MARKET MEDICINE AND MALPRACTICE

Edited by
Amar Jesani
P.C. Singhi
Padma Prakash

Published by
CEHAT
Centre for Enquiry into Health and Allied Themes, Mumbai
and
Society for Public Health Awareness and Action, Mumbai

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To those who were deceived and harmed by the medical traders, and who instead of burying their heads in sand decided to raise the banner of consumer rights.

To all those who are selflessly involved in providing health care to the needy and are also struggling for the universal acceptance of people's right to health care and for patients' rights.

ACKNOWLEDGEMENT

It is not so easy to write about one's suffering and the trauma. Three authors: P C Singhi, Raghunath Raheja and Yasmin Tavaria, lost their near and dear ones in the course of medical care. They have done a great service by sharing their experiences here in detail. Saroj Iyer's sensitive narrative of the problems of the Parabs and their comatose daughter is, to say the least, moving.

Many of the other papers have been published in various journals (or newspapers), either in the same form or have been appropriately edited here. We thank authors of these papers and editors of the journals in which these papers were published for readily granting us permission to include them in this book. They are:

Medico Friend Circle (MFC) Bulletin: Amar Jesani, 'Size of Private Sector in Health Care in India', No: 173-74, July-August 1991.

Radical Journal of Health (RJH): Mihir Desai, 'Medical Malpractice and Law', March 1988.

FRCH Newsletter: N H Anita, 'Misuse of Medicine', Vol V, No 4, July-August 1991.

The National Medical Journal of India: Sunil Pandya, 'Rot in the Maharashtra Medical Council', Vol 6, No 2.

The Times of India (Bombay): S S Tinaikar, 'Medical Ethics and Patients',

The Hindu (Madras): M S Venkatraman, 'A Patient's Right to Know' Sunday, December 8, 1991.

The Indian Journal of Social Work (IJSW): Arun Bal, 'Consumer Protection and Medical Profession', Paper at a seminar sponsored by the Medico Friends Circle (MFC) Tata Institute of Social Sciences (TISS), and Association for Consumer Action on Safety and Health (ACASH) held on August 30, 1992, at TISS, Bombay.

There are a number of individuals and groups whose help and constant encouragement made it possible for us to bring this book out. We thank all of them.

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FOREWORD

What is ethics? Is it superior justice? Since in the legal set up justice is justice according to law, is ethics higher than legal justice? But if we consider legal justice and ethical justice as distinct and separate, the problem is not solved since what is taken as 'superior justice' is open to different interpretation depending on the values reflected in the society in general and the individuals in particular. In our society, the Constitution itself sets up the standard of values, namely, 'justice – social, economic and political'. All ethical principles designed for individual or state action in private or public life must ultimately centre around this basic value system which embodies the best of human endeavour and accomplishment.

The Lexicon of the Sydenham Society defined 'ethics, medical' as "the laws of the duties of medical men to the public, to each other and to themselves with regard to the exercise of their profession". This can well apply to lawyers. But in both cases, their role in society is heavily oriented towards public interest.

The Hippocratic Oath is said to be about 25 centuries old; however, its basic tenets remain as valid as ever. Its archaic language and formulation, however historically attractive, have become anachronistic, leading to its restatement in the Declaration of Geneva (by the World Medical Association after the second World War). Amongst the solemn pledges which a new entrant should know, the following are important:

> I solemnly pledge myself to consecrate my life to the service of humanity...
> I will practise my profession with conscience and dignity.
> The health of my patient will be my first consideration.
> I will respect the secrets which are confined in me .....
> I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient.
> I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity...

The International Code of Medical Ethics prescribes *inter alia*, the following duties:

> A doctor must practice his profession uninfluenced by motives of profit.

The following practices are deemed unethical: (a) Self advertisement. (b) Collaboration in any form of medical service in which the doctor does not have professional independence. (c) Receiving any money in connection with services rendered to a patient other than a proper professional fee, even with the knowledge of the patient.

Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest.

A doctor must always bear in mind the obligation of preserving human life.

A doctor owes to his patient complete loyalty and all resources of his science ...

A doctor shall preserve absolute secrecy on all he knows about his patient because of the confidence entrusted in him.

A doctor must give emergency care as a humanitarian duty.

But the more important question is how these ethical prescriptions and prohibitions are observed in day-to-day situations? Ultimately, medicine is what medicine does, just as "law is what law does". The Bar Council of India formulated certain rules relating to standards of professional conduct and etiquette. They relate to the duties of the advocate which he owes to the public, to the court, to his client, to his opposite counsel and to colleagues in the profession. But what we hear today is very depressing. A number of astonishing unethical practices are being reported daily, even at the highest levels of the legal profession – a menace, slowly but surely and perceptibly threatening the foundations of a fair and objective justice system in this country. What about medical practice? Is it in any way different?

