Chapter 9

Accountability and Continuing Education

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Introduction: Unchecked Authority in the White Coat

Doctors occupy an exalted position in Indian society. Their prescriptions are rarely questioned; their opinions treated as final. But when accountability structures are weak and **continuing education is optional or unregulated**, this authority becomes vulnerable to outdated science, commercial distortion, and even negligence.

In India, there are few mechanisms to **audit a doctor's knowledge, ethics, or prescription practices** post-qualification. While the medical landscape evolves—new diseases, drug resistance, biotechnologies—**most doctors never undergo mandatory retraining**. This chapter explores the dangerous consequences of this knowledge and accountability vacuum.

1. The Accountability Black Hole

Once a medical degree is earned in India, it often becomes a **lifetime license**. There is:

- **No mandatory re-licensure**
- **No periodic skills assessment**
- **No national prescription review system**

Unlike aviation, law, or even education, Indian doctors **aren't routinely assessed for continuing competence**.

"It's possible to graduate in 1980 and never update your pharmacology—and still prescribe today." — Senior public health educator, Hyderabad

2. The Continuing Medical Education (CME) Gap

The **Medical Council of India (MCI)** mandated 30 hours of CME

every 5 years. Its successor, the **National Medical Commission (NMC)**, retained this clause. However:

- Enforcement is weak or absent
- CME content is **often pharma-sponsored**
- Certification mechanisms vary by state

| Table 1: CME Implementation Status (2023) |

State	Mandatory CME Hours	Enforcement Mechanism
Maharashtra	30 hrs / 5 years	Linked to license renewal
Delhi	30 hrs / 5 years	Advisory only
Tamil Nadu	30 hrs / 5 years	Not enforced
National (NMC)	30 hrs / 5 years	Non-binding guideline

Source: State Medical Council notifications, 2023 [1]

Most CMEs are **attended to collect certificates**, not knowledge. Since many are funded by pharma, content often **lacks neutrality or depth**.

3. Pharma-Dominated CME: Learning or Lobbying?

Pharma-sponsored CMEs blur the line between education and promotion:

- Doctors are flown to resorts and luxury hotels
- Sessions are product-focused
- "Experts" are often **paid key opinion leaders** (KOLs)

"When a CME is titled 'Optimizing Proton Pump Inhibitor Therapy' and funded by the top PPI brand, you know what's coming." — Gastroenterologist, Pune

In the absence of **independent accreditation bodies**, there is no system to vet content, ensure balanced viewpoints, or remove promotional bias.

4. No Standardized Re-Certification

Globally, doctors are required to undergo **relicensing or board exams** every few years. For example:

| Table 2: Global Re-Certification Models |

Country	Re-Certification Interval	Method
USA	Every 10 years	Specialty board exams
UK	Annual appraisal + 5-year revalidation	Portfolio & peer review
Australia	3–5 years	CME + Performance feedback
India	None	Not applicable

Source: WHO Global Health Workforce Survey, 2022 [2]

India lacks a national framework for:

- Re-licensure
- CME credit tracking
- Audit of malpractice history
- Peer evaluation

5. Weak Oversight by Medical Councils

Until 2020, the **Medical Council of India (MCI)** handled ethics and misconduct complaints. After its dissolution, the **National Medical Commission (NMC)** and **State Medical Councils** took over.

However:

- Many councils are **understaffed and underfunded**
- They lack **investigative or enforcement infrastructure**
- Decisions are often **delayed or overturned**

| Table 3: Ethics Complaints vs Action Taken (2015–2022) |

Metric	Number
Complaints received	~3,400
Disciplinary inquiries	~800
Doctors suspended	57

Source: RTI Data from NMC & State Councils, 2022 [3]

Compare this with the **millions of prescriptions** and **thousands of surgeries** happening annually—and the scale of **unaddressed negligence becomes evident**.

6. Prescription Audit Systems: Missing in Action

In most countries, prescriptions are **digitally tracked and audited**. In India:

- Prescriptions are mostly **handwritten and untracked**
- There is no **national prescribing database**
- Errors or irrationalities remain **invisible**

Only Tamil Nadu and Rajasthan have **piloted prescription audits** in public hospitals—using:

- Sample reviews
- Red flag categories (e.g., excessive antibiotics)
- Peer-to-peer feedback

These pilots remain **non-scaled** due to **bureaucratic inertia and medical opposition**.

7. Defensive Medicine and Unregulated Procedures

The lack of oversight also encourages **defensive or revenue-linked medicine**:

- Unnecessary diagnostics
- Unproven or outdated procedures
- Avoidance of low-cost generics
- Excessive follow-ups

"If I don't order 5 tests and something goes wrong, I can be sued. But there's no system to check if I'm over testing." — Consultant, Private Hospital, Bengaluru

Hospitals link doctor salaries to revenue generation, further distorting medical judgment.

8. No National Blacklist for Repeat Offenders

Doctors penalized in one state can **continue practicing elsewhere**. There is:

- No **national misconduct database**
- No **cross-verification system between states**
- No public notification mechanism for license revocations

Some cases, such as botched surgeries or unethical IVF practices, only come to light after **media intervention** or **patient lawsuits**.

9. What Reforms Are on the Table?

| Table 4: Proposed Accountability Reforms |

Proposal	Status (as of 2023)
National CME Accreditation Authority	Under NMC review
Mandatory digital prescriptions	Pilot in 2 states
National Doctor Registry with audits	Proposed in 2018, pending
Linking CME to license renewal	Not implemented
Ethics Ombudsman for NMC	Suggested, not appointed

Other initiatives, like **e-Sanjeevani (telemedicine)**, could facilitate **centralized prescription data collection**—but are still underused.

10. Moving from Deference to Transparency

In a culture that places doctors on a pedestal, accountability reforms are often resisted as "insulting" or "bureaucratic". But public health cannot depend on **unchecked discretion**.

"Doctors must be respected—but also held to the highest ethical and scientific standards. Especially when lives are on the line." — NMC Advisor, 2023

Transparency in practice standards, **feedback loops**, **peer reviews**, and **structured re-education** are the hallmarks of every mature health system.

India cannot afford to treat accountability as optional.

Conclusion: The Missing Audit in Indian Medicine

India has world-class doctors—but no national system to ensure they stay world-class. In the absence of **mandatory CME**, **license renewal**, **digital prescriptions**, and **practice audits**, the system runs on blind trust.

Accountability is not about punishing doctors—it's about **ensuring patients are protected**, and **science remains current**. Until India closes this gap, the damage will be cumulative—and eventually, irreversible.

References

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