanatorium or home for the blind or aged, may be advertised in the lay press, but such advertisements should not contain anything more than the name of the institution, types of patients admitted, facilities offered and the residential fees. The names of the superintendent or the doctors attending should not appear in the advertisement.

The code of ethics forbids cheap exhibition by doctors in the form of interviews and articles published for the purpose of advertising themselves or soliciting practice.

The doctor is permitted to write to the press under his own name, on matters of public health or hygiene, or to deliver public lectures or give talks on the radio or television on subjects of public interest. He is also permitted to make a formal announcement in the press regarding the following:

- starting practice,
- change of type of practice,
- change of address,
- temporary absence from duty,
- resumption of practice and
- succeeding to another practice.

On a more pragmatic note, the Indian code of ethics categorically states that the “solicitation of patients directly or indirectly by a physician, by groups of physicians or by institutions or organisations is unethical.” The physician who advertises his skills, achievements, and qualifications lowers his own dignity and that of the profession.

No physician should use touts or agents for procuring patients. He should neither pay nor receive a commission for referring patients.

Etiquette of inter-professional relationships

The British Medical Association (2) and the Medical Council of India (3) state that a practitioner in whatsoever form of practice should take positive steps to satisfy himself that a patient who applies for treatment or advice is not already under the active care of another practitioner before he accepts him. Furthermore, a practitioner should not accept as a patient any patient whom he has attended as a consulting practitioner, or as a deputy for a colleague. Implementing this directive is not an easy task in a country like ours where private practice is rampant and where patients often switch doctors at will. Patients literally go shopping from clinic to clinic, or from hospital to hospital for doctors’ opinions. Unscrupulous doctors readily accept any and every patient, often with full knowledge that the patient is under the care of a colleague. Such a commercial approach to patient care reduces the profession to a business venture.

Ethics in consultations

Consultations are a time-honoured custom and they should be encouraged in cases of serious illnesses, especially in doubtful or difficult conditions. In every consultation the benefit to the patient is of the first importance. The rights of the patient to ask for a second opinion should be respected. As in most situations, the attending practitioner is the best judge but his vanity should not prevent him from recommending it, or from acceding to the patient’s request for consultation with some other doctor. No medical practitioner can claim to be a specialist in every branch of medicine.

The following suggestions made by the Maharashtra Medical Council in its Code of Medical Ethics tersely state the important

circumstances under which a practitioner should ask for a consultation:

- in serious illness,
- in doubtful conditions,
- in operations of a mutilating or destructive nature upon an unborn child and
- in operations which may vitally affect the intellectual or generative function of the patient. (3)

The attending doctor may certainly suggest the names of the consultants of his choice but even then, in the event of a difference of opinion between him and the patient or the relatives of the patient the choice of the latter should prevail.

In the event of an irreconcilable difference of opinion between the two doctors, the circumstances should be impartially and frankly explained to the patient concerned. It is now up to the patient to decide which of these he will follow or, indeed, whether he will seek further advice from a new consultant.

There are points on the proper etiquette of consultation laid down in the International Code of Ethics which are summarised as follows:

- The attendance of the practitioner should cease when the consultation is concluded unless the patient has dispensed with the services of his first doctor and engaged those of another.
- In no case should the consultant treat the patient alone or hand him over to his assistant or admit him to a nursing home or hospital without the knowledge of the referring physician or injure the latter's position in any respect. (Emergencies form an exception to this rule. In such an event, the consultant should inform the referring physician at the first opportunity after the crisis has been tided over.)
- When a consultant sees a patient in his rooms at the request of a medical practitioner, it is his duty to write to the latter, stating his opinion on the case and the line of treatment he thinks should be adopted. He should not see this patient again without a fresh note from the first doctor.
- A doctor called upon in an emergency must treat the patient, but after the crisis the consultant must retire in favour of the original attendant of the patient.

Fees – insofar as they concern our colleagues

A practitioner's fee should be commensurate with the services rendered and the patient's ability to pay. They must be reasonable. It is advised that his fee be on par with those charged by his colleagues. The Medical Council of India's code of medical ethics further states that remuneration received for medical services should be in the form and amount specifically announced to the patient at the time the service is rendered. It is unethical to enter into a contract of 'no cure no payment'.

The practice of splitting fees must be condemned as infamous conduct. A medical man is a professional. He is not doing business. Splitting of fees stinks of commercialism.

Dichotomy or splitting of fees is illegal. When a practitioner consults a specialist in the interests of his patient, he is not acting as a business agent. The practitioner has no right to demand or expect a cut from the specialist for calling him in. The specialist in turn can charge the patient the appropriate fee for his consultation visit.

Conclusion

The Code of Medical Ethics offers this advice: "To other members of the profession you owe a duty as a colleague. You should never do or say anything that may make the position of your colleague awkward." There is a vast body of literature on ethical issues written by medical men, lay public and by those who understand the law. One sardonic statement, obviously written by someone who had clashed with the medical profession, reads as follows: "There are three subjects on which the medical profession in general is woefully weak. They are manners, morals and medicine."

Ironically the author of that comment was himself a doctor. There are many people in different walks of life who share this view.

On introspection, there is no doubt that from time to time doctors do forget their moral obligations to each other. Our colleagues and the layman are quick to notice these deviations. If we aspire to retrieve the situation, we need to look back at our graduation day and have another close and honest look at the oath we swore when we so proudly assumed the prefix 'Doctor'.