In 1989 Dr Hiranandani wrote a strong article on 'The Kidney Traders'. He wrote, "Apparently we believe that if money is to be gained, nothing is sinful. We burn our brides, do amniocentesis to find out the sex of the unborn baby and abort it if it is going to be a girl. In such a setting doctors perhaps do not think it is unethical or cruel to rob a kidney from an unsuspecting person." He then says, "Recently, more gristly rumours (news) are making rounds: (1) kidneys removed clandestinely without the donor's knowledge; (2) donors not adequately paid; (3) Bangladeshi women lured with job offers and their kidneys are removed; (4) So called missing persons we see on TV land up in the hands of specialists, their kidneys removed and they are killed and their bodies are disposed of in Bombay's sewers." Hiranandani refers to an advertisement which appeared in the *Times of India*, May 21, 1989 by Gambro Nexin (India) Medical which said, "Once in a lifetime opportunity for dialysis patients – kidney transplants for dialysis patients on a subsidised rates". Hiranandani could not get the names of doctors who were behind this. But obviously, the advertiser was going to give kidneys on demand. The recent incidents and the cases discovered have shown that all these allegations were true. In India, it is estimated that kidney transplanting was a billion rupee industry and the beneficiaries were doctors, agents, hospitals, etc. Perhaps these doctors may justify these actions on grounds 'medical'. But what justification can there be on the ground of 'ethics' or for that matter, even in law?

Diana Brahams, the editor of *Medico-legal Journal* (London) says, "In a civilised society, no one should have to sell non-regenerative flesh or organs for his sustenance, and such contracts which are unethical and abhorrent, cannot be regarded as satisfying a valuable social purpose even though for the recipient the benefits of transplanted kidney may be considerable. Arguably, the evil in the transaction outweighs the good." Plainly, it is against public policy and illegal. Removal of a kidney is a major operation, the operation is not for the benefit of the donor and therefore, it cannot be said that the donor has consented to physical harm on himself. The result is that all persons involved in the removal of such organs can be charged for causing grievous hurt, or perhaps theft and perhaps other serious offences under the law. However, in reality, the malaise continues unchecked. It is only recently all commercial transactions pertaining to removal of organs and transplantation have been prohibited by a central statute, though not applicable to all states.

The International Code of Medical Ethics expressly says that doctors should be uninfluenced by motives of profit. That is because medical aid is a matter of service to humanity. The Hippocratic Oath says, "Into whatever houses I enter, I will go into them for the benefit of the sick, and will abstain from every voluntary act of mischief and corruption". But as in court, so in life, the Oath has scant respect, and the profession has become a business – a trade – and the rule is to exploit and make money by means fair or foul. When a patient comes to a doctor, he suffers from more than his illness, he suffers from social dis-

advantages. He is nervous, fearful and perhaps even terrified. But he has trust. If this trust is exploited, what is left for medicare? Excessive medication, over-prescription or over-investigations, dubious nexus between the specialists and the general practitioners resulting in the patients being made to go from one specialist to the other ostensibly for investigations but really to fleece the patient! P C Singhi's case in this volume is a pathetic illustration of the pachydermic attitude of the profession. Equally exasperating is the legal proceedings in which the only question is one of assessing damages, the negligence having already been upheld by the Medical Council. Yet the case has appeared on the board 200 times, Singhi requiring to change his advocates not less than eight times!

The law gives monopoly to the lawyers through the Advocates Act and the Bar Council, and to the doctor through their Medical Councils. That is on the assumption that their role in society is heavily oriented towards the cause of public interest. If the right to life (Article 21 of the Constitution) is to have any meaning, it can only be on the basis that the right to medical care and health is guaranteed to every Indian by all those who are concerned about it. If the state denies this, he can enforce it through writs. But if the medical profession neglects, he can only thank his stars. In 1977, the World Health Assembly declared its global goal of 'Health for All by 2000 AD'. I wonder whether we are anywhere nearer to the goal by that time.

With this anthology on medical practice – and malpractice – and health care, the editors have shown how with increased scientific skill and high technical expertise, modern medicine has tended to be less human and more mechanic, the worst sufferers being the poor and the underprivileged. If medicare, just as legal-aid, should have any meaning for those who need it most, it must prominently find a place in a public service agenda in which the best of professionals – surgeons, consultants, specialists – would be required to serve the most poor and the most deserving.

Justice H Suresh

Retired Judge, Bombay High Court,
Mumbai.

Introduction

Amar Jesani

"How can this be? The doctors said she was getting better!" How often have we heard the lament. And how very often do most people attribute the tragedy the death of a loved one to ill-luck, destiny, etc. Yet, as the cases in this book tell us, there are many occasions when both medical science and medical practitioners betray the faith placed in them by people. Medical negligence and malpractice are not new phenomena, but in recent years in India, they are being recognised as offences in the eyes of the law.

This book is, partly, an outcome of the work done by members of the Bombay group of the Medico Friend Circle (MFC), their friends and supporters over the last 10 years. The MFC is a nation-wide organisation of doctors and health activists working for pro-people changes in health care for the last 24 years. The MFC evolved as a national level thought current of socially conscious doctors and health activists in the early 1970s to fulfill their need to meet, share experience, evolve alternatives and discuss health related issues of the country. Since then, its members have been meeting at least once a year to discuss health issue(s) and bring out the *MFC Bulletin*, 231 issues of which have already been published. These core activities of the MFC are self-financed by members. Its members did not have a regular local activity in the name of the MFC. However, in the aftermath of the Bhopal gas disaster and the substandard gycerol (drug) tragedy at the J J Hospital (and the Lentin Commission inquiry into it), these members, individually and together, were increasingly called upon to intervene and make their views known, particularly on the criminal neglect shown by the medical professionals. While their collective work became publicly known as that of the MFC, the formal constitution of Bombay group came in 1988 when on November 7, Dr Arun Bal, a consumer activist, was dismissed from a hospital allegedly for his campaign against the marketing of hazardous drugs by the pharmaceutical industry.

