Doctors and health in India: an outsider's perspective

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Medical practice in India is under intense scrutiny, and hardly a day goes by without another scandal, about poor treatment meted out to patients, absence of doctors from the workplace in rural areas, fraud in the medical education system, and so on. With rising costs, access to modern medicine is becoming a challenge, and there is little assurance of quality services and patients feel vulnerable and powerless; a real 'caveat emptor'. This is against the backdrop of a massive expansion in health services both in the private and in the public sector, the promise of increased government funding, reforms in medical education, and other policy initiatives with the potential to deliver equitable access to healthcare by all as suggested by the recent High Level Expert Group on Universal Health Coverage for India(HLEG) (1)

Can we expect to eventually see the effects of planned development get down to the 'common people' in India, and make a difference to their lives?

Of course, it will take time for these changes to have an impact, given the scale of the challenge and the need for massive reforms. However, time alone not is not enough; it will also require an active leadership and a change of mindset. If the last two decades were focused on economic prosperity, the next few years must be concerned with health services, since maintaining economic growth requires a healthy population. This cannot be done without the support of doctors; engaging them in policy making and planning of health services will be crucial. However, for doctors to gain the confidence of the public the medical profession must first do some reflection.

This paper seeks to stimulate debate and action to promote professionalism in medicine, and to start a movement for leadership in health in India. I write this with some trepidation as I have been out of India since 1980 and have been working largely in the National Health Service (NHS) in the UK. Nonetheless, I hope that an 'outsider's' perspective will be useful.

Doctors and society

There has always been a love-hate relationship between (parts of) society and doctors. George Bernard Shaw described this quite well in his book *The doctor's dilemma*:

> "All that can be said for medical popularity is that until there is a practicable alternative to blind trust in the doctor, the truth about the doctor is so terrible that we dare not face it...In this predicament most people, to save themselves from unbearable mistrust and misery,

or from being driven by their conscience into actual conflict with the law, fall back on the old rule that if you cannot have what you believe in you must believe in what you have... You have a wildly urgent feeling that something must be done; and the doctor does something. Sometimes what he does kills the patient; but you do not know that; and the doctor assures you that all that human skill could do has been done."

Whilst not being so directly critical, Illich also had concerns about the medicalisation of society and iatrogenesis:

> Medicine has the authority to label one man's complaint a legitimate illness, to declare a second man sick though he himself does not complain, and to refuse a third social recognition of his pain, his disability, and even his death. It is medicine which stamps some pain as 'merely subjective', some impairment as malingering, and some deaths - though not others - as suicide.

Ambrose Bierce was more succinct when he defined the physician as "one upon whom we set our hopes when ill and our dogs when well".

At the same time, there is acknowledgement of the massive contribution by generations of doctors in alleviating suffering over the centuries through better science and treatments, starting in the 16th century with the understanding of human anatomy, to improved knowledge about disease processes in the 18th century, better methods of physical examination and finally more effective treatments in recent times. Have people forgotten the immense human toll due to infectious diseases, most of which are now history, at least in the UK, due to advances in immunisation and antibiotics? Do we need further reminders about the benefits of total hip replacements, kidney transplants, cataract surgery and management of many chronic diseases?

Medical practice at the start of the 21st century is at a crossroads. On the one hand, due to scientific and technological advances there is an unprecedented potential to improve the quality of life for people suffering from various ailments. On the other hand, health inequalities are widening and access to affordable and good quality healthcare is becoming difficult for vast sections of the population. Policymakers and the public look to doctors to provide the necessary leadership to tackle shortcomings, and help design better systems of care so that everyone can benefit from modern medicine. But are doctors up to the task? What should be done to ensure that they rise

to the occasion? Are they still true to the Hippocratic tradition and to the vocational nature of medicine, or have they become hypocrites, interested only in money? How can we restore doctors' pride and support them and at the same time gain the confidence of patients and policy makers?

To answer these questions and promote discussion I had collated a list of the charges levelled against doctors over the years in the UK, explored possible contributory factors and made suggestions on the way forward(Appendix) (2).

