UNDERSTANDING THE POWER-KNOWLEDGE RELATIONSHIP IN THE HEALTH CARE PRACTICES IN PAKISTAN: CASE STUDY FROM A HEALTH CARE FACILITY IN ISLAMABAD

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CERTIFICATE

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Author's Declaration

I, Ayesha Nazir, hereby state that my MPhil thesis titled 'Understanding the power-knowledge relationship in the health care practices in Pakistan: Case study from a health care facility in Islamabad' is my own work and has not been submitted previously by me for taking any degree from Pakistan Institute of Development Economics or anywhere else in the country/world.

At any time if my statement is found to be incorrect even after my Graduation the university has the right to withdraw my MPhil degree.

Date: 08/09/2021

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Dedication

I would like to wholeheartedly dedicate this thesis to my parents. My mother, late Nasreen Kauser, who gave me constant love and support at every step of my life. Being an educationist herself, she taxed herself dearly over the years for my intellectual development. My father, Nazir Ahmed Chaudhry, who is nothing short of an inspiration, a man of faith and resilience.

I would also like to dedicate this thesis to my husband, Osman Rehman Syed, for his unending encouragement, patience, and support.

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ABSTRACT

The weak design and implication of healthcare policies in Pakistan have led to numerous problems that affect every stakeholder in society. The patients are unaware of their rights due to low health literacy. Conversely, doctors are excused from being held accountable for their medical decisions and are given supreme authority. This study will analyze the PMC code of ethics, its poor implementation in the doctor-patient relationship, and the reasons behind the increasing negligence cases in Pakistan. It will draw mainly from the Michael Foucault's theory of power-knowledge relationship. Qualitative research has been conducted online where doctors and patients were selected for semi-structured questionnaires through nonprobability purposive sampling. The study is based on patients and doctors who visit and work at hospitals located in Islamabad and Rawalpindi, respectively.

Keywords: Power-Knowledge Relationship, Health Care System, Pakistan Medical Commission (PMC), Medical Code of Ethics

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LIST OF ABBREVIATIONS

PMC	Pakistan Medical Commission
PM&DC	Pakistan Medical and Dental Council
NHSRC	Ministry of National Health Services, Regulations, and Coordination
WHO	World Health Organisation
WMA	World Medical Association

CHAPTER 1

INTRODUCTION

The health care system is considered of high quality when its providers attend to the patients with due diligence; ask relevant questions, listen attentively to the patients, assign, and perform appropriate tests, draw sound and credible conclusions from the information gathered, and execute the procedures skillfully.

Since 1947, Pakistan's health care system experiences a deterioration of law and order, low quality of public and private services, and dysfunction of governance; poor licensing, certification, and performance evaluation of health professionals (Khan, 2019, p.6). Kazim (2007) notes that the Pakistan Medical and Dental Council (PM&DC) code of ethics includes the principles of beneficence, confidentiality, and non-maleficence. However, it excludes the power of autonomy. It has an ambiguous language that can result in several interpretations, and there is no legal binding to it. It causes a lack of accountability because the cultural values have elevated the status of the doctors and have given them complete authority for medical decisions.

Peerson (1995) has discussed the power-knowledge relationship ideology brought forward by Michael Foucault. According to it, the state, physicians, surgeons, and families aim to preserve the body's political anatomy for their interests and control over an individual in society. An increase in knowledge leads to an increase in power and vice versa; therefore, the physicians do not consider the patients' medical opinions during the diagnosing process. According to Foucault, the medical dominance of doctors/physicians is beneficial for both; doctors and patients, because being questioned by the patient breaks down the entire medical encounter. He has used the term 'good doctor' who diagnoses a patient quickly, does not spend a long

time with the patient, is accustomed to handling deaths and embarrassing treatments, etc.; they take over the decisions and advise patients on treatments and procedures. Good doctors should also have strong moral and value judgments.

Given this power-knowledge relationship, the patients accept the faults of the doctors, do not question their negligence/malpractice, and comply with their medical decisions and outcomes faithfully.

There are many cases reported throughout Pakistan where physicians and doctors use defective operation techniques, forget gauze pieces and medical instruments in the body after surgery, use expired medication, administrate wrong injections, diagnose diseases and perform treatments which leads to complications or even a casualty (Shiwani & Gadit, 2011, p.610). The victims of medical negligence should be compensated for their loss according to the rule of law. Unfortunately, the public is unaware of the procedure for reporting such cases; they either do not have the time or the financial means. Most of the people are humiliated at the hands of the Executive Director of Health Officers (EDHC) and 'nazims' (Khurji et al.,2016, p.603). This lack of law enforcement could be one of the reasons doctors are bold in suggesting unnecessary medical procedures. Courts are unwilling to charge medical practitioners under charges of criminal liability hence, they shift the cases to civil liability. As noted by Waraich (2018, p.85), incorporating medical services within the consumer law capacity is unfair and abominable. There is also discrepancy in compensation.

In the last two decades, the healthcare systems around the globe have been moving towards a patient-centered approach. This study will attempt to assess the current situation of the healthcare system of Pakistan in terms of doctor-patient relationship. It will evaluate the level of awareness among the patients regarding their medical rights, doctors' medical dominance, and the main issues that prevail during a medical

encounter. It will analyze the importance and implementation of the PMC code of ethics and draw attention towards the reasons behind the increasing negligence cases in Pakistan. This study will investigate the issues mentioned above according to the Foucauldian model and provide solutions for improving it.

1.1 Statement of Problem

The weak design and implication of the healthcare policies in Pakistan have led to numerous problems that affect every stakeholder in the society. The patients are unaware of their rights due to low health literacy; hence, they allegedly have low negotiating power. Conversely, doctors are excused from being held accountable for their medical decisions and are given supreme authority which might be a major reason for the increase in medical malpractice cases.

Michael Foucault's theory, power-knowledge relationship, states that ‘good’ doctors are dominant in power because they have more knowledge and vice versa. They are following a legally and professionally prescribed role and the patients should be compliant. However, given the increasing medical malpractice cases and the patients’ resistance in medical encounter, is the doctor’s medical dominance justified? Should a patient rely completely on the doctors' medical decisions?

> Summing up all the above-stated ideas brings us to the main study topic: Understanding the power-knowledge relationship in the health care facilities in Pakistan: Case study from a health care facility in Islamabad.

1.2 Research Questions

- What is the concept of a ‘good doctor’ in Pakistan? Do the Pakistani doctors embody the attributes of a 'good doctor?

Explanation: This research question is crucial since it will help conceptualize the study's theoretical framework. There is a need to define the term 'good doctor' in the Pakistani context and localize the definition while considering the history of Pakistan's medical field and culture. An attempt to define this term will help in assessing the preferred attributes of doctors according to the patients and whether it covers the essentials of the ‘good doctor’ definition as proposed by Michael Foucault; doctors that make sound moral and value judgments.

- What is moral and value judgments in the medical encounter, and does it cause resistance from the patients?

Explanation: This question will help understand how the doctors deal with good or bad patients from their perspective. It will try to determine whether the PMC ethical code is being followed, which prohibits class, gender, and status discrimination, and asks doctors to save the patients until they pass away. It will also try to assess whether the patients are satisfied with the medical services that they are receiving. It will also help in assessing the level of compliance or resistance shown by the patients and the reasons behind it; it will help resolve the barriers to a better doctor-patient relationship.

- What is malpractice? How do doctors and patients interpret the concept of medical malpractice?

Explanation: This question will determine whether doctors and patients acknowledge the existence of medical malpractice and are aware of its consequences. It will

highlight the importance of constructing a policy that informs both the doctors and the patients about their medical duties and rights. Hence, it will try to speculate the importance of spreading health literacy.

1.3 Research Objectives

The objective of this study is to highlight the medical code of ethics taken by doctors. The doctors must make sound medical and value judgments irrespective of the nature, race, status, or gender of the patient given the code proposed by the PM&DC. The power-knowledge relationship in the Foucauldian model shows that the medical decisions are the responsibility of the doctors; however, it is only possible if the patients have complete faith in the doctors. This study will try to determine the viability of the power-knowledge relationship in Pakistan; attributes of a 'good' doctor, effective medical encounter, and a sound doctor-patient relationship. It will further try to disseminate whether the increasing cases of malpractice are related to the doctors' medical dominance or lack of knowledge of the patients.

1.4 Significance of the Research and its Limitations

There is little research conducted on the health care system in Pakistan, especially the doctor-patient relationship, bioethical issues, and ethical code. This study can prove helpful in further research for improving the health care system of Pakistan. The medical schools are liable for training doctors in making better moral and value judgments. If there is a lag, then the curriculum of medical schools must be revised, as advised above. Shedding light on the reasons behind the increased medical negligence cases can lead to creating better policies and strict laws so that doctors are

held liable or responsible for their medical decisions. This will also help strengthen the malpractice laws and revising the complicated procedure of filing a malpractice claim. This research did not include the views of hospital management and how they manage issues of doctors, patients, and malpractice claims. It would be helpful to know their side as well because the doctors blame patient overload, irresponsible hospital management and inadequate resources for most of the issues in the doctor-patient relationship. Purposive sampling was conducted online due to pandemic restrictions at the hospitals. One of the major drawbacks of purposive sampling is researcher bias. This research study tries to minimize it after following the six phases of thematic analysis approach based on the trustworthiness criteria, mentioned in detail later (refer to section 3.6).

1.5 Organization of the Thesis

The next section of this research study covers a more detailed background in the form of 'Literature Review' that also shows the research gaps. After that, research methodology is explained followed by key findings and discussion of the results. Finally, the study ends with conclusion and recommendations section. This would be important in building and creating an effective doctor-patient relationship.

1.6 Key terms

1.6.1 Power-knowledge relationship

Michael Foucault introduced the term 'power-knowledge relationship'. According to him, the concept of power is non-economic and non-repressive. Doctors are rewarded power through social stratification that is necessary to serve society's interests. The

knowledge that they gain from their education, training, and expertise gives them the power to make decisions on behalf of the patients who readily comply. The relationship of doctors and patients is fundamentally based on ‘patienthood’ itself; doctors are attentive and insistent which can be comparable to parental qualities while the patients are compliant, and they reveal or conceal their disease which is similar to a child-like behavior (Lupton, 1995, p.159).

1.6.2 Health care system

A health care system comprises of people, institutions, and resources that deliver health facilities to the population. A balanced health care system focuses on disease prevention, diagnosis, management, as well as health promotion, treatment, rehabilitation, and *palliative care services* according to the patients' needs (Kumar & Bano, 2017, p.1).

1.6.3 Pakistan Medical Commission

A regulatory body in Pakistan, formerly known as, Pakistan Medical and Dental Council (PM&DC), is responsible for establishing the standard of basic and higher medical qualifications; by controlling entry and exit of medical practitioners, protect the interest of the patients, give guidelines on ethical issues, and setting educational standards for medical colleges and universities.

1.6.4 Medical Code of Ethics

The Medical Code of Ethics is a document that establishes the rules for medical practitioners and dentists. It states their priorities in the professional work, and their relationship with the patients, colleagues, and the community as a whole. Pakistan Medical Commission has constructed its medical code of ethics in line with the World Medical Association and Islamic bioethical laws.

CHAPTER 2

REVIEW OF LITERATURE

2.1 Background of Health Care System of Pakistan

Pakistan took its first health initiative by signing WHO Alma-Ata Declaration in 1978. It entailed certain health policies that the signatory countries had to implement. However, these policies were implemented in the year 1990 when the Federal Ministry of Health was created under the first national health policy. The focus of this Federal Ministry of Health was solely on the health promotion and public health perspectives such as school health services, family planning, nutrition programs, and control of non-communicable diseases. In 1997, the second health policy was introduced which, apart from the above-mentioned goals, also included *health education*. Thereafter, in 2001, a new national policy was made according to the Millennium Development Goals and focused more on the preventive aspects (control of diseases, reproductive health, malnutrition, etc.) while ignoring the curative or rehabilitative aspects such as prevention and control of non-communicable diseases. However, the new national policy was merely a concise description rather than a detailed policy document.

Collectively 1990, 1997, and 2001 policies included several objectives, chief among these were health financing, human resource management, medicines, health information, trade-in health and research. These were to be managed and overseen by the Federal Ministry of Health. However, these policies failed to achieve their designated purpose – the opportunity cost of having such a massive volume of tasks led to the failure of accomplishing and relegating appropriate time, effort, and resources to the public at the provincial and local level. This led to a lag in the

fundamental tasks of policy formulation: collecting and implementing evidence, planning, and regulation. To address this lag, the National Health Policy Unit was created which existed for 10 years only. Both, Federal Ministry of Health (FMH) and the National Health Policy Unit were plagued with limited capacity to analyze information; they were consistently donor-driven and supported through international aid. More than 70% of health care encounters were driven by private sectors with their profit-oriented goals. The lack of collaboration between the government and the private sector meant that the potential benefits for the public were not realised by the government.

After the 18th Amendment in 2009, when Pakistan turned from a semi-presidential to a parliamentary country, the Federal Ministry of Health dissolved, and the tasks were delegated to the provincial governments. The provincial governments were responsible for the health services, program implementation, and strategic planning of the health sector. As they were still inexperienced in strategic planning, the WHO decided to help them by providing technical assistance. The new provincial health strategies were based on the WHO's health system framework and would have been beneficial for the community as a whole if the provinces were given autonomy in real as well. Even though the health department was delegated to the provinces, the federal government was still in control of the actual policies that were developed and implemented on a provincial level. The federal government indirectly intervened through vertical programs and therefore, the needs of the people on provincial and district levels were ignored. This, furthermore, created a lack of coordination and loss of already limited resources. The support put forward by WHO, that is, conducting capacity building in strategic planning and reviewing the provincial health sector remained a theoretical theory.

The provincial government insisted on separate policy objectives for improving their capacity, human resource management, and institutional arrangements. This was a valid suggestion considering the separate social determinants of each province. However, due to financial constraints, the federal government was unable to provide them with the budgetary cost. As a result, provincial policies were ignored, and the provincial governments were unable to accomplish their health policy objectives.

Due to the financial constraints, the Ministry of National Health Services, Regulations, and Coordination (NHSRC) was founded in 2012 to implement basic health reforms in the country. To date, NHSRC has created 196 laws including preventive, curative, rehabilitative, and other miscellaneous laws that are instigated throughout the country. After the deadline of Millennium Development Goals in 2015, NHSRC has set a framework for the National Health Vision 2018-2025 per the Sustainable Development Goals. It follows WHO's health system framework, which is, health financing, health service delivery, human resource for health, health information systems, governance, essential medicines and technology, and cross-sectoral linkages. The National Health Vision mainly focuses on the health and wellbeing of children and women providing them with easy access to quality health services. However, it has yet to be implemented as it is still in its planning phase.

National Health Policy of Pakistan has shared its new objectives of solving the problems faced in the health sector, that is, by improving its governance, finance, health service, human resource, information system, technology, and monitoring.

2.2 Major Issues in the Health Care System of Pakistan

Khurji et al. (2016, p.603) have talked about many health reforms that took place since 2015. According to their research, the health care facilities have increased but

most of them have poor management and quality of health, limited storage of resources and drugs/medicines, lack of trained staff, unavailability of female staff, non-attendance of staff, and the medical professionals are operating private clinics along with their public posts because of lack of incentive to improve their performance. This could be due to a lot of corruption that is deep-seated in the health care sector. This hinders the confidence and trust of the people who are employed in this sector. It also deters their contribution towards an efficient execution of the health care policies, programs, and innovation (Khan & Heuvel, 2007, p.283). This causes disparity of power structure as people distrust the health care system.

There is not any authority established that could act against the corruption in the health care system. Consequently, poor governance of the public health providers escalates the uncertainty and distrust of the public to opt for them. Therefore, they prefer private doctors, but the latter charges a lot for their services. The shortage of finances means that the poor do not have a choice but to pay health cost and have restrictions on deciding their health. (Khurji et al., 2016, p.603). Javed et al. (2018, p.11) mentioned that even if the patients prefer the private sector over the public sector due to its responsiveness, the private sector still lacks reliability as they assign unnecessary tests or medicines for a profit share. This shows that patients are not fully satisfied in either private or the public health sector.

The public sector is underused. It has weak human resource; there is a lack of health education among most of the patients, lack of openness and many barriers between the doctors and the patients due to language and cultural gap (Khurji et al., 2016, p.603). Lupton (1995, p.160) stated that biomedical knowledge and technical competence are the foremost requirements of being a doctor, and other attributes such as compassion and good 'bed-side manners' are only secondary.

However, according to postmodern theorists Deleuze and Guattari, patients have started challenging the medical dominance, but this resistance is shown by patients who have *awareness* or are educated. (Lupton, 2012, p.113).