MFC members immediately took up the cause of the victimised doctor, published pamphlets for public education, helped orga-

nise a public meeting and a demonstration in defence of Bal. The formally constituted Bombay Group found a prominent place and soon requests for taking up various health related tasks poured in. While the group laboured well on many general issues, it did not at that point envisage regularly helping individual cases of medical malpractice till P C Singhi arrived in Bombay with a mission to obtain justice for the pain suffered by his wife due to the alleged negligence of a top cancer specialist.

In December 1989, on the advice of the national convenor of the MFC, Singhi met the Bombay group members and Bal. While we sympathised with him and his cause, we were somewhat sceptical about the possibility of getting justice from the medical council and the courts. We, however, had no hesitation in inviting him to present his case at the workshop on 'Medical Malpractice and Ethics' conducted by the MFC as a part of the national level conference on 'Social Movements, Human Rights and Law' organised on December 27-30, 1989, in Bombay. His presentation and overwhelmingly positive response from activist lawyers convinced us that the MFC should also be handling individual cases. It was clear during the discussion that for medical malpractice there was no separate statute, and the tort law on it had not adequately developed in India for the sheer lack of number of cases being fully tried in the court. We all realised that unless patients or their relatives were provided good moral and technical support to fight for justice in the courts, it would be difficult to change the situation. Soon after, on January 6, 1990, the MFC organised a press conference demanding that the medical council should take stern action against unethical and negligent medical practice. At this press conference, Singhi's presentation was widely reported by the media.

We were completely swayed by the overwhelming response we received from people who suffered at the hands of the medicare system. The very fact that an organisation of medicos was making a public commitment to help all those who had genuine grievances against the system helped many to come forward with their problems. We were literally flooded with cases.

In retrospect, what we witnessed was a veritable explosion of pent up anger of people against the system which has got substantially alienated from people's needs. The MFC perhaps acted as a catalyst and a channel for articulating people's grievances. The rising cost of medical care, the growing arrogance of providers and their refusal to be socially accountable and sensitive, had created objective ground reality to enable the MFC to play the role of catalyst. In this initial period, the way the MFC campaigned on the issue also helped in generating such a response. The MFC plunged straight on, strongly condemned medical negligence and medical insensitivity, refusing to accept the argument that it was the handiwork of few black sheep in the profession by questioning the indifference shown by the medical councils and medical associations. By refusing the counsel of others to tone down the campaign, MFC created a sense of urgency and forced all concerned people to respond. Consumer organisations started finding their rightful place in the debate and in handling cases.

In the first three years (1990-92), the Bombay group was approached by about 60 victims or their relatives. For an organisation having no office, no full or part-time employed staff and no financial support, it was a daunting task. The people who came needed more than technical support. These individuals had been somewhat traumatised by the system. They wanted to talk about their experiences again and again. They wanted somebody to empathise with them. All of them invariably wanted information so that they could understand what went wrong. One common complaint was doctors' indifference to their information needs. Most of them did not find the idea of becoming litigants and fighting long drawn cases, attractive. In fact, they were cynical about the efficiency of the judiciary in giving them justice and their opinion of lawyers was not better than the doctors against whom they were complaining.

Very few cases that came to the MFC actually went to court and medical councils. Those who have pursued their cases, have largely done so to achieve something 'good' to establish legal precedents which could deter doctors from repeating similar mistakes and could provide a means to future victims for getting justice. Most of them have, in their petition for compensation for the harm sufferred, made explicit commitment that if the compensation were granted by the court, the amount would be used

for charitable purposes. Most of these are individuals who have shown exemplary public spirit even at the time of losing their near and dear ones at the hand of negligent doctors. Three of the four case studies (that by P C Singhi, Raghunath Raheja and Yasmin Tavaria) presented in this volume belong to this category. Their desire to share experiences with people was so strong that they have written their own story of trials and tribulations. Undoubtedly, this is something remarkable, as one needs some courage to re-live the traumatic days of the tragedy and its often frustrating aftermath. The last case study, done by the public spirited journalist, Saroj Iyer, is of a woman who became comatose as a consequence of an allegedly negligent caesarian section delivery. She remained in coma for five long years and died only recently. This is one of the most tragic cases in which the patient's family were completely devastated, emotionally and financially.

Many of these victims had not contacted the MFC in the first instance. Most had begun their search for facts on the assumption that the particular doctor who treated their relative or friend was perhaps 'bad'. They continued to hold the profession in high esteem. However, they were in for many shocks. They found in time that the doctor and the hospitals could refuse to give them a copy of the medical records (the case papers). Since the MFC always needed a copy of the case paper in order to understand what exactly went wrong and to guide them accordingly, they had to use some ingenious ways to obtain such a copy. They were shattered to learn that other doctors, after going through the case records which they had obtained after great struggle could tell them that the negligence was the cause of death or injury but not give the same opinion in writing. In Raheja's case, a doctor even charged money for going through the case record and for giving the opinion in writing, but refused to sign it. Singhi encountered a situation where he found that the hospital had changed its operation theatre register to protect the doctor against whom he was fighting the case in the medical council. Tavaria, on the other hand, was amazed to learn that the regulatory authorities of the government and municipal corporations had no idea of what standards for the private hospital they were supposed to regulate. Ashwini Rane (nee Deepa Parab) died in deep coma without getting a single hearing from the consumer court simply because her relatives and friends failed to persuade even one doctor to give in writing an opinion that her coma was the result of negligent medical care while the court continued to demand such an opinion as a precondition to admitting the five-year-old case.

