

RTI regime needs a shot in the arm

The Information Commission can help

SHAMSUL BARI and RUHI NAZ

I can't waste my time responding to RTI queries from riff-raffs and vagabonds," a public official was recently heard saying. Right to Information (RTI) workers throughout the country are familiar with such statements, which reflect the attitudes of many public servants, even seven years after Bangladesh's RTI Act 2009 came into force. Few are willing to open up public records for scrutiny by the public, which is the basic objective of the law.

A large number of civil servants, bureaucrats and other employees belonging to the three branches of the Government - the executive, judiciary and the legislative - semi-government authorities, entities that run on or enjoy public fund, like schools, colleges and universities, NGOs that receive foreign funding and other agencies covered by the RTI Act, are still unprepared to abide by the transparency requirements of the RTI Act.

As a result, when citizens ask them for such information, they fret and fume and threaten them with unpleasant consequences. Whether they serve at the union, upazila, district or national level, many public officials cannot believe that ordinary people who trembled before them in the past would now dare to ask them for disclosure of information which was out of bounds for them. They get particularly angry with RTI activists and NGO workers who help ordinary citizens to make RTI demands. Officials are unwilling to reconcile

with the fact that the days of secretive governance are gone, with the advent of RTI.

A research project recently completed by an NGO on the challenges and prospects of RTI in Bangladesh gives voice to these attitudes. Quotes from officials include:

- "We have lots of work to do at office. If you people add to our burden by asking for unnecessary information, where shall we go? You better withdraw your application or be prepared for trouble."
- "Because of you I have now been summoned to appear before the Information Commission. How could you do that? Don't you know, we could put you in trouble? So please inform the Commission that you got the information now, so both you and I will not have to appear before it."

The research findings also revealed that ordinary citizens avoid exercising their right to information for fear of retaliatory measures by public authorities. Some of their comments include:

- "I am afraid to apply. I may be summoned to the office and threatened with dire consequences simply because I have asked for the information. This has happened to people I know. I would rather starve than make an RTI application."
- "Who will protect me if the authorities file a fake case against me or send the police to arrest me? I know of people who receive

telephone calls from concerned officials threatening them to withdraw their RTI applications or face consequences."

- "People are afraid to confront public authorities. In my union, we know that we always get less than our entitlements under the government's safety-net programmes. But I dare not complain or ask, as I am afraid my name may be struck off the beneficiary list altogether."
- "People don't see public authorities as friends. They are afraid to ask them any question. They would rather avoid them. I don't see RTI gaining popularity with ordinary people."

Such opinions go some way towards explaining the slow progress of the RTI Act in the country. The public must have confidence in the efficacy of the law, and public officials a healthy fear of it, if we are to make full use of this right.

The three main players who can do something about this situation are the government, the Information Commission and the civil society. Civil society remains divided because many key NGOs who fall within the ambit of the law are reticent to promote it for fear that it may boomerang on them. Some smaller NGOs have played a sterling role to keep the RTI ball rolling among the marginalised sections of the country, although their efforts to engage the middle and upper classes have largely failed so far.

There are positive signs that the Government of Bangladesh is slowly

moving towards greater engagement with the law, not unexpected for a government which adopted the law to fulfill its election pledge. However, the government appears not to have fully discovered yet the value of RTI as an instrument to improve governance and bring citizens closer to it. In fact, in most developing countries, governments tend to see RTI/Freedom of Information laws as unnecessary encumbrances on their use (or abuse) of power. Normally, it is citizens who keep RTI alive.

The Information Commission (IC) has borne the bulk of the responsibility to take the RTI Act forward in the last seven years. For a new entity entrusted with an unknown task, it has made significant contributions to put the law on track. In previous columns, we have written about what more it can do.

Till the time the government comes out fully to play its role and the civil society is engaged to promote the law more vigorously, the IC must take the lead to provide the much needed shot in the arm for the sagging RTI regime. Some simple steps would achieve a great deal.

