"We need to invest in our teaching hospitals"

When we were students, we had role models who came from the Independence struggle. They were morally, mentally and physically oriented to doing their best for the country. In the '60s, these individuals, like Dr Phadke, Dr Baliga, Dr P K Sen, put in tremendous time and energy in teaching. They spent more than four to five hours every day in KEM hospital, even as honoraries. I remember Dr. Baliga coming to take a class for us, after postponing a case in his private clinic. Such was their commitment.

However, even in those days, it was not uncommon for surgeons to operate in KEM and collect fees in their private clinics. The amount collected, however, was paltry. There was subtle priority granted to such patients. It was the era of 'Note cases'. The patients who had a note for the named physician would get priority. However, each subsequent dean realised that this was not a fair practice and the note cases got priority only on the concerned physician's admission day. This is an example of the inequities in practice even then.

While I do agree that ethics in the medical profession have deteriorated over the years, I must say that it is just a reflection of ethics in society. It would be unfair to say that only doctors are unethical. In today's world the definition of corruption will have to be modified. A fair amount of tipping for essential services has become institutionalised and people are more matter-of-fact about it.

I also feel there was less competition among consultants in those days. The pressure to earn money was not as high as it is today. I think, as in politics, the introduction of capitation fee colleges has increased the investment made by a doctor and his parent. There is pressure to recover that investment, either through a quick, high-income practice or at the time of marriage. It is inevitable, then, that medicine is seen as a trade. This is where unethical practices like fee-splitting come in. The greedy want to earn far beyond their ability to even spend it. This has very little to do with medicine and its practice, but the peculiar desire to compete. It is a pressure typically seen in trade and business.

The last straw on the camel's back is the current practice of 'starving' teaching public hospitals. This is because of pressure from private health care vendors who stand to gain if less money is spent on public hospitals. When we entered the teaching profession, teaching hospitals like KEM were the top hospitals. Anything complicated would be done first in the teaching hospitals, then it entered the private sector. With the entry of corporate and non-profit hospitals, coupled with the poor funding of public hospitals, public hospitals now cater only to the poor. The current scenario does not attract the best medical talent. In our time, the teaching job was the best job anyone could hope for. Though my monthly salary was only Rs 400 then, I was looked up to, as a teacher. Most of us did not mind waiting till middle age to earn a reasonable salary and lead a comfortable life. Today's post 1975 generation, are the 'here and now' generation. They are not living on ideals, they want to earn while they are young. This social phenomenon is prevalent among other professions like engineering and business administration, where they are under pressure to earn.

This leads us to two basic tensions between society and doctors. Society accepts that a doctor can earn money but cannot accept that a doctor should earn money at the cost of everything else. This is because a doctor has educated himself at society's expense. When a doctor asks 'Why should I do charity when architects and accountants are not expected to do so?' he forgets that resources he has consumed from society, in both human and monetary terms, are far more than any other profession. This social awareness has been lost somewhere down the line, more so with capitation fee colleges where they feel they have paid for their education and there are no obligations.

Another **tension is related to the phenomenon of doctor shopping**. During our time, there was faith in the doctor and his integrity. Today, patients suspect their doctors, and every case demands a second opinion. Patients shop for doctors, looking for "competitive quotes". Doctors are resigned to this phenomenon and give advice without commitment to their patients, because they know the patient may not come back. There *is* no doctor-patient relationship. Today's patient is just a client who pays. The doctor is no longer an advisor giving out holistic advice. Today's doctor does not feel responsible for the health of society. He feels that is the responsibility of politicians, administrators, the country in general. He is just there for health care delivery. This is a basic conflict.

Due to my personality, very rarely has anyone offered me a bribe. Any offers of donation would be directed to the departmental development fund, the poor box or to the Dean. My seniors did not take any money, but by the time I became a professor, it was well known that **certain** lecturers were 'free-lancing' in the evenings. The attitude was that if we got caught we would resign immediately. This was related to poor academic stimulation coupled with low salaries. A financial disadvantage is tolerated when compensated for by a professionally satisfying atmosphere.

A model example is the Christian Medical College, Vellore. You may receive less cash in hand, but all your other needs are taken care of. The lack of competition locally and the existence of strong religious tenets add to the dedication of the doctors there.

