

CORRUPTION IN HEALTHCARE AND MEDICINE

Corruption in healthcare and medicine: Why should physicians and bioethicists care and what should they do?

SUBRATA CHATTOPADHYAY

Professor, Department of Physiology, College of Medicine and JNM Hospital, West Bengal University of Health Sciences*, Kalyani, Nadia 741 235, West Bengal, INDIA
email: linkdrsc@yahoo.com, linkdrsc@gmail.com

Abstract

Corruption, an undeniable reality in the health sector, is arguably the most serious ethical crisis in medicine today. However, it remains poorly addressed in scholarly journals and by professional associations of physicians and bioethicists. This article provides an overview of the forms and dynamics of corruption in healthcare as well as its implications in health and medicine. Corruption traps millions of people in poverty, perpetuates the existing inequalities in income and health, drains the available resources undermines people's access to healthcare, increases the costs of patient care and, by setting up a vicious cycle, contributes to ill health and suffering. No public health programme can succeed in a setting in which scarce resources are siphoned off, depriving the disadvantaged and poor of essential healthcare. Quality care cannot be provided by a healthcare delivery system in which kickbacks and bribery are a part of life. The medical profession, historically considered a noble one, and the bioethics community cannot evade their moral responsibility in the face of this sordid reality. There is a need to engage in public discussions and take a stand – against unethical and corrupt practices in healthcare and medicine – for the sake of the individual's well-being as well as for social good.

Introduction

Corruption is, to say the least, a complex phenomenon and a difficult problem. It is complex because of its deep roots in the social, cultural, economic, political, legal, and ethical value systems of individuals, communities, cultures, and countries. It is a difficult problem because it defies easy answers and resists any single-track, copy-book model of solutions.

There was a period in the not-so-distant past when corruption was considered, at best, merely an issue of development and, at worst, a socioeconomic issue beyond the world of scientific medicine. In the recent past, however, corruption in the health sector has raised serious concern and received global attention among researchers and policy-makers (1–4). In October 2003, the UN General Assembly adopted the United Nations Convention against Corruption, which came into force in 2005. Other UN agencies have also undertaken anti-corruption measures in health. For example, the Good Governance for Medicines programme, launched as part of the World Health Organisation Medicines Strategy, 2004–2007, incorporated corruption as a priority issue. Further, having recognised the

relationship between child mortality and corruption, the United Nations Children's Fund linked its promotion of child rights to good governance (5).

Undermining the moral vision—and nobility—of the art of healing, corruption is arguably the most serious ethical crisis in medicine today. Thus, understanding corruption, its varied nature and its adverse effects on health outcomes is absolutely necessary for healthcare professionals in the 21st century, not only to steer clear of fraud, but also to devise effective strategies to tackle the menace and safeguard the moral vision of medicine (6, 7).

What is corruption?

Corruption has been defined as “the abuse of public office for private gain” (8). This definition appears to be narrow as it does not cover areas other than “public office.” Transparency International, a global anti-corruption watchdog, defines corruption as “the abuse of entrusted power for private gain” (3). Questions may arise about how terms such as “private” (or “public”) are defined and whether it would be ethically justifiable to abuse entrusted power for *shared collective gain*. Private gain may also be either actual (or immediately available) or potential (to be realised in the future), and financial or even political. It is thus extremely difficult, if not impossible, to provide a definition of corruption which is applicable to all its forms, types and degrees across various cultures to the satisfaction of all stakeholders. In the absence of such an all-inclusive and precise definition, “the abuse of entrusted power for private gain” may serve as a ‘working definition’ as it could cover, in general, most of the unethical and corrupt practices in the health sector.

Corruption is pervasive across cultures and endemic in countries, be they small or large, poor or rich, capitalist or socialist or in the North or South (3). Newspapers generally capture only startling instances of large-scale corruption. Petty corruption, however, has long been a part of, or rather a way of, ‘normal’ life in many parts of the globe. Furthermore, those who take or give bribes in a particular setting (eg an office or the residence of an official) may claim in another setting (e.g. a court) that these were ‘gifts’. Thus, cultural interpretations and legal implications of what is perceived of as corruption may also vary from one context to another.