References

1. Dunstan CR, Dunstan GR. *The artifice of ethics*. London: SCM Press; 1974.
2. William AR, Thomson A. *A dictionary of medical ethics and practice*. London: John Wright and Sons Ltd; 1977.
3. Mehta HS, Taraporevala VJ. *Medical law and ethics in India*. Bombay: The Bombay Samachar Private Ltd; 1963.
4. Udwadia FE. Ethical problems in medical education. *Issues in Medical Ethics* 1997; 5: 37-39.

Published in: Volume 4, Issue 4, October-December 1997



The ethics of medical referral

Eustace J De Souza

At the heart of medical practice is the physician-patient relationship which is based on trust. This relationship is an unwritten contract where the patient consents to advice and treatment given by the doctor while the doctor assumes responsibility for the patient's welfare. The writer discusses matters that arise when the doctor or patient consult another physician, introducing a third party — whose obligations are less well defined — into this contract. The third party's entrance may not always be in the patient's interests, or with the knowledge of the doctor. There may be other, pecuniary, interests, such as kick-backs for the referring doctor. At times, a patient shops around for specialists without the knowledge of his primary doctor.

Introduction

The relationship between doctors and patients has undergone a sea change in the last 60 years. The old family physician is fast disappearing, no longer friend, philosopher and guide.

Advancing technologies and umbrellas of chemotherapy and antibiotics now override careful history taking and clinical examination.

Finally, the taint of lucre can tip the scales of ethical restraint.

Various arguments are raised. "Is not the labourer worthy of his hire?"; "Doctors too, must live"; "The cost of medical education is so high, and even a room to practice in costs a bomb"; "In all justice, is he not entitled to a fair return?"

These may be fair questions but can never justify unethical conduct. This is the first criterion that must pervade the medical profession if it is to rise above the ethic of the market place.

A patient made aware by the media of these concerns weighing on the medical profession may question the essence of the fiduciary contract between doctor and patient.

When we add to this the ambit of the Consumer Protection Act (CPA), we are certainly at a crucial crossroad. If the CPA is empowered to view the professional services rendered by a doctor as goods, on the same plane as a toaster supplied by a manufacturer, we lose sight of several subjective factors that separate a professional service from goods supplied.

In the latter case, objective criteria of claims made or protections prescribed can clearly be spelled out and independently tested. Obviously, to protect themselves doctors prescribe or at least recommend that certain objective tests be undertaken. While perfectly certain of his diagnosis, the doctor feels he must order the test primarily as 'insurance protection'. Naturally, this raises the cost to the patient.

The doctor-patient contract

When a patient comes to a doctor, whether he knows it or not, a contract comes into effect. This contract is essentially between two parties who agree to deliver on the one hand and to receive on the other.

Between doctor and patient, this contract is essentially based on faith. His consent can be inferred by his voluntarily coming to the doctor for assistance, or in some cases made overt when he signs a declaration accepting some mode of therapy, especially in declarations for admission to hospitals or nursing homes. In public hospitals (and to a slightly different degree, in private hospitals), the hospital is the 'delivering' party and its doctors are, in a sense, its special agents. The honorary doctors are not paid agents and bear a greater degree of independent responsibility.

Introducing a third party

I have particularly indicated two parties with regard to this contract, because the question of a referral immediately involves a third party or person into this contract.

The problem of the third person must be seen in the light of individual rights and obligations as well as professional responsibilities and inferred ethical norms, codes and guidelines.

A fundamental principle in medical ethics holds that the human being has a unique value, status and dignity. In no professional transaction must the obligation to uphold this right be violated.

While the first consent can be inferred, in a referral this consent cannot be so easily inferred. The patient must be informed of the new entrant into the contract, with reasons for the introduction of this third party. In this circumstance the third 'person' or specialist is called because the conditions of the case warrant the need for another supportive or additionally required form of expertise. Thus it is the welfare of the patient that is the only reason for this referral.

Here lies the evil of the kickback or 'commission'. In trade or business, a commission can be part and parcel of the mechanism of the contract, where the prime purpose of commerce is profit. The ethics of business is primarily the prevention of fraud or exploitation and the gimmick of false representation by skilfully worded advertising, where glamour is often a cover. The ethical 'evil' here lies when the skill is often deliberately used to carefully skirt the law of misrepresentation or actual fraud.

In business, another ethical difference is that of 'putting one over' a serious competitor by skilful advertising which is forbidden in professional ethics.

The question of responsibility

In the matter of medical referral, there is also another ethical consideration with medico-legal significance.

It is the question of primary responsibility. This depends on the nature of the referral.

If, for instance, it is a consultation between general practitioner and specialist, the latter is mainly responsible for the continued care and concern for his patient. The general practitioner merely follows the advice of the consultant, reporting to him the progress of the patient so as to modify therapy or obtain further instructions with regard to continued care.

On the other hand, if the referral is such as to need the independent care by the consultant, the patient is transferred to the care of the consultant. The general practitioner moves aside, though courtesy and etiquette demand that the consultant keeps the referring doctor informed of the progress of the patient. Once the immediate

specialised care is completed, the patient can then be returned to the general practitioner for such continued care and advice as may be necessary.

Unfortunately, in both public and private hospital health care systems, the patient decides for himself which consultant specialist or department he should go to. The result is a waste of time, undue expense and the unnecessary shuffling of a patient from one consultant to another. For instance, a young woman decides that her pain is due to appendicitis and goes to a surgeon. He decides that there is no disease in the appendix but suspects the need for gynaecological intervention. The patient is referred to a gynaecologist. A general practitioner would have identified the need for a gynaecologist and made the appropriate referral, at diminished expense and certainly a saving of valuable time on the part of consultants as well as the patient. The two-tier system, which poses definite advantages, needs to be resuscitated. Here all patients can be first seen by individuals or teams of general practitioners adequately qualified to treat and deal with the ordinary run of ill health while at the same time equally qualified to know which consultant to go to and to order appropriate tests prior to the visit to the consultant.