I do not think that the moral fibre of doctors today is corroded to a great extent as compared to our time. There are many fine role models even today. The stories about doctors refusing to operate because they have not been paid are exaggerated. The vast majority of doctors today are practising ethically. The black sheep are just a handful who, because they are in the limelight and openly promote

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unethical practice, are bringing the entire fraternity down.

I would like to tell young entrants to medicine that unfair and unethical practice is no lasting solution. It may give quick returns initially, but soon, such people start losing sleep and join the club of doctors with stress disorders, which are on the rise. The only marketing that works in the long run is that of word of mouth. Such doctors may have to wait a little longer, but they will get returns for their patience. In my case, the best referrals come from the patients themselves, not from general practitioners and peers.

Patients want an honest doctor. They may be dishonest themselves, but where their own body is concerned they want honesty.

There is a clear dividing line between a good living and greed. During my time medical professionals were the richest of the community. Not any more. Medicine is no longer in the running for the best paying profession. There are no more doctor millionaires. Today, the richest people are entrepreneurs and other professionals. Parents pushing their children into medicine need to consider their wards' mental make-up, their ability to sustain physical hardship. They must also keep in mind that the respectability of the profession is slipping. Privatisation of health care is not a satisfactory model for India. On the pretext of lack of funds for sewage disposal, good water supply, primary care and immunisation, the government is inviting the private sector to participate in curative health. Medical education must remain government aided. The private sector has to be regulated by the government so that exploitation is minimised. Also, charitable institutions need to be transparent in their functioning.

On the other hand, the government needs a 'corporate style of accountability and management'. Instead of closing down public hospitals, there is a need for better managed public hospitals. The false sense of socialism needs to be abandoned. Those who can afford it must pay for the facilities, with a clause that they may be used for teaching. This money can be pumped back to pay teachers better, and to buy better equipment. This model will work. Free health care for everyone is a bad idea.

As told to ***Nobhojit Roy***

Mental health

■Some articles in the July 2002 issue of *aaina, a mental health advocacy newsletter:* The editorial looks at the new Code of Medical Ethics and its relevance to mental health professionals. A number of legal judgements in the area of mental health are discussed. For more details on the publication, write to the Center for Advocacy in Mental Health, 36 B Ground Floor, Jaladhara Housing Society, 583 Narayan Peth, Pune 411 030. Email wamhc@vsnl.net or visit www.wamhic.com .

aaina, a mental health advocacy newsletter **2002; 2 (2).**

Need a heading

■ The May-June 2002 issue of the *National Medical Journal of India* contains many inputs of the non-medical type. An editorial on the equity implications of managed care comments on the discrepancy of a national health policy which claims concern for equity while calling for a greater involvement of the private sector. For the former, "govenments must be prepared to play a stronger role in the health sector…". Another editorial notes that current research in injectable contraceptives is a direct product of coercive population policies; neither will provide women with the choice of safe, effective and user-friendly contraceptives. An Eye on the Web provides a review of internet resources on medical ethics. And the letters from Johannesburg, Chennai and Mumbai provide valuble pictures of the political, social and economic influences on health and medical practice.

Thind A. Managed care and developing countries: what are the equity implications? 121-3. Rao M. Injectables, incentives and disincentives: short-sighted population policies. 123-7. Roy N. An eye on the web. 164-8. Letter from… 169-72. ***Natl Med J India*** **2002; 15 (3):**

More on drug regulation

■ In the May-June 2002 issue of *the Bulletin on Drug and Health Information*, Andrew Herxheimer describes the way in which drug companies have influence prescribing practices and the reasons for this happening, and proposes a system to prevent conflicts of interest guiding medical decisions. The same issue reviews the deaths following contaminated glycerin in JJ Hospital, Mumbai, in 1986, when an investigation revealed a nexus between the drug industry and regulatory authorities. But no lessons were learned, the writer points out, as similar contamination killed patients 12 years later. In the absence of proper quality control, and given the "unholy alliance of drug manufacturers, bureaucrats and their political masters," we can expect more such tragedies in the future. To subscribe to BODHI write to Foundation for Health Action, 254 Lake Town, Block B, Calcutta 700 089. Email: fha@cal.vsnl.net.in

Herxheimer A. Doctors and drug industry: dancing to different tunes. ***BODHI*** **2002; 46: 33-36. Kundu S. Unholy nexus hits doctor and patient alike. (Adapted from the** ***Bulletin of the WHO*** **2001; 79: 88-95.)** ***BODHI*** **2002; 46: 37-40**