What are the forms of corruption in healthcare and medicine?

The problem of corruption in healthcare is of a multi-dimensional nature. Corruption may be involved, for example, in construction of health centres/hospitals, purchase of instruments, supply of medicines and goods, overbilling in insurance claims and even appointment of healthcare professionals. Another aspect of the problem is the involvement of multiple parties, e.g. policy-makers, ministers, economists, engineers, contractors, suppliers, and doctors. All this may give rise to innumerable clandestine transactions of a corrupt nature among various stakeholders.

Forms of corruption in healthcare and medicine may include, but not be limited to, the following (1,3,5):

Bribes and kickbacks

Characterised as hallmarks of corruption, bribes and kickbacks can be paid by individuals and firms to (i) procure government contracts, leases or licences for the construction of healthcare facilities, and for the supply of medicines, goods and services, as well as ensure the terms of their contracts; (ii) prefix and 'rig' the bidding process; (iii) manipulate and falsify records, and modify 'evidence' to give the appearance of its being in compliance with the norms of regulatory agencies; (iv) speed up the procedure of permission to carry out legal activities, eg obtaining institutional affiliation, company registration or construction permits; and (v) influence or change legal outcomes so as to avoid punishment for wrong-doing (3,5).

Theft and embezzlement

This may occur as theft of public assets and goods, such as instruments and medicines, by individuals for sale, personal use or use in for-profit private clinics. The theft of government revenues, such as patient registration fees, and the payment of salary to deceased or "ghost" workers are other forms of corruption (3, 5).

Intentional damage to public goods for private gain¹

Public assets and instruments in government hospitals may also be intentionally damaged so as to make them unavailable to patients, with the ultimate aim of ordering the services from private clinics in return for financial incentives or "commission."

Absenteeism

Perceived somewhat less often as a form of corruption, absenteeism (not attending work but claiming salary) in the health sector has been a major concern in some developing countries (5).

Informal payments

In some countries, patients commonly make informal payments to healthcare professionals for better services. The imposition of such a "tax" on "free" healthcare services has a negative impact on access to health services (5).

Use of human subjects for financial gain

Clinical researchers get paid by the biomedical industry for the recruitment of poor and illiterate, ie vulnerable, human subjects for clinical trials (9). Another way in which hospitals and physicians use patients is by charging uninsured patients and patients with other health plans far more than the actual costs involved and what the health insurers pay.

Institutionalised potential corruption

In some for-profit hospitals, physicians have contractual obligations to admit a fixed number of patients to allotted beds and prescribe a number of laboratory investigations (even if unnecessary) to generate revenues.

Whatever the form, corruption has far-reaching consequences on patient care, clinical research and medical education, as outlined in Table 1.

Case studies: windows into how corruption affects health sector

Published reports on the exploitation of human subjects in clinical trials and the scam in the National Rural Health Mission (NRHM) in Uttar Pradesh (UP), India, give us a window into how unethical and corrupt practices can mar clinical research and public health programmes, turning them, quite literally, into "killing fields".

1. Clinical trials

Illiterate persons not to be used for clinical trials (9)

Hyderabad: Reeling under allegations of using poor and illiterate people as guinea pigs for clinical trials [emphasis added], five of the 12 registered clinical research organisations in the state...claimed to have even decided against using illiterate volunteers for trials (emphasis added).