Whilst the context is important, and not everything from the NHS will be directly applicable in India, there are parallels between the UK situation and what is happening here. I have had the privilege of meeting many dedicated and committed doctors over the years in India. Equally I hear frequent laments about a lack of professionalism, and comments about doctors overcharging, ordering unnecessary interventions, and being interested only in money.

This last issue of a close relationship between money and medicine is especially pertinent to the Indian health system, as a vast proportion of healthcare is in the fee-for-service sector as the HLEG observed in its report(1). From paying huge amounts to secure admissions to both under- and postgraduate programmes (I am told that students can expect to pay Rs two crore to get a postgraduate place in specialties like orthopaedics and radiology), to receiving commissions for referring patients for tests/procedures (with referral commissions reportedly representing a substantial proportion of the costs of laboratory tests, for example), to hospital doctors being given 'quotas' of admissions or procedures to retain their admitting privileges (leading to unnecessary interventions), there seems to be a malignant financial angle to almost every patient interaction in the private sector. Although in theory there is a comprehensive public health system, it is disorganised, with widespread absenteeism and poor facilities, and does not inspire confidence, with the result that even the poor choose the fee-for-service private sector.

My purpose here is not to make judgements. Regardless of which healthcare system one looks at, there will always be good and bad doctors. This is because they are both victims and perpetrators. They are victims of a less than perfect science, a society that demands zero risk, and the pervading moral and ethical culture. They are also perpetrators of the crimes they are charged with as they fail to address and adapt to the changing societal and healthcare context.

What can be done?

How can we then meet the challenge of ensuring that everyone benefits from advances in medical science within limited resources? How can we reconcile the aspirations of society with the aspirations of doctors? And how can we balance the science (complex and technical) with the art (simple and humane) of medicine?

A useful start is facing up to the big questions: how can people become and remain healthy? How can we ensure affordable, good quality healthcare to all? Health as defined by the WHO - a complete state of physical, social and mental well being and not merely an absence of disease or infirmity - is not just due to healthcare but is dependent on a range of factors: education, employment, housing, transport, crime prevention, for example. So a holistic approach and a focus on public health are crucial. Whilst health may be a human right, modern medicine, in the 21st century with its technological and scientific discoveries, is becoming a privilege. Therefore there is an urgent need to define what care is essential – not everything that happens in medicine is affordable or safe.

This is the debate that doctors must engage with. However, doctors are becoming disengaged, and increasingly, focussing on the technical aspects of healthcare. Of course, the system distorts 'priorities', but there is still a lot that doctors can influence health policy, service provision and quality improvement. They can help people become and stay healthy by promoting preventive measures. They can inform better use of limited resources by using evidence. Medicine is as prone to fashion as any other profession, and doctors have often done things because they can be done rather than that they need to be done. My favourite example concerns tonsillectomy. In a survey in New York in 1935(3), 1,000 school children were examined, 61% had already had a tonsillectomy. The remaining 39% were examined by a group of doctors and 45% were advised tonsillectomy. The remainder were examined by another group of doctors and 46% were advised tonsillectomy and this happened a third time. By then only 65 children were left who had not been advised the operation. The researchers ran out of doctors to send these children to for re-examination and stopped the study. And in the 21st century there is still debate about the benefits of tonsillectomy. At a recent meeting of orthopaedic surgeons, delegates were asked why surgeons had abandoned the Charnley prosthesis (one of the best and a very cost-effective implant for hip replacement); 48% said those who did this were 'victims of fashion' and 19% said: 'surgeons repeat mistakes of history'. Another meeting concluded that 'quality control of [the] surgeon may be more important than that of the implant'. Skrabanek and McCormick(4) and Fido's books (5)on the subject are very sobering reads about how prone doctors are to fashions. Evidence-based medicine remains a dream, rather than a part of everyday medical practice.

So, doctors have the responsibility of sorting out the problems currently facing the healthcare system. They must steer the agenda and not wring their hands or pass judgement from the sidelines. We are in a vicious cycle whereby relentless advances (not always better or needed) in medicine and technology are widening inequalities and reinforcing people's dependency on medicine. The more we give drugs, the more people will take, and need, them. There is an infinite demand and we are heading towards a pill for every 'ill' and surgery on demand. We need to break this cycle, for the sake of our patients and for our own sake.