The concept of 'malingering' (feigning of symptoms for a secondary motive) was overruled in the 1970s due to the introduction of ecological and psychological models of health by the scholars of public health. However, most of the doctors in Pakistan hold onto this concept. Sheikh et al. (2013, p.152) suggested in their research that many patients come up with diseases such as malingering, hypochondriasis (voluntary mimicking of symptom), and Munchhausen (where a person avoids working and obtain compensation) which proves to be a source of delay for attending other patients who need immediate help. Then again, how can the doctors be sure a patient is feigning disease or not if they are not taken seriously by the doctors, given proper attention or adequate time for consultation? Or worse, they are given the wrong diagnosis?

2.3 Hippocratic Oath

It is an ethical code for physicians that were written between the third and fifth centuries BC. Physicians swore, by several healing gods such as Apollo, Asclepius, Hygieia, Panaceia, et cetera., that they will uphold the standard medical ethics, especially medical confidentiality, and non-maleficence. Over the years, it has been amended according to the cultural values of each country. However, a Hippocratic Oath is not mandatory to follow by many modern medical schools. Few schools have implemented the new versions that are better suited in this century; new additions and changes introduced in the medical technology sector and discoveries.

2.4 International Code of Ethics

World Medical Association (WMA) formulated a detailed code of ethics based on the Declaration of Geneva to state the duties of medical and dental practitioners. It was approved in 1949 and has been amended twice; in 1968 and 1983. The following are the three duties of the physicians outlined by WMA. The detailed policy can be viewed in Appendix D.

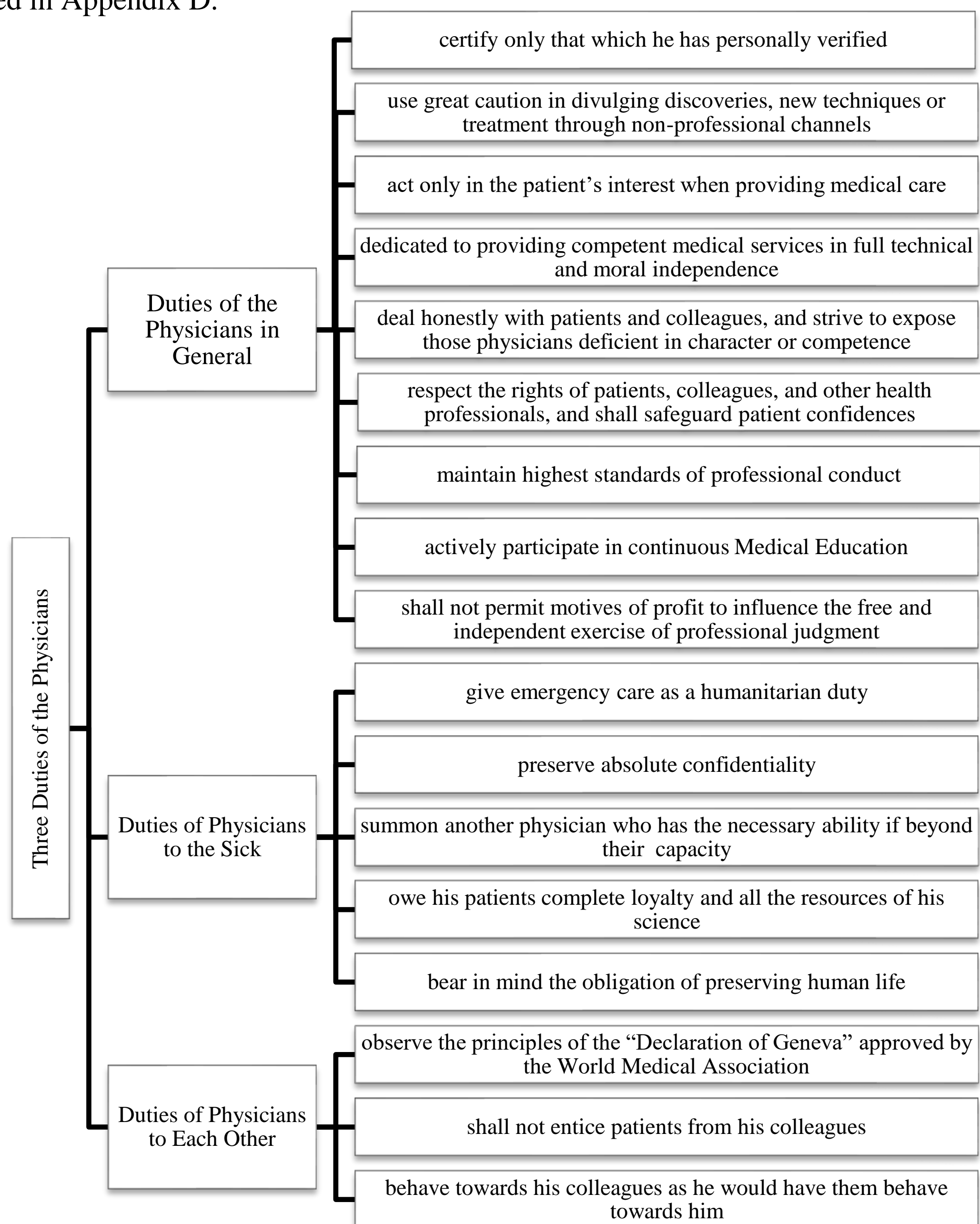

Figure 2.1: Duties of the doctors/physicians according to the WMA

According to this code of ethics, physicians or doctors are obligated to follow three types of duties: general, towards the sick, and towards their colleagues. Regarding the duties in general, physicians must maintain professionalism and keep themselves updated of the changing innovations in the medical system. They should diagnose the patients without being influenced by profit motive as they have the medical dominance. They should be *competent*, *compassionate*, *honest*, and respectful towards their patients.

Regarding the duties towards the sick, physicians should foremost try to preserve human life. They should be loyal, *sincere* and keep things confidential unless the treatment is beyond their capacity. As for their duties towards their colleagues, they must observe the 'Declaration of Geneva' that has been approved by the WMA.

2.5 Medical Ethics and Islam

Sickness is seen as a trial in Islam. Therefore, patients are compelled to seek cure and treatment. Islamic bioethics is formulated from the ethical principles of the Quran, Sunnah of the Prophet Muhammad (Peace Be Upon Him), and the interpretation of the Shariah (Islamic) law. It has emphasized precaution and then sets guidelines for both the doctors and the patients. The doctors have the duty of doing their best in healing the patient concurrently recognizing Allah as the ultimate healer. They must consider all three dimensions of the disease during a medical encounter, such as, physical, mental, and spiritual of the illness. Although the main principles of the Hippocratic Oath and Islamic Code of ethics are the same, the latter used the term 'Oath of Muslim Doctors' instead. This was to omit the supplication of multiple gods that exists in the Greek version.

2.6 Pakistan Medical Commission (PMC) Code of Ethics

The Pakistan Medical Commission code of ethics highlights the ethical principles and standards that regulate the responsibilities and morality of doctors/physicians. It is derived from the World Medical Association and Islamic bioethical laws. According to the PMC, the WMA ethics code focuses on individual rights whereas, Islamic bioethics focuses on the liabilities and obligation of the doctors and patients; preserve life or seek treatment. Therefore, PMC has incorporated both when forming its code of ethics. It was first proposed by the PM&DC Ordinance in 1962 and was approved in 1968. After that, it has been revised by the Council twice; in 1974 and 2001. The code of ethics was also intended to become a document that will educate the public on professional ethics so that *everyone knows their rights*. If any medical professional is questioned, they will be judged according to this code.

The PM&DC code of ethics declares (Appendix C):

> "I solemnly pledge myself to consecrate my life to the service of humanity… the health of my patient will be my first consideration; I will respect the secrets which are confided in me, even after the patient has died; …I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient; I will protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain and anxiety. To be, all the way, an instrument of Allah's mercy, extending medical care to near and far, virtuous and sinner and friend and enemy".

The detailed PM&DC code of ethics can be viewed in Appendix C. It has been divided into twelve parts:

1. Preliminary
2. General
3. Teaching ethics to students
4. Expectations of the council
5. Fundamental elements of patient-physician relationship
6. Ethical standards of professional competence care and conduct
7. Professional fee and timings
8. Research ethics and consent
9. Miscellaneous
10. Punishment and disciplinary actions
11. Matters relating to pharmaceutical industry
12. Repeal

As opposed to the original idea, Islamic jurists were not involved in formulating the PM&DC ethics of code (Kazim, 2007, p.41). Islamic bioethical concepts are not incorporated fully or are very ambiguous. Such as the 'end of life care' concept where Islamic bioethics supports the autonomy of the patient and the family, but the PM&DC code has a paternalistic approach to it where doctors are the main decision-makers and can refuse further treatment if they deem it to be futile. Giving full control to the doctors puts a huge responsibility on them for being accountable for their actions and decisions as well. Anwar (2011, p.208) has talked about the lack of

accountability in Pakistan that allows health care professionals to act irresponsibly and cause ‘serious morbidity’. He has proposed establishing a ‘Clinical Governance’, an idea taken from the Kennedy report that states that the patient and medical professionals would both be equal in decision making and become team players. The standards set would be used to monitor the health care services and the indicators would help in assessing the areas which need to be improved.

2.7 Critical Analysis on the Medical Code of Ethics in Pakistan

Kazim (2007) has critically analyzed PM&DC code on consent, social structure of the society, and the jurisdiction and the religion. Her analysis has led to the view that the anatomy and rights of the patients are not acknowledged or recognized in Pakistan because the code of ethics is *too ambiguous*, and the doctors are not held accountable for their actions. The family is more involved in decision making than the patient himself/herself.

An example of the language of the code of ethics being too ambiguous can be the section regarding ethics being taught to the medical students. PM&DC has stated their expectations regarding it and proposed that the ethics course should be taught at medical schools. They have mentioned that the information of ethics code has been developed to include in the curriculum, however, they have not made it compulsory and left it at the discretion of the administration and academic professionals to find ways to include it as they see fit.

The lack of research in Pakistan regarding the bioethical issues and ethical code further proves how it is ignored or neglected. The lack of implementation of the code of ethics has led to increasing malpractice cases in clinical and research medicine.

Farooq et al. (2018) conducted a cross-sectional study where they carried out structured questionnaires aimed at MBBS graduates to gauge the understanding of medical ethics. They have concluded in their research that doctors have low awareness of ethical concepts such as confidentiality, non-maleficence, informed consent, respect for privacy, and desirable attitudes in healthcare professionals. This is due to the ineffective teachings, lack of legal actions taken by patients, and lack of PM&DC monitoring and implementation of the code of ethics.

Kazim (2007, p.54) elaborated in her research that the revised curriculum designed by the PM&DC contains the course of ethics, but it is incorporated as an additional optional subject. Doctors often skip this course thus creating a wide gap between the theoretical ethical principles and medical practice in Pakistan. Jafarey & Farooqui (2003) researched that only one medical college in Pakistan is teaching bioethics as a compulsory subject and even those students are not ready to make sound moral and value judgments. This is because, among the many questions asked, the students at this college mostly agreed to the idea of performing breast examination without the consent of the female patient under anesthesia as 'she will not know and it's important for our learning'. Therefore, the curriculum must be revised where students deal with first-hand ethics dilemmas from the first year of their education, especially during their clinical years (year 3 onwards). Similarly, Ahmad et al. (2015, p.7) concluded that despite the curriculum of a medical institution being patient-centered, the student doctors are still not as sympathetic as they should be towards the patients when practicing medicine. They proposed that doctors should adequately be exposed to patients from the beginning of their training. This stance is supported by Jafarey and Farooqui (2003) where they have talked about the lack of formal ethical education in the medical colleges in Pakistan. According to them, the necessity of

introducing bioethics as a compulsory course would help the medical students in being well-equipped with sufficient reasoning skills in identifying ethical dilemmas in practice.

Shiwani and Gadit (2011, p.610) have questioned the efficiency of the healthcare system in Pakistan, specifically the health policies, quality of medical education, professional ethics, parallel private practice, and non-implementation of professional laws. However, they have focused only on the problems existing in the health sector by advising to monitor the medical training, that promotes or standardizes the obligation and liability of the doctors, legal security of doctors and patients, increasing the salary of doctors and giving absolute authority to the PM&DC. But they have not talked about the inconsistency of policies within PM&DC or the irregularities and ambiguities in the health policy itself that has caused such problems. PM&DC is the sole regulatory body for medical practitioners, therefore, repercussions for medical errors and negligence are rare. (Farooq et al., 2018, p.82)

2.8 The Power-Knowledge Relationship in Pakistan

The health ministry and PMC controls and regulates the health care system/facilities in Pakistan. As mentioned above, doctors can make major decisions at their discretion. Thus, the culture set by the society of endorsing the power and knowledge relationship of the government (law) and the medical professionals (diagnosis and treatment) makes the patients more susceptible to the outcome without questioning the possibilities of a better outcome.

Kazim (2007, p.3) remarked in her research paper that medical paternalism is very strong in Pakistan because of various factors as mentioned before: lack of awareness among people, high illiteracy rate, trust and faith in the medical profession, a social

structure where family members become the decision-makers, and religious concept that death is inevitable.

Peerson (1995, p.112) has talked about the significance of laypersons who are concerned that the patients have little or no power over the limits on medicine. The policies and procedures are reviewed by medical professionals only and the population is treated merely as experiments. This hegemony is supported by the bureaucrats and legal structure that arises from power. Legal and ethical concerns arise as society is faced with humanity and morality.

Detached health professionals who are unable to efficiently communicate with the patients cause an increase in malpractice litigation. Sheikh et al. (2012) researched that more than 68.7% of the 319 surgeons in Pakistan were unaware of the term ‘malpractice’. Only 4.1% were sued for malpractice. They concluded that doctors do not have a sense of responsibility due to a lack of accountability. This is because a comprehensive law system does not exist in Pakistan.

The doctor-patient relationship will be more effective if it has genuine patient-centeredness. It will create a positive placebo effect and can be achieved through the efforts of the medical profession. Taking a case study from Pakistan, Akbani et al. (2020, p.812) concluded in their research that patients’ preferences change according to the demographic area and to strengthen the doctor-patient relationship, these attributes should be given importance, such as, doctors being polite/friendly, no language barrier, and experienced professionals. If we identify and try to imply the preferred attributes of doctors by the patients and other factors that cause dissatisfaction in the medical encounter, then a country can address gaps in the health care system. It can also help in building reforms and improving the overall health status of its population (Naseer et al., 2012, p.56). Akbani et al. (2020, p.810) also

suggested that knowing the preferred attributes of the doctors by the patients will certainly benefit the doctors to create a bond of trust and help future medical doctors in delivering a higher quality of healthcare in Pakistan.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Research Strategy: Qualitative

Qualitative research is where people's experiences are discovered and their preferences are recognized (Silverman, 2020, p.3). It is concerned with the subjective 'meanings' compared to 'facts' obtained through quantitative research.

I will be applying the qualitative research strategy that has an inductive approach. It is when after observing patterns and similar experiences, conclusions are proposed via theories. The ontological stance for this study is 'Social Constructionist'. According to this stance, social realities are continuously evolving and are subject to change. The social phenomenon is not static or inorganic; there is always room for new meaning and motivation behind every social action. Knowledge is developed from an individual's interaction with the culture and society. According to Lev Vygostsky (1978, p.57), cited in (MacBlaine, 2018, p.59), cultural development occurs twice in an individual, on a social level and later at an individual level. The stance of social constructivism is applied in this study because on a societal level, doctors have medical dominance and patients comply to the prescribed diagnosis and treatments without challenging their power and knowledge. However, over the time, individual experiences of the patients have started causing a resistance. Patients' experiences will be accumulated and their change in perspective will be gathered which will lead to a new meaning of the theory proposed, that is, power-knowledge relationship. As the social realities are always evolving, this study aims to find out reasons behind the change of social action; resistance, no matter how small it may be.

3.2 Research Design

Research design is a research method that helps the researchers in collecting and logically analyzing data. There are three types of questionnaires: structured questionnaires, semi-structured questionnaires, and unstructured questionnaires. For this study, primary data was collected by conducting semi-structured questionnaires.

Initially, I had decided to use semi-structured interviews, however, it was not possible due to COVID-19 and the reluctance of the doctors. Therefore, semi-structured questionnaires were conducted which allows a researcher to ask questions from the interviewee in a flexible, non-restricted manner. It can be helpful in case studies to obtain information in a consistent and comparable manner (Scapens, 2004, p.266).

Semi-structured questionnaires helped in developing knowledge and understanding of the changing opinions of the doctors and the patients by asking about the challenges they have faced in medical encounter and trying to find the reasons behind these challenges. Their responses helped in explaining the current situation of the doctor-patient relationship and provided suggestions to improve it.