The Times of India, Hyderabad, September 7, 2011

Only 45 of 2868 clinical trial deaths [in India] compensated since 2005 (10)

Business Standard, New Delhi, March 5, 2013

Few would disagree that clinical trials hold the promise of making a positive difference in the lives of people. However, there is no room for such a pleasant illusion in the face of the unethical and corrupt practices in health research. Nearly 2900 people died in India during clinical trials of drugs conducted by various pharmaceutical companies from 2005–12, and compensation was paid in only 45 cases (10). This news came after an earlier news report that victims of the 1984 Bhopal gas tragedy were also enrolled, without their knowledge or consent, in clinical trials sponsored by certain pharmaceutical companies (11). Further, as revealed in 2008, 49 babies had died during clinical trials for new drugs at the All India Institute of Medical Sciences, India's premier medical institution, over a period of two-and-a-half years (12).

Table 1

Primary areas	Specific aspects under primary areas	Types of unethical and corrupt practices	Implications
Patient care	Construction of healthcare facilities	Bribes and kickbacks for procuring contracts, speeding up procedure	High cost, low-quality construction work and facilities that do not fulfil needs, resulting in inequity in access
	Purchase and supply of medicines, goods and services	Bribes, kickbacks to fix winner of bids in advance Unethical marketing and sales of medicines Suppliers not held accountable for failing to deliver	High-cost, sub-standard or inappropriate drugs and goods and equipment Health inequity
	Distribution and use of medicines	Sale of "free" drugs or supplies Theft of drugs/supplies at storage and distribution points_	Undue "tax" on free drugs and supplies Lack of access to essential medicines for poor patients Interruption of or incomplete treatment of patients
	Access to healthcare, admission into hospital	Bribes and informal payments	Lack of access to basic healthcare for poor patients Health inequity
	Monitoring and regulation of quality in products, services	Bribes for approval of registration and quality of drugs Bribes or political considerations influencing results of inspections or suppressing findings	Circulation of counterfeit or fake drugs in market Spread of infectious and communicable diseases Death of patients from improper treatment or inadequate services
Biomedical research	Clinical trials	Recruitment of human subjects for drug research for financial incentives Absence of adequate compensation policy for participants in trials in case of injury or death	Exploitation of "guinea pigs in human form" in unethical trials Death of trial participants without compensation
	Students' research	Bribes or informal payments for "supervising" students' research projects	Fraud and misconduct in research and publication
Medical education*	Admission	Bribes to gain entry into medical education Political influence, nepotism in selection of students	Entry of incompetent healthcare professionals into medicine Loss of faith, cynicism and frustration with an unfair system
	Examination	Bribes to pass qualifying examinations or top merit list	Ethically compromised professionals who perpetuate the vicious cycle of unethical and corrupt practices
	Appointment of physicians and medical teachers	Nepotism, favouritism, political influence in selection of healthcare professionals	

Note:

*The head of the Medical Council of India, removed from his post for allegedly taking bribes to grant permission for the establishment of private medical colleges, was president-elect of the World Medical Association (WMA).

Perhaps this is the price for putting economics before ethics. In 2005, as a policy pursuant to economic liberalisation, the Government of India amended Schedule Y of the Drugs and Cosmetics Act to permit concurrent phase II and phase III trials in India (13). A myriad of factors, such as substantial reduction in time and cost in conducting clinical trials, diverse population, English-speaking healthcare professionals and less stringent regulatory mechanisms, made India one of the most attractive locations of clinical trials. Not surprisingly, there was a substantial growth in the number of clinical trials held in India from 2005. In 2000, the Indian Council of Medical Research (ICMR) had issued ethical guidelines for biomedical research on human subjects (modified in 2006) and the registration of clinical trials was made mandatory by the Drugs Controller General of India (DCGI) in 2009. However, the ICMR guidelines are not legally binding, while the DCGI is understaffed and ill-equipped to monitor and regulate research effectively. Thus, blatant unethical practices, such as providing lucrative financial incentives for the recruitment of human subjects, obtaining “informed-but-not-understood-consent” from poor illiterate “volunteers,” and failing to provide compensation for the death of participants in trials, have become a part of the booming industry of clinical trials in India (14–17).