These testimonies in this volume bring out numerous such issues. These people, who had high respect and hope for the medical and judicial system of the country, are now much wiser. What they have learnt, and that is clear from their narratives, is that the patients and people are pitted against a very powerful, well integrated, deeply entrenched and largely money or profit driven private medical care system. Of the cases narrated here, Singhi has travelled the longest in getting justice. For he got a favourable judgement or order from the medical council, though the doctor was only warned as a punishment. But in order to get the criminal case against him moved further, he had to travel all the way to the Supreme Court in order to get the preliminary part of the trial cleared so the local court could begin the trial. Tavaria became part of a public interest litigation to enforce minimum standards for private nursing homes and hospitals in Maharashtra state. As she mentions, it resulted in the high court appointing a committee to oversee the implementation of the Bombay Nursing Homes Registration Act. On the other hand, Raheja lost his case against the medical council in the high court, filed an appeal against it in the Supreme Court, where also he lost; but the judgement of the high court ratified his claim that patients have a right over the copy of medical record and the doctor and hospitals should provide a copy to them. Despite all the frustrations experienced by these people in their struggle, they have not allowed their efforts to slacken. This volume is a modest attempt to document their sufferings, their pain and their struggles and most importantly, their never-say-die heroism.

* * *

The book is in three sections. The first is in the nature of a preamble which attempts to locate the problem in the physical reality of today's medical care system. The second section, comprises the four case studies , the narratives of struggle. The

third section is a collection of articles which elaborate on the issues and problems which emerge in the case studies.

This section focuses on the ethical responsibility of the medical profession and examines the functioning of the medical councils. Ethics are inseparable from the medical practice and therefore, medical malpractice is only a public expression of the erosion of ethics and the profession's failure to internally self-regulate its members. It draws attention to medical negligence, ethics and consumer protection. In this part, a detailed analysis of the meaning of negligence and the legal remedies under the Tort Laws available to consumers is discussed. In another article, the extension of the Tort Law facility in the Consumer Protection Act and how the objections raised by the medical profession to the CPA are misplaced, is explained.

This book has not of course covered all aspects of medical malpractice, as for instance, those related to human rights issues, namely, the general right to minimum health care and doctors' role in human rights violation. However, during this period the MFC has done some work on the subject. Its members participated in teams investigating human rights violations such as police custody deaths, rape and police firings. The 1991 annual meet of the MFC also discussed at length the policy changes in order to make basic minimum health care universally accessible to people. In all these works and discussions, ethical issues and patients' rights were prominent.

Lastly, this book is a collective effort. Many individuals participated and played important roles in buiding the campaign against medical malpractices. Likewise for the production of this book, many individuals donated their hard earned money and many provided their expertise, skill and time. While at the a end a few individuals always take credit for editing a book like this, the contribution of all whose names do not appear on the cover has been as vital as that of the editors.

We hope that this volume makes a modest contribution by informing people about the present state of medical care in our country and what they can do to make it socially accountable.

I
Contours of Care

Misuse of Medicine

N H Antia

There is no field of human endeavour where misuse of privileges, authority and funds can be entirely eliminated. Hence society devises methods for limiting such misuse in the form of rules, regulations and legal measures even though enlightened self monitoring and self restraints are ideal. What differentiates professions from trades is that the former not only possess special knowledge and skills but also evolve a code of conduct and ethics to monitor their own members. This is in order to ensure not only the level of technical competence but also the obligation to the society which has entrusted them with responsibility and has placed trust in them. The medical profession has enjoyed a uniquely privileged position because of its technical skill as well as the intensely personal relationship which develops between a doctor and his patient, whereby the latter puts his/her entire faith in the doctor who not only cures but also cares and consoles the patient as well as the family. The epithet 'noble' is symbolic of the love and respect that this profession has enjoyed over the ages, which is somewhat akin to that of the priest.

It is unfortunate that there is now a rapid deterioration of this happy relationship between the profession and society at large. A degree of suspicion and mistrust pervades this relationship today. Before we blame the profession as a whole, let us not forget that there still exists the same relationship between the family physician and his clientele; only that this breed is rapidly diminishing as a result of the new, impersonal and materialistic trends which affect not only this profession but also the rest of society of which they are an integral part.