Referral of patients admitted to hospitals

In-patient referrals, both in public and private hospitals, are either for particular supportive consultation or to effect a transfer to another appropriate speciality. Generally, these consultations are facilitated between the various consultants on the staff of the hospital. If a patient seeks another doctor not on the staff, he has a perfect right to seek discharge from the hospital to be treated by the doctor of his choice elsewhere.

Respecting patient autonomy, in some private hospitals there is a provision whereby the hospital will permit the second consultant (not on the staff of the hospital) being called at the request of the patient provided the current treating doctor also agrees. If it is a mere consultation, the original treating doctor bears full responsibility for continued treatment. In cases of surgery where an outside consultant is actually involved in the surgery jointly, it is only ethical that both doctors continue to bear joint responsibility.

Legally, this problem of joint responsibility is quite vexing. However, the doctor in whose unit or under whose care the patient is registered cannot abdicate responsibility, unless the patient has been transferred to the care of another specialist who must accept this independent responsibility. Here, too, the patient's informed consent is an ethical necessity.

Second opinion

In the matter of referral, it sometimes happens that the patient will ask (rather hesitantly – for fear of offence) that the treating doctor agree to a second opinion. No one should see this as a lack of faith but rather respect a patient's right to total autonomy and gladly give his consent unless he honestly feels it would not be in the best interest of his patient. In this latter case, he should explain his reasons for not agreeing, but clearly leave his patient free to seek treatment from the other doctor. However, as the doctor too has rights and professional autonomy, he should make it clear that the discharge from his care also involves discharge from future responsibility. Incidentally, this discharge does not absolve the first treating doctor from proven incompetent or negligent treatment while under his care. Thus, if the second surgeon were to operate again and find that a swab had been left behind, the first operating surgeon is ethically, morally and legally responsible.

It frequently happens that a patient 'shops around' from doctor to doctor, often in the hope of getting an opinion that he or she would find either convenient or conforming to pre-formed expectations. Or the patient seeks treatment from one doctor for a period of time, then leaves to go to another without telling the second either the details or facts of the previous treatment.

Doctors should understand that patients are human beings, especially vulnerable under the burden of sickness. While the doctor is certainly entitled to a true and full past history, failure on the part of the patient to disclose an earlier consultation should not always be construed as an inability to keep the faith so vital to the contract. Prudent questioning is certainly the right of any doctor who is concerned to give of his best to his patient, and part of good history taking.

Can a doctor refuse to treat a patient?

Being a professional in his own right, the doctor certainly has an ethical right to refuse to treat a patient who will, in his view, not follow treatment directions to their logical ends.

This right not to treat or accept for treatment also extends to those situations where a patient approaches a doctor insisting on a predetermined mode or line of treatment.

My only plea in this context is that the doctor is a man of morality first. By morality, I mean that every man, be he theist or atheist, agnostic or secular humanist, has the right and obligation to choose between what he sees as right and wrong. Every doctor is a professional, who by his chosen vocation agrees to abide by a code of ethics guided by morality. Finally, as social beings, both doctor and patient are guided and restricted by the laws of the land in which they live. They may not agree with those laws. For this they must seek legal redress to get these laws changed.

Published in: Volume 5, Issue 3, July-September 1997

An objective look at ‘cut practice’ in the medical profession

P A Kale

This distinctive feature of Indian medical practice is a matter of great concern for ethical doctors and for patients. The author describes the various types of fee-splitting within the modern medical system, and why it leads to malpractices and can harm the patient. Patients may be subjected to unnecessary investigations and receive substandard care. A solution requires fundamental change in every aspect of medicine, from remuneration to public hospital staff, transparency in the fee structures of general practitioners and consultants, continuing medical education and universal insurance to external deterrents such as consumer courts and greater public awareness.

Introduction

All doctors qualified to practise modern medicine take the classical Hippocratic Oath before beginning their professional careers. The idealistic values learned during the period of training get shaken up when the doctor steps out from a world of ‘practice of medicine’ to one of ‘medical practice’. Here he sees ‘practical’ adjustments that he is required to make in his clinical and therapeutic decisions, and encounters open offers of referral of patients for a predetermined and regularised practice of fee-sharing (‘cut practice’). Since the schedule of charges for professional services is totally individualistic, the illegal and unaccounted fees to be given to the referring doctor usually get added on to the specialist’s fees and are paid unknowingly by the patient.

How ethical is this practice? The subject is debated by doctors in social and academic get-togethers but a status quo has persisted with some doctors for and some against it.

Variations on the theme

Cut practice occurs in many forms. I list some of them:

- Giving a share of fees to the referring doctor.
- Referring patients for unnecessary consultations or tests to ensure a kickback from the consultant or laboratory.
- Giving expensive gifts periodically to the referring doctor.
- Appointing junior specialists to a super-specialty hospital so that procedural work is always referred by them to you.
- Sponsoring of a conference or payment of travel expenses by a company in return for the use of its equipment or prescription of its drugs.

If one reads the Hippocratic Oath carefully, there is no condemnation of the act of sharing one's fees with another doctor involved in the care of a particular patient. It is only by implication that the Oath stipulates that a doctor shall charge a reasonable fee and will not increase it for sharing it in order to obtain a larger number of referrals.

Basis for charging fees

Every doctor determines his/her professional fees on the basis of experience, wisdom and self-perception of the level of skills required for a particular treatment. Fees thus vary widely from doctor to doctor. Hence a particular amount cannot be termed unreasonable as long as the patient is aware of the sum to be paid before the service is rendered. What the treating doctor does with the fee after he receives it is entirely and solely his concern and the patient or any other person has no say in it. Hence if a doctor decides to give a portion of his fees to another person (medical or non-medical) it is entirely legal and ethical to do so, provided this is done openly and after obtaining a receipt.