Part of the threat that the industry of clinical trials poses to India stems from the fact that these trials, conducted mostly by the contract research organisations (CROs) hired by pharmaceutical companies, are essentially commercial ventures in the garb of benevolent medical research. The question arises as to whether the drugs tested in India will actually benefit or be affordable for needy patients. The crisis is further compounded by the dampening “ethical climate” of the Indian institutions that are related to the conduct of clinical drug trials. India ranks 94th in the list of 178 countries in the corruption perception index (18). In a country where corruption is undeniably an all-pervasive part of life, including healthcare and medicine, it is hard to imagine that if at some point, provisions are made for ethical oversight of all clinical research, such oversight will be of the highest standards and that “guinea pigs in human form” will get high-quality care in keeping with ethical standards. Questions thus arise whether it is ethically justifiable to allow the conduct of clinical trials to begin with, in the absence of ethical oversight, effective regulatory mechanisms and an appropriate compensation policy for the participants, especially in countries plagued by corruption.

2. National Rural Health Mission, Uttar Pradesh

Half a dozen babies are born in the clinic daily, but the water tank is broken, so deliveries are performed without running water. The centre has an ambulance, but it, too, is broken. Repairs would cost only about \$30, but there is no cash to pay for it. Crucial medical supplies, like oral rehydration salts for children with diarrhoea, have been out of stock for months. Mr Tiwari [centre’s vaccination officer] said that the money to fuel the generator ran out, leaving workers scrambling to keep vaccines cold (19).

In 2005, India launched a centrally-funded country-wide health programme, the NRHM, in order to revamp rural health. The Government of India allocated the state of Uttar Pradesh (UP), which can rival sub-Saharan Africa in terms of infant mortality and child malnutrition, “the largest sum of money of all states” to improve the abysmal status of its health services (19–22).

What went wrong with the NRHM in this state?

- According to the report of India’s Comptroller and Auditor General (CAG), the UP State Health Mission failed to fulfil its mandate and was responsible for an unaccounted loss of Rs 5754 crore out of the total amount of Rs 8657 crore (20).
- “[I]n the case of NRHM in Uttar Pradesh, it was organised looting of government funds.” (21)
- According to the Central Bureau of Investigation (CBI), “Large-scale bungling took place in the implementation of NRHM. The modus operandi for siphoning off state wealth included overpricing, fake supply of medicines and hospital equipment by fictitious firms as well as huge kickbacks in construction activity to improve health services in government-run primary health centres in rural areas. The CBI also discovered how some persons acted as middlemen between contractors and influential bureaucrats and ministers to supply medicines and equipment under the programme” (20).

How did people suffer when the NRHM was beset by corruption?

Subhadra Chaurasia developed cataract in her right eye four years ago. In the past one year, visibility in her left eye has also faded. If the 75-year-old doesn’t receive medical attention soon, she will go completely blind. She has two sons, both married, who barely make a living from the 2.5 bighas [of land] they own in Raipur village, 10 km away from Lucknow. The yield from this landholding is just enough to save the family from starvation. With no money to buy even basic necessities of everyday life, Subhadra can’t dream of having an eye operation, something that would cost more than Rs 15,000. But if you go by official records, Subhadra has already been operated upon and cured (22).

NGOs, private nursing homes and doctors have siphoned off crores of taxpayers’ money intended for eye operations for the rural poor in the state over the past five years (22).

Tehelka [investigative journalists’ team] visited more than half a dozen villages in and around Lucknow and found that the women, children and men who should have been the beneficiaries of the NRHM funds are living without the most basic health services. The funds meant for them have been siphoned off by the politician–bureaucrat–private contractor nexus (22).

NRHM’s Mothers Protection Scheme, known as Janani Suraksha Yojana, was launched in 2005 to provide conditional cash transfers to pregnant women for facilities like transportation to encourage them to give birth in

health facilities. But civil society organisations find pregnant rural women didn't receive quality maternal health services, especially if they were from lower income groups... (23).