The wholesale adoption of the western model by our policy and decision makers after independence, based on an alien culture and its science and technology has shaken the entire social and economic fabric of our society and distorted age-old values associated with our civilisation and its culture. It has

polarised our society with a small, wealthy elite group marginalising the vast majority whose life is being increasingly degraded, as clearly observed by the burgeoning urban slums. While this western science and technology has given the knowledge and technology to provide for the basic needs of everyone on this planet, yet, because of its very materialistic nature and lack of a human and moral basis, it is used chiefly as a tool for aggrandisement and exploitation. Such misuse is not only restricted to the western nations where it has originated, but is also rampant in the poor countries, in the hands of those who have been able to obtain access to this technology. The gross misuse of such knowledge and technology in the field of medicine is demonstrated by the fact that the most simple, cheap and efficient aspects of the cure and control of communicable diseases (which still remain the major health problem for the vast majority of our people, especially the poor) are neglected and undue emphasis is paid to the most expensive, complex and cost ineffective diseases like cancer, heartstroke which affect the small, affluent sections of our society. This clearly demonstrates that the dominant consideration in the import and use of such science and technology is dictated by the requirements of the rich and that of the medical profession rather than the needs of the vast majority. In the process, medicine is being converted from a profession to a lucrative trade in human suffering; an area where consumer resistance is at its lowest.

The gross overproduction of doctors, drugs and sophisticated medical instruments and that too, of the wrong type has ensured that malpractice has been built into our present health system. Unfortunately, over the years, this has become an accepted form of medical practice by both the medical profession as well as the public. This is further compounded by the absence of any regulatory measures like public information and education on health and suing for malpractice, as exists in the US and many other western nations.

In the case of the urban rich this is demonstrated by the unnecessary, excessive and even dangerous investigations and medications, inclusive of surgery and the pressures to impose the latest and most expensive glamour technology imported

from the west regardless of its appropriateness. Also, the patient or the public is seldom informed of the attendant dangers which are reported in western journals, leave aside the far greater shortcomings in our own limited experience. Due to availability of easy money, the rich are unwittingly at the greatest peril of iatrogenic (doctor-made) diseases, as is demonstrated by the mushrooming 'five star' urban hospitals with the latest specialities, the latest scanners and the latest drugs and operations. Intensive care units are indiscriminately used, even for terminal care patients, who now have to end their life in stark aseptic conditions monitored by the latest gadgets, rather than in an ordinary hospital bed or preferably in the home, surrounded in their last moments by loving and caring relatives and friends. Each one of these facilities have their specific limited use, but when unintelligently or deliberately pushed to their limits by those trained as technical robots or for satisfying their monetary greed, these 'wonders' of modern science prove to be counter productive, if not actually harmful.

The growing middle class has now been caught in a cleft stick between providing the latest medical care like renal dialysis, kidney transplant and coronary bypass surgery for their loved ones and being pauperised in the bargain. Many search for a good, old fashioned family doctor, who is now in short supply, or turn to other cheaper and more acceptable alternative systems such as ayurveda and homeopathy. Without insurance and adequate financial resources, the thought of illness has become a source of anxiety and neurosis for this rapidly enlarging section of our society.

For the vast majority of the poor who live in villages and urban slums, this poses an entirely different problem. While the middle class is their role model, they can hardly conceive of using the private hospital with its specialists or even the nursing home for their medical needs. And yet they too have been hooked by the medical profession, albeit by those in the lowest rungs, to the universal injection as a panacea for all ills. The 'blunderbuss' therapy of Rs 20 or more for a so-called 'cocktail' injection consisting of an antibiotic, corticosteroid, vitamin B, antihistaminic and analgesic is now familiar even to most

villages leave aside the older 'heat' producing injection of calcium gluconate. The public hospital, whose malfunctioning was so starkly revealed by Justice Lentin, remains their last resort. Fear of these institutions now drives them to small, unhygienic private nursing homes, often after a preliminary visit to the moneylender. The government primary health centre, which was designed to serve the preventive, promotive and basic curative health needs of the 70 per cent of our population that lives in rural India, has ceased to undertake any of these functions as a result of its almost total devotion to family planning and its accessories like immunisation and MCH. Shrouded in secrecy, the PHC is unaccountable to the people for whom it is meant.

What is it that has led to this lack of accountability of the public sector and the exploitative nature of the private one? The answer lies clearly in the inappropriate western model that has been chosen for the development of this country. While we may forgive Nehru for being enchanted with the postwar euphoria for western science, the continuation of the use of this model, that too in its worst aspects, despite ample experience to the contrary, can only be ascribed to the selfish and exploitative nature of those who continue to promote and operate this form of development.

It is regrettable that this type of medical practice now poses a threat to the health of our people. The public health colleges produce doctors who are mostly trained for and work in the private sector. It is inconceivable that any sane politician honestly believes that private medical colleges, which levy a capitation fee of several lakhs in declared and undeclared monies, are for the benefit of the rural masses. The mad rush for securing the highest marks for admission to government medical colleges, or paying high capitation fees by the rich, for their children who cannot get into the former colleges, does not demonstrate love for the health of the people, but a clear indication of the extent of safe monetary returns that this profession ensures them. The type of medical education and even worse, the values inculcated in them are directly opposed to the health needs of our people. Permission to produce 60,000 drugs and formulations (costing Rs 3,600 crore), when the

WHO lists only 258, is surely not for the benefit of the people but that of the pharmaceutical industry and those who give them licences on the basis of kickbacks. The multinationals who control the major drug companies and increasingly, the medical instrumentation industry, do not come to India for the health of our people.

The medical profession and the associated health industry have the unique opportunity to trade in an area where consumer resistance is at its lowest, as a result of fear and ignorance. Public ignorance and absence of consumer resistance is demonstrated by the fact that malpractice insurance premium of doctors in India is Rs 100 per annum, while that in the UK it is over 1200 Pounds Sterling, and for certain specialities in the US over $ 60,000 per annum. This is not to advocate legal action as the optimal way for improving the health services, but under the prevailing conditions of increasing material values and human greed, public awareness and threat of legal action remain the only way out.