Together with awareness-building and other stipulated activities, the IC should consider: a) removing procedural difficulties faced by applicants in submitting RTI applications; b) encouraging greater use of the law through more positive interpretation of its provisions; and c) putting the punitive provisions of the law to greater use so that recalcitrant public officials realise that they must respect the law or face penalties.

Towards these objectives, the IC could consider the following:

- 1) Allow applications to unnamed Designated (Information) Officers: Among issues which both RTI applicants, the requirement to address RTI applications to specifically-named Designated Officers is foremost. This is because, apart from the difficulty in obtaining the names, in many offices the DOs have not been appointed or been changed/transferred or incorrectly named on the website. The rejection of applications for such mistakes frustrates applicants, leading many to abandon RTI. A significant number of complaints are "discharged" by the IC for this reason. Simply allowing RTI applications to be addressed to unnamed DOs would improve the situation dramatically. Similarly, other reasons for "discharging" about 43 percent of all complaints over the years could also benefit from a more accommodating attitude of the IC.
- 2) Consider registered mail to be definitive proof of receipt: A significant number of RTI applications are lost because the authorities concerned deny having received them, even when dispatched by registered mail. The IC's leniency on the DOs impacts negatively on the applicants. Simply adopting a rule that applications sent by registered mail will be deemed to have been received can remove the problem.
- 3) Hold Designated Officers

accountable: In another large number of complaints heard by the IC, the DOs concerned justified their failure to provide information by claiming ignorance about the law. About 78 percent of DOs agreed to provide information only at the prodding of the IC. While the law provides for punitive measures for such failures, the IC has consistently been reticent to impose them. In seven years, only six penalties were imposed on DOs, while hundreds went scot free. As a result, people's trust in the law suffered. Their fear of public officials will reduce significantly if punitive measures foreseen in the law are applied more stringently. However, the fact that DO's are often guided by the views of senior colleagues, against whom no penalty provisions exist, must also be addressed.

- 4) Follow-up of decisions: Applicants are also discouraged when they fail to obtain the information even after IC directives. A better follow-up mechanism can end their gripes.
- 5) Alternative venues for redress: The holding of complaint hearings by the IC at different locations in the country and/or through video conferencing will reduce cost for complainants and remove another impediment to the growth of RTI. The IC has the ball in its court. If it plays it well, the entire nation will benefit.

The writers are Chairman, Research Initiatives, Bangladesh (RIB) and Project Coordinator (RTI section), RIB, respectively. Email: rib@citech-bd.com.

DEATH WITH DIGNITY

Time to start a dialogue

DR WASEK FAISAL

In a society where living with dignity is often seen as a privilege rather than a right, it might sound imprudent to even talk about dying with dignity. This, however, has become necessary to talk about given the technological, medical and public health advances in recent times and the advent of high-end medical care in hospitals, which is turning us into a "death denying culture". As Phillip Aries wrote in his 1977 book, *The Hour of Our Death*, "Death should simply become a discreet but dignified exit of a peaceful person from a helpful society...without pain or suffering and ultimately without fear". This is not necessarily the case for a lot of our terminally ill patients with life-limiting illness and irreversible medical conditions, as there is a very high prevalence of over-medicalising the "end-of-life care", including routine intubation/putting patients on so-called "life-support" and significant lack of clear communication between treating medical teams and patients' families regarding expectations/goals of care. This is not an isolated problem in Bangladesh, where some argue that aggressive, invasive medical interventions near the end-of-life is done by hospitals driven by financial gains, but is actually also prevalent in the western world where data has consistently shown a high rate of inappropriate, invasive medical procedures in the last 30-days of a person's life.