Quality of care in UP is poor, according to non-governmental organisations, and may have worsened due to the corruption (23).

Crores of rupees were thus spent on the construction of non-existent healthcare facilities, and on the acquisition of goods and services which never reached the intended beneficiaries. This scam not only perpetuated ill health and suffering among the rural poor, but also cost six lives. Among the six persons who died are top-ranking medical officers, murdered presumably as part of a cover-up operation to hush up the wrongdoing.

What is fearsome is that it is only the tip of the iceberg which is visible; the bottom of the "iceberg" of corruption is almost untraceable. Sadly, the art of healing has turned into a science of stealing and the conspiracy to cover up has introduced criminality into medicine. What is scandalous is that doctors are not only among the victims of corruption; they are also beneficiaries and perpetrators, together with the others involved in the larger nexus that is threatening to undermine the very foundation of medicine. The question arises as to what physicians and bioethicists should do to tackle the menace of corruption and to answer this, one must be clear on why they should do something in the first place.

Medical corruption: why should physicians and bioethicists care?

There are a number of good reasons why physicians and bioethicists should care about corruption, discuss the problems that corruption creates and perpetuates in healthcare and medicine, explore possible remedial measures to tackle the menace, and take a stand against unethical and corrupt practices in the health sector.

The first is, to put it simply, corruption *kills*. The difference between life and death, good health and suffering is often determined by corruption. Not surprisingly, the poor suffer the most. Three of the UN's eight Millennium Development Goals, which are intended to reduce poverty by half by 2015, relate directly to health: reducing child mortality, improving maternal health, and combating HIV/AIDS, malaria and other diseases.

Corruption in the healthcare system has been revealed as one of the factors responsible for the failure to fulfil these goals by the target date (3). Corruption also exacerbates the harm caused by natural disasters. For example, the death toll in the earthquake in Haiti was directly related to corruption. Buildings certified as earthquake-resistant had not been constructed properly because the system was plagued by corruption and thus, there was a lack of oversight (24). If physicians are really opposed to serving the machinery of death, oiled by corrupt practices in medicine, they need to address the issue, discuss it and take a stand against it.

The second is that corruption fosters ill health and prolongs suffering. On the other hand, good governance (reduced corruption) is associated with better health outcomes. A transnational study found that the quality of governance was positively associated with higher life expectancy, lower mortality rates for children and mothers, and higher levels of subjective feelings of health (25). By taking a stand against corruption and in favour of appropriate anti-corruption measures, healthcare professionals may create opportunities for good governance and consequently, better health outcomes for the population.

Thirdly, corruption undermines the patient's trust in the physician and healthcare delivery system. Trust lies at the core of the doctor-patient relationship in medicine. "Trust is critical to patients' willingness to seek care, reveal sensitive information, submit to treatment, and follow physicians' recommendations." (26). Patients would not like to see a doctor they do not trust and would be loath to accept such a doctor's advice. By taking a stand on corruption, physicians and bioethicists can start rebuilding the trust of patients and the people at large.

The fourth is that corruption destroys the moral vision of medicine. Ethics lies at the heart of medicine—it is difficult to imagine a good but corrupt physician. Few would disagree that medicine sans morality turns this praxis into one of stealing, killing and criminality. Those who have embraced a noble profession like medicine cannot afford the luxury of "doing nothing" when its ethical foundation is being endangered by unethical and corrupt practices (27).

Towards a new beginning: what should physicians and bioethicists do to tackle the menace of corruption?

Corruption in the health sector is not just an issue of development, or a legal issue pertaining to fraud and abuse, but also an issue concerning ethics. As darkness is characterised by lack of light, corruption is characterised by a lack of moral values. Regrettably, the word "corruption" is conspicuous by its near absence in the agenda and vocabulary of academic medicine. At most, mention is made of "professional misconduct." Worse still is the deafening silence of the medical profession when the cause of ethics in medicine is at stake. Furthermore, bioethicists, who are the modern-day custodians of morality in medicine, have little, if any, interest in addressing this "dull" social problem. Unlike esoteric ethical puzzles such as determining the moral status of a part-human part-animal embryo, this problem does not trigger enough hair-splitting debates to satisfy their philosophical minds. The initiation of proactive measures to counter corruption in all its manifestations is long overdue. A number of anti-corruption measures that could provide a starting point are outlined below.