Medical Practice: Private and Public

Amar Jesani

What role does medicine play in improving the health status of the people? This question is of fundamental importance, but its answer is more or less practically settled by the research done in the last one and half centuries. As early as in the mid 19th century, Rudolf Virchow who did pioneering work in the study of infectious diseases and epidemiology, stressed the importance of social, economic and political factors. He indeed coined the slogan that "Medicine is a social science and politics nothing but medicine on a grand scale". These views of Virchow have been reinforced by many researchers since then. A decade and half back, Thomas Mckeown undertook a historical analysis of data on the developments in the socio economic fields, their effect on the health of the people and the contribution made by medicine. He concluded that though clinical medicine had its own place in health care, other factors like nutrition, environment, behaviour, etc had long term impact on the health status. It is now widely accepted and also reinforced in the Alma Ata Declaration of the World Health Organisation, that health should be viewed as a part of development, and the political will of the government plays a decisive role in orienting development for improving the health of the people.

Since the health care services also contribute, albeit in a limited way, to the improvement of health status, it is relevant to ask: what should be the nature of medical practice so that it can make maximum contribution in the nation's efforts to achieve better health status for the people? In other words even if we accept that social, economic and political issues are beyond the scope of medical personnel, what should be the nature of medical practice in order to make it more effective? This question is of great relevance, especially for underdeveloped countries which cannot afford high cost medicine.

The Bhore Committee Report (1946) while emphasising the need for rapid socio-economic development for the success of

its health care plan, did not want medical practice to remain confined to its traditional role of curative care. In fact it wanted to orient medical practice to actively aid in the improvement of health status. Thus, it suggested that "preventive and curative work should be dovetailed in order to produce the maximum results". This was argued not from an idealist and a moralist, but from a very practical standpoint, for "a combination of curative and preventive health work is in the best interest of the community and of the professional efficiency of the medical staff employed. In fact the two functions cannot be separated without detriment to the health of the community".

Health care in the private sector has been almost entirely curative in nature. Of late, efforts of the government at creating consciousness about immunisation and its actual provision through a wrongly conceived but high powered target oriented programme have created substantial markets or demand for immunisation in the private sector, too. Many private practitioners nowadays provide immunisation services. But the comprehensive or integrated medical approach is otherwise effectively ignored by the private sector. The overwhelming majority of doctors (estimated to be over 85 per cent of all systems of medicine) working in the private sector, practise chiefly curative medicine. Not only that, since the expansion of the private sector is taking place rapidly and accounts for over 80 per cent of the health expenditure of the country, the overall trend is towards curative medical care. This is detrimental to the interests of the community and is progressively reducing the social efficiency of the medical profession in making contributions towards improving the health status of the people. Thus, it is clear that the greater the importance given to the private sector (which is not controlled in the health planning process), the more reinforcement will be provided to the almost exclusively curative medical practice.

In the public sector, on the other hand, the situation is a mixed one. The urban component of the public sector in many ways resembles the medical practice in the private sector. And indeed a greater part of the public sector resources is spent on urban health care. This is also true for the rural hospitals or the community health

centres (CHCs). However, when we take the primary health centre (PHC) infrastructure separately, a different picture emerges. All the health workers at the PHC and the sub-centres are supposed to practise comprehensive medical care. This does not apply only to the doctor who is the leader of the health team at the PHC, but also to the paramedical staff. The paramedical staff, the health workers and the health assistants are supposed to provide curative, preventive and promotive health care. The paramedics are no longer trained only to help the doctors but to provide all aspects of health care in a relatively autonomous manner. They are also required to run sub-centres, with drugs made available for curative care; and the doctor normally supervises from a distance as the doctor is located at the PHC. As a team leader the doctor is formally accountable for the performance of the PHC as a whole. Thus, at least, he comes under administrative pressure to pay some attention to the preventive and promotive work. The now largely defunct village health guides, were also trained in order to provide comprehensive primary health care.

Unlike the private sector and the urban public sector, medical practice in the rural PHCs is sought to be oriented towards comprehensive care. This does not mean that this orientation has been successfully implemented in actual practice. Almost all government reports, committee reports and numerous studies have shown inadequacies in implementation. But at the same time, though done in an unacceptable bureaucratic way, doctors at the PHCs have been forced to pay attention to the promotive and preventive medical care in spite of them not being so prevention-minded and being more interested in doing their illegal curative private practice. The preponderance of curative medical practice in the health care services in our country is chiefly due, directly or indirectly, to the domination of the private sector. This is compounded by the government's almost non-implementation of the preventive care orientation in the urban and its weak implementation in the rural public health care sector. All these contribute collectively to the low overall social and professional efficiency of the health care services in our country. And indeed this situation, as the Bhore Committee had put it, is detrimental to the interest of the community.

Private Sector

Although a lot has been written about the predominant curative care orientation of health care services in India, very little is written about how curative care is actually practised. Traditional organisation of curative medical practice revolves around the preponderance of general practitioners (GPs) and family physicians (FPs) supported by the consultants. The first two categories could be combined in a single practitioner in the sense that the family physician is normally a general practitioner but all general practitioners are not family physicians. In the traditional organisation of medical practice, the consultant plays a role of specialist to whom the GP/FP refers cases for getting advise on diagnosis and the line of treatment to be pursued in cases requiring greater skill or facilities. This organisation of medical practice is so ingrained that the code of medical ethics has laid down certain general rules regards the relationship between the GP and the consultant.