However, such disbursements occur only in theory. In actual practice the referral pattern is based more on the fact that a particular doctor is ready to split his fees rather than that he is the best qualified to render a particular treatment. Several malpractices accompany such referrals. The limitations and scope of a particular procedure are not fully explained in advance. Patients are admitted to a hospital or nursing home in spite of the fact that the place is not adequately equipped to impart a standard of medical care available at another place in the area. Patients are referred to manifestly substandard

laboratories. Reports from such laboratories are manipulated to suit the requirements of the referring physician.

Various specialised procedures – such as endoscopy, angiography and angioplasty – form lucrative sources of income and are therefore frequently advised even when the stated indications are not scientifically valid. (At times it is difficult for a doctor to say that the procedure advised by another was not required because on most such issues, opinions published in the medical literature support both points of view. There is truly no substitute for one's own competence and conscience acting as an internal judge and counsel.)

A malpractice that has come to stay

Pernicious as it is, the cut practice has come to stay. The medical profession itself has nurtured it. Indiscriminate proliferation of medical colleges with open and shameless support of those in power is adding hundreds of inadequately trained medical graduates every year to the pool of practising doctors. A large majority of these are concentrated in urban areas with attendant intense competition and battle for survival which favour cut practice. In the absence of a clear, logical, bold and community-oriented health care policy on the part of the government and a lobby of strong, honest, clear thinkers representing the medical profession in the corridors of power, the present situation is unlikely to change in the near future.

Some practical alternatives

All financial transactions between doctor and patient must be above board with receipts being provided to the patient.

- Each general practitioner must charge a publicly stated fee from the patient for the act of medical examination, making a diagnosis and recommending appropriate treatment or referral to an appropriate consultant or hospital.
- A fixed percentage of the specialist's fees for procedures should be openly given to the family doctor on the ground that the latter will offer follow up care to the patient at his home after the procedure. This measure also transfers legal responsibility on to the family doctor for competent medical care.

- A body of experts in each hospital or nursing home should monitor the performance of various procedures to ensure that they are based on scientifically valid indications.
- Health insurance should be made compulsory and fees for various examinations, procedures, visits, etc, should be fixed from time to time by a committee of professionals consisting of representatives from the medical bodies, insurance companies, government and the legal profession.
- Medical councils at central and state levels should be given adequate powers to punish erring doctors even without a formal complaint. At present positions on such councils are used only to enhance one's prestige and members of the councils are almost completely incompetent.
- The annual output of medical graduates should be governed by actuarial data like annual loss of practising doctors, density of doctors in a given area, the local population and its medical needs and so on. If an area has a supersaturated doctor/ population ratio in a given speciality then the redundant doctors should be made to relocate to another suitable area.
- The monthly salary and other benefits of full-time doctors, especially in teaching hospitals, should be such that they are able to maintain a decent standard of living commensurate with their position and seniority. There will then be no need or incentive for unethical ways of earning extra income. The present pay structure is insultingly low in this respect.
- Compulsory attendance by general practitioners and consultants at continuing medical education programmes will help to bring about uniformity of approach in management.

An increased general awareness and education in society and fear of consumer courts will certainly act as an external deterrent as in western countries.



JOHN BROWN

A VICTIM OF CUT-PRACTICE

The physician and the pharmaceutical industry

G D Ravindran

The pharmaceutical industry and the medical practitioner are inter-dependent: physicians need the industry's drugs and the industry must rely on the physician to prescribe them. But the industry spends nearly 15 per cent of its gross income on promotional practices –literature, free samples, gifts, incentives, sponsorships, seminars and the like – to influence the prescribing practices of doctors. The author discusses the various ways in which a physician's duty towards his patient is subverted by such inducements. A particularly topical issue discussed here is the involvement of general practitioners in medical research where they are unaware of the research protocols and have no control over the data.

The drug industry, the medical profession and the patient have a unique relationship. The industry makes products that it cannot sell to the patient (consumer) directly. On the other hand, the medical profession cannot treat the patient without drugs produced by the industry. Thus the industry and medical profession are interdependent and have a common aim. One should be able to evaluate them according to the principles of beneficence, non-maleficence, patient autonomy and justice. The industry must provide drugs to the patient, not manufacture drugs that have harmful effects. It must make reasonable profits and help in the research of newer drugs.

The primary objective of this joint effort is to alleviate pain and suffering. The secondary objective is to be rewarded for this effort. The drug industry expects a profit and the physician expects a suitable reward. There is nothing improper in these objectives.

As in all partnerships there can be conflict between the partners. One major area of conflict is the industry's tendency to influence doctors. The KeFauver Committee hearing on drugs states: "The incidence of disease cannot be manipulated and so increased sales

volume must depend at least in part on the use of drugs unrelated to their utility or need or in other words improperly prescribed. Human traits can be manipulated and exploited and this is a fertile ground for anyone who wishes to increase profits.”

Advertisements

Drug promotion and advertisement are a major part of the drug industry’s budget. In 1988, the top 16 companies in the United States spent about \$85 million in this area, up from \$6 million in 1974. Companies are estimated to spend anywhere between six and 15 per cent of their gross income on drug promotion. No business enterprise would spend shareholders’ money unless it was sure of getting something in return. If advertising does not influence, a lot of people are wasting a lot of money and time.