3.3 Units of Data Collection (UDCS)

3.3.1 UDC 1: Patients

Explanation: Semi-structured questionnaires of patients were conducted. This helped in getting the opinion of the patients on the topic at hand. It is essential to understand their concept of the term 'good doctor' and what attributes they would prefer in a doctor. It helped in determining whether the patients are satisfied with the current health services provided by the doctors or if they want to propose any suggestion that

might improve their medical encounter. This highlighted their experiences of facing bad medical encounters and medical malpractice.

3.3.2 UDC 2: Doctors

Explanation: Semi-structured questionnaires from the doctors were conducted to understand the doctor-patient relationship from the doctors' perspective. It determined whether the doctors are aware of the consequences of their medical decisions, malpractice laws, and their familiarity with the PMC ethics code. It also helped in identifying their issues and concerns regarding the policies and the problems they face while catering to the patients.

3.4 Research Methods

For this research, I would be choosing semi-structured questionnaires and sampling.

3.4.1 Semi-structured Questionnaires

To better understand the challenges faced by doctors and patients, two separate questionnaires were created via Google Forms. This helped in collecting data from the perspectives of both parties involved in the medical encounter. The forms can be viewed in Appendix A and B. Few close-ended questions were asked which led to the open-ended questions. The open-ended answers were descriptive and explanatory where respondents shared their experiences and opinions for improving the doctor-patient relationship.

The forms / questionnaires are fully recorded solely by the author to ensure accuracy of each form in coding, that is, *Thematic analysis*. In the form, they were also given the option to omit their name and contact information. The identity of the

participants/respondents has been kept confidential. A consent form was attached at the beginning of the questionnaires which explained the background of the research study, the purpose behind it and asking their permission to save, store, transcribe and use their form output solely for the academic and research purposes. Only those questionnaires are included in this research that meets the criteria, that is:

- the respondents are residing in Islamabad or Rawalpindi and visit/work at the hospitals in these cities only.
- The respondents gave the consent for their answers/forms to be used in this research.

The questionnaires for patients and doctors were structured in the following manner:

a. Patients (for detailed questionnaire, please view Appendix B):

The questionnaire was divided into three sections:

1. Introduction: Background and reason for conducting the research study.
2. Informed consent form: This includes age, gender, area of residence, name of the hospital they visit frequently and their consent for allowing the form to be used for academic and research purposes.
3. Close and open-ended questions: preferred attributes of a doctor, problems faced in medical encounter, experiences of medical malpractice or complaints, and their views on lawsuits.

b. Doctors (for detailed questionnaire, please view Appendix A):

The questionnaire was divided into three sections:

1. Introduction: Background and reason for conducting the research study.

2. Informed consent form: This includes age, gender, name of the hospital they are currently working at and their consent for allowing the form to be used for academic and research purposes.
3. Close and open-ended questions: encounters with hospital management and patients, their views on the term ‘good’ doctor and limitations on being one, their views on PMC code of ethics and medical curriculum taught at medical schools.

3.4.2 Sampling

Sampling is a method used by the researchers in which they choose a specific group from a population as units of data collection. The participants, who filled in the questionnaires, were not incentivized by any means to take part in this research. As mentioned above, before starting the questioning process, the respondents/ participants were asked for their consent to save, transcribe, and use their forms for academic and research purposes. Their identity has been kept confidential and only the author of Google forms has the right to go through the forms and use it for this study.

Since this study was aimed at participants who were doctors and patients who recently visited the hospital, nonprobability sampling was conducted. More specifically, purposive sampling where individuals took part in the research study on their own accord once the questionnaires were advertised to them via social media platforms.

Sample characteristics of both questionnaires, that is, doctors and patients, can be viewed in Table 3.1 and Table 3.2. Total sample population is of 38 participants (29 patients and 9 doctors). Participant ID consists of the participant number so that it’s easier to quote them in the data analysis.

Table 3.1 includes the demographic locations of the participants(patients), gender, and their preferred type of hospital. The age range of patients is between 18-42 years, most of the participants are females and they prefer going to a private hospital.

Table 3.1: Sample characteristics of study participants (patients).

ID	Age	Gender	City of residence	Which type of hospitals do you mostly visit	Name of the hospital you mostly visit / recently visited	Name of the department you recently visited
P01	26	Female	Islamabad	Private	Shifa International Hospital	ENT
P02	26	Female	Islamabad	Private	KRL Hospital	Gynae
P03	26	Female	Rawalpindi	Private	Ahmed Medical Complex, Bilal Hospital	OPD
P04	27	Female	Islamabad	Private	Family Health Hospital	Medical specialist
P05	30	Female	Rawalpindi	Public	CMH	Gynae
P06	42	Female	Islamabad	Private	Ali Medical Centre	OPD
P07	26	Female	Islamabad	Public	Polyclinic	Dermatologist
P08	28	Female	Islamabad	Private	Shifa International Hospital	ENT
P09	24	Female	Islamabad	Private	Shifa International Hospital	OPD
P10	28	Male	Islamabad	Private	PIMS	ENT and OPD
P11	24	Female	Islamabad	Private	Life Care Hospital	Emergency
P12	24	Female	Islamabad	Private	Akbar Niazi Hospital	Ent
P13	30	Female	Rawalpindi	Private	Bilal Hospital	OPD
P14	21	Male	Islamabad	Private	Quaid e Azam Intl. Hospital	OPD
P15	39	Male	Islamabad	Private	Shifa International Hospital	OPD
P16	26	Female	Islamabad	Public	PIMS	OPD
P17	23	Female	Islamabad	Private	Ali Medical Hospital	ER
P18	24	Female	Islamabad	Private	Get Well Hospital	Gynae
P19	21	Female	Islamabad	Private	Ali Medical Hospital	Gastroenterologist
P20	27	Female	Islamabad	Private	KRL / Shifa International Hsp	OPD
P21	50	Female	Islamabad	Public	KRL Hospital	Emergency
P22	48	Male	Rawalpindi	Private	KRL Hospital	Neurosurgeon
P23	36	Female	Islamabad	Public	Polyclinic	OPD
P24	28	Female	Islamabad	Public	PAEC hospital	ENT
P25	24	Female	Islamabad	Public	CMH	Gynae
P26	30	Male	Islamabad	Private	PNS Hafeez	ENT and OPD
P27	19	Male	Islamabad	Public	PIMS	Dental
P28	18	Female	Islamabad	Private	PAF Hospital	OPD
P29	18	Female	Rawalpindi	Public	Holy Family Hospital	OPD

Table 3.2 includes the age, gender, and the demographic locations of the hospitals where participants (doctors) work at. Most of the participants are females and work at a private hospital. The age range of doctors is between 25-61 years who have 2-3 years of experience to those who have up to 30 years of experience in the medical field.

Table 3.2: Sample characteristics of study participants (doctors).

ID	Age	Gender	How long have you been working as a doctor?	Name of the hospital that you are working at?	Area of hospital	Name of the hospital department you work at
D01	27	Female	4 years	Riphah Hospital	Islamabad	Gynae
D02	28	Female	3 years	Shifa international Hospital	Islamabad	Oncology
D03	48	Female	21 years	KRL Hospital	Islamabad	Gynae and obstetrics
D04	25	Female	3 years	PIMS	Islamabad	Neurology
D05	28	Female	4 years	HBS Dental Hospital	Islamabad	Prosthodontics
D06	27	Female	2 years	CarePlus Medical Center	Islamabad	Gynae
D07	26	Female	3 years	Al Mustafa Hospital	Rawalpindi	OPD
D08	45	Female	21 years	Holy Family Hospital	Rawalpindi	Medicine
D09	61	Male	30 years	PIMS	Islamabad	Gastroenterology

3.5 Ethics of Online Data Collection

The Google forms shared on various online platforms disclosed the presence, affiliation, and intention of this research study in detail (refer to Appendix A and B). This is one of the foremost conditions for online research according to Sugiura et al. (2016, p.188). The participants were given the option to decline participation and those who did, their answers are omitted from this research study. The form also includes a section where participants are informed regarding complete confidentiality and anonymity. The participants were given the option of omitting their name and contact details. Each participant is given a code for easy access of audit trial and anonymity. The contact details of the researcher/author are also available in the form and the participants can opt to exclude themselves from the research.

It was difficult to find the target audience, that is, participants from Islamabad and Rawalpindi. Therefore, the sample size is not as large but sufficient. Many form submissions were from different areas which were omitted from the research.

3.6 Method of Analysis

After the data collection, thematic analysis approach, Braun and Clarke (2006), was adopted to systematically identify, organize and offer insights into patterns of themes. After the Google forms were submitted by the participants, Excel sheets were created. The criteria of trustworthiness, as introduced by Lincoln and Gaba (1985), cited by Nowell et al. (2017, p.3), were followed to ensure that the results were legitimate, reliable, and valid. The criteria of trustworthiness are credibility, transferability, dependability, and confirmability. The incorporation of this criteria has been described in detail along with the six phases of thematic analysis (Nowell et al., 2017, p.4):

1. Familiarizing yourself with your data

2. Generating initial codes

3. Searching for themes

4. Reviewing themes

5. Defining and naming themes

6. Producing the report

All the answers were read repeatedly and coded manually. All the raw data was archived and viewed again from time to time during the data analysis process to ensure adequacy. A unique identifier for each source was created, for example, the participant code, along with the date on which the answers were submitted so that an

audit trial is available for confirming data analysis and interpretations of adequacy. The repeated themes were organized in a table to figure out the feedback of majority of the participants. Another table was created which included all the major themes and sub-themes, for example, compassion is a major theme, and the sub-themes were understanding, empathy, kind, et cetera. There are few sub-themes that were included in more than one major theme, such as, lack of knowledge. This is because the theme has been repeated by the respondents in different contexts that suits better under different themes. According to Braun and Clarke (2006, p.89), the idea of thematic analysis is not to ignore data to provide smooth outcomes rather to show consistency in the ideologies of the individuals. The surrounding data was kept to manage the process of theme identification and its analysis. The analysis was data driven to avoid any analyst-oriented biases. To be specific, deductive codes formed the main themes based on the conceptual framework and research questions. However, inductive thematic analysis was conducted for the sub-themes where the data was coded without trying to fit in the pre-existing coding frame. The development of the themes and subthemes were documented in the form of tables in excel sheets so that an audit trial is available to help establish confirmability. The themes and sub-themes were reviewed again to check whether they are too thin (not enough data to support them) or too diverse and need to be broken down further. A detailed analysis of each theme was added to show how it fits in the overall story of data set in relation to research questions. Direct quotes are added to help in understanding the specific points of interpretation. Extracts from raw data and extensive paragraphs are added to go beyond the description of data and show the merit and validity of the data. It is also an attempt to theorize the significance of the patterns, their meanings, and implications in relation to literature. After organizing all the 'Findings' (refer to section 5.1) and

offering insights or narratives to the themes (as mentioned above), the literature was added to the data analysis in the 'Discussions' section (refer to section 5.2).

3.7 Locale

This research is conducted online from patients residing in Islamabad and Rawalpindi and doctors working at Islamabad and Rawalpindi hospitals (area of respondents' residence and hospitals can be viewed in Table 3.1 and Table 3.2).

Most of the patients are from Islamabad and majority of the doctors also work at hospitals located in Islamabad.

CHAPTER 4

CONCEPTUAL FRAMEWORK: NARRATIVE

In this study, Michael Foucault's concept of the power-knowledge relationship will be applied to the health care system of Pakistan. The study will analyse the dominance of medical professionals over the patients. The concept of power is perceived as a strategy rather than the property of the dominant class. Power is transmitted from those with more knowledge to those who do not (Lupton,1995, p.159). Patients should have complete trust in their doctor's abilities and should not question their decision for an effective diagnosis and treatment. The sentiments are similar to the 'power' of clergy who is benevolent, *caring* and *friendly* but at the same time has the position of authority (Lupton, 1995, p.159). This trust is necessary considering the uncertainty of illness, pain, and physical examination experience.

Michael Foucault introduced the term of 'good doctor' where the doctors get things done quickly, do not spend too much time with the patient and take over the control from the patient, and have a paternalistic approach towards the diagnosis and treatment. However, the procedure is informed to the patients beforehand to avoid malpractice claims. Good doctors should also have strong moral and value judgements.

Understanding the power-knowledge relationship in the health care system of Pakistan is very crucial; analyzing the mostly unquestionable faith and trust patients have in their doctors, how the state institutions (medical regulatory authority: PMC) legitimize the authority of doctors by giving them medical dominance. They do not mostly encounter patient resistance and can avoid accountability for their medical

decisions. According to Foucault, the cultural mindset gives power to the doctors. If a patient starts questioning the doctor, then the whole process is futile.

Applying this theory in Pakistan, the patients have started showing resistance in medical encounters due to an increase in medical negligence cases and an overall poor health care system. Therefore, according to Foucault's theory, an issue arises when the doctors are not as capable as they are perceived-to-be by the patients.

Medical students experience learning communication in a highly artificial and controlled environment, that is, their experience comes from patients that are actors or a simulation of surveillance. They are unable to diagnose the patients as quickly as possible without understanding the situation of the patients and talking to them in detail (Marshall and Bleakley, 2008), cited in Bleakly & Bligh (2009, p.378). This might explain the need for a medical encounter that is patient-centered and very democratic.

However, Bleakly and Bligh (2009, p.380) concluded that with the change of technology and innovations since the time of Foucault, we need to renew our ideology of doctor-patient relationship, but we *need to incorporate the insights of Michael Foucault for future theories*. The idea of flattening hierarchies is 'democratically seductive but not productive'. A balance of power-knowledge relationship is required. Doctors have to be aware of the absence and presence in consultation (Bleakley and Bligh, 2009, p.381). They can learn this at the bedside of the patients or in the community. Stimulation of communication skills in medical education does not lead to in-depth knowledge of the human body. In a simulated environment, student doctors have the power, but they lack tolerance and are uncertain in the real clinical world. This creates 'inhumanity' in medical education (Bleakley et al., 2009, p.382).

Taking this concept forward, the postmodern theorists Deleuze and Guattari came up with the concept of body-without-organs. According to this concept, although the body can be territorialized by the discourse and practices, there is a potential for resistance by the patients (Lupton, 2012, p.113). Foucault agreed to this notion later in 1988. However, the resistance will come from rich patients who have the luxury of choosing alternative medical guidance.

Applying this new Foucauldian theory to the health care system of Pakistan, a place where 63% population is from rural areas, it is not possible to choose another doctor due to the high illiteracy rate or low availability of doctors. The doctors need to take accountability for their action and use their power-knowledge status to balance the doctor-patient relationship for better cooperation, low medical negligence cases, and an effective health care system.

In conclusion, this research will draw mainly from Michael Foucault's theory of power-knowledge relationship. However, it will also draw on contemporary Foucauldian power-knowledge relationship theories. According to their considerations, both patients and doctors have an agency. Even if the doctors have the decision power, most of the time patients resist and question the medical practices and encounters based on their social positioning.

CHAPTER 5

RESULTS

5.1 Findings

There are nine core themes identified, after performing the thematic analysis approach (refer to section 3.5), that tries to cover the research objectives of this study: compassion, attentive, competent, unexplained diagnosis, second opinion, medical encounter, medical malpractice, and medical curriculum. Each theme has been divided into further distinctive sub-themes that sheds light on the issues, challenges and suggestions of the doctors and patients in a medical encounter. Narratives and direct quotes have been added for better explanation and understanding of the analysis (refer to section 3.5). Sub-themes are written in bold font for better understanding.

The themes and sub-themes can be viewed in Table 5.1.

Table 5.1: Themes and sub-themes derived from Thematic analysis

Themes	Sub-themes
Attentive	Good listener Gives time and energy Diagnosis mid-sentence Limited consultation time Long queues Tough schedule Inadequate resources
Medical malpractice	Lawsuit Lack of knowledge Tough schedule
Second opinion	Insincere Depends on severity Unsatisfied
Competency	Knowledge Professional Smart
Unexplained diagnosis	Prescribing tests and medicines Patience Explain consequences Supportive
Medical jargons	Language barrier Lack of knowledge
Medical encounter	Doctors blamed for everything Social discrimination
Medical curriculum	Modular system PMC code of ethics
Compassion	Understanding Non-judgemental Empathetic Humble Considerate Friendly Kind

5.1.1 Compassion

The theme of compassion, in this analysis, reveals the qualities that the patients as well doctors think a professional physician should possess to have an effective medical encounter. Doctors should be **understanding** of the patient's situation, **non-judgmental**, **empathetic**, be **polite, humble, kind,** and **friendly** so that the patient feels comfortable in explaining his/her symptoms:

P09: "Some doctors don't take me seriously or say negative things about what led the symptoms to happen, instead of being non-judgmental."

