

The National Medical Arbitration Commission: 20 years

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When the Ministry of Health still had the blue logo that read "SSA", we were going through difficult times because there was no money and the idea of creating new institutions was received with reservations not only by President Zedillo, always generous and attentive to the population's health needs, but also, as usual, by the Finance Minister, who is responsible for looking after public funds. And the thing is that the idea of increasing the government current expenditure was perceived, not without reason, as an act that could inflict the risk of fomenting inefficacious and obese administrative structures. This has not been the case of the National Medical Arbitration Commission (CONAMED – *Comisión Nacional de Arbitraje Médico*), since its approximately 200 workers continue to perform an immense task with a light structure.

Many things have changed in these 20 years, including the setting where the physician's practice is carried out. The fundamental change I perceive has been that of the rights of patients and their families. The doctor-patient relationship has also significantly changed: the doctor is no longer the sovereign. In the doctor-patient relationship, sovereignty rests more on the patient today. The historical alliance between doctor and patient, which has been the most ancient therapeutic component there is in medical practice, has suffered important transformations that seriously influence on the practice of our profession. Science arrived to medical practice relatively recently, by the end of the 19th century, but before, doctors also cured and, to a large extent, they did it based on the power of a relationship

that was, by itself, therapeutic. Today, the forces of that alliance have changed and patient rights come first. In that sense, the creation of the CONAMED was an opportune answer to changes that were anticipated and that demanded the creation of an organism of this nature.

Suffice it to recall that, in those days, claims against doctors were proliferating, and specialized areas were starting to emerge in some law firms to promote different types of law suits against medical acts. As many colleagues, I didn't think that was the best way. The experience in the USA had left a very negative balance. The cost of medical practice was becoming more expensive and insurance companies, always lucrative, were ready to leap into market "in defense" of the law suits doctors would have to face. With the CONAMED, errors or negligence occurring in medical practice and that have to be sanctioned were not trying to be concealed, but the intention was to generate balances and understand the fallibility of a professional activity like ours. And the thing is that medicine is not like physical science or mathematics; its objectives and methods are those of biological sciences, but with important psychosocial components that make it more complex. Doctors make mistakes, and if we make mistakes we have to be prepared to assume the consequences, but there are unpredictable, unavoidable mistakes, and, in addition, incidents and accidents happen when working with patients, which are not errors that are necessarily attributable to somebody. They are circumstances that form part of medical practice. That difference, subtle but important, was a fundamental part of the reason for an agency such as CONAMED to be created. Medicine, we have to insist,

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is not infallible, it is not an exact science; doctors are not astronomers, we cannot accurately calculate what is going to happen in 200 million years in some constellation far away from our planet. We deal with human beings, organisms governed by their own laws, many of them still insufficiently understood.

So, medicine is a human science that oscillates between biological sciences and social sciences, with an unavoidable subjective component. That is why the differences between medical science error margins have to be identified when we have to deal with unexpected factors, which sometimes act in favor and sometimes against a clinical decision. When the physician is facing a complex problem with some patient that considers him/herself as being “complicated”, with an uncertain diagnosis, even the best decision can fail. Conversely, let’s also think for a moment on how many good things have been discovered in medicine by serendipity, when the existence of an association of events apparently disconnected between each other was not foreseen, and suddenly a sagacious doctor manages to connect them and generates a new piece of knowledge, he/she discovers something that helps the patient without this being expected to happen beforehand.

Furthermore, we should also take notice on the value of statistics. Although they do not explain the entire reality, they do reflect an important part of it. For example: what is the percentage of complications expected of a surgical procedure in patients with congenital heart diseases? I mention this because, recently, in the setting of an international cardiology congress, I had the opportunity to talk with some renowned surgeons from great institutions such as Johns Hopkins, the Mayo Clinic and others. I asked about their statistics, about their margins of error, because accidents occur even in such institutions. Certainly, in lower proportions, since they concentrate larger experience, possess better technology and offer more complete trainings. But surgery in subjects with congenital conditions is a high-risk procedure everywhere, worldwide experts concurred. Then, to what extent can we speak about medical errors when a procedure of such high complexity is being practiced? Can they really be regarded as errors? In the same sense, it could be argued: do not previously-reported drug reactions not occur? Iatrogenesis is one thing, unavoidable mistakes, accidents are another. Iatrogenesis is negligence, is ignorance, is avoidable and can even be criminal. If some drugs are already known to be incompatible under certain conditions and even so they are

prescribed, we are talking about pure iatrogenesis. Nothing to do, in my opinion, with the mistake a surgeon can make at some point, regardless of his/her skills, when confronted with a complication in the operating room due to the high degree of difficulty of the problem he/she is trying to solve. Who judges that incident? How should it be evaluated before the eyes of society? To what extent are there responsibilities?

CONAMED has advanced in the task of understanding these problems, and that is as it should be. That’s its mission. That was the basis of the decree that created it 20 years ago, after that long journey where we went first to the National Academy of Medicine, presented it there, and later published a note in the *Gaceta Médica de México* for public knowledge¹. Obviously, what we wanted was to generate an organization that could take care of medical practice’s own problems, that acted as a support for doctors, but that would not conceal negligence or cover up irresponsibility, let alone ignorance; we were looking for a space that also supported the patients, but able to prevent those claims or lawsuits without a real basis from succeeding. That organization would have to move on that line of priorities. There was certain concern in an important sector of the community. Some interesting debates arose, which were welcomed. They helped us to clarify the benefits of a project that was not “a court designed to judge the medical profession”, as some insisted. Careful! This is how false alarms are set off, with false arguments that may appear to be true. Fortunately, they did not prosper.