The word ‘advertise’ is derived from the Latin word ‘*advertere*’ which means ‘to turn towards’. Advertising is generally regarded as a legitimate means of fostering the competition that drives a free market economic system. The moral justification is that consumers benefit. Businesses that satisfy consumers will prosper at the expense of those that do not. Consumers are presumed to benefit from advertising because it is presumed to broaden their choice and maximise their chances of getting the most value for their money. Yet advertisements by their very nature simplify and contain an element of potential deception. Virtually any advertisement is capable of misleading, though it can be made less misleading by the addition of detailed disclaimers.

Drug advertisements which include product information are circulated to health professionals through journals, medical representatives and the mail. Persuasive advertising highlights the product’s beneficiary properties. “X the drug of choice for enteric fever.” Certain facts can also be manipulated, focusing on the good effects without mentioning the bad effects. “The typhoid bacterium resistant to many antibiotics except X...” Finally, advertisements can also intimidate to get the doctor to prescribe: “The top 100 doctors prescribe X for enteric fever: Do you belong to this group?”

This process of simplification, highlighting and concealing enables companies to withhold essential information on indications and

contraindications and to sell a drug differently in different parts of the world.

Medical representatives

The main promotional thrust of the pharmaceutical industry is through its medical representatives (reps). There is one rep for every four to five doctors. The meeting between a doctor and the rep leaves little to chance. Reps profoundly affect the way a doctor prescribes. They have been aptly described as the ‘stealth bombers’ of medicine. Their bottom line is: “Prescribe my drug.” These are invariably polite and reasonably knowledgeable. Before meeting a doctor they study the doctor’s prescribing habits on the basis of information gathered from local pharmacists and a preview of patients’ prescriptions. They also get to know something about the doctor’s likes and hobbies, family life and social interests and generally cultivate them. It has been estimated that it takes between one and two years before a practitioner can be prevailed upon to change practice.

Some reps categorise doctors according to whether they are ‘conservative’ or ‘risk takers’. Conservative doctors will not try out a new product unless it has proven itself. Risk takers are willing to try out new products; reps will try and obtain a commitment to use new products on a few patients. Conservatives will start using new products only when used by opinion formers or local consultants, also called ‘educationally influential physicians’ – hospital consultants in major hospitals whose prescriptions are imitated by other practitioners.

Reps try to persuade doctors into trying their products by using reason. If it fails, then they try to manipulate by offering gifts, or by intimidating them or by appealing to their professional pride. If all fails, then they appeal to the doctor’s mercy “If you do not give me business I will not get my salary.”

As the major source of information for a majority of doctors and pharmacists, medical reps have a role in helping practitioners know about the drugs available in the market and their costs. It is the practitioner’s duty to use reps while taking care not to be unduly influenced by their sales pitch.

Gifts act as regulators of human relationships. By offering a gift a person is really offering a friendship. Accepting a gift is accepting the initiation or reinforcement of a relationship and triggers off an obligatory response. The recipient generally assures grateful conduct and reciprocation of the gift. While giving can be an act of generosity, it also serves the self-interest of the giver.

Gifts may be personal when given to an individual or impersonal when given for a cause. A donation to the AIDS fund of the hospital may be impersonal; a donation to the hospital director is personal.

The physician accepting gifts has three major ethical dilemmas. Gifts cost money and the cost is ultimately passed on to the patients. Secondly, gifts may erode the concept that the medical professional best serves his patient's interest. Thirdly, they establish a relationship between the donor and recipient.

The following ethical issues are involved

They are in conflict with the principle of distributive justice. The drug company spends the patient's money for the doctor's benefit without the patient's knowledge. The burden is passed on to the patient and the benefits are passed on to the physician (gifts) and the drug companies (profit). A medical bag presented to physicians by a company manufacturing anti-TB drugs will be funded from profits that the company makes from the sale of anti-TB drugs. Many patients may have struggled to buy these drugs.

They interfere with the patient-doctor relationship. Physicians are supposed to safeguard the patient's interests. Accepting gifts may interfere. A physician may be influenced by the gift to prescribe a particular brand of drug when more cost-effective brands are available.

They affect the physician's character. Gifts may disturb the delicate balance in every physician between self-interest and patient welfare. Conscientious physicians may be especially vulnerable to the obligation that comes with gifts.

The practice of medicine requires a constant balancing act between altruistic concern for others and one's own self-interest and ambition. Gifts from drug companies feed our human tendencies towards self-interest but do nothing to foster concern for our patients.

The General Medical Council of the UK

It may be improper for individuals to accept, from a pharmaceutical company, monetary gifts, loans or expensive items of equipment for their personal use. No exception can, however, be taken to grants of money or equipment by a firm to an institution, hospital, health care centre or university department when they are donated for the specific purpose of research.

To the best of my knowledge, there are no specific guidelines laid down and expounded by the Medical Council of India. Hence it may be useful to refer to those laid down by the General Medical Council of the UK.

The term hospitality has been used very frequently. Hospitality means friendly and generous entertainment of guests.

Should a physician accept gifts like paper pads or ball pens? Most people would consider this practice acceptable. The grey areas come when it concerns larger gifts. Holidays and sponsorships for attending conferences are unacceptable.

Drug companies are also involved in holding seminars, conducting research and sponsoring programmes of professional societies and institutions. Though this does not affect physicians directly, there is always a fear that office bearers of the society may be influenced. Sometimes the topics for seminars are chosen in such a way that a drug can be promoted. Drug companies may influence the speakers. Sometimes they provide useful continuing medical education for the physicians but most often these symposia tend to promote a particular drug.

Research

In our country the Drug Controller requires a multi-centric trial to be conducted before it accepts a drug, even if the drug has already been established in the West. Many general practitioners nowadays get carried away by the importance placed on research. This research involves getting general practitioners to try the new drug on their patients. But what if a newly-started drug is found to be beneficial to the patient but becomes unaffordable after the trial is over? Hence it is essential that researchers discuss the drug

protocols, the way the results will be handled and the control of data that is generated by the study.