P21: "(A doctor should be) attentive, friendly, ask questions to figure out what is actually the reason."

P25: "She (the doctor) didn't listen with care."

P26: "(A doctor should have) an empathetic attitude towards my concern and pay attention to what I'm saying."

The patients want their doctors to be **considerate** when it comes to consultation. Some patients felt that the doctors were not considerate enough, and would prescribe medicines and tests which are expensive and not easily available in the market:

P13: "He (doctor) should not just start prescribing all the medicines he knows of and before prescribing he (doctor) should also inquire about the budget of the patient. Everyone cannot afford high end imported medicines."

P26: "(A good doctor should) pay attention to details, no attitude, proper guidance and most importantly prescribe generic medicine."

Most of the doctors are of the same view that to be a 'good doctor', one must be compassionate, empathetic, humble, and kind when dealing with patients.

D05: "They(doctors) must be empathetic."

D06: "A good doctor should be humble and sincere."

D09: "Doctors should be empathetic and caring."

5.1.2 Attentive

Attentiveness in this analysis developed as a factor explaining the qualities of a doctor. An attentive doctor, who is a **good listener** and **gives time and energy** to his/her patient will most likely have an effective medical encounter. If the patients feel heard and listened to, they would be more willing to explain their symptoms in detail which will result in a better diagnosis. According to the patients, a doctor is considered 'good' if:

P01: "He (doctor) is willing to give time and energy. His ability to put aside all externalities."

P04: "He (doctor) is a good listener…does a detail check-up of patient rather than being in a hurry to accommodate as much patients as he can."

P05: "They must be good listeners."

P08: "(A) good listener. Gives quality time."

P13: "He (doctor) should have patience to listen to the patient."

P16: "(They should have) patience."

P21: "Attentive, friendly, asks questions to figure out what is actually the reason."

P25: "Concerning and should be a good listener."

P26: "Attention to details."

Very few doctors mentioned attentiveness as an important characteristic of being a 'good' doctor:

D01: "Patience. Doctors have and need to be patient."

D07: "Doctors should be good listeners and give appropriate time to the patients."

Many patients feel that the doctors do not give them appropriate time and **diagnose mid-sentence**:

P01: "Doctor try to diagnose mid-sentence."

P08: "Doctors don't listen properly and seem uninterested in the patient."

P10: "Doctors do not listen properly and diagnose patients after only partially hearing them."

P12: "Not listening properly, assuming they already know"

Conversely, when asked if the patients conveyed their symptoms properly, most of the doctors' answers were negative:

D02: "Nope, most symptoms are not conveyed; some are vague."

D04: "They change history when a senior comes."

D05: "Some patients hide their symptoms."

D07: "I feel difficulty sometimes."

D09: "Patients are always vague in the description of their symptoms."

Doctors ask specific questions to help the patient report their symptoms more clearly:

D03: "You need to inquire properly."

D06: "I need to ask some specific questions to get to the right diagnosis."

The issue of attentiveness can also be linked to the **limited consultation time**. Patients wait in **long queues** and when they finally get to meet the doctor, they are not given proper time as latter are in a hurry to move on to the next patient.

P01: "Busy doctors do not have enough time to listen attentively and entirely."

P04: "There are long queues at the main reception. The sitting area is overcrowded. There is lack of guidance and help from the staff. The doctors are not open to discuss every tiny aspect of the problem or disease faced."

P05: "I kept waiting for the doctor."

P10: "Doctors often disregard the concerns of the patients and give a diagnosis after only a cursory examination."

P16: "The doctors are always in a hurry."

However, doctors pointed out the deficiencies in the hospital management which might have caused these issues such as **tough schedule** and **inadequate resources**.

D01: "Hospitals have inadequate resources."

D02: "Doctors have duty hours and tough schedule."

D03: "There is a lack of funding."

D07: "Patient load is too much; we are not able to give proper time to individual patients."

5.1.3 Competency

This theme discusses the capability of a doctor as a preferred attribute by the respondents. The medical profession is very difficult career path and doctors go through rigorous education years and training before becoming a doctor.

Patients want their doctors to have a strong grasp of **knowledge**. They should be competent enough to diagnose efficiently and be **professional**. The doctors should:

P06: "…be specialised in his area of concern, could diagnose the problem properly."

P11: "…have knowledge of the field and show professionalism."

P22: "… diagnose well and is a true professional."

Doctors have also stressed on this characteristic a lot. According to them, doctors must be efficient in diagnosing diseases, be **smart** and professional when dealing with patients or their relatives. When asked about the characteristic of a 'good doctor', they replied that a good doctor should be:

D03: "…honest, careful, professional, competent and kind."

D04: "…smart and have good documentation."

D08: "…efficient, rationale, honest and professional."

5.1.4 Medical Jargons

This theme analyses the **language barrier** between the doctors and the patients. Sometimes, patients do not understand the diagnosis that the doctors are trying to explain due to the medical jargons. It also makes it difficult for the patients to explain their symptoms to the doctor which might lead to wrong diagnosis:

P04: "One of the challenges in explaining symptoms to the doctor is lack of understanding of proper medical terms. They (doctors) should take time in understanding patient problems, identifying the disease and then provide an appropriate solution."

P13: "Sometimes, you are not aware of the correct medical term to describe the symptoms and doctors start their assumptions way too early."

P27: "Sometimes I fail to find the correct words to describe my problem."

Doctors find **lack of knowledge**/language barrier as a huge challenge when it comes to dealing with patients:

D07: "It is difficult to treat patients because of language barrier and non-compliance of treatments."

D08: "Illiterate patients are difficult to counsel."

D09: "A patient's poor understanding/description of their problem causes problems for the doctors."

5.1.5 Unexplained Diagnosis

This theme focuses on the complaints of patients against doctors who do not explain the diagnosis. Doctors should be able to explain the diagnosis well and discuss the options with the patients before **prescribing medicines and tests**. Otherwise, patients are very confused and unsure regarding the diagnosis made:

P01: "They either write pointless tests or keep giving mild medication and ask for a follow-up session."

P11: "They (the doctors) mostly just suggest the medicine."

P10: "Doctors only inform me about the medications without properly explaining my disease and diagnosis. My experience (with the doctors) is generally frustrating and unsatisfactory. Doctors do not pay attention or listen properly and do not explain the diagnosis in detail."

P19: "Everything has been very helpful from Ali Medical Hospital, but they did not tell whether the patient had a heart problem or not."

P20: "The doctors listen but do not comment on symptoms/issues that I tell them which makes the issues sound very insignificant. They just prescribe medicine and tell to come for a follow-up. Even if they do explain, they have a very 'isn't it obvious' attitude. I would prefer someone who explains the possibilities of the symptoms I am having and what can be done about it rather than just giving me medicines."

P22: "My mother is currently hospitalized at Shifa International Hospital. The doctors do not even let me review the reports to ask for a second opinion and keep it (medical reports) confidential according to their policies."

This makes the patients become more inquisitive:

P13: "I always ask the doctor about what is happening to me and why is he prescribing the medicines. However, they sometimes avoid telling you the actual problem."

P21: "You have to ask them a lot of questions to know what is actually going on. Sometimes they even get annoyed."

P22: "My encounters with the doctors are not very informative. They (doctors) give us options and procedures that they will carry out, but we do not know the reason of what is actually happening unless specific question is asked."

All the doctors are of the opinion that it is helpful to explain the diagnosis to the patients:

D07: "It helps them to get the treatment properly."

The diagnosis is explained to mostly the patients and the guardians, both. If the patient is stubborn, doctors tend to exercise **patience**, and **explain the consequences** of the disease and the treatment to them and their relatives/attendants:

D01: "I cater to them with patience."

D02: "I try to tell them the consequences."

D03: "It is very difficult, but I try by giving reasoning and logic behind every point. "

D04: "…with patience and counselling and by involving his close relative."

D05: "I try to talk to their attendant."

D06: "…by repeatedly doing counselling."

D07:" I try talking with his/her attendant and make them understand the patient issues."

D08: "I try to counsel them."

D09: "I tend to avoid arguing with patients."

If the patients require palliative care, doctors try to be **empathetic** and **supportive**. They cater to them:

D01: "…with patience."

D04: "…by giving supportive care, listening to him/her with more care."

D05: "…by trying to talk to the patient and explaining the problem."

D06: "…by explaining the exact demands of their disease."

D09: "…providing him with the standard palliative care."

5.1.6 Second opinion

This theme analyses how a bad medical encounter usually leads to patients opting for a **second opinion** or visit another doctor because they are either **unsatisfied** by the first diagnosis or the treatment did not go as well as they had hoped:

P01: "Mostly for anything and everything doctors suggest surgery. I go to other doctors to make sure. Recently, for a stomach-ache, I was asked to get admitted to a hospital for appendectomy."

P04: "(It) depends on the type of disease or problem that has been identified. For instance, if it's a normal viral flu/ infection then another doctor is not considered for their opinion However, if the problem/disease is intense in nature and doctor has prescribed huge amount of medicine and test then other doctor can be consulted for their opinions."

P13: "It depends on the diagnosis of the doctor. If he prescribes way too many medicines and exaggerates my symptoms into some horrific disease, I will definitely go to another doctor. For example, once my daughter had diarrhea because she had spicy food and I kept telling the doctor that her stomach is upset because she wasn't used to consuming spicy food. Still, he prescribed useless tests worth Rs 15000. So, I went to another doctor who prescribed a couple of medicines, and my daughter was absolutely fine in two days."

P18: "Yes sometimes (I visit other doctors) if I am not satisfied from the first opinion or not getting better even after taking prescribed medication."

P19: "Pain was not being properly diagnosed."

Patients think that the doctors are **insincere** hence they look for multiple opinions especially if the diagnosis is too severe:

P03: "Yes, (I visit more than one doctor) for multiple opinions or treatments of the disease."

P06: "Yes, I do visit more than one doctor, just to make sure that both diagnoses made are consistent."

P08: "Yes, because every doctor is not sincere to the patient so there's a need to get multiple opinions in order to make a better decision."

P09: "We only do this if the diagnosis/treatment is pretty serious."

P10: "Yes, (I visit more than one doctor) because usually two different doctors provide two different opinions: one extreme and one mild."

P14: "Second opinion always helps."

5.1.7 Medical Encounter

This theme tries to elaborate the good and bad medical encounters which ultimately shows the strength of the doctor-patient relationship. In the results, patients were divided between good and bad encounters:

P03: "I had satisfactory encounters with private sector hospitals."

P05: "CMH's doctors are really cooperative and take extra care of their patients."

P11: "It has always been comfortable and good."

P12: "Yes (I have had bad encounters), they (doctors) can be reckless."

P18: "Sometimes (the encounter is) pleasant and sometimes just okay."

P24: "My encounters are intellectual as I know a lot about the diseases."

P26: "A good encounter, mostly I found good doctors."

P27: "I have had good encounters; they are usually quite understanding."

Those with bad encounters repeated the issue of inattentiveness and less consultation time. However, there were other causes as well such as wrong diagnosis:

P01: "I have had doctors commenting on my appearance, commenting on my health even. Mostly doctors are apparently being chased by a train and in such a hurry that they don't listen. Many just blame it on genetics. Many are rude as they have had a long day."

P04: "Yes, if doctor lacks good listening skills and identify disease without proper inspection and provide you with his own irrelevant theories, bad encounter can take place."

P13: "Some doctors are money making machines. Once my mom got severely constipated and we took her to the doctor. The doctor first administered an IV drip, then a few injections then an ultrasound and at the end of the day he called me in his room to tell me that she has some sort of cancer. I was just heart broken, crying alone in the corridor. Then my brother came in and he took my mom to another doctor who said that she is completely fine. I wanted to sue him (the doctor) for his wrong diagnosis."

P28: "They conduct a non-serious check-up."

Social **discrimination** is also one of the reasons for a bad medical encounter:

P01: "I wear an 'Ali' necklace. My doctor told me how all Shias are Kafir and exaggerate all things, just like I was exaggerating my symptoms."

P10: "Generally, I have seen preferential treatment given to other patients based on their social standing and contacts."

P20: "Usually when we took our mother to the hospital in emergency, we would be in house clothes and the doctors were rude and gave judgmental looks. Instead of giving her palliative care, they would just yell that they cannot do anything. My mother was terminally ill and was often hospitalized."

P25: "She (doctor) didn't carry out the surgery in the OT, rather in a random room. Maybe because patient was a civilian."

Majority of the doctors agreed that the doctor-patient relationship in Pakistan needs improvement:

D02: "It is not as good as it should be. There are several barriers."

D04: "Still many things are lacking in Pakistan. I have to explain the conditions repeatedly to different attendant every time and deal with angry and fussy attendants who are in denial."

D07: "Most patients do not respect doctors and usually demand to get a specific test or medication and if you do not do it, they get angry."

D09: "There is poor communication."

Some doctors were of the view that they get **blamed for everything** even if it is out of their control:

D03: "Patient sometimes thinks that everything is in doctor 's hand so they blame him or her for every failure. The hospital management doesn't take any responsibility if something goes wrong. Doctors suffer in the end of every dispute."

D06: "Due to less knowledge, they (patients) consider doctors to be responsible for any fault."

5.1.8 Medical Malpractice

This theme focuses on finding the rate of medical malpractice occurrences and whether the respondents are aware of the consequences of it. Many patients had experienced medical malpractice, however, none of them have ever filed a lawsuit:

P01: "A tiny part of a surgical tool was left inside my dad's abdomen when they opened him up for an appendectomy. My doctor ignored my symptoms of diabetes for the longest period of time."

P03: "I had a pollen allergy attack for which they treated me with a steroid shot (injection) rather than suggesting a more effective medication. The injection further worsened my condition and health."

P04: "A doctor in a private hospital referred my mother to an orthopedic specialist without understanding her problem fully and in-depth. My mother actually needed to visit a neurologist because of the illness."

P08: "My brother was given less anesthesia during the surgery and the doctors kept defending themselves."

P09: "My mother recently had some issues with her liver/gallbladder. She told the doctor that she was unable to take very high medications because of her ulcer. But the doctor ignored this and prescribed very high doses of medication which made her fall severely ill. When we went to another doctor for a second opinion, she told us that the first doctor had overmedicated my mother."

P13: "My sister-in-law's baby died due to heavy dose of an injection. She was hospitalized for three months just for the protection of the baby. The doctor didn't inform my brother or my sister-in-law about the baby's death and kept injecting more

injections. After one week, when my sister-in-law started having labour pains in her eighth month, doctor told them that the baby had died a week earlier."

P17: "He(dentist) was not listening and started treating the wrong tooth."

P20: "My mother was diagnosed with TB by the doctor without conducting proper tests. She had breast cancer. The TB medicine made her lungs condition worse."

P21: "Once I was given very high potency dose for a throat infection and I fell more ill. I stopped taking the medication and visited the hospital again and told them the same. The doctor was very rude and scolded me for leaving the medicine course and that 'all patients do what they like'. I felt better after leaving the medicine."

P29: "A family friend's sick mother was not looked at properly due to the hospital being overcrowded because of COVID, she later passed away."

Most of the patients agreed that a **lawsuit** should be filed in case of medical malpractice:

P01: "Yes, depends on the gravity of the situation."

P04: "Yes, if the case is of a serious nature."

Few believe that a lawsuit should be filed for medical malpractice but it's a hassle in Pakistan and not worth the time or effort:

P09: "Yes, but not in Pakistan."

P20: **"***Yes. However, you need a strong background for it. I don't think you will win the case otherwise."*

Most of the doctors also agreed that medical malpractices occur quite often. Major reason being **tough schedule**:

D02: "Mostly it happens when doctors are overburdened due to patient load or long working hours."

D04: "Negligence in medical field often occurs because of long duty hours of doctors when they already are sleep deprived and often when there are less doctors during duty hours. It can be minimised by decreasing the doctor-patient ratio."

D06: "It happens due to over timings and work overload".

Few respondents concluded that malpractice happens due to weak system and policies:

D03: "It is because of weak systems."

D07: "Malpractice happens all the time because there is no proper check on doctors."

P20: "My father complained against the TB doctor (mentioned in another question that the doctor misdiagnosed her mother who actually had breast cancer) to the Director of the Hospital but nothing happened, he was simply dismissed from the case and my mother's case was handed over to another 'competent' doctor."

Another reason is **lack of knowledge**:

D08: "Malpractice means not treating patient rationally. Yes, it happens in the hospitals due to lack of knowledge."

However, few said that it doesn't occur that often:

D09: "Generally doctors are very caring in Pakistan and there rarely is a case of negligence."