Modern medical care tends to focus on curing, and restoring, which may sometimes conflict with accepting death as a natural event. Like the population, physicians and other health professionals have diverse backgrounds and levels of experience with end-of-life care, and some may feel they have a duty to prolong life at all costs and/or see death as a medical failure. For others, they may not realise their patient is nearing or is at the end of life until very late. There may also be a perception amongst some health professionals that palliative care and end-of-life discussions are less relevant or more difficult to broach for patients with non-malignant diseases, such as dementia, frailty,



neurodegenerative disorders, and progressive cardiac or respiratory failure. All of these, in turn, leads to the discrepancy between the actual clinical prognosis/life-expectancy of the patient and the patient/families' perceived understanding/expectations of the treatment outcome. That then feeds into the cycle of communication breakdown, unrealistic expectations, over investigations, unnecessary invasive procedures and ultimately, a "bad death" which is over-medicalised with no sense of "closure" for the family and a resentment towards the treating medical team/hospital.

So how do we break this cycle? The first step towards solving any problem is actually acknowledging the fact that there is indeed a problem that exists. Talking about death is often considered a taboo and, if not done in a culturally and religiously sensitive manner, can create unwelcome distress and anxiety. In the context of a life-limiting illness (i.e. cancer), the bulk of the onus falls on the treating

physician to have an open and honest discussion about the diagnosis, the best- and worst-case scenarios with or without treatment including treatment goal, intent & outcome, and most importantly prognosis. This discussion can then be followed through with understanding patients/families' expectations and finding common ground, respecting patient's right of autonomy and formulating an "advanced care directive" and "end-of-life care" management plan.

So what is advanced care directive? Advanced care directive is the process of planning for a person's future health and personal care. This helps ensure that an individual's choices are respected for future medical treatment and their beliefs, values and preferences are made known. This could include guidance/directives regarding whether or not to institute invasive medical procedures in the face of inevitable death, withholding life-prolonging treatment when there is no irreversible cause of clinical decline, only


instituting treatment to maintain comfort at the end of life and also appointing a surrogate decision maker when the patient no longer retains capacity to make decisions. As intimidating as it may sound, this complex discussion can save an enormous amount of time, energy and resources both for the patient/family and the medical teams, which can then be diverted to maintain a meaningful quality of life. Ideally, this discussion should always take place well in advance of an acute clinical decline, sometimes even months ahead, at the time of a life-limiting diagnosis, provided the clinician had the professional integrity and willingness to have this discussion. For advanced care directive to become part of mainstream patient-centred care, hospitals and medical fraternities must educate colleagues and patients about the purpose and mechanics of advanced care directive, mandate this for all eligible patients, document appropriately in accessible formats, and evaluate congruence between expressed

patient wishes and actual care received. To achieve a "good death", good quality end-of-life-care is of paramount importance. By definition, this is something that ensures a better quality of life for the patient before death, preserves the person's dignity, minimises physical and psychological burden of disease-related symptoms, addresses the patient's/families' cultural and spiritual needs and increases the engagement and satisfaction of the healthcare staff. Good end-of-life care enables patients nearing the end-of-life to live as well as possible, and then to die without unnecessary prolongation of the dying process. This, however, should never be confused with euthanasia, which is an "active process of ending someone's life" which is not compatible with the current ethical, legal and religious framework of our country. Knowing when to withhold or limit treatment that is inappropriate or potentially futile to the patient is a key component of good end-of-life care. This could include refraining from putting the patient on a ventilator in the context of progressive, metastatic cancer, not instituting cardiopulmonary resuscitation and withholding active, parenteral feeding & hydration. If explained well to families of a terminal patient, most will opt to spend time at their loved one's bedside in the final days of their illness rather than seeing him/her connected to a "life-support machine" with no realistic hope of recovering to a normal pre-morbid condition.

Modern medicine is as much of science as it is an art; it is about balancing hope and expectations. The complexities of human life can never be captured or simplified in an equation of health and disease, and there is nothing wrong in accepting death as a normal extension of our mere existence and not a "failure to preserve life". To even think, as physicians, we can cure illness and restore health, is arrogant and ignorant at the same time. We are not healers, we are merely helpers, to promote health and wellbeing, to maintain our patients dignity in life and more so in their death.