1. Zero tolerance for unethical and corrupt practices in health

Physicians, professional medical associations of diverse disciplines and the bioethics community should discuss

possible anti-corruption measures and implement a *publicly declared policy of zero tolerance for unethical and corrupt practices in the care of patients, clinical research and medical education*. This entails, among other things, taking appropriate measures to counter unnecessary investigations and overbilling, censuring members with questionable integrity, developing mechanisms to handle allegations of misconduct, and promoting transparency and accountability in diverse aspects of medicine.

2. Whole-hearted support for anti-corruption measures

Physicians and bioethicists should support, whole-heartedly and without reservation, the anti-corruption initiatives undertaken by the other sections of society and state, such as civil society, patient rights groups, voluntary health associations, non-governmental organisations (NGOs), the judiciary, and the media. This would help build good governance and a just society.

3. Protection of whistle-blowers

Physicians and bioethicists should provide moral support and legal help to members of their profession or discipline who have dared to expose serious wrong doing in any aspect of healthcare and medicine. This is necessary because whistle-blowers run the risk of facing harassment, if not harm, by vested interests. (27)

4. Legislation

Physicians and bioethicists should play a more proactive role in pressing for the enactment and implementation of legislation and regulations for good governance, transparency and accountability in healthcare and medicine. Anti-corruption laws are frequently breached because of inadequate regulation and monitoring, or the absence of effective penalties. One solution could be to set up an office of ombudsman to deal with corruption (eg *Lokpal*) in every district, province and state capital. The ombudsman should be equipped with adequate resources, infrastructure and real powers.

5. Education

The importance of (continuing) education can hardly be overemphasised. It is hard to believe that all young men and women join medicine only to make money out of people's illness. Education in ethics through the use of positive role models may reinforce moral values. It would help present and future healthcare professionals not only to steer clear of fraud and abuse, but also to create a favourable ethical climate within the profession (27).

Conclusion

It is time to acknowledge that corruption in healthcare entails crimes against humanity. There is no room for complacency—history will not forgive physicians and bioethicists if they fail in their moral duty to safeguard the cause of ethics in medicine when it is necessary.

Note: This author witnessed an incident in which a delegation of doctors were complaining that intentional damage had been done to the only laparoscope in the department of surgery in a

government medical college in India. The laparoscopic surgeon kept the instrument out of order intentionally, and then referred the patients to the nursing home where he had a private practice.

Acknowledgements

This paper is dedicated to Sri Ramakrishna and Sri Sri Thakur Anukulachandra for their teachings against unethical and corrupt practices in medicine.

**Disclaimer:* This author works as Head of the Department of Physiology at the College of Medicine and JNM Hospital, West Bengal University of Health Sciences, India. The views and opinions expressed here are those of the author and do not reflect the view of the College or University or any of its offices.