We must be constantly vigilant that we keep the interest of the patient at heart and not be led astray by drug companies.

Suggested readings

1. Rodning CB, Dacso CC. A physician / advertiser ethos. *Am J Med* 1987; 82: 1209-1212.
2. Rawlins MD. Doctors and the drug makers. *Lancet* 1984; 2: 276-278.
3. Chren MM, Landefeld S, Murray TH. Doctors, drug companies and gifts. *JAMA* 1989; 262: 3448-3451.

Published in: Volume 7, Number 1, January-March 1999



Whistle-blowing in the health-related professions

Gerald Vinten

Should you speak up if you witness unethical or illegal practices being condoned by your seniors? Whistle-blowing is a controversial topic. Some regard it as an ethical duty and others believe it is irresponsible professional behaviour. The law usually sides with the authorities. Whistle-blowers have been punished for speaking out. In this context it is interesting to know that most whistle-blowers are not deviant employees, but law-abiding and sincere people.

Introduction

The correspondence and publicity following the disciplining and subsequent settlement in his favour, prior to an industrial tribunal, of Stockport Health Authority Charge Nurse Graham Pink, suggested that the urge to blow the whistle was at almost epidemic proportions in the British National Health Service (NHS). It might be surmised that the only device that kept this under control was the fear of discipline and dismissal. This fear has been increased by the contracts of employment of the NHS Trusts which have outlawed whistle-blowing. There are similar pressures for those working in other health-related professions, and in health and safety and environmental protection (1).

It is important to question whether such severe strictures are in the public interest, or whether they are there to make the life of senior managers easier, or to make it possible to ensure that doctors, nurses and other caring professionals and support staff conform to budgetary constraints without resort to campaigning.

Definition

Despite the considerable discussion on whistle-blowing, it is rare to find an exact definition. The first time 'whistle-blowing' was used was in 1963 in the case of Otto Otopeka (2). He gave classified

documents on security risks in the new US administration to the chief counsel of the Senate Sub-committee on Internal Security. The Secretary of State, Dean Rusk, dismissed him from his job in the State Department for conduct unbecoming an officer. Alternative terms may be conscientious objector (3), ethical resister (4), mole or informer (5), concerned employee (6), rat (7) or licensed spy (8).

My own definition is: “The unauthorised disclosure of information that an employee reasonably believes evidences the contravention of law, rule or regulation, code of practice, or professional statement, or that involves mismanagement, corruption, abuse of authority, or danger to public or worker health and safety.”

The lack of authorisation can apply to internal and external whistle-blowing. The internal variety refers to bypassing the normal managerial hierarchy such as one’s immediate boss, or reporting to another department or to a general manager when there are other available channels. This variety is open to manipulation and suppression. External whistle-blowing refers to going to those outside the organisation – the media, a member of Parliament or a professional body. It indicates a serious breakdown of communication between employer and employee and may lead to dismissal.

The legal situation

Does the law side with the whistle-blower or with the employer? English law has an implied common law duty not to misuse confidential information belonging to the employer and this duty may continue after the employment has finished. Since there are practical problems in taking legal action against ex-employees, the employer’s best option is to seek from employees an express restraint clause.

An exception is made when disclosure is in the public interest. In the 1968 case of *Initial Services Ltd vs Putterill*, in the UK, Putterill had resigned as sales manager and then handed to the *Daily Mail* documents providing details of an unlawful price protection ring involving the employers, and of price rises attributed to employment tax in order to disguise higher profits. Lord Denning held that the public interest exception to the duty of confidence extended to

“...any misconduct of such a nature that it ought to be disclosed to others... The exception should extend to crimes, frauds and misdeeds, both those actually committed as well as those in contemplation.”

The only legislation to support whistle-blowing concerns oil rigs (9), the Offshore Safety (Protection Against Victimisation) Act 1992. Offshore workers dismissed for raising valid concerns could now make a complaint of unfair dismissal to an industrial tribunal.

The law: whistle-blower protector?

Is the law on the side of the whistle-blower? A series of stringent filters need to be passed for the public interest defence to be upheld. Some of these:

- There were serious misdeeds or serious public harm.
- The whistle-blower acted reasonably and in good faith.
- The information should be communicated to an appropriate recipient. (Who is an appropriate recipient remains unclear.)
- The way in which the information was acquired was not more of a threat to the public than the value of what was revealed.

Is the way ahead unproblematic? Again, the answer has to be ‘No’. Apart from the ambiguities and crudities of employment law, there are practical aspects. In 1973, in the wake of a number of well publicised hospital scandals to which attention was drawn by whistle-blowing, the Committee on Hospital Complaints Procedure, chaired by Sir Michael Davies, added realism: “We have never had any doubt that in the hospital service the investigation and satisfaction of complaints is primarily a function of management. But in the past there have undoubtedly been occasions when management has not discharged this function... It would be unrealistic to suppose that there will never be breakdowns in the future.”

Despite this recognition, the path of the whistle-blower is never easy (10-14). Conduct and character come under scrutiny and many begin to wonder that the matter seems to have been turned on its head with the whistle-blower now in the dock. The whistle-blower may find that the normal courtesies of the organisation have been withdrawn and every infraction of rules and procedures, howsoever petty, is acted upon.

The trouble with whistle-blowing is that there is plenty through which to blow. Gerald Mars shows that occupational crime, sometimes referred to as 'part-time crime' (15) is an accepted part of everyday jobs (16). Covert rewards are so intimately connected with some occupations that it is impossible to understand sections of the economy without reference to them. It is necessary to be highly selective to avoid becoming a professional full-time whistle-blower.