5.1.9 Medical Curriculum

This theme analyses whether the doctors are familiar with the PMC code of ethics and satisfied with the medical curriculum.

Most of the doctors were familiar with the **PMC code of ethics** and did not propose any changes to it. However, there were few who did not know about the code. When asked about the medical curriculum and their experience as a student, half of the respondents termed the medical curriculum ‘good’ as compared to the other half that commented that it was ‘excellent’:

D01: “It was tough. An easier alternative would be better.”

D02: “It was hectic yet learning. There should be more practical exposure of medical students with patients, so they are sufficiently trained for practical work in house job.”

D04: “It is satisfactory but must be updated yearly.”

D05: “It is a bit long. Give more time and lessen the course.”

Few doctors proposed the introduction of **modular system** to make it easier for the students.

D07: “The curriculum is okay, but the annual examination method needs to change. There should be quarterly modular system.”

D08: “It needs improvement. Modular system should be introduced.”

5.2 Discussion

This study identifies nine key themes that highlights the doctor-patient relationship in the hospitals of Islamabad/Rawalpindi: compassion, attentive, competent,

unexplained diagnosis, second opinion, medical encounter, medical malpractice, and medical curriculum. Each theme has sub-themes, shown in Table 5.1, that are interlinked and difficult to explain on its own. All these themes were constructed to answer the three research questions (refer to section 1.2).

According to the semi-structured questionnaires, the concept of doctor-patient relationship in Pakistan needs significant improvement. If we watch through the lens of both doctors and the patients, the duties and rights of both parties are not fulfilled, as can be seen in the results. Most of the patients are unaware of the rights and duties of both the parties, that is, doctors and the patients.

First and foremost, the hospital procedures are too complex with regard to the appointment and payment procedures. Patients have to wait in long queues to wait for their turn which indicates that the doctors have tight schedules, as confirmed by Qidwai et al. (2003) who conducted a survey at Aga Khan University Hospital, in Karachi, Pakistan which stated that the average waiting time period for the patients was 30 minutes as compared to the expected12.69 minutes. Patients have also complained about the uncooperative and rude hospital staff who are unwilling to help in either understanding the hospital procedures or guiding on the availibility of the doctors. The charges for each appointment is too high as compared to the services provided. It is worth mentioning here that although this study is only concerend with the doctor-patient relationship, doctors mostly hold the hosptal management responsible for the most of the issues mentioned by the patients. The doctors have stated that the management provides inadequate resources and allots tough schedules. There is also a lot of politics which causes a stressful enviornement and hinders an *effective* diagnosis.

Majority of the doctors stated that the patients do not convey their symptoms properly. This could be due to medical jargons or language barrier, as noted by Rimmer (2014). Other reasons include, but not limited to, changing their medical history when they visit with an attendant or unable to explain their symptoms unless the doctors ask specific questions.

In the last two decades, the health care system has become more patient-centered around the globe. Doctors are expected to explain the diagnosis to the patients in simple terms and preferably in their language so that there is not any confusion because the patients are often nervous or too embarassed to ask obvious questions (Rimmer, 2014). Akbani et al., (2020, p.820) has also noted in their research that patients located in Karachi, Pakistan prefer doctors who are able to communicate in their language. This eliminates the communication gap and also helps the patients in explaining their symptoms more clearly. Oftentimes, patient's agony or discomforts are not taken seriously and they are judged based on their symptoms therefore, patients are also reluctant to convey the whole medical history.

Defining the attributes of a 'good doctor', patients believe that it is someone who is compassionate, attentive, considerate, and a true professional who explains the symptoms and diagnosis before prescribing tests and medicines, which goes along with the findings of Akbani et al., (2020, p.820). This is because they should be more involved in the process of taking care and avoiding future recurrences. They will be fully aware of the risks and benefits involved in the treatment and also the consequences if they choose to ignore it. However, patients find it challenging to have a proper conversation with the doctors regarding their symptoms due to absense of these qualities in the current doctor-patient relationship which is in line with the research of Adnan et al. (2020, p.54). As mentioned later, and also proposed by

Deleuze and Guattari (refer to chapter 4), the priority in the health care system has been shifted from doctors' making all the decisions to keeping patients in the loop of what and why something is happening, that is, the diagnosis and treatment (Akbani et al.,2020, p.820). Doctors lack empathy and are not considerate enough. They prescribe tests and medicines that are often not available easily or are expensive.

Doctors have less consultation time, therefore, the doctor-patient meetings are rushed. This is backed by the research of Qidwai et al. (2003) who conducted a survey at Aga Khan University Hospital, in Karachi, Pakistan which states that the consultation time is around 13.89 minutes as compared to the expected 16.37 minutes. This was also stated by Akbani et al., (2020, p.820), that patients in Karachi prefered doctors that take time in listening to their concerns. According to Michael Foucault's theory (refer to chapter 4), this is a satisfactory medical encounter as a 'good' doctor has a paternalistic approach and gets the things done quickly and efficiently, that is, in limited time frame. The patients should have complete trust in the ability of the doctors and should not question the doctors as it makes the medical encounter futile.

Doctors start diagnosing mid-sentence rather than listening to the patients or inquiring about the symptoms themselves, that is, they do not help patients explain the symptoms due to medical jargons. This is also satisfactory according to Foucault's 'good' doctor standards as long as the doctors explain the diagnosis and the treatments to the patients. However, that is not the case in the hospitals. Doctors *do not* explain the diagnosis which leaves the patients confused and totally dependant on the decision of the doctors as they have more power and knowledge. Much like what Qidwai et al. (2003) prosposed in their research, patients would prefer an explanation of the diagnosis rather than being prescribed medicines and treatments.

Most of the patients are of the view that doctors lack patience and tolerance. Given the results mentioned above, mostly patients do not inquire about the diagnosis and the treatment prescribed due to the power-knowledge relatonship and even if they do, doctors are either hesistant or have a 'isn't-it-obvious' attitude which further widens the barrier in the doctor-patient relationship. Doctors must be aware of the absence and presence in consultation (Bleakley and Bligh, 2009, p.381).

On the other hand, doctors have stated that they explain the diagnosis to both the patients and their attendants because it is necessary to have them onboard for the treatment, but it is difficult to make them understand the diagnosis given the patient's lack of knowledge, also concluded by Rimmer (2014). A lot of patience and good communication is required. And for that they need time, so the issue lies with long working hours and tight schedules.

This barrier has led to some patients questioning the sincerity of the medical profession. An effective communication creates a 'meaningful and trustworthy relationship' (Akbani et al.,2020, p.812). This is in line with Naseer et el. (2012, p.59), that trust on doctors and word of mouth are highly and positively associated between doctors and patients. Many patients have had bad encounters with the doctors, resulting in 'resistance'- a term used by postmodern theorists Deleuze and Guattari (Lupton, 2012, p.113). Nowadays, patients are more aware and confident about their expectations from the health care system, therefore, an effective doctor-patient relationship is needed to deliver modern medicines (Ahmad et al., 2015, p.2).

Patients have started visiting multiple doctors before following the initial prescription and often opt for the most mild treatment out of all the opinions. This is also because the first treatment reacted badly or worsened the conditions of the patients or their relatives. Patients receive wrong injections or heavy dosage, as also recognised by

Khowaja et al. (2008, p.674), and the basis is again lack of knowledge, poor communication skills and long working hours which contributes to stressful enviornment.

Most of the patients claimed that they have not been treated unfaily by the doctors given their social status, caste, et cetra,. However, those who did, experienced a very rude encounter with the doctors. This has further made them question the competency and the sincerity of the doctors.

Most of the patients encountered numerous incidences where the doctors made major mistakes in diagnosing the symptoms, jeopardizing their health or the health of their relatives. Patients are of the view that lawsuit *must* be filed against medical malpractice, however, they are unaware of the procedure for filing a lawsuit. Some are of the view that although a lawsuit must be filed, it is not beneficial to do so in *Pakistan*, given the weak judicial system, that is, corruption and social status (Gadit, 2012, p.406). Even after all the incidences mentioned by the patients, none of them filed a complaint or a lawsuit against the respective doctors. This can be linked to the power-knowledge relationship because as stated earlier, doctors are not held liable in criminal courts as the courts are reluctant to charge them with criminal liability under the Pakistan Penal Code It's unfair to charge criminal cases equivalent to consumer laws and the compensation is unequal as well (Waraich, 2018, p.92). It is also due to the cultural values of putting the doctors on a high pedastal which again reflects the power-knowledge relationship. According to the results, doctors are also of the view that medical malpractice occurs because of weak systems, overburdened doctors, and *lack of accountability* and knowledge. Few doctors in this study even stated that they are unaware of the code of ethics for medical professionals. This further highlights the need to make the course of ethics mandatory in medical schools and colleges.

Doctors have stated that the medical courses are lengthy and difficult, however, they have concerns regarding the medical curriculum taught in the universities such as limited practical exposure which makes it challenging for them to work in the field later on. Other than that, the courses are not updated yearly and modular system should be introduced.

Ahmad et al. (2015, p.7) has also concluded that the current education medical curriculum is not fulfilling its aim. Students should be exposed to a more patient-centered care from the beginning of their medical education. Adnan et al. (2020, p.56) also stated that effective communication skills training programs should be introduced in tertiary care hospitals focusing on the cultural and lingual diversity. This can be linked to Bleakly and Bligh (2009, p.381-82) which states that doctors lack tolerance as they have been trained in a stimulated enviornment. Adnan et al. (2020, p.56) has also stated similar results that there is lack of communication-based training which effects the interpersonal and social communication between the doctors and the patients.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

The theory of Michael Foucault, power-knowledge relationship, states that doctors and patients have a relationship of 'patienthood' where doctors are attentive and insistent (have a paternalistic approach) whereas patients are like children who conceal their symptoms. Therefore, doctors have medical dominance given the upper hand in power and knowledge. They must be quick to diagnose, spend less time with the patients, explain the treatment beforehand, and have strong moral and value judgements. They make effective diagnosis and treatment that should not be questioned by the patients. PMC code of ethics goes along the same lines as well. It has a paternalistic approach where doctors are given medical dominance, however, issue arises when doctors are not as capable as they perceive-to-be. The PMC code of ethics covers almost all the aspects of doctor-patient relationship, the rights and duties that needs to be followed (Appendix C). However, the language is ambiguous and takes more of a 'suggestive' rather than a 'definite' tone.

Taking into consideration the contemporary theories of Foucauldian power-knowledge relationship, doctors are not given practical exposure to cater to ethical dilemmas, hence, they cannot diagnose the patients as quickly as possible. The health care systems cannot be completely patient-centered because it will cause an imbalance between the doctor-patient relationship. However, there is a potential of resistance from patients who are aware, are rich and have some knowledge.

Moving forward with these theories, the health care system has evolved over the last two decades around the globe. It has become more patient-centered. However, most of the patients, according to this research, feel unheard and misunderstood given the

lack of attentiveness and empathy which makes them doubt the prognosis and distrust doctors. This consequently has a negative effect on the doctors as well because the resistance from the patients in the form of inquiries makes them feel challenged. This vicious cycle can be ended if a genuine patient-centered approach is implied. Doctors must keep up with the changing times and keep the patients more involved in the discussion of the diagnosis and prescriptions. They must try to make patients feel more comfortable by describing their symptoms and proposed diagnosis and treatment. That way, the patients will understand their symptoms, will not be confused, and comply with the treatment. Preference of attributes by the patients' needs to be considered for strengthening the doctor patient relationship.

To bring this change, medical curriculums need to be revised. Firstly, PMC needs to make the course of ethics compulsory for every medical student. Secondly, medical students should be given practical exposure from the beginning of their study. They should have an idea how to deal with the patients and their attendant under the supervision of their teachers and have first-hand experience how to execute an effective medical encounter. This is not to say that patients are at times unreasonable and stubborn but since it is the profession of the doctors to provide effective diagnosis to the patients, given the PMC code of ethics, it is their duty to handle them with empathy, care, and kindness.

PMC code of ethics has an ambiguous language. There is not any legal binding to it. There is also lack of legal action taken by the patients. Doctors can take bold decisions and are not held accountable to it due to medical dominance. Detached and unaccountable health professionals lead to an increase in medical malpractice (Pauli, White, McWinney, 2000c, p.174-75), cited in Bleakley & Bligh (2009, p. 370).

Doctors argue that they are overworked and therefore should not be obligated to follow the code of ethics.

PMC code of ethics needs to be clearer and taught to the medical students as a compulsory subject so that they are aware of their duties, rights, and consequences of failing to comply with the code of ethics. Strict measures are needed to guarantee the implementation of the code of ethics. Its language needs to be changed into a more definite/demanding tone and the consequences should also be added in case the requirements are not met. It is true that the doctors cannot be blamed for everything, however, there are many incidences where the mistakes can be avoidable. PMC needs to take strict action against doctors who violate the code so that they are held accountable for their actions. A mere warning in the disciplinary hearing is not enough. This will be beneficial for the doctors as well because it will decrease the number of 'quacks' in the society and the patients will start trusting the true medical professionals.

Courts need to start charging medical malpractice cases under criminal liability rather than civil. This might put an emphasis on dire need of catering to the 'accountability' issue that is taken lightly by the doctors. Of course, now too, most of the cases are dismissed as being charged for a medical malpractice case has a strict criterion but it can still be tried under 'Law of Torts' (negligence cases). Patients should be advised on how to move forward with their complaint, that is, either

- take their case to PMC (Pakistan Medical Commission);
- report to their province's healthcare commission;
- file case in consumer courts.

Summing up, effective communication is important in improving the doctor-patient relationship. This can be achieved by considering the preferred attributes of the doctors by the patients: compassionate, attentive, and professional (explains diagnosis and treatments). Doctors need to strengthen their moral and value judgements. This is possible by updating the medical curriculum yearly and giving the medical students practical exposure before they start working in the field. Otherwise, they will receive continued resistance by the patients who have had bad medical encounters. Patients will not trust their own doctors and will seek multiple medical opinions which might end up confusing and harming their situation even more. An effective communication can also help in reducing malpractice cases as the doctors will feel less detached and make more competent medical decisions.

Furthermore, doctors must be held accountable for their actions by learning how crucial it is to follow the PMC code of ethics. This way, issues such as social discrimination and medical malpractice can be avoided. PMC needs to make changes in the code of ethics by making it more authoritative and adding consequences for not complying to the code. Strict actions should be taken in the PMC disciplinary hearings against medical malpractice charges. The courts should not be reluctant in charging the liable doctor under criminal code so that further negligence cases can be avoided.

The health commission can also start campaigns in alerting the public regarding the duties and rights of both patients and the doctors; explaining the ways they can file complaints. In the beginning, they might receive many unrelated and emotional queries but in the long run it will be beneficial for the health care system as a new system can be developed for monitoring the medical services.

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Appendix A

Semi-structured questionnaire for doctors that was shared via Google Forms. This form is divided into three sections.

Section 1: Introduction and Background of the research study
I am Ayesha Nazir, an MPhil Development Studies (DS) student at Pakistan Institute of Development Economics (PIDE), Islamabad. I am conducting research on, 'Understanding the Power-Knowledge Relationship in the Health Care Practices in Pakistan: Case Study from the Health Care Facilities in Islamabad/Rawalpindi'.

PURPOSE AND BACKGROUND

The purpose of this study is to shed light on the doctor-patient relationship; to reflect on the issues and challenges faced by both the doctors as well as patients. Your participation will help in attaining in-depth knowledge and understanding the doctor-patient relationship from a doctor's perspective.

CONFIDENTIALITY

The record of the interview will be kept as confidential as possible. The data from the questionnaire will be analyzed using thematic analysis, that is, the participant's name will be omitted. Only the main investigator of the research will have access to the file of research study. Therefore, confidentiality of the participant is my foremost priority.

BENEFITS OF PARTICIPATION

This research study is not sponsored by any public or private organization; therefore, I cannot guarantee any direct or indirect benefit to the participant.

VOLUNTARY PARTICIPATION

Your decision of participating in this research study is voluntary. If you want to withdraw your consent and discontinue participation at any time in the future, email me at ayeshanazir.19@pide.edu.pk and I will remove your submitted form from the data without any questions asked.

Section 2: Informed Consent Form to Participant in a Research Study

After reading the Introduction mentioned above, if you are willing to participate in the research study, please answer the following questions. These questions will indicate that you have decided to participate in the research study.

1. I have read all the information mentioned above and agree that the data from this questionnaire can be used in the research study, 'Understanding the Power-Knowledge Relationship in the Health Care Practices in Pakistan: Case Study from the Health Care Facilities in Islamabad/Rawalpindi'.