Comparing the current situation in India with the NHS, it is worth noting that 'free markets' in healthcare were prevalent

in the UK until the establishment of the NHS in 1948, and despite its problems with the NHS, British society has hung on to the founding principle of a "free at the point of use" health service for everyone. At the time of writing this paper, there is an ongoing debate about the future of the NHS, and what is really fascinating is that the vast majority of doctors, and other professions, are resisting the call for increasing involvement of the private sector in the NHS. What a contrast from when the NHS was being set up, and when doctors were not in favour of its establishment.

Equally, however, conditions in the early part of the 21st century are very different from those in the 1940s, and in any case the Indian context has to be kept in mind. Public-private partnerships are seen as the solution in India, and whatever one's views, it seems that a mixed system of public and private health sectors is the only practical way. The current discussions about universal coverage in India are interesting and timely, but it seems to me that unless the increased investment is coupled with reform especially to promote a balance between preventive and curative services, and between access, effectiveness and quality, the money will not have the necessary population health impact. In fact, India may end up like the USA where the healthcare budget has kept rising, but so have the numbers of uninsured Americans, and general population health indicators are, in many respects, of concern -- a real lose-lose situation.

India can do better. My sense is that although there are pockets of excellent leadership, there is not enough momentum to tackle the fundamental challenges including the close relationship between money and medicine at every level, and create a healthcare system that has some, if not, all of the necessary features. Most of the current developments in India are focused on high-tech, hospital-centric care with limited systematic attention being paid to the four fundamental issues essential for sustainable health systems:

1. Better governance, especially clinical governance;

2. Raising educational standards and building research capacity;

3. Primary care as the foundation of the health system, and

4. Investment in public health for long-term sustainable development.

I am aware of the attempts being made by, for example, the National Rural Health Mission or the currently reconstituted Medical Council of India or the Public Health Foundation of India, to address exactly such fundamental issues. But it cannot be left to a few organisations; we need to ensure that all doctors join in these efforts and, more importantly, lead by example. We need to strengthen the public health system at the same time as we support private sector development, holding both to account for providing safe, high quality and affordable care. Of course I recognise that underlying corruption, and the lack of governance and civic society, and limited (albeit increasing) accountability are contributory factors, and not all of these can be tackled by doctors alone.

So, what exactly can be done, apart from talking and reflection? I do not think there are any easy solutions in India. While reluctant to offer specific suggestions, here are a few things that may provide a useful foundation for the long journey ahead:

1. The creation of a new 'code of conduct' or 'professional framework'. Over the last few years, I have encouraged exchanges between the (various incarnations of) the MCI and the General Medical Council in the UK (www.gmc-uk.org) whose *Good medical practice* and related publications and overall approach to professional regulation are seen as exemplary. (I must declare a bias since I am on the GMC Board.)

2. The establishment of a systematic "leadership for health development" programme in order to develop a new cadre of medical leaders who can see the big picture and help design a health system that befits the high and rising status of India on the global stage. At the recent meeting of the Global Association of Physicians of Indian Origin (www.gapio.in), this area was seen as a priority.

3. An independent 'think tank', like the American Institute of Medicine (www.iom.edu) or the 'Leapfrog Group' (www.leapfroggroup.org), to create a body of experienced and influential stakeholders who help steer the agenda and maintain momentum. Again there are examples including the Medico Friend Circle (www.mfcindia.org), and locally-based and committed individuals like the Eisenhower Fellows (www.efworld.org) who are increasingly organising themselves to deliver their mission of 'peace with justice' through a focus on human development and consequential outcomes.

4. A mechanism for sharing and celebrating learning. I have been impressed by how much is being done with limited resources by committed people in various parts of the country. However, the learning remains localised and is not spread (at least not enough) and of course these heroes remain unrecognised. Something like the National Health Systems Resource Centre (www.nhsrcindia.org) can be utilised to create such a mechanism.

5. Better use of the Right to Information Act and requiring providers to publish details on quality of their services and on incidents of patient harm as happens in the NHS initiatives like the Patient Safety Alliance (www.patientsafetyalliance.in), to empower patients to prevent harm, being set up in Mumbai can help with this.

