LETTERS

Women in the healthcare system

The comment on the manner in which women are treated in healthcare facilities (1) like others critiquing doctors' behaviour, comes from researchers in health management. Tragically, doctors don't seem to take notice of this problem. It may be that they are too busy curing the ill to notice the human, or because medical education lacks the ethics component.

I would like to add an insider's view to the article.

One such example is the HPV vaccine. The targeted group is young girls on the threshold of puberty. They are to be given the vaccine with the aim of protecting them from likely HPV infection that may lead to cervical cancer. Are girls informed about how and when they may encounter HPV, and how they can prevent it? How does this intervention fit the bill of a public health measure? Is it justified based on the cost of the intervention and its efficacy, and the incidence and prevalence of cervical cancer? The advertisements of this vaccine amount to emotional blackmail of parents who may not be able to afford it. However, all parents can afford to empower their little girls to take care of themselves and prevent HPV.

Privacy and dignity: Once, when we asked for RMOs to be instructed to keep women covered while doing gynaecological examinations, a senior (and sensitive) professor opposed the demand saying that if the hospital was unable to provide the sheets required, patients might start complaining! The hospital administration as well as supervisory staff must be required to provide private space and a comfortable setting for a very private examination like the gynaecological examination, which should be conducted in the presence of an attendant.

Cases like the ones narrated by the authors are rampant. Why are they not considered to be sexual harassment?

Refusal to answer questions: This is the most common professional misdemeanour doctors commit against their clients/patients. The reasons are many:

For one, doctors treat women as well as men as diseased bodies, not as humans with brains, anxieties and concerns, and believe themselves to be gods providing a cure. Secondly, some doctors do not know the answers to their patients' questions and fear a loss of face if their ignorance were to be revealed. Surely patients would respect doctors who are truthful in admitting their limitations. In my view, patients should be encouraged to ask questions as- the better they understand their problems, the less likely they are to have false hopes or expectations. Finally, patient education seems to be the last thing on a doctor's mind. This is especially true in the private services where doctors can charge what they want and patients pay out of their own pockets. In systems where the state pays, doctors are more careful.

Urban vis-a vis rural: Rural women are practically invisible. But yes, even a well-off urban woman often goes through humiliation, harassment and violation of rights at the hands of doctors. She suffers quietly, for fear of being called either a prude or weak.

What are the solutions?

First, as in the Delhi High court judgement (2) on the examination of sexual assault victims, positive guidelines for gender sensitive healthcare must be brought out by state medical councils as well as the Medical Council of India.

Second, patients' rights charters must be displayed in all facilities. Third, clinical or applied ethics must be mandatory in all curricula.

Finally, male doctors must examine a woman client only in the presence of a nurse, ayah, female doctor or a relative with whom the client may be comfortable. Posters advising this must be put up in every chamber where a healthcare provider may examine a female client.

References

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The Clinical Establishment Act, 2010: need for transparency

The article on the Indian Medical Association and the Clinical Establishment Act (CEA), 2010 (1), was well written and showed the author's grasp of the state of affairs in the bureaucracy. The opposition to the CEA is largely because of private practitioners' fear of extortion in the hands of 'babus'. The government should let health be administered by health professionals rather than by babus who are typically both junior in service to government doctors and also have lower pay scales, at least at the district level. Since senior government doctors resent being commanded by a junior government officer, the honest and the expert keep away from government service. The CEA will bring private practitioners under the direct control of bureaucrats. This state of affairs is largely unacceptable to the medical profession, what with the rampant corruption in the bureaucracy. Extortion is already rampant in the case of the Pre-conception & Pre-natal Diagnostic Techniques Act, 1994. And if that law is any indication, the CEA, when it is implemented,

will turn out to be the biggest legalised extortion racket in the world. Obviously people cannot say this on public platforms, which is why there have been many voices saying different things which might sound like irrational ramblings. But the stand of the IMA -- that registration should be online (to eliminate the need to pay any suvidha shulk) and accreditation should be optional and done by an independent agency -- more than speaks for the underlying apprehensions of its members.

Note: *The above is not an official communiqué but the personal views of the writer.*

Reference

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White coated corruption: time to begin even with small steps

This refers to a thought provoking article by Vijay Mahajan (1) and a commentary by Arun Sheth (2).What both authors have stated is, unfortunately, true. Dr Sheth's comments reflect the hopelessness of the situation, as he does not suggest any remedial steps except "time-tested, age-old golden practices in spirituality..." Dr Mahajan states that the list of things that doctors must do is long, and spells out a very long list of do's and don'ts for doctors, authorities and the people. He concludes: "Corruption is spreading its tentacles far and wide in the medical system. To restore its noble and distinct status, all sections of society must work together to stamp out the biggest killer in the medical system - corruption."

Is this corruption rampant and confined to the medical profession only? The answer is: no. Can we justify and continue to tolerate corruption in the medical profession because it occurs in even severe forms in the society? Again the answer is: no. It is high time for introspection and taking remedial steps. It is better to begin with small steps in the right direction rather than wait to work on all out measures all at once. There is an urgent need to make a beginning.

The January-March 2010 issue which published Mahajan's article had two articles on financial incentives for prescribing newer and costly vaccines (3, 4). Both articles highlighted the huge margin between the maximum retail price (MRP) of some vaccines and the price at which they are sold to doctors. GSK, one of the manufacturers of the varicella vaccine, had, in the past, increased the MRP even as it lowered the cost of vaccine to doctors, thus increasing the margin of profit for doctors. Recently, GSK has reduced the MRP by Rs 200 per dose, but has not changed the price for doctors. This reduction in doctors' margin is a positive step and should be welcomed.

Referral of patients, especially for investigations, is a contentious issue that needs attention. Ideally, recommending investigations should be akin to prescribing drugs for a patient. Drugs may be purchased from any drug store; similarly investigations may be done from any diagnostic centre. If facilities exist in the same place that a doctor practises, the doctor may suggest getting these investigations done at that centre, but the patient or caregiver may opt for any other centre. Some doctors insist that investigations be done at a particular diagnostic centre only.

A doctor does not get any financial benefit from a drug store in the form of a cut or kick-back. Similarly a doctor is not supposed to get any financial benefit from laboratories conducting investigations. It is said that some manufacturers give monetary incentives to doctors for prescribing their products, which is outright reprehensible. Similarly, accepting monetary benefits in the form of a kickback or cut from a diagnostic centre is bad, but, is being practised in many places including some hospitals. This issue should be taken up by the Indian Medical Association, the Medical Council of India, or the *Indian Journal of Medical Ethics* by organising a national consultative meet to formulate comprehensive guidelines for the medical profession. The consultative meet should deliberate on all aspects, including guidelines for investigations suggested, accreditation, quality control, charges etc. of the diagnostic laboratory. Should some sort of incentive be paid or not be paid to the referring doctors and also the mode of payment in case payment is made? Thus, if payment is made it should become official, i.e. records be made so that it is treated as expenditure by the diagnostic centre, and payments made to the doctors be treated as income and taxed accordingly.

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