2. Name (optional)
3. Age / Year of birth
4. Gender
5. How long have you been working as a doctor?
6. Contact information in case a follow-up question is required (optional). Please enter your email address or contact number.
7. Name of the hospital that you are working at?
8. Name of the hospital department (e.g ENT, Gynae, OPD, etc.)

Section 3: Questionnaire

1. What are the characteristics of a good doctor?
2. What are the challenges you have faced while studying to become a doctor?
3. What are some of the problems you have faced when dealing with patients?
4. What are some of the problems you have faced when dealing with the hospital management?
5. Do the patients convey their symptoms properly? Do you face any difficulty when they do?
6. Do you explain the diagnosis to the patients or their guardians or both?
7. Is it useful to explain the diagnosis to the patients?
8. How do you cater to a stubborn patient?
9. How do you cater to a palliative care patient?
10. How would you define a doctor-patient relationship in Pakistan's health care system?
11. Are you familiar with the PMC code of ethics?

12. Would you like to suggest any changes in the PMC code of ethics?
13. How do you define medical malpractice/negligence? How often does it happen in hospitals? Why does it happen?
14. How was your experience as a medical student?
15. How would you describe the curriculum at the medical school?
16. Would you like to propose any changes in the curriculum?

Appendix B

Semi structured questionnaires for patients that was shared via Google Form. This includes three sections.

Section 1: Introduction and Background of the research study

I am Ayesha Nazir, an MPhil Development Studies (DS) student at Pakistan Institute of Development Economics (PIDE), Islamabad. I am conducting research on, 'Understanding the Power-Knowledge Relationship in the Health Care Practices in Pakistan: Case Study from the Health Care Facilities in Islamabad/Rawalpindi'.

PURPOSE AND BACKGROUND

The purpose of my study is to shed light on the doctor-patient relationship; to reflect on the issues and challenges faced by both the doctors as well as patients. Your participation will help in attaining in-depth knowledge and understanding the doctor-patient relationship from a patient's perspective.

CONFIDENTIALITY

The record of the interview will be kept as confidential as possible. The data from the questionnaire will be analyzed using thematic analysis, that is, the participant's name will be omitted. Only the main investigator of the research will have access to the file of research study. Therefore, confidentiality of the participant is my foremost priority.

BENEFITS OF PARTICIPATION

This research study is not sponsored by any public or private organization, therefore, I cannot guarantee any direct or indirect benefit to the participant.

VOLUNTARY PARTICIPATION

Your decision of participating in this research study is voluntary. If you want to withdraw your consent and discontinue participation at any time in the future, email me at ayeshanazir.19@pide.edu.pk and I will remove your form from the data without any questions asked.

Section 2: Informed Consent Form to Participate in a Research Study

After reading the Introduction mentioned above, if you are willing to participate in the research study, please answer the following questions. These questions will indicate that you have decided to participate in the research study.

1. I have read all the information mentioned above and agree that the data from this questionnaire can be used in the research study, 'Understanding the Power-Knowledge Relationship in the Health Care Practices in Pakistan: Case Study from the Health Care Facilities in Islamabad/Rawalpindi'.
2. Name (optional)
3. Age
4. Gender
5. Area of residence
6. Contact information in case a follow-up is required (optional). Please enter your email address or contact number. (optional)
7. Which type of hospitals do you mostly visit
8. Name of the hospital you mostly visit / recently visited
9. Name of the department you recently visited (e.g ENT, Gynae, OPD, etc.)

Section 3: Questionnaire

1. What are some of the challenges you have faced when visiting a hospital?
2. Are you able to convey your symptoms to the doctor properly?
3. What are the challenges you have faced when describing your symptoms to the doctors?
4. What qualities would you prefer in a doctor?
5. Do doctors inform you about the diagnosis of the disease properly, that is, explain the cause and remedy of the disease?
6. Do you visit more than one doctor for a second opinion? If so, what are your reasons?
7. How would you describe your encounter with the doctors?
8. Have you ever experienced a situation where you think you have not been treated fairly by a doctor? (e.g., any discrimination based on social class, attire, etc.)

9. Have you/your relatives ever faced a situation where you/they think the doctor made a mistake or ignored your/their complaint? If yes, can you briefly explain the situation?
10. Are you aware of the procedure for filing a complaint against medical malpractice?
11. Would you advise anyone to pursue a lawsuit if they experienced a medical malpractice/negligence case?
12. Do you know about the duties and rights of a patient?
13. Do you know about the duties and rights of a doctor?
14. Have you ever filed a complaint against a doctor or hospital management?

Appendix C

Code Of Ethics of Practice For Medical And Dental Practitioners' Regulations, 2011

S.R.O.80(KE)/2011, dated 3-6-2011. ---In exercise of the powers conferred by subsection (1)(i) of section 33 of the Pakistan Medical and Dental Council, Ordinance, 1962 (XXXII of 1962), the Pakistan Medical and Dental Council, with the previous sanction of the Federal Government, is pleased to make the following regulations, namely: --

PART-I

PRILIMINARY

Short title and commencement. ---(1) These regulations may be called the Code of Ethics of Practice for Medical and Dental Practitioners, Regulations, 2011.

(2) They shall come into force at once.

(3) They shall extend to whole of Pakistan

PART II

GENERAL

2. Declaration before registration. ---Each applicant, at the time of making an application for registration with the Council, shall submit a declaration that he has read, understood, and agreed to abide by these regulations on the format set out in the Annexure I of these regulations.

3. Duties of physicians in general. ---A physician shall always maintain highest standards of professional conduct and shall actively participate in continuous medical education and as such a physician shall. -

(a) not permit motives of profit to influence the free and independent exercise of professional judgment on behalf of patients;

(b) in all type of medical practice, be dedicated to providing competent medical services with full technical and moral independence, with compassion and respect for human dignity;

(c) deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence or who engage in fraud or deception;

(d) respect the rights of patients, colleagues and of other health professionals and shall safeguard patient confidences;

(e) act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient;

(f) use great caution in divulging discoveries or new techniques or treatment through non-professional channels; and

(g) certify only that which he has personally verified.

4. Duties of Physicians to the Sick. ---A physician shall-

(a) always bear in mind the obligation of preserving human life;

(b) owe his patients complete loyalty and all the resources of his science;

(c) summon another physician who has the necessary ability whenever an examination or treatment is beyond the former physician's capacity;

(d) preserve absolute confidentiality on all he knows about his patient even after the patient has died; and

(e) give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

5. Duties of Physicians to each other. ---A physician shall--

(a) behave towards his colleagues gently;

(b) not entice patients from his colleagues; and

(c) observe the principles of the "Declaration of Geneva" approved by the World Medical Association.

6. Medical Ethics and religion. ---A medical or dental practitioner shall respect the beliefs of the patients and shall not impose his beliefs on the patient.

7. Practice of medicine, surgery and dentistry prohibited without registration etc. with Council. ---(1) No person shall practice modern system of medicine or surgery unless that person is a doctor or dentist having registered qualification and valid registration with Pakistan Medical and Dental Council.

(2) Every medical or dental practitioner has to ensure that his registration with the Council is valid.

8. Display of registration numbers. ---(1) Every medical or dental practitioner shall, in his clinic or place of practice, display a copy of valid registration certificate issued to him by the Council and refer his registration number in all his prescriptions, certificates, money receipts given to his patients.

(2) No medical or dental practitioner shall display suffixing to his name those degrees or diplomas which have not been registered by the Council. A medical or dental practitioner shall not be considered a specialist unless an additional qualification of that specialty has been registered by the Council against his name.

9. Rational use of drugs. ---(1) Every Medical or dental practitioner shall adopt practice with good and rational practices to prescribe drugs.

(2) A medical or dental practitioner shall

(a) be free to choose whom to serve, with whom to associate and lay down the timings and place of professional service for the patients;

(b) not be bound to treat each and every person asking his services, but he shall not only be ever ready to respond to the calls of the sick and the injured, if in his opinion the situation warrants it as such, but shall be mindful of the high character of his mission and the responsibility he discharges in the course of his professional duties;

(c) in his treatment, never forget that the health and the lives of those entrusted to his care depend on his skill and attention; and

(d) if not available due to any reason and the patient requires continuous monitoring or care, then the Medical or dental practitioner shall arrange for another Medical or dental practitioner of sufficient proficiency as an alternate and inform the patient.

(3) For a medical or dental practitioner to advise a patient to seek service of another medical or dental practitioner is acceptable, however, in case of emergency, the medical or dental practitioner must treat the patient first.

(4) No medical or dental practitioner shall normally refuse treatment to a patient, however for good reason if the medical or dental practitioner thinks it would not be appropriate to provide his professional services to a particular patient or when a patient is suffering from an ailment which is not within the range of experience of the treating medical or dental practitioner, the medical or dental practitioner may refuse treatment and refer the patient to another medical or dental practitioner.

PART III

TEACHING ETHICS TO STUDENTS

10. The Teaching of medical ethics. ---(1) The curriculum committee of the Council will ensure that adequate information on this Code of Ethics is included in the undergraduate medical college curriculum and that case studies have been prepared and disseminated to provide guidance to medical or dental practitioners.

(2) The goal of teaching medical ethics shall be to improve the quality of patient care by enhancing professional performance through a consideration of the clinician's values, beliefs. knowledge of ethical and legal construct, ability to recognize and analyze ethical problems and interpersonal and communication skills and consideration of the patient, whereby students shall be able to identify, analyze and attempt to resolve common ethical problems of medical and clinical nature.

(3) All medical and dental colleges running MBBS and BDS courses, College of Physician and Surgeons of Pakistan and universities running the postgraduate medical courses in Pakistan may incorporate medical ethics into their curriculum.

(4) Relevant books and journals shall be made available in the central and departmental libraries of the medical institutions, and publication of papers on issue related to medical ethics.

(5) All medical or dental practitioners may develop strategies for dissemination of information about ethics and ethical issues to their colleagues and students, public and patients specifically when teaching medical and dental students.

PART IV

EXPECTATIONS

11. Council's expectations.---The Council expects each medical or dental practitioner to--

(a) promote fundamental principle of responsibility of physicians to the right of individuals and societies to stated standards of professional competence, appropriate care, conduct and integrity of medical or dental practitioners;

(b) uphold the ethical principles of medical practice that is to say autonomy, beneficence, non-maleficience, and justice;

(c) ensure the protection of individual patients against harassment, discrimination and exploitation;

(d) take their responsibilities as a teacher seriously;

(e) be responsive to cultural and religious sensitivities;

(f) declare in a transparent manner, any potential conflict of interest;

(g) inculcate these values in students, through instruction and role modeling;

(h) promote the education of the public on (a) health issues and (b) their rights to quality care;

(i) ensure continuation of practice only when in normal physical and mental health; and

(j) bring colleagues to comply with these generally accepted norms of practice and expose physicians and dentists deficient in competence, care and conduct.

PART V

FUNDAMENTAL ELEMENTS OF PATIENT--PHYSICIAN RELATIONSHIP

12. Rights of the Patient.---(1) To share with physicians the responsibility for their own health care the patient-

(a) has right to receive information from physicians and to discuss the benefits, risks, costs of appropriate treatment, alternatives and optimal course of action:

(b) is entitled to obtain copies or summaries of their medical records, to have their questions answered and to receive independent additional professional opinions;

(c) has the right to make decisions regarding the health care that is recommended by his physician and as such the patients (or his next of kin) may accept or refuse any recommended medical treatment in writing;

(d) has the right to courtesy, respect, dignity, timely responsiveness to his health needs, and respect of his gender and sanctity;

(e) has the right to confidentiality; and

(f) has the right to continuity of health care.

(2) The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient.

13. Second opinion.---Patients are entitled to a second or further medical opinion about their illness and on request, medical or dental practitioner must either initiate or facilitate a request for this and provide the information necessary for satisfactory referral.

14. Rights of the medical or dental practitioner.---It is obvious that patients and their attendants shall respect the privacy of the medical or dental practitioner. Patient shall call the medical or dental practitioner on telephone only in a dire emergency and not otherwise and on telephone, patients shall restrict themselves to their medical or dental problem only and not use this facility for seeking other information.

PART VI

ETHICAL STANDARDS OF PROFESSIONAL COMPETENCE, CARE AND CONDUCT

15. Conduct of medical or dental practitioner.---In all dealings with patients, it is expected that the interest of patient and advantage to the patient's health will be the major consideration to influence the medical or dental practitioners conduct. The physician-patient-relationship shall be developed as one of trust. A professional shall always maintain and demonstrate a high standard of professional conduct by:--

(a) being in conformity with the principles of honesty and justice;

(b) not permitting motives of profit to influence (free and independent exercise of) professional judgment;

(c) working with colleagues in ways that best serve patient's interests;

(d) not paying or receiving any fee or any other consideration solely to procure the referral of a patient or for prescribing or referring a patient to any source:

(e) maintaining the honorable tradition by which the physician is regarded as a friend to all persons of any class, caste, color, religion, sex, ethnicity, occupation, creed, religion and social status; and

(f) being honest, factual, objective, unbiased as a reviewer for scientific material for publication; for funding purposes; and when providing reference, ensuring that comments are honest, justifiable, unbiased and contain evidence on the subject's competence, performance, reliability and conduct, taking steps to ensure the accuracy

of any public communications including the communication of degrees, institutional affiliation, extent of services offered and credentials.

16. Statement to patients and their relatives or representatives.---All statements to the patients or their representatives shall be made only by the consulting medical or dental practitioners and not by any associates or assistants etc.

17. Examination, consultation or procedures on a female patient.---(1) A female patient shall be given consultation either by a female medical or dental practitioner or shall be examined in the presence of a female attendant by a male doctor. Under no circumstances a male attendant, assistant or husband or relative etc. shall be allowed during a gynecological and obstetrical consultation, examination or during normal delivery being conducted by a female medical practitioner. However in exceptional circumstances a patient may file a request with the medical practitioner to allow her husband to witness a normal delivery and the medical practitioner may consider the request and shall ensure that sanctity of the female patient is preserved during procedures and consultation and there is no unnecessary exposure.

18. Assistance of unregistered person prohibited.---(1) A medical or dental practitioner will not assist an unregistered person to practice or teach medicine or dentistry or associate professionally with such a person performing the functions as a medical or dental practitioner and knowingly assisting such an individual shall make a registered medical or dental practitioner liable to disciplinary action. This does not preclude a medical or dental practitioner from imparting proper training to medical students, nurses, midwives and other paramedical personnel, provided the doctor concerned keep a strict supervision over such individuals when treating patients.

(2) A medical or dental practitioner shall use great caution in divulging discoveries or new techniques or treatment through non-professional channels.

(3) A medical or dental practitioner shall not allow his name to be used by any other person or let any other person sit in his place of practice if that person is not a registered medical or dental practitioner.

(4) A physician shall owe his patients all the resources of his science. Whenever an examination or treatment is beyond the physician's capacity he shall consult another physician who has the necessary ability.

19. Prisoners.---Prisoners who are ill must be treated in the same manner as other sick people. However, doctors have a right to take appropriate precautions if they think there is a possibility of physical violence by the patient. Where a suspect refuses consent to a medical examination, the doctor unless directed to the contrary by a court of law, shall refuse to make any statement based on his observation of the suspect other than to advise the police whether or not the suspect appears to require immediate treatment or removal to hospital. This does not of course, preclude the doctor from making a statement in court based on such observation in circumstances where the accused later gives his consent to disclosure.

20. Permission of patient before examination.---A doctor shall normally take permission from a patient before making a physical examination. In case of minors, the child's guardian shall be present or give permission for the examination. For any intimate examination the patient, irrespective of age, patient is entitled to ask for an attendant to be present. Such requests shall be acceded to whenever possible.

21. Care.---(1) The patient-physician or patient dental practitioner relationship constitutes a fiduciary obligation, requiring physicians to be responsible to serve the interests of patients above their own financial or other interests. The medical or dental practitioner is expected to provide a quality of care for a patient which is timely, compassionate, respecting human privacy and dignity, non-discriminating and does not exploit vulnerable situations. Negligence in respect of professional duties may justify suspension or removal from the Register.

(2) The medical or dental practitioner shall bear in mind the obligation of preserving life and will not discriminate on the basis of age, sex, gender, class, race, ethnicity, national origin, religion, sexual orientation, disability, health conditions, marital discord, domestic or parental statute, criminal record, or any other applicable bias as prescribed by law, and ensure that personal beliefs do not prejudice patient care.

(3) The Medical or dental practitioner shall not exploit persons over whom they have direct or indirect supervisory, evaluative, management or other authority, such as

students and patients, supervisees, employees or research participants, whether for personal, professional or economic reasons.

(4) The medical or dental practitioner shall delegate to a student or other physician, only those responsibilities that such persons, based on their education, training and experience, can reasonably be expected to perform either independently or with the level of supervision provided.