6. Better quality and affordable education to develop capacity is crucial in India. It saddens me to see how dated our medical education is, both in terms of scope and methods of delivery. Also, there is not enough capacity to deliver the much needed workforce for public health. As regards the latter, initiatives like the Peoples Open Access Education Initiative (www.peoples-uni.org) working in partnerships

with others like the Public Health Resource Network (www. phrnindia.org) can help.

In outlining the above agenda for change, I have offered suggestions where I have knowledge and am personally involved to ensure that I practise what I preach, by doing something and not just commenting. However, this runs the risk of self-promotion, and of ignoring many other deserving initiatives. I do not intend either, and see this paper as the start of a dialogue.

Conclusion

The beginning of the 21st century is a defining moment and history will judge us by what we, as doctors, do to promote health and ensure basic, affordable and good quality healthcare to all.

Society will always need doctors, for the reason Lantos also observed:

> Medicine today is facing many problems, many changes. Doctors fifty years from now will do things that we cannot imagine, just as we do things that our forebears would have found miraculous. There may not even be doctors as we know them today. And yet, doctors today do some of the same things that doctors have always done and will always do. That permanence, it seems to me, has nothing to do with science, nothing to do with technology, nothing to do with whether we work in fee- for-service solo practices, HMOs, the British NHS, or the Veterans Administration. It doesn't have much to do with tort reform, managed care, or 'safe havens' from conflict of interest legislation. And, oddly enough, it doesn't even have much to do with whether what we do works or doesn't work. Instead, it has to do with whether, like William Carlos Williams, we nurture the capacity to respond to "the haunted news" we get from "some obscure patient's eyes." No matter how good our science gets or how our health system is organized, someone will always have to do that (6).

We need to move from *Primum non nocere* (First, do no harm) to *Primum bonum faceri* (First, do good). If we keep practising medicine as we have been doing we are creating more inequalities, taking away individual responsibility, and creating dependency and depriving people of other essential services for human development. Doing good requires being imaginative, thinking differently and getting involved. It also means being passionate – passionate for change and continuous improvement. Being a doctor is a privilege and comes with responsibilities. We must take the heat just as we take the good times, and work for a better society.

This responsibility is all the more acute for Indian doctors. With one in six persons in the world being an Indian, India carries a huge global health burden. Equally we have over one million Indian doctors worldwide who with their ingenuity, commitment to excellence, and leadership are in an ideal position to make a real difference in the world.

Doctors in the last millennium are remembered for major discoveries and advances in science and technology. Doctors in the new millennium should be remembered for their leadership, their humanity and for enabling people to achieve and maintain health.

Note: *This paper is partly based on the Milroy Lecture given by the author at the Royal College of Physicians in London in 2003. The views expressed here are personal.*

APPENDIX

Charges against doctors

1. *Doctors kill patients:* Deaths due to medical errors are the eighth leading cause of death and account for more deaths than due to motor vehicle accidents, breast cancer or AIDS each year according to studies in the USA; in the UK, Harold Shipman alone has killed over 200 patients.

2. *Doctors cause harm.* When they are not actually killing patients they continue to do harm; one in 10 hospital admissions is associated with an adverse outcome, most commonly caused by medication errors and hospital-acquired infections.

3. *Doctors are only interested in money:* The inception of the NHS was fiercely resisted by doctors until "Nye Bevan (the minister responsible) stuffed their (doctors) mouths with gold", and since then many major reforms have been financially incentivised.

4. *Doctors are not good researchers:* With the pressures to 'publish or perish', good quality and important research is being compromised.

5. *Doctors cannot teach:* The 'See one, do one, teach one' method of teaching has gone on for too long.

6. *Doctors obstruct reforms*: Implementing best practice and modernisation of the NHS is being blocked, and if they are not actively resisting, few doctors are actively promoting the reforms. Doctors have become disablers, not enablers.

7. *Doctors discriminate against fellow doctors:* The 'Old Boys Network' continues and manifests itself in discrimination in appointments within the NHS without regard to merit.

8. *Doctors are not good team players:* They do not always acknowledge the important contributions of other clinicians, especially nurses, and the divide between doctors and managers/policymakers seems to be getting wider day by day.

9. *Doctors are not self-critical:* They tend to blame everyone else for the shortcomings of the health services.