The writer is a medical oncologist based in Melbourne, Australia.

QUOTABLE Quote



THOMAS AQUINAS

If the highest aim of a captain were to preserve his ship, he would keep it in port forever.

CROSSWORD BY THOMAS JOSEPH

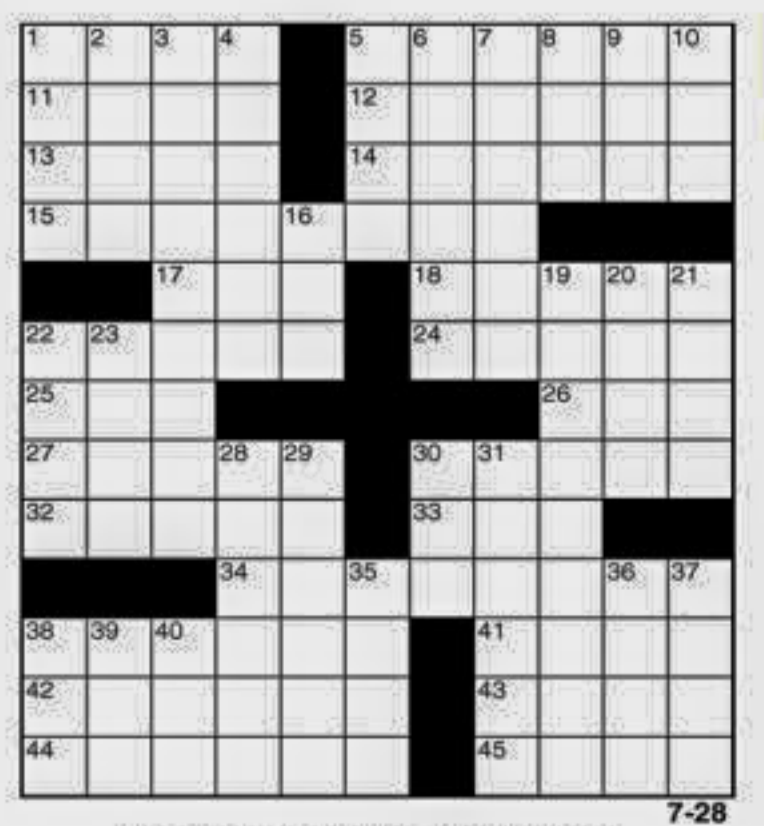
ACROSS

- 1 Rigging support
- 5 Was rude, in a way
- 11 Spelunking site
- 12 Prof protector
- 13 Crooked
- 14 Ticks off
- 15 Way out
- 17 Museum focus
- 18 Put in office
- 22 Mesa's kin
- 24 Relish
- 25 Peyton's bother
- 26 Mine matter
- 27 Derivise sound
- 30 Kitschy
- 32 More reasonable
- 33 Pitcher's stat
- 34 Short scene
- 38 Inhabitant
- 41 Even, as a score
- 42 Late hour
- 43 Saddle part
- 44 Take out
- 45 "The King and I" heroine

DOWN

- 1 Surgery souvenir
- 2 Lacking color
- 3 Hobby
- 4 School paper
- 5 Headliner
- 6 Past, present, and future
- 7 Germany's Merkel
- 8 Wish undone
- 9 Goof up
- 10 -- Moines
- 16 Salt Lake
- 19 Summoning
- 20 Bottle plug
- 21 Deuce beater
- 22 Porgy's love
- 23 Radius partner
- 28 Bring back
- 29 Hot dish support
- 30 Hamilton's bill
- 31 Singer Franklin
- 35 Heredity unit
- 36 Ocean bird
- 37 Writer Ferber
- 38 Homer's neighbor
- 39 Brewpub order
- 40 -- Aviv

BEETLE BAILEY by Mort Walker



YESTERDAY'S ANSWER

B	E	C	K	S	Q	U	A	W	K
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BABY BLUES by Kirkman & Scott