(5) The Medical or dental practitioner shall additionally--

(a) identify themselves to patients whom they are treating;

(b) treat all patients with dignity and respect;

(c) listen to patients and respect their views;

(d) give patients (and provided patient agrees, family members) information (about their illness) in a way that they can understand;

(e) respect the rights of patients to be involved fully in decisions about their care;

(f) ensure that conflict of interest does not prevent them from performing their professional work in an unbiased manner; and

(g) adhere to veracity (truth telling) as judged in the patient's interest.

22. Details of information.---It is obvious that patients do not always fully understand the information and advice given to them by doctors. They shall be encouraged to ask questions. These shall be answered carefully in non-technical terms if necessary with or without information leaflets, as the aim is to promote understanding and to encourage compliance with recommended therapy. The doctor shall keep a note of such explanation and if it is felt that the patient still does not understand, it may be advisable to ask the patients permission to speak to a relative. The medical or dental practitioner shall break all news to the patient and relatives etc. himself and shall not allow his coworkers to do that.

23. Maternity care.---Registered medical practitioners who agree to undertake the antenatal and delivery care of a woman shall clearly inform her, in advance, the

arrangements for delivery. In Pakistan, according to law a pregnancy can be terminated only if there is a serious risk to the life of the pregnant women. The choice of gender of baby by any means shall be illegal and the gender of the foetus shall not be disclosed unless it is absolutely sure that no harm shall come to the baby and mother as a result of this disclosure.

24. Information about doctor or dentist conducting procedures.--Patients undergoing procedures or treatment of any sort have the right to be informed as to which doctor or doctors are to be involved and what will be nature of the procedure with its advantages, disadvantages, risks and alternative, options.

25. Competence.---(1) A medical or dental practitioner in active clinical practice is expected to continuously strive for improving his knowledge and keep abreast with the latest advancements in the field. He shall seek out sources of such knowledge and try to attend professional meetings or activities for advancement of professional knowledge. He shall maintain knowledge of CME programmes by Council and try to participate in them to gain CME credits. CME credits shall be provided by specialist boards authorized by Council for the purpose.

(2) The medical or dental practitioners will attempt to maintain the highest levels of competence in their work more specifically the skill in diagnosing, clinical decision-making, planning, implementation, monitoring and evaluation of intervention and teaching; and shall accept responsibility for their actions. They shall therefore.-

(a) only undertake tasks for which they are qualified allowed by virtue of education, training or experience and know their limitations;

(b) keep abreast of latest information about their subject through continuing education;

(c) ensure that their approach to patient management is consistent with current research, literature and practice;

(d) have an approach that favours competent clinical care through a careful assessment of the patient's problem, based on elicitation and analysis of the patient's history and physical examination; careful decisions on need for further investigation

and request for additional consultation, appropriate management and prompt action where indicated, an approach that shuns internet prescribing or telephonic prescribing except when the physician is cognizant of the individuals past medical history;

(e) acquire the knowledge and skills to provide proper training and supervision to their students so that such persons perform services responsibly competently and ethically; and will be honest and objective in the assessment and certification of performance of students supervised;

(f) monitor and maintain an awareness of the quality of the care provided by himself through a review of carefully recorded data and respond constructively to assessments by self and peers which identify need for further training or education;

(g) recognise the realistic efficacy of investigation and medication and use technology and medicine only where appropriate; and

(h) restrict prescription of drugs, appliances or treatments to only those that are beneficial to the patient.

26. Treatment without direct patient contact.---Prescribing of medications by medical or dental practitioners requires that the physician shall demonstrate that a documented history and physical examination and drug reaction history are available and that there has been a sufficient dialogue between the patient and the doctor on options in management, and a review of the course of the illness and side effects of the drug but the Council accepts that in an emergency, during on call or cover call, or when in a partnership the case records are available, a physician may prescribe a new prescription without seeing the patient but only emergency single dose shall be prescribed and the patient shall be called over for a checkup. Telemedicine to the extent of radiological reporting is allowed.

27. Confidentiality.---The physician has a right to and shall withhold disclosure of information received in a confidential context. whether this is from a patient or as a result of being involved in the management of the patient, or review of a paper, except in the following specific circumstances where he may carefully and selectively disclose information where health, safety and life of other individual may be involved, namely:-

(a) The medical or dental practitioner cannot seek to gain from information received in a confidential context (such as a paper sent for review) until that information is publicly available;

(b) There is no legal compulsion on a doctor to provide information concerning a criminal abortion, venereal disease, attempted suicide, or concealed birth regarding his patients to any other individual or organization. When in doubt concerning matters, which have a legal implication, the medical or dental practitioner may consult his/her legal adviser;

(c) The professional medical record of a patient shall not be handed over to any person without the consent of the patient or his/her legal representative. No one has a right to demand information from the doctor about his patient, save when the notification is required under a statutory or legal obligation and when in doubt, the medical or dental practitioner or a dentist may consult a legal advisor;

(d) confidences concerning individual or domestic life entrusted by patients to a medical or dental practitioner and defects in the disposi tion or character of patients observed during medical attendance shall never be revealed unless their revelation is required by law;

(e) a medical or dental practitioner who gains access to medical records or other information without consent shall be guilty of invasion of privacy; and

(f) the medical or dental practitioner who grants access of an information of a patient to a third person except, Council or law enforcing agencies, without consent shall be guilty of breach of confidentiality, but where a medical or dental practitioner is of the opinion to determine it his duty to society requiring him to employ knowledge about a patient obtained through confidence as a medical or dental practitioner, to protect a healthy person against a communicable disease to which he is about to be exposed, the Medical or dental practitioner shall give out information to concerned quarters.

28. Conflicts of interest.---For guidance of medical or dental practitioner a detail on conflict of interest is given at Annexure-II of these regulations.

29. Dealing with conflict of interest.---(1) A medical or dental practitioner must act in patient's best interests when making referrals and providing or arranging treatment or care and no inducement, gift or hospitality which may affect or be seen to affect judgment may be accepted and nor shall such inducements offered to colleagues.

(2) Financial or commercial interests in organizations providing health care or in pharmaceutical or other biomedical companies must not affect the way that patients are prescribed, treated or referred.

(3) Financial or commercial interest in an organization to which a patient is to be referred for treatment or investigation must be declared to the patient

(4) Before taking part in discussions about buying goods or services, any relevant financial or commercial interest which the medical or dental practitioner or the medical or dental practitioner's family might have in the purchases, must be declared.

30. Truth telling.---In the practice of medicine, it is obvious that truth telling involves the provision of information not simply to enable patients to make informed choices about health care and other aspects of their lives but also to inform them about their situation. Patients may have an interest in medical information regardless of whether that information is required to make a decision about medical treatment.

The physicians shall strive to create a true impression in the mind of the patient which requires that information be presented in such a way that it can be understood and applied. Patients shall be told the truth because of the respect due to them as persons as patients have a right to be told important information that physicians have about them.

31. Advertising.---(1) When publishing or broadcasting information the medical or dental practitioner must not make claims about the quality of services nor com pare services with those provided by colleagues. Announcements must not, in any way, offer guarantees of cures, nor exploit patients' vulnerability or lack of medical knowledge.

(2) Published information about services must not put pressure on people to use a service, for example by arousing ill-founded fear for their future health. Similarly,

services must not be advertised by visiting or telephoning prospective patients, either in person or through a deputy.

(3) Medical or dental practitioners may announce any change of address or hours of practice in the local press either once in three papers or three times in the same paper, on three consecutive days, and the announcement shall be made in a normal manner and not unduly prominently as by big advertisements.

(4) Name plates may be fixed at the residence and on the premises where the medical or dental practitioner practices and at his residence. The name plate shall not be ostentatious.

32. Certificates, reports and other documents.---When medical or dental practitioners are requested for certificates, medical reports birth or death certificates and any other documents, such documents shall be factual to the best of their knowledge. Due care shall be taken in regard to stating the date on which the patient has been examined etc.

33. Business and contractual obligations.---Physicians and dentists must ensure that they do not engage in any behaviour that negatively impacts directly or indirectly on patient care. Business and contractual obligations must never interfere with clinical decisions or negatively impact on patient care in any way. Physicians are discouraged from entering into business or other arrangements that include financial incentives; sharing of fees including refund based on successful outcomes and payments for referral of patients for laboratory investigations or other procedures except when a partnership is publicly known to exist.

34. Informed Consent.---For guidance of medical or dental practitioner a detail on informed consent is given at Annexure-III of these regulations.

35. Medical and dental students.---it is obvious that medical and dental students must identify themselves by name and must obtain permission from patients before examining them. It is advisable to limit the number of students examining any one patient.

36. Taking of photographs or videos for teaching purposes.---Taking of patients photographs and videos shall be done in such a manner that a third party cannot identify the patient concerned. If the patient is identifiable, he or she shall be informed about the security, storage and eventual destruction of the record.

37. Adoption.---Doctors shall remember that in cases of proposed adoption there are several parties involved all of whom need continued support and counselling. Pregnant women who are considering giving up their babies for adoption shall be helped to approach advisory bodies or attorneys as the circumstances may be.

38. Leader of the medical or dental team.---The Medical or dental practitioner shall take his responsibilities as leader of the medical or dental team seriously as all responsibility of the care of the patient rests on him and not the Paramedical staff. The medical or dental practitioner shall not accept any paramedical staff to be in his team if he is not comfortable with him and this opinion shall be binding on the employer.

PART VII

PROFESSIONAL FEE AND TIMINGS

39. Fees and other charges.---(1) The fee charged from the patient for the treatment or consultation shall be as decided by the medical or dental practitioner. The treatment shall commence if the fee is acceptable to the patient, medical or dental practitioner and the hospital or clinic. If there is any disagreement the patient may seek care elsewhere. For poor or non-affording patients, the medical or dental practitioner may make a concession if he so desires. However, the medical or dental practitioner is bound to provide first aid to the patient in emergency and only then refer him.

(2) The medical or dental practitioner shall ensure that the fee is commensurate with his qualification and level of services offered and the hour at which his time was spent in providing the services.

(3) A Medical or dental practitioner shall announce his fees before rendering service and not after the operation or treatment is under way. Remuneration received for such

services shall be in the form of currency only and its amount specifically announced to the patient at the time the service is rendered.

(4) The fee shall not be in the form of a favour of any kind.

(5) Medical or dental practitioners rendering service on behalf of the Government shall refrain from anticipating or accepting any consideration.

(6) A medical or dental practitioner shall clearly display his fees and other charges in his chamber and/or the hospitals he is visiting.

(7) A medical or dental practitioner can receive compensation of any medicine dispensed by him.

(8) A medical or dental practitioner shall write or stamp his name and designation in full along with registration number in his prescription letter head

(9) A medical or dental practitioner shall consider it as a pleasure and privilege to render gratuitous service to all Medical or dental practitioners and their immediate family dependants

40. Rebates and Commission.---A medical or dental practitioner shall not give, solicit, or receive nor shall he offer to give solicit or receive any gift, gratuity, commission or bonus in consideration of or return for the referring, recommending or procuring of any patient for medical, surgical or other treatment.

41. Communication with Patients.---To address many complaints to the Council referred due to lack of communication, or discourtesy, on the part of the doctor, where differences have arisen between the doctor and the patient or the patients relatives there is much to be gained and rarely anything to be lost by the expression of regret by the doctor and feeling that any such expression would amount to an admission of liability may have inhibited doctors.

42. Maintenance of medical records.---Every medical or dental practitioner shall ensure proper documentation of his professional services along with necessary reports results maintained an easily discernable scientific method.

PART VIII

RESEARCH ETHICS AND CONSENT

43. Research Ethics and Consent.---(1) When conducting medical research involving human subjects, investigators shall remember their obligations with respect to individual patients. Ethical conduct of research requires that a human subject must participate willingly, having been adequately informed about the research and given consent that there is a favourable balance between the potential benefit and harm of participation; and that protection of vulnerable people is ensured. The validity of findings must address questions of sufficient importance to justify any risks to participants. In any clinical trial there must be genuine uncertainty as to which treatment arm offers the most benefit, and placebo controls shall not be used if equally effective standard therapies exist. When doubt exists, researchers shall consult the existing literature and seek the advice of experts in research ethics.

(2) All research projects involving human subjects, whether as individuals or communities, or the use of fatal material embryos and tissues from the recently dead, shall be reviewed and approved by an Ethical Review Committee of the institution before the study begins.

(3) Written consent shall be obtained if patients are to be involved in clinical trials. The aims and methods of the proposed research, together with any potential hazards or discomfort, shall be explained to the patient. The consent document must be clearly written using non-technical language as to be understandable to subjects and use local language in addition wherever applicable.

(4) In situations where study subjects are too young or too incapacitated, as well as the mentally ill or unconscious person, consent to take part in research may be unobtainable. Research is best avoided unless it can be shown to be relevant and potentially beneficial to the patient and there is no objection from parents or relatives.

(5) Medical research involving human subjects shall be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person.

(6) The right of research subjects to safeguard their integrity must always be respected. Every precaution shall be taken to respect the privacy of the subject, and the confidentiality of the patient's information.

(7) Research results must always preserve patient anonymity unless permission has been given by the patient to use his or her name.

(8) Volunteers and patients may be paid for inconvenience and time spent, but such payment shall not be so large as to be an inducement.

(9) Refusal of a patient to participate in research must not influence the care of a patient in any way.

44. Decisions of national bio-ethic committee and declaration of Helsinki.---The Council endorses the decisions of national bio-ethic committee and declaration of Helsinki resolutions as adopted by the 18th World Medical Assembly and revised by the 48th World Medical Assembly shall be binding on all medical or dental practitioners.

45. Organ Transplantation and Consent.---A doctor involved in organ trans plantation has duties towards both donors and recipients. Prior to considering transplant from the dead donor, brain death shall be diagnosed, using currently accepted criteria, by at least two independent and appropriately qualified clinicians, who are also independent of the transplant team. If family of the dead donor cannot take care of the funeral of donors body, then the transplant doctor involved in organ transplantation shall take car of transplantation and funeral. Living donors shall be counselled as to the hazards and problems involved in the proposed procedures, preferably by an independent physician. All statutory human organ transplant rules and orders shall apply.

46. Resource Allocation.---All resource allocation decisions must be transparent and defensible. Questions of resource allocation are difficult and can pose practical and ethical dilemmas for clinicians. The unequal allocation of a scarce resource may be justified by morally relevant factors such as need or likelihood of benefit. To what extent the physician's fiduciary duty towards a patient shall supersede the interests of other patients and society as a whole is also a matter of controversy. However, the

allocation of resources on the basis of clinically irrelevant factors such as religion or gender is prohibited.

PART IX

MISCELLANEOUS

47. End-of-life care.---(1) End-of-life care requires control of pain and other symptoms, decisions on the use of life-sustaining treatment, and support of dying patients and their families. Futile treatment need neither be offered to patients nor be provided if demanded. A treatment is qualitatively futile if it merely preserves permanent unconsciousness or fails to end total dependence on intensive medical care or when physicians conclude, either through personal experience, experiences shared with colleagues, or consideration of reported empiric date that a medical treatment has been useless.

(2) The physician is not compelled to accede to demands by patients or their families for treatment thought to be inappropriate by health care providers.

48. Genetics in Medicine.---For guidance of medical or dental practitioner or a dentist a research study of various characteristics of genetic information is given at Annexure-V of these regulations.

PART X

PUNISHMENT AND DISCIPLINARY ACTION

49. The following acts of misconduct commission or omission on the part of a Medical or dental practitioner shall constitute professional misconduct rendering him/her liable for disciplinary action, namely:-

(a) if he/she commits any violation of these Regulations;

(b) forgery, theft, fraud, plagiarism ,indecent behavior or any other offence, liable to be seen as moral turpitude is liable to disciplinary action;

(c) Any form of sexual advance, to a patient or colleague or coworker with whom there exists a professional relationship, is professional misconduct. A registered

medical or dental practitioner or dentist's professional position must never be used to pursue a relationship of an emotional or sexual nature with a patient, the patient's spouse or a near relative of a patient. Sexual contact or intent there of with patient or patient's spouses, partners, parents, guardians, or other individuals involved in the care of the patient is liable to lead to exclusion from the Register. A registered medical or dental practitioner or dentist will ensure that they do not engage in sexual harassment of any person, including employees, patients, students, research assistants and supervisees. The following constitute harassment that is to say single, multiple or persistent acts of abusive verbal language or gestures, demeaning speech, insult in front of juniors, sexual innuendoes, sexual solicitation, physical advance, throwing objects, and other threatening unacceptable gestures and these shall render a medical or dental practitioner liable for disciplinary action and cancellation of registration. The administration shall also be held responsible for any such untoward event. Physicians shall not use language that will interfere with the work of others;

(d) Abuse of professional knowledge, skills and privileges is unacceptable conduct. Any registered medical or dental medical or dental practitioner found guilty of causing an illegal abortion or prescribing drugs in violation of any law or who becomes addicted to a drug or is convicted of driving under the influence of alcohol or any other drug, is liable to be suspended or have his name removed from the Register;

(e) No medical or dental practitioner shall accept illegal gratification and such acts shall be cognizable;

(f) The following practices are deemed to be unethical conduct namely:-

(i) self advertising by physicians, unless permitted by the laws of the country and the code of ethics of the Pakistan Medical Association; and

(ii) paying or receiving any fee or any other consideration solely to procure the referral of a patient or for prescribing or referring a patient to any source.