In a survey of 87 American whistle-blowers from the civil service and private industry, all but one experienced retaliation, with those employed longer experiencing worse reprisal. Harassment came from peers as well as superiors and most of those in private industry and half of those in the civil service lost their jobs. Of the total, 17 per cent lost their homes, eight per cent filed for bankruptcy, 15 per cent got divorced and 10 per cent attempted suicide (17).

A similar result emerged from a six year long US study of 64 whistle-blowers, ethical resisters who felt impelled to speak out because they had witnessed a serious violation of legal and ethical standards. Most were in their 30s or 40s and were conservative persons devoted to their work and organisations. They had built their careers by conforming to the requirements of bureaucratic life. Most had been successful until they were asked to violate their own standards of workplace behaviour. Whistle-blowing resulted in economic and emotional deprivation, disruption of careers and personal abuse (18).

There could be few instances more tragic than that of Stanley Adams, a former executive with the Swiss pharmaceutical manufacturer Hoffman La Roche. Adams was imprisoned under Swiss law for exposing, in 1973, the company's illegal price-fixing methods to the European Commission. His wife's probable suicide, the financial ruin of the family and lack of support from the European Commission are portrayed in the film *Song for Europe*. With an ironic twist, Adams was arrested at Bristol railway station in 1993 for plotting to kill his new wife.

Not all favour whistle-blowing. Peter Drucker views it as 'informing' and shows that western societies that encouraged informers were bloody and infamous tyrannies – Tiberius and Nero in Rome, the Inquisition in the Spain of Philip II, the French Terror

and Stalin. Drucker feels that there is no mutual trust, no interdependency and no ethics when whistle-blowing prevails. Milton Friedman is also of this school of thought. Their views have not gone unchallenged. But informing is itself a value-laden interpretation, not a neutral description, of whistle-blowing. It is by no means self-evident that whistle-blowing is informing and Drucker offers us no support for his claim. Such support requires as its basis rigorous normative reflection, and it is reflection of this kind that is precisely the province of business ethics (19).

It can be argued that evading questions about the ethical implications of one's actions constitutes moral negligence (20). Sound ethical thinking must be based on as full an understanding of a situation as it is possible to obtain and there is also a need to consider unintended or undesirable consequences of decisions (21). Any view of life that stops short of a rigid totalitarian attitude must make allowances for the legitimacy of individuals asserting alternative moral standpoints and occasionally, in extremes, blowing the whistle. There are comparisons between whistle-blowing and civil disobedience (22). A text on strategic management includes a chapter on business ethics and suggests that whilst thoughtless observers may criticise whistle-blowing as squealing, in fact, any enforcement of law and ethics must rely partly on whistle-blowers. Public good emanates from whistle-blowing. The problems with the cargo doors on DC-10 aircraft in the 1970s were highlighted thus (23).

A procedural point over which whistle-blowers need to take particular care is that when they report abuse, there is no delay in making the report. Trained members of the staff whose responsibilities include the reporting of such incidents are likely to face disciplinary action themselves if their reports are made long after the abuse.

The outcome

Even assuming near saintliness and a cast-iron psychological constitution capable of withstanding considerable pressures on self and family, there remains the question as to what exactly will be the outcome of whistle-blowing.

An industrial tribunal can order an employer who has wrongfully or unfairly dismissed or victimised an employee to compensate the employee for his losses. Awards are low in relation to the economic harm and damage to career suffered and rarely exceed £ 2, 500.

Reinstatement can be ordered but this actually occurs only in about one per cent of cases. The reason is that relations between the employer and the whistle-blower have invariably deteriorated to the extent that it is easy for the employer to convince the tribunal on the impracticality of reinstatement. The employee too is usually not willing to re-enter a hostile work environment.

Case studies

Ken Callanan, student nurse in a psychiatric hospital, reported a charge nurse for constantly abusing patients. Callanan was discriminated against by management, other staff and the trade union. Forced to resign by such behaviour, he received compensation in a tribunal for constructive and unfair dismissal.

Dr Helen Zeitlin appealed successfully at a special hearing at the Department of Health in London against her redundancy, which came on the heels of her comments at a public meeting about inadequate resourcing of certain services in her health district in Redditch.

Dr Chris Chapman, biochemist at the Leeds General Infirmary, exposed fraud relating to medical research and additional waste of public money. He was sacked the day before his 50th birthday to avoid paying him pension. He was re-instated following his legal victory.

Desmond Smith, a black health visitor, won damages of £ 27,000 against the racism of which he complained in his health authority.

Utilising the services of whistle-blowers

Whistle-blowers can act on faulty perceptions. A few manipulate to their advantage after being justifiably accused of a disciplinary offence. This counter-attack is the converse of a tactic often adopted by employers against their whistle-blowers. Research shows that most whistle-blowers are not habitual troublemakers. Rather, they are of the type that forms the bedrock of any organisation. Devoted, loyal and, if anything, conservative, they are spurred to blow the whistle only by intense disquiet on witnessing unethical action.

The best approach is for the institution to invite comments, observations and criticism with proof to back the statements made. Managers with foresight will ensure that they learn about nasty problems in their organisations before these stories hit the media by setting up hotlines and encouraging employees to use them (24). The US has passed Whistle-blower Protection Acts for the public sector with a compensation fund of up to \$500,000 per individual. This country recognises that whistle-blowers have an important contribution to make. They can save lives and increase efficiency and effectiveness.