But this traditional relationship between the GP and the consultant is undergoing a profound change. C N Chandrachud (1970) in his *Memories of an Indian Doctor* observed

> "(now) it is common for a consultant to see and examine a patient without being called in by a general practitioner. A consultant often deals directly with the patient and carries out further the job of giving injections, etc. I have known consultants who have maintained dispensaries much against the rules and dispense medicines in the dispensary. Some of the consultants have almost made it a rule to ask a patient to seek consultation after a week or fortnight and tempt the patient with the offer that the fees for the next consultation would be half of what was charged for the first consultation".

What Chandrachud observed in the 1950s and 1960s as growing unethical behaviour of the consultant has now become established practice. The intense market competition and the profit orientation in the virtual absence of adequate machinery to implement professional self regulation, does not honour old traditions nor the traditional code of ethics.

Another change that has come about is in the location of a doctor's medical practice in the economic system. Earlier, the

doctor was a person owning his/her skills and instruments, compounding drugs in his/her clinic and treating patients. He could be well described, in the terminology of economics as an artisan or a petty commodity producer, who produced use value and sold them for exchange value. However, in modern times, the relationship between the customer (patient), the trade person (doctor) and the technology used for curing (drugs, instruments) is no longer of the old type since the doctor as a professional is essential for the sale and the use of goods produced by the health care industry, s/he while acting as 'a small commodity producer or an artisan', simultaneously works as an 'agent' (or a sales person) of the industry (drugs, equipments, and now even hospitals) in the market for the realisation of profit. This new role of the doctor is almost universal because he or she no longer gathers herbs and chemicals, and compounds drugs. The increasing technological use (including hospitals as technology) in diagnosis and the treatment has, therefore, thoroughly changed the social organisation of medical practice.

Convergence of interests of the industry and the practising doctors takes place most visibly in the 'for profit' medical care. In our country the private sector almost exclusively works on user charges, because insurance coverage is negligible. Even where the state partially provides insurance, as is the case with industrial workers, the situation is not so rosy. In any case, insurance schemes for industrial workers and the government employees have not helped in making any significant dent in the practice of user charges in the urban areas. Insurance schemes like Mediclaim by the United India Insurance have actually helped in the increasing usage of hi tech, high cost medical care in the private sector.

In our country there are no restrictions or no guidelines from the Medical Council or the state on the quantum of fees charged by the doctor, the nursing home or the hospital. In the 'for profit' private sector this situation has encouraged cost escalation. Doctors earn disproportionately high income as compared to their declared income. If the reports appearing in the print media are any indication of the trend, then the complaints of the under-the-table charges by doctors and hospitals are on the increase.

In contrast to this observed trend, no reliable information on the earnings of doctors is available. The income tax authorities have not published any survey of the medical profession's income at any time. In a study of 152 doctors (119 of them working in institutions) located in Jodhpur (Rajasthan) by Ambika Chandani, it was found that the average income of private medical practitioners from their practice was Rs 783.80 per month. This is undoubtedly a ridiculously low figure for the income of city-based doctors. Some pilot studies have been conducted on doctors' income. Alex George in a survey of 33 doctors (general practitioners, specialists and allopaths, non allopaths) in Bombay found that their average monthly net income was Rs 18,333. But in a relatively larger survey of 177 doctors in Delhi done by Kansal at the Indian Statistical Institute (ISI), it was found that the average net income of a doctor practising at clinic or residence was Rs 29,800 per month and of a doctor running a nursing home it was Rs 80,000 per month! These findings indeed confirm our earlier diagnosis of profiteering in the 'for profit' medical care, if not for the entire country, at least for doctors in our metropolitan centres.

While millions of people in the rural areas have no access to basic health care, in the urban areas where curative care medical practice is highly concentrated, the rising cost of medical care is becoming an important issue. This rise in cost is not related only to the earnings of doctors, but also to the use of high technology. There is a phenomenal increase in the production and import of hi tech medical instruments. In addition to increasing cost, it encourages unethical 'cut practices' and direct advertisement of such technology to the general public. This becomes necessary because the high investment involved in the purchase, housing and maintaining of such instruments and for getting adequate returns on such investment, their continuous and even unnecessary use becomes an economic necessity.

The issue of over medicalisation and iatrogenesis were forcefully raised by Ivan Illich and Ian Kennedy. In the last one decade, the efforts of the constituent organisations of the All India Drug Action Network and many other such socially oriented health, science, women and consumer organisations

have helped focus attention on the production and sale of irrational medical goods and their use by doctors. Modak (1984), Phadke (undated), Jayarao (1985) and many others have conducted scientific scrutiny of drugs produced by the industry and used by doctors. The ICSSR/ICMR Committee (1981), too, expressed serious concern about the pattern of drug production in our country. All these efforts by socially conscious organisations and individuals have demonstrated that a large majority of 50,000 drugs and formulations available and used by doctors in our country are hazardous, useless, unnecessary and irrational. Such products not only harm the interests of consumers and inculcate irrational medical practice, but are also causing a waste of resources and increasing the cost of medical care.