References

1. Vian T. Review of corruption in the health sector: theory, methods and interventions. *Health Policy Plan*. 2008 Mar;23(2):83–94. doi: 10.1093/heapol/czm048. Epub 2008 Feb 14.
2. Schönhöfer PS. Controlling corruption in order to improve global health. *Int J Risk Saf Med*. 2004;16(3):195–205.
3. Transparency International. *Global Corruption Report* 2006. London: Pluto Press; 2006.
4. Editorial. Corruption in health care costs lives. *Lancet*. 2006 Feb 11;367(9509):447.
5. United Nations Development Programme. Fighting corruption in the health sector – methods, tools and good practices [Internet]. New York: United Nations Development Programme; 2011 Oct 31 [cited 2013 Jul 4]. Available from: http://www.undp.org/content/undp/en/home/librarypage/democratic-governance/anti-corruption/fighting_corruption_in_the_health_sector/
6. Abbasi K. Guiding the moral vision of medicine. *J R Soc Med*. 2012;105(4):139.
7. Chattopadhyay S, Gillon JJ Jr, De Vries R. Where are all the bioethicists when you need them? *J R Soc Med*. 2012;105(4):143–5.
8. World Bank. Helping countries to combat corruption. The role of the World Bank. World Bank; 1997.
9. Anonymous. Illiterate persons not to be used for clinical trials. *Times of India* [Internet]. 2011 Sep 7 [cited 2013 Jun 12]. Available from: http://articles.timesofindia.indiatimes.com/2011-09-07/hyderabad/30122246_1_cros-clinical-trials-axis-clinicals
10. Press Trust of India. Only 45 of 2,868 clinical trial deaths compensated since 2005. *Business Standard.com* [Internet]. 2013 Mar 5 [cited 2013 Jun 13]. Available from: http://www.business-standard.com/article/pti-stories/only-45-of-2-868-clinical-trial-deaths-compensated-since-2005-113030500403_1.html
11. Varma S. Bhopal gas victims now turn guinea pigs. *Times of India* [Internet]. 2011 Feb 24 [cited 2013 Jun 13]. Available from: http://articles.timesofindia.indiatimes.com/2011-02-24/india/28627612_1_gas-victims-bhopal-memorial-hospital-gas-disaster
12. Sinha K. 49 babies die during clinical trials at AIIMS. *Times of India* [Internet]. 2008 Aug 18 [cited 2013 Jun 13]. Available from: http://articles.timesofindia.indiatimes.com/2008-08-18/india/27947426_1_clinical-trials-aiims-administration-foreign-drugs
13. Srinivasan S, Loff B. Medical research in India. *Lancet*. 2006 Jun 17;367(9527):1962–4.
14. Sengupta A. Fatal trials: clinical trials are killing people. *Indian J Med Ethics*. 2009 Jul-Sep;6(3):118–9.
15. Nundy S, Gulhati CM. A new colonialism?—Conducting clinical trials in India. *N Engl J Med*. 2005 Apr 21;352(16):1633–6.
16. Yee A. Regulation failing to keep up with India's trials boom. *Lancet*. 2012 Feb 4;379(9814):397–8.
17. Chattopadhyay S. Guinea pigs in human form: clinical trials in unethical settings. *Lancet*. 2012 May 26;379(9830):e53.
18. Transparency International India. New Delhi: Transparency International India; c2013 [cited 2013 Jul 4]. Available from: <http://www.transparency.org/country#IND>
19. Polgreen L. Health officials at risk as India's graft thrives. *Gainesville.com*

- [Internet]. 2011 Sep 17[cited 2013 Jun 4]. Available from: <http://www.gainesville.com/article/20110917/ZNYT04/109173020>
20. Bhalla A. How they made the NRHM sick. *Tehelka.com* [Internet]. 2012 Mar 17[cited 2013 Jun 4];9(11). Available from: http://archive.tehelka.com/story_main52.asp?filename=Ne170312HOW.asp
 21. Chatterjee P. How free healthcare became mired in corruption and murder in a key Indian state. *BMJ*. 2012 Feb 6;344:e453 doi: 10.1136/bmj.e453
 22. Khetan A. Where did Rs 8,500 cr of UP's health funds go? *Tehelka.com* [Internet]. 2011 Aug 20[cited 2013 Jun 4];8(33). Available from: http://new.tehelka.com/story_main50.asp?filename=Ne200811COVERSTORY.asp
 23. Shukla S. India probes corruption in flagship health programme. *Lancet*. 2012 Feb 25;379(9817):698.
 24. Ambraseys N, Bilham R. Corruption kills. *Nature*. 2011 Jan 13;469(7329):153–5.
 25. Holmberg S, Rothstein B. Dying of corruption. *Health Econ Policy Law*. 2011 Oct;6(4):529–47.
 26. Hall MA, Camacho F, Dugan E, Balkrishnan R. Trust in the medical profession: conceptual and measurement issues. *Health Serv Res*. 2002 Oct;37(5):1419–39.
 27. Campbell AV. Can virtue prevail? Safeguarding integrity in medicine and science *Indian J Med Ethics*. 2013 Jan–Mar;10(1):11–13.