A code of ethics for whistle-blowers

Norman Bowie lists his requirements of justifiable acts of whistle-blowing:

- The whistle-blowing stems from the moral motive of preventing unnecessary harm to others.
- The whistle-blower has used all the available internal procedures for rectifying the problem before making public disclosure. (This may be precluded under certain special circumstances.)
- The whistle blower has “evidence that would persuade a reasonable person.”
- The whistle-blower perceives serious danger from the violation.
- The whistle-blower acts in accordance with responsibilities for “avoiding and/ or exposing moral violations.”
- The whistle-blower’s action has reasonable chance of success. (25)

Others have suggested practical points to ponder:

- How comprehensive is the worker’s knowledge of the situation? Is the worker’s information accurate and substantial?
- What exactly are the unethical practices involved? Why are they unethical? What public values do these practices harm?
- How substantial and irreversible are the effects of these practices? Are there any compensating public benefits that justify these practices?
- What is the employee’s obligation to bring up such practices by working within the organisation or by going outside it? What probable effects will either alternative have on the company’s practices? On society? On the firm? On the employee? (26)

Sisela Bok sees three cascading levels of conflict: Is whistle-blowing in the public interest? The professional ethic requiring collegial loyalty clashes with responsibility to the public. Third is the fear of retaliation (27). Jenson asks whether the whistle-blower has a low tolerance for shortcomings and asks how often and with what intensity does one blow the whistle (28). Jenson also contrasts one's obligation to the organisation and colleagues with that to the profession, the family, oneself, the general public and to basic values such as truth, independence, fairness, cooperation and loyalty.

The Government Accountability Project in Washington, DC, has produced a survival guide for whistle-blowers which states: "A well planned strategy has a chance of succeeding but unplanned or self-indulgent dissent is the path to professional suicide."

Whistle-blowers may never have it easy. Career mortality and occupational morbidity should be maintained at the lowest possible level. Positive whistle-blowing should be recognised as being intended for the general good. Increasing awareness of health ethics will improve the quality of debate and action.

References

1. Vinten G. *Whistle-blowing: subversion or corporate citizenship?* London: Paul Chapman Publishing; 1994.
2. Petersen IC, Farell D. *Whistle-blowing: ethical and legal issues in expressing dissent.* New York: Kendall/Hunt Publishing; 1986.
3. Beardshaw V. *Conscientious objectors at work. Mental hospital nurses - a case study.* London: Social Audit; 1981.
4. Glazer MP, Glazer PM: The whistle-blowers. *Journal of Business Ethics* 1989, 1: 23-28.
5. Benson GC. Business ethics in management strategy. In: Dean BV, Cassidy JC, editors. *Strategic management: methods and studies.* Amsterdam: North Holland Publishers; 1990.
6. Thompson CM Jr. The auditor and the informant. *Internal Auditor* 1987; February 24: 28.
7. Orr LH. Is whistle-blowing the same as informing? *Business and Society Review* 1981; Fall: 4-17.
8. Clitheroe J. Reporting fraud. In: *Financial fraud – what next?* Institute of Chartered Accounts of England and Wales; 1986. p 59-70.
9. Vinten G. Blowing whistle on disaster. Letters to the Editor. *The Times* 1992; November 22: 13.
10. Vinten G. Whistle-blowing and the company secretary. *Company Secretary* 1992; January 17-18.
11. Vinten G. Whistle blowing: corporate help or hindrance? *Management*

- Decision* 1992; 30: 44-48.
12. Vinten G. Blowing the whistle at work: good practice or bad idea? *Public Finance and Accountancy* 1992; March 13: 18-19.
 13. Vinten G. The final whistle? *The Health Service Journal* 1992; 102: 26-27.
 14. Vinten G. Whistle-blowing auditors - the ultimate oxymoron? *Business Ethics: A European Review* 1992; 1: 248-256.
 15. Ditton I. *Part-time crime. An ethnography of fiddling and pilferage*. London: MacMillan; 1977.
 16. Mars G. *Cheats at work. An anthropology of workplace crime*. London: George Allen and Unwin; 1982.
 17. Soeken K, Soeken D. *A survey of the whistle-blowers: their stressors and coping strategies*. Maryland: Association of Mental Health Specialities; March 1987.
 18. Glazer MP, Glazer PM. *The whistle-blowers. Exposing corruption in government and industry*. New York: Basic Books; 1989.
 19. Hoffman WM, Moore JM. What is business ethics? A reply to Drucker. *Journal of Business Ethics* 1982; 1: 293-300.
 23. Lewis HD. The non-moral action of collective responsibility. In: French P, editor. *Individual and collective responsibility*. Cambridge, Massachusetts: Schenkman Publishing; 1972.
 21. Schelling TC. Analytical policy and the ethics of policy. In: Caplan AL, Callahan D, editors. *Ethics in hard times*. New York: Plenum Press; 1981.
 22. Elliston FA. Civil disobedience and whistle-blowing. *Journal of Business Ethics* 1982; 1: 23-28.
 23. Beauchamp TL. *Case studies in business, society and ethics*. New Jersey: Prentice Hall; 1989.
 24. Brody M. Listen to your whistle-blower. *Fortune* 1986; November 24:53-54.
 25. Bowie N: *Business ethics*. New Jersey: Prentice Hall; 1982. p 143.
 26. Velasquez ME. *Business ethics. Concepts and cases*. 2nd edition. New Jersey: Prentice Hall; 1988.
 27. Bok S: Whistle-blowing and professional responsibilities. In: Callahan D, Bok S: *Ethics teaching in higher education*. New York: Plenum Press; 1980.
 28. Jenson JV: Ethical tension points in whistle-blowing. *Journal of Business Ethics*, 1987, 6: 321-328.

Published in Volume 4, Number 4, October-December 1996