Another example of irrational practice is the indiscriminate use of injections. In a study of 100 doctors in Bombay city by Uplekar and Rokle (1987) it was found that the injections most commonly used by the general practitioners were antibiotics (46 per cent) and vitamin preparations (24 per cent). In their study the most frequent use of injections for vaccination was mentioned by only 4 per cent of general practitioners. Further, when they interviewed 10 drug distributors supplying drugs to the general practitioners practising in the areas surveyed, they were told that 'dexamethasone injection' (a life saving very useful steroid, indiscriminately misused) was one of three top selling products. A growing trend in medical practice is of irrational therapeutics, over prescription, unnecessary investigations and unnecessary surgeries.

Why are doctors resorting to such practice? There are many reasons. The first factor responsible for this state of affairs is 'ignorance'. To say that doctors are ignorant of rational medicine may sound a contradiction in terms, but unfortunately it seems so. In two studies of prescription practices by private general practitioners in Bombay city, Uplekar (1989a, 1989b) found that they had grossly inadequate knowledge of highly prevalent diseases like leprosy and tuberculosis as well as of the standard regimen for their treatment.

Second, in our country there is no systematic and effective continuing education of doctors engaged in medical practice by

independent scientific body. Once registered with the medical council, the doctor is not required to undergo retraining or examination for renewal of registration. For non allopathic doctors, continuing education is virtually non-existent. As a result, there is no effective mechanism to provide correct information to doctors and to orient them to rational medical practice. This lacunae in doctors' continuing education is sought to be filled up by the industry through their medical representatives (MRs). Unethical practices like providing drugs free to the doctor in the name of samples, cut practices, commissions, treating doctors in posh hotels by organising the industry-sponsored seminars, offering foreign trips and so on by the industry have been reported. All these things make doctors ignore cost and rationality of drugs used by them.

Of these factors, the most important one is private practice in the unregulated market. What happens when health care is provided on the market? We know that health being a state of well being of the body as well as the mind, it is not tradeable. In the achievement of health, health care plays an important role but not a central role. Health care, however, is tradeable. In a market situation, thus, health care becomes a commodity. For an exchange to take place on the market, the demand for health care from the consumer is essential. The demand, for obvious reasons, is chiefly of curative care. From this it follows that in a society where private practice in unrestrained the market dominates, health care provision is also dominated by the curative orientation. Now, the doctors themselves play a crucial role in generating demand for health care by the consumer. This is for the simple reason that health care is a different kind of commodity, the patient being always much less informed than the supplier, the doctor. Further, the information with the patient is usually unscientific and irrational. Above all, an ill person is vulnerable and usually has no alternative but to choose from the alternatives suggested by doctors. Thus, the dual role of doctor's, in generating demand as well as in being a monopoly supplier, creates a situation of supplier induced demand.

That is why many studies [Auster, and Oaxaca 1981; Green 1978; Funchs 1978] have shown that when there is an increased

supply of health care providers instead of lowering demand, as it should happen in the classical market, there has been normally an increase. This is usually brought about by increased number of unnecessary investigations and surgeries, irrational drug prescriptions and so on. In a way, thus, the market competition in health care is dominated by irrational, unnecessary and undoubtedly harmful medical practices.

Public sector health care does not merely co-exist with the private sector. Since the private sector is dominant with almost 80 per cent of doctors working in it, the public sector is in many ways led by the private sector. This does not need much explanation as it is quite obvious. It is evident in the location of medical colleges, in the content of medical education, in the way Medical Council function and so on. The norms of curative medical practice are, therefore, set by the private sector. The value system of private sector medical care, namely commercialisation, high technology orientation, etc have come to dominate the practice of medicine. The public sector is also greatly influenced by this value system of the private sector in curative care. As a result, one witnesses increasing illegal or unofficial private medical practice by government doctors in PHCs and hospitals. There are even agitations by doctors to make their private practice official. It is not unusual either to see government doctors doing private practice, sometimes even using the medicines from the PHC and the hospital.

Although the state is involved in the production of drugs, the PHCs and hospitals are supplied drugs in inadequate quantity and in an irregular manner. Often a significant proportion of drugs supplied is irrational, useless and hazardous. Due to the inadequate supply and corruption, even at the government hospitals patients are given prescriptions to buy drugs from the open market. From our experience we have strong reasons to believe that a majority of drugs prescribed by government doctors for purchase by patients are combination drugs and are irrational. Further, the average cost of medicine borne thus by the patient is perhaps three to four times the average expenditure made by the government on drugs for a patient. That is why we find that the drug industry's medical representatives visit the

government doctors in the same way and for the same purpose as they do doctors in the private sector.

Just before independence, the Bhore Committee expected the public sector to lead in health care development. However, in reality, it is being led by the private sector. An analysis of corruption, so-called inefficiency, political problems, problems of orientation, etc, of the public sector gives only a one-sided picture which reinforces the pro market privatisation votaries. It is also misleading to assert that malfunctioning of the public sector provides a scope for the expansion of the private sector. A holistic approach first recognises the predominant position of the private sector (which it could acquire undoubtedly due to the conscious policies of the government) and its negative influence over the public sector. That is the reason why there is little to choose between *curative* medical practice in the private and public sectors.

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