Indian Council of Medical Research: then and now

SUNIL K PANDYA

Department of Neurosurgery, Jaslok Hospital and Research Centre, Dr GV Deshmukh Marg, Mumbai 400 026 INDIA e-mail: shunil3@gmail.com

'O, what a fall was there, my countrymen!'
—*The tragedy of Julius Caesar*,
by William Shakespeare (Act 3, Scene 2)

Successor to the Indian Research Fund Association (IRFA), the Indian Council of Medical Research (ICMR) had Dr CG Pandit as its first director. He set high standards of probity and economy and was scrupulous in all his activities. He ensured ethical conduct in all activities of the council.

The contrast between the reputation of the council in its early days and that today is striking. I have chosen two heads of the council—Dr CG Pandit and Dr NK Ganguly—and have used illustrative examples from their tenures. I have also used an example from 1996, before Dr Ganguly was appointed director-general, to highlight the impotence of the council today when faced with a catastrophic breach of medical ethics.

A noticeable decline from Dr Pandit's standards was noted over the decades following his departure and reached a nadir when Dr NK Ganguly publicly praised Dr P Venugopal for his use of stem cells in the treatment of cardiac disease (1). The recent scandal in which Dr Ganguly has been implicated (2) adds nothing to his stature or that of the council.

Spartan values

Dr CG Pandit remains the gold standard against whom all succeeding heads of the council must be measured. His life and work have been recorded in his own words (3). I strongly recommend this work to all those having the best interests of medical research in India at heart.

Dr Pandit has described in this book the foundation and functions of IRFA and his appointment to IRFA as secretary in 1948 by Dr Jivraj Mehta. When IRFA was replaced by ICMR in 1950, Dr Pandit was appointed as its first director.

Let me provide some examples of his philosophy concerning the council.

A head clerk at the council told me in the 1970s that he had been with the ICMR since its beginning: "I remember the day when Dr Pandit moved into his room. It was spartan in its simplicity. It had a cupboard for his files and books, a table and two simple chairs—one for himself and the other for a visitor. A fan whirred overhead during the summer. . . Now there is wall-to-wall carpeting, air-conditioning, fancy lighting, a number of telephones, an array of other machines and an annexe where the personal assistant awaits summons from the director-general."

As an afterthought, he added: "And there are fancy flowerpots and other decorations."

The clerk also narrated a conversation with Dr Pandit's driver. "As director he was entitled to the use of an Ambassador car. On one occasion he had to attend a meeting with the minister and his secretary in the afternoon. As it progressed he realised that the meeting would go on beyond 5 pm. Excusing himself briefly from the meeting, he came to the driver and told him to return to the ICMR, as he would be delayed. 'What will you do about returning home?' asked the driver. 'Oh, I will manage. I cannot keep you and the car waiting beyond office hours,' he replied as he returned to the meeting."

On page 332 of Dr Pandit's book we learn that while he was at the helm, the yearly expenditure on the headquarters office of the council always remained around 7% of the total grant received by the council. About 4% of the grant was spent on laboratory animals, scientific reports, publications, library and stores, and other such activities; 89% of funds were spent on research and development activities including grants, pay and running expenses of scientific workers.

Critical self-analysis

When Dr Pandit neared the end of his stint at the ICMR, Dr S Sriramachari, additional director-general, suggested that he analyse the activities of the council from 1948 to 1965.