The name itself was also not easy to conceive. After giving further thought to the subject, Jorge Carpizo’s view (Dr. Carpizo was the great promoter of the issue of human rights in the country, first from the National Autonomous University of Mexico and then at the National Commission of Human Rights) was very helpful to find out how we could generate an organization that would not be perceived as a threat, that would be accepted by doctors, patients and NGOs, and that in addition would gain spaces in academic and social grounds. The term *commission* was much more appropriate than the word *court*; the *arbitration* idea had good acceptance since it is a neutral term. All of these nuances were vehemently discussed, with the participation of many doctors and non-doctors.

I retrieved the presentation I made on that occasion at the Academy of Medicine (with slides because there was no PowerPoint back in 1996). I comment them now just as they were presented. One of them shows that CONAMED objectives were very clear: “To strengthen

the system of social justice. It is fundamentally a matter of justice that attempts to improve the quality of medical services, opportunely solve conflicts, ensure impartiality”, hence the creation decree emphasizing on technical autonomy. CONAMED is autonomous, and should remain autonomous, as well as state commissions, regardless of them working in collaboration, as it has been happening, with academies, colleges, universities, etc.

Other slide warned that social scrutiny was going to be of great exigencies. In reality, later we realized that it was not a matter of exigencies, but of rights, of rights that had to be addressed, since the project surpassed its social demand component and invaded another of more complexity with deep ethical considerations. The environment then was of lawsuits, litigations and abuse on one hand and claims and counterclaims on the other. It was, therefore, necessary to find a space that gave room to patient rights but also to doctor rights. Although the context has changed, all these purposes still prevail.

Another element mentioned in the CONAMED creation decree is the one referred to health culture, because since then it was insisted that it should be oriented to prevention and not that much to treatment. To my judgment, in this subject we are still failing, because we haven't been able to make of health culture an efficacious element to prevent disease as much as possible and when feasible. An unobjectionable proof of this failure in Mexico (although not exclusive to us) is the case of obesity, overweight and metabolic disorders. If we would have been effective on this, maybe the problem or its dimensions would be different. Anyway, this is a good moment to pick up on the issue.

The CONAMED decisive actions included the appointment of the President Commissioner, which was fundamental because it gave it a sense of hierarchy and authority, together with the appointment of the 10 board members, which included the presidents of the medicine and surgery academies. When that started, the simple administrative structure was well remunerated, as were the doctors' salaries (which in those times were homologated in the entire country). Today, there is great salary shortfall again. In order to demand quality service there should be dignified remuneration. It's an unavoidable principle.

Since its origin, CONAMED has contemplated strengthening the historical alliance between doctors and patients as a goal intended to be preserved even amidst a changing and complex social scenario. Recovering the trust in our institutions would be also

desirable, because this country cannot be conceived without Social Security. How can the Mexican Institute of Social Security be helped to recover that great spirit of caring, respect and solidarity that has declined over the years? I would say the same about the ISSSTE, the Ministry of Health and all federal and state institutions of the sector. And I don't exclude private establishments from the list, many of them without the necessary quality controls. The only ones who can restore the trust in our institutions (with the immense help of our teammates, especially the nurses, but also social workers and administrative workers), the only ones who can rebuild that trust in our profession, our competence and our organizations, are we, the doctors.

Mexico requires a great deal of institutional trust, and that can be generated through stimuli for those who perform better: we should award the good ones, rather than only sanctioning those who are not that good or those who fail. Human beings respond to stimuli, and that occurs in spheres that go from our personal and family life to our public or private institutional life. Good work should be further encouraged, and that is also a CONAMED task, together with continuing to address complaints and looking for conciliation, which is an essential element to resolve conflicts. And the thing is that we, human beings, want to solve our problems. The basic principle is this: if somebody was deficiently attended to or feels deficiently attended to, a good explanation is sometimes enough for the complainant to remain satisfied. Some has to give that good explanation, and there is where CONAMED plays a crucial role. Conciliating when possible, sanctioning when necessary and excusing whenever the circumstances deserve it.

Our profession has had formidable stages, and in our country there are examples of great teachers in different branches of medicine. The common denominator of the great architects of health of this country has been their ethical posture before life. As long as this is preserved, as long as we don't lose sight that the doctor has to be first of all an ethical social being, with principles, and in consistency with the values that are inherent to the profession, that alliance with his/her patients, even in changing scenarios, will continue to be effective in professional practice. When a doctor stands up for the rights of his/her patients, he/she is standing up for his/her own rights.

I will comment one more slide from back then. I ignore how the strengthening of state commissions has advanced. We started the state commissions also in 1996, but we had not enough resources anymore, and

a stimuli system had to be generated in order for not only complaints to arrive to CONAMED, but also positive comments on the work done. I believe this remains an unresolved matter; let's not forget it.

Although there is still much to be accomplished and solved, when making an objective balance, I cannot but feel satisfied when I witness that this sensitive and delicate task has been fruitful. I am certain that the new Commissioner, Dr. Onofre Muñoz Hernández, full member of the National Academy of Medicine, professor at UNAM, and irreproachable civil servant at the IMSS, has the attributes to steer CONAMED's destiny: experience, broad knowledge, temperament to conciliate and make decisions, ethical attitude and academic perspective. Those who have remained in CONAMED for these 20 years should be the first ones to receive wide recognition. Your work has been fundamental to

preserve it, since in Mexico we need more institutions that are not short-lived, as if they were fashions that pass or fade away, not because they do not function, but because the six-year Presidential term when they were created is concluded. Fortunately there are projects that are above this meanness and assume that not everything must depend on an agenda or political party calendar. When it comes to health, solid and enduring institutions, perfected with long-term vision to better serve the country are required. Making things as best as possible is the key of quality, trying to make them increasingly better is the secret for excellence. Such is the challenge that lies ahead for CONAMED.

References

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