(g) Conviction by Court of Law for offences involving moral turpitude/Criminal acts.

(h) Any substance abuse or addiction.

50. Other misconduct.---(1) It must be clearly understood that the instances of offences and of Professional misconduct which are given above do not constitute and are not intended to constitute a complete list of the infamous acts which calls for disciplinary action, and that by issuing these regulations is the Pakistan Medical and Dental Council is in no way precluded from considering and dealing with any other form of professional misconduct on the part of a medical or dental practitioner. Circumstances may and do arise from time to time in relation to which there may occur questions of professional misconduct which do not come within any of these categories. Every care shall be taken that the code is not violated in letter and spirit. In such instances as in all others, the Council has to consider and decide upon the facts brought before it.

(2) Professional negligence or incompetence shall be judged by the peer group known as the disciplinary committee of the Council.

(3) It is made clear that any complaint with regard to professional misconduct and violation of these regulations can be brought before the Council for disciplinary action. Upon receipt of any complaint of professional misconduct and violation of these rules, in the first instance, the Registrar PM&DC shall call the practitioner over and counsel him/her. Upon non settlement and failure to comply despite counselling, the Council would hold an enquiry and give opportunity to the registered medical or dental practitioner to be heard in person or by pleader under Council rules. If the medical or dental practitioner is found to be guilty of committing professional misconduct, the Council may award punishment under the rules or as the case may be, including removal altogether or for a specified period, from the Register of the name of the delinquent registered medical or dental practitioner. Removal of name from the Register shall be widely publicized in local press including conveying to different medical associations or societies or bodies internationally or nationally.

PART XI

MATTERS RELATING TO PHARMACEUTICAL INDUSTRY

51. Accepting gifts, inducements or promotional Aids.---(1) Registered medical or dental practitioners shall ensure that they do not compromise their professional autonomy or integrity once any gift, benefit in kind or economic advantage is offered

to them as an inducement to prescribe, supply, administer, recommend, buy or sell any drug or medical equipment as the case may be.

(2) Notwithstanding anything to the contrary contained herein, registered medical or dental practitioners may occasionally accept promotional aid items (e.g. stethoscope, BP apparatus, weight machine, tongue depressor, hand wash etc.) from drug manufacturers or distributors as the case may be, provided that these items are primarily for the benefit of patients

(3) In addition to items listed in sub-regulation (2), registered medical or dental practitioners may accept from drug manufacturers or distributors as the case may be, text or reference-books medical journals. CDs and other educational materials if they are satisfied that these serve a genuine, demonstrable and direct educational function.

(4) Registered medical or dental practitioners may not enter into a written or verbal agreement of any kind, with any manufacturer or distributor of drugs or medical equipment, for personal gain of any kind whatsoever other than employment.

52. Drug Samples.---(1) Registered medical or dental practitioners must appreciate that free drug samples are provided to them for the benefit of patients only and to raise awareness of the drug and that they do not accept such samples as an inducement to prescribing any drugs or as reward for having done so.

(2) Registered medical or dental practitioners should accept free drug samples for patient use only and not for the personal gain or re-sale.

(3) Notwithstanding anything to the contrary contained herein, registered medical or dental practitioners may purchase drugs at a discount directly from the manufacturer provided that this discount is duly passed on to the patients.

53. Meetings, conferences and hospitality.---(1) If registered medical or dental practitioners wish to engage in or undertake any academic pursuits they should make all possible efforts to generate their own funds either through institutions with which they are affiliated or from personal contributions.

(2) Since continuing medical education (CME) or scientific an educational conferences or professional meetings contribute to the improvement of patient care,

registered medical or dental practitioners may accept support from manufacturers or distributors of drugs or medical equipment in this regard provided that any financial support provided is strictly through cheque or bank draft deposited in a duly designated account rather than in their personal bank accounts and shall be disclosed to the institution and to the Council on demand.

(3) Registered medical or dental practitioners should also ensure that the primary purpose of any educational meeting is the enhancement of medical knowledge and they should participate in these events with the objective of gaining current, accurate and balanced medical education in an ethical and professional manner.

(4) In organizing an educational meeting, congress or symposium the organizing medical or dental practitioners should ensure that a minimum of eighty per cent of the time allocated for such meeting, congress or symposium is spent on core educational activities and only a maximum of twenty per cent of the total time is devoted to recreational activities which are in accordance with the dignity of the medical profession.

(5) Registered medical or dental practitioners may accept an invitation and financial support for a domestic or international trip from manufacturers or distributors of drugs or medical equipment subject to the following conditions, namely:--

(a) the trip is primarily for an academic purpose and preferably the selected medical or dental practitioner is presenting a paper in the course of the trip or participating in the proceedings in a similarly meaningful manner;

(b) the trip is to attend an event of international nature featuring Pakistani as well as non-Pakistani participants;

(c) the invitation and financial support is for the registered medical or dental practitioner only and not for his or her spouse or children; and

(d) the medical or dental practitioner shall disclose the purpose and invitation to the institute and to the Council.

54. Endorsement.---(1) No registered medical or dental practitioner below the rank of a professor may endorse any drug or medical equipment publicly or in the print, air

or electronic media and shall make all possible efforts to ensure that any study conducted on the efficacy or otherwise of any drug or medical equipment is communicated to the public through appropriate scientific bodies or published in the appropriate scientific literature.

(2) A registered medical or dental practitioner may, however participate in celebrity based disease-awareness programs or customer driven campaigns to create public awareness on matters of general hygiene or measures for disease prevention. A medical or dental practitioner may appear in any media event or program if is so duty bound to do so.

(3) A registered medical or dental practitioner shall not promote a drug or medical equipment or a manufacturer or distributor in the course of scientific presentations in any manner whatsoever, including but not limited to by.-

(a) stating the name of the drug or equipment brand in the slides; or

(b) stating the name or logo of the drug or equipment manufacturer or distributor in the slides; or

(c) All medical or dental practitioners shall abide the drug laws.

(4) Any registered medical or dental practitioner presenting a paper at a conference, seminar or symposium shall issue or announce a disclaimer in respect of any personal financial rewards from interest in or association of any kind with the manufacturer or distributor sponsoring the conference, seminar or symposium.

55. Medical Research. ---(1) No registered medical or dental practitioner may accept direct payments from any drug manufacturer or distributor for conducting research studies of any nature whatsoever and all such research funding should only be received through approved institutions in accordance with the rules and byelaws of such institutions.

(2) Every clinical trial conducted by a registered medical or dental practitioner must meet the current scientific and ethical requirements and the existing legal regulations and must conform to the internationally recognized principles of Good Clinical Practice.

(3) All financial sources of research shall be disclosed to the Council on demand.

(4) Every registered medical or dental practitioner must ensure that the funding party does not influence the research agenda, methodology employed, participant selection, data analysis or publication of findings. All research proposals must be assessed and approved prior to initiation by the ethical review committee (ERC) of the relevant institution.

(5) At the time of publishing any papers or making a presentation which provides the results of any medical research the relevant registered medical or dental practitioners shall make a declaration of any funding provided by manufacturers or distributors of drugs or medical equipment to carry out such research.

(6) Registered medical or dental practitioners may accept an honorarium from their institutions and not directly from any donors providing funding for such research, against the time of their involvement in a clinical trial or research study ensuring complete disclosure and without any conflict of interest, in the following cases, namely:-

(a) Industry initiated trials or studies; and

(b) Investigator or doctor initiated trials or studies.

56. Decisions regarding pharmaceutical industry and its interaction with the medical or dental practitioners and the funding by the pharma-industry, various guidelines and decisions including those for continuous medical education events as developed by the National Bio Ethics Committee shall also apply.

PART-XII

REPEAL

57. Repeal.---The Code of Ethics made by the Council in its 98th meeting at Karachi on 24th and 25th August, 2002 and any regulation in these matters made earlier are hereby repealed.

Annexure I

At the time of registration, each applicant shall be required to make following declaration agreeing to abide by the same.

DECLARATION

(See regulation 2)

(a) I solemnly pledge myself to consecrate my life to the service of humanity:

(b) I will give to my teachers the respect and gratitude which is their due;

(c) I will practice my profession with conscience and dignity;

(d) The health of my patient will be my first consideration;

(e) I will respect the secrets which are confided in me, even after the patient has died;

(f) I will maintain by all the means in my power, the honour and the noble traditions of the medical profession:

(g) My colleagues will be like my sisters and brothers and I will pay due respect and honour to them.

(h) I will not permit considerations of age, disease or disability, creed, ethic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient;

(i) I will protect human life in all stages and under all circumstances, doing my utmost to rescue it from death, malady, pain and anxiety. To be, all the way, an instrument of Allah's mercy, extending medical care to near and far, virtuous and sinner and friend and enemy;

(j) I shall abide by the medical or dental practitioners of Medicine and Dentistry (Code of Ethics) Regulation, 2011 of the Council and understand that I shall be punished upon its violation by me;

(k) I make these promises solemnly, freely and upon my honour.

Signature .. date ..

Name

Council's Registration number .

E mail ..

Address Current

Permanent: .

Contact number Mobile . land line

Annexure II

A conflict of interest

(See regulation 28)

A conflict of interest "is a set of conditions in which professional judgment concerning a primary interest tends to be unduly influenced by a secondary interest." In the clinical context the primary obligation of physicians shall be to their patients whereas in the research context scientific knowledge may be the primary interest. A secondary interest may be of a financial nature, but it may also consist of personal prestige or academic recognition and promotion. In research involving patients, the research interests, although often in concordance with it and is above mentioned definition the reference to "a set of conditions" is important having a conflict of interest is an objective situation and does not depend on underlying motives. Stating that someone has a conflict of interest does not imply a moral condemnation per se. It is the person's action in the context of a particular situation or a lack of transparency that may be a cause for concern.

Annexure III

Informed Consent

(See regulation 34)

(1) Consent is the "autonomous authorization of a medical intervention by individual patients." Patients are entitled to make decisions about their medical care and have the

right to be given all available information relevant to such decisions. Patients have the right to refuse treatment and to be given all available information relevant to the refusal. Consent may be explicit or implied. Explicit consent can be given orally or in writing. Consent is implied when the patient indicates a willingness to undergo a certain procedure or treatment on him or his behaviour. For example, consent for venipuncture is implied by the action of roiling up one's sleeve and presenting one's arm. For treatments that entail risk or involve more than mild discomfort, it is expected that the physician will obtain explicit rather than implied consent. Signed consent forms document but cannot replace the consent process. There are no fixed rules as to when a signed consent form is required. Some hospitals require that a consent form be signed by the patient for surgical procedures but not for certain equally risky interventions. If a signed consent form is not required, and the treatment carries risk, clinicians shall seriously consider writing a note in the patient's chart to document that the consent process has occurred. When taking consent the physician shall consider issues of adequate disclosure, the patients capacity, and the degree of voluntariness. In the context of patient consent, "disclosure" refers to the provision of relevant information by the clinician and its comprehension by the patient. Disclosure shall inform the patient adequately about the treatment and its expected effects, relevant alternative options and their benefits and risks, and the consequences of declining or delaying treatment and how the proposed treatment (and other options) might affect the patient's employment, finances, family life and other personal concerns. "Waiver" refers to a patient's voluntary request to forego one or more elements of disclosure. For example, a patient may not wish to know about a serious prognosis (e.g., cancer) or about the risk of treatment.

(2) "Capacity" refers to the patient's ability to understand information relevant to a treatment decision and consequences of a complying or not complying with a treatment decision. A person may be "capable" (have adequate capacity) with respect to one decision but not with respect to another. When any doubt exists, a clinical capacity assessment by a third party may be required. In addition to assessing general cognitive ability, specific capacity assessment, determines the patient's ability to appreciate information and implications of action. "Voluntariness" refers to a patient's right to make health care choices free of any undue influence. However, a patient's freedom to make choices can be compromised by internal factors such as pain and by

external factors such as force, coercion and manipulation. In exceptional circumstances -- for example, involuntary admission to hospital -- patients may be denied their freedom of choice; in such circumstances the least restrictive means possible of managing the patient shall always be preferred. Clinicians can minimize the impact of controlling factors on patients' decisions by promoting awareness of available choices, inviting questions and ensuring that decisions are based on an adequate, unbiased disclosure of the relevant information.

(3) An informed consent can be said to have been given based upon a clear appreciation and understanding of the facts, implications, and future consequences of an action. In order to give informed consent, fulfil the legal standard of informed consent with a completed, dated and signed consent form. True informed consent requires a number of elements:

(a) that the patient is competent;

(b) that appropriate information is presented to the patient by the medical and dental practitioner; and

(c) that the patient understand the material presented by the medical and dental practitioner;

(d) that the patient acts voluntarily (without coercion or under duress) and that the patient agree to the plan presented.

(4) Special circumstances affecting the consent process are listed below:-

(a) The unconscious patient's, - consent may be implied or assumed on the grounds that if the patient were conscious they would consent to their life being saved.

(b) A doctor asked to examine a violent patient is under no obligation to put him in danger but shall attempt to persuade the person concerned to permit an assessment as to whether any therapy is required.

(c) The mentally ill of the doctor is in any doubt as to the patient's capacity to consent it is advisable to seek specialist opinion as well as discussing the matter with parents, guardians or relatives.

(d) For Mentally Handicapped patients the doctor shall attempt to obtain consent but, depending on the degree of handicap, may have to consult with the patient's parents or guardians, and, in particularly difficult cases to obtain a second opinion.

(e) Children are entitled to considerate and careful medical care as are adults. If the doctor feels that a child will understand a proposed medical procedure, information or advice, this shall be explained fully to the child. Where the consent of parents or guardians is normally required in respect of a child for whom they are responsible, due regard must be given to the wishes of the child. Also, the doctor must never assume that it is safe to ignore the parental or guardian interest.

Annexure V

Genetics in medicines

(see regulation 48)

Molecular genetics is concerned with the process by which the coding sequences of DNA are transcribed into proteins that control cell reproduction, specialization, maintenance and responses, Inherited or acquired biologic factors that result in an error in this molecular information processing can contribute to the development of a disease. Medical genetics involves the application of genetic knowledge and technology to specific clinical and epidemiologic concerns. Although many common diseases are suspected of having a genetic component, few are purely genetic in the sense that the genetic anomaly is adequate to give rise to the disease. In most cases, genetic risk factors must be augmented by other genetic or environmental factors for the disease to be expressed. Moreover, the detection of a genetic anomaly does not help us to predict the severity with which the syndrome will be expressed. Certain ethical and legal responsibilities accompany the flood of genetic knowledge into the current practice of medicine. This is because of three general characteristics of genetic information, that is to say the implications of genetic information are simultaneously individual and familial genetic information is often relevant to future disease: and genetic testing often identifies disorders for which there are not effective treatments or preventive measures.

Appendix D

World Medical Association has divided the duties of physicians into three categories:

1. Duties of Physicians in General:

A physician shall always maintain the highest standards of professional conduct and should actively participate in continuous Medical Education.

A physician shall not permit motives of profit to influence the free and independent exercise of professional judgment on behalf of patients.

A physician shall, in all type of medical practice, be dedicated to providing competent medical services in full technical and moral independence, with compassion and respect for human dignity.

A physician shall deal honestly with patients and colleagues and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences.

A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental condition of the patient.

A physician shall use great caution in divulging discoveries or new techniques or treatment through non-professional channels.

A physician shall certify only that which he has personally verified.

2. Duties of Physicians to the Sick:

A physician shall always bear in mind the obligation of preserving human life.

A physician shall owe his patients complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond the physician's capacity he should summon another physician who has the necessary ability.

A physician shall preserve absolute confidentiality on all he knows about his patient even after the patient has died.

A physician shall give emergency care as a humanitarian duty unless he is assured that others are willing and able to give such care.

3. Duties of Physicians to each other:

A physician shall behave towards his colleagues as he would have them behave towards him.

A physician shall not entice patients from his colleagues.

A physician shall observe the principles of the "Declaration of Geneva" approved by the World Medical Association.