10. *Doctors are a closed tribe:* They collude when the going gets tough and protect each other. Things do not seem to have changed much from George Bernard Shaw's time: "The truth is, there would never be any public agreement among doctors if they did not agree to agree on the main point of the doctor being always in the right."

References

1. High Level Expert Group (HLEG). High Level Expert Group Report on Universal Health Coverage for India [Internet]. New Delhi; Planning Commission of India: 2011 Nov [cited 2012 Sep 24]. 343p. Available from: http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf.

2. Madhok R. Milroy Lecture-Doctors in the new millennium: Hippocrates or hypocrites? [Internet]., London;Royal College of Physicians: 2003 Sep 16[cited 2012 Sep 24]. 28p. Available from: http://ebookbrowse.com/milroy-lecture-2003-pdf-d38353278.

3. Kissoon N. A paradigm shift. *Jacksonville Medicine*[Internet]. 2000 May[cited 2012 Sep 24];51(5). Available from: http://www.dcmsonline.org/jax-medicine/2000journals/may2000/editorial.htm

4. Skrabanek P, McCormick J. *Follies and fallacies in medicine*. Glasgow: TarragonPress;1989.

5. Fido M. *The world's worst medical mistakes*. Bristol: Parragon;1996.303p.

6. Lantos JD. *Do we still need doctors?* London: Routledge; 1997

Medical humanities in the undergraduate medical curriculum

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Abstract

The medical humanities have been introduced in medical curricula over the past 30 years in the western world. Having medical humanities in a medical school curriculum can nurture positive attitudes in the regular work of a clinician and contribute equally to personality development. Though substantial evidence in favour of a medical humanities curriculum may be lacking, the feedback is positive. It is recommended that medical humanities be introduced into the curriculum of every medical school with the purpose of improving the quality of healthcare, and the attitudes of medical graduates.

Introduction

The dictionary defines the word "humanities" as "learning or literature concerned with human culture, especially literature, history, art, music, and philosophy." The humanities should not be confused with "humanism," a specific philosophical belief, or with "humanitarianism," the concern for charitable works and social reforms. Medical humanities (MH) can be defined as the application of the techniques of the traditional humanities fields to medical practice. Over the past 30 years, there has been a trend towards the development of a humanities curriculum in medical education, both in the United States and Europe (1). There are variable reports regarding the usefulness and the effectiveness of such curricula all over the world (2-3).

The purpose of a medical humanities curriculum

Modern allopathic medicine is considered scientific, objective and evidence-based. Due to an overemphasis on objectivity, it sometimes lacks a holistic approach, as the patient is treated as a case, and not as a whole person. The growth and development of current medical practice is deeply rooted in science but there is definitely too little emphasis on the "art of medicine". Over the years, due to an evidence-based approach and objective assessment of students (especially in CET-based career choice examinations) there has been a loss of comprehensiveness and of a holistic approach to medicine. However, one must understand that medicine is as much an art as it is a science. There is not always one right answer. Not every patient is cast in the same mould and the broad brushstrokes of a one-size-fits-all treatment model are not always appropriate. In addition to economic factors, there are tremendous cultural differences in the community that determine treatment choices. Innovation and creative thinking are necessary to develop new methods of healthcare delivery, discover new medicines or treatment options, and prevent the emergence of new diseases. By educating healthcare practitioners to be more receptive to creative input and encourage innovative thinking, those entrusted with delivering healthcare will not be stifled by the repetition and lack of originality that is today's healthcare system.

The medical humanities were introduced into various university curricula with the intention of enhancing this aspect of the "art of medicine". The medical humanities can have both instrumental and non-instrumental functions in a medical school curriculum. The term ʹinstrumentalʹ function implies that learning can be directly applied to the daily work of the clinician. The clinician has to develop the ability to observe and recognise visual clinical signs of disease in the patient. This ability can be directly enhanced by the study of the visual arts (4,5). The study of literature can help develop another important skill of handling ambiguity and empathy (6). Likewise, the evaluation of case study narratives has been used to improve clinical skills (7).

The humanities exert a non-instrumental function when they help to develop the concept of medicine as art, general education, personal development, or instil new ways of