Indian healthcare at crossroads (Part 2): Social and environmental influences

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It is no measure of health to be well adjusted to a profoundly sick society.

—Jiddu Krishnamurti

In Part 1, we noted that the doctor–patient relationship in India has progressively deteriorated over the past few decades.[1] In addition, doctors' status in society has declined to an abysmal low. Doctors no longer evoke respect from the patients and their families, and instead are viewed with suspicion and distrust. They are viewed as greedy people, who are in cahoots with pharmaceutical companies and device manufacturers and are engaged in 'cut practice'.[2] In fact, many doctors have themselves voiced these concerns.[3] This lack of trust frequently manifests as incidents of violence against doctors. Part 2 examines the factors responsible for this change.

MORAL DECLINE AMONG DOCTORS

There is widespread perception among people that doctors have become less honest and more immoral. Although objective data to prove this may be limited, the belief is so prevalent that one may assume that there is truth in it.

The public expects a doctor to be an empathetic, selfless, compassionate and dedicated professional, who should always intuitively (without any tests) arrive at the correct diagnosis and provide a cure without any side-effects and without fail. A doctor should also be willing to provide service for little or no money. Any deviation from this perceived image invites criticism. These expectations are unrealistic. First, a firm diagnosis is not always possible without extensive investigative work-up. Moreover, all diseases cannot be treated. Besides, just because a person has chosen medicine as a vocation, he/she cannot be expected to not have any material needs and put aside desire for either wealth or luxuries of life. Having said that, we must realize that doctors are derived from the same stock of people as the general public, thus the two have similar proportions of greedy people. Despite this, most doctors do try to live up to what is expected of them. However, several changes in society have led to a deleterious shift in the actions of medical professionals.

First, the medical education system has transformed over the past two decades. The opening of a large number of private medical colleges that charge large amounts as fees (of various types) is not conducive to building dedicated and selfless doctors. If someone pays almost ₹3 million (₹30 lakhs) to get admitted to a medical college and nearly ₹1 million (₹10 lakhs) every year as college fees,[4] one or one's parents would seek methods to get quick returns on the 'investment'. Such returns are impossible if one believes in societal service or ethical practice. Hence, many young doctors from such colleges have started looking at medicine from a business standpoint; especially if a person has obtained admission to a medical school despite obtaining minimal marks in the medical entrance test, such as the National Eligibility-cum-Entrance Test (NEET).[5]

Second, in our medical colleges, good role models are disappearing. The degree of decline in role models can be gauged when a previous president of the Medical Council of India, the watchdog that supervises and regulates the quality of medical education and ethics of medical practice, was arrested by the Central Bureau of Investigation in April 2010 while accepting a bribe of ₹20 million (₹2 crores) to grant licence to a medical college in Punjab. Even more importantly, the moral standards of medical teachers, whom the students observe on a daily basis and are expected to follow, have deteriorated; they are no longer the icons that the teachers of yesteryears were. Of course, much of this has to do with the general decline in probity and integrity in society and in deteriorating administrative structures in our medical institutions that reward those who 'suck up' to the powers that be.

Third, the world in general has become more materialistic and mammon enamoured. Over the years, as income levels and prosperity have increased, the disparity in social strata have become more exaggerated. Medical students and young doctors end up comparing their earnings with those of their siblings and peers in school, who decided to pursue other streams—the latter often start earning much earlier and much more. They read stories of how companies vie with each other to offer higher pay packages to trainees passing out of engineering and management institutions. All altruistic intentions are swept away when society judges one's success in monetary terms.

And finally, doctors are falling prey to temptations offered by third parties to cross the line. These are people or organizations who can profit from a doctor's authority to order tests, prescribe drugs or choose medical devices for treatment. The issue of doctors in India preferring branded medicines over generic ones has received much attention. But it is a fact that India has hardly any generic medicines.[6] What we have are multiple brands for each drug—which have been termed by some as 'branded generics'. For example, one website lists 581 brands of rabeprazole in India.[7] If one were to also count various fixed-dose combinations of rabeprazole with other drugs, the total number of brands of this drug in the Indian market would be several folds higher. In this crowded marketplace, each pharmaceutical company wants to sell its brand, and is willing to do anything to make doctors prescribe it. They thus resort to unhealthy practices to influence doctors in ways far beyond the imagination and comprehension of the average doctor. Such interactions corrupt and malign the doctor, while the companies make profit.

OTHER INFLUENCES (THE VULTURES)

As explained in Part 1, the doctor–patient relationship is no longer a relationship between two parties. Today, several external forces influence this relationship and try to gain from it (*see* Fig. 1 on p. 44, *Natl Med J India* 2019;**32:**41–5). The issue of pharmaceutical companies has been alluded to above. Corporate hospitals have transformed the healthcare delivery scenario. Since healthcare affects every living being, the government has decided to regulate it; for the same reason, the medical profession has also become the favourite whipping boy of the media. Several other 'vultures' too earn their livelihood from the doctor–patient relationship. We examine below the role of these parties in the deteriorating doctor–patient relationship.

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DOCTORS' EMPLOYERS

Doctors' employers have a big say in the doctor–patient relationship. Today, doctors work in one of the three settings: (i) in corporate hospitals; (ii) in government-owned or public hospitals; and (iii) as independent practitioners working individually or in small groups. Doctors who run private establishments or nursing homes also often have the mindset of corporate hospitals; whereas charitable hospitals often have a mindset that resembles that of public hospitals.

CORPORATE MEDICINE

Corporate medicine in the private sector emerged in the early 1990s in the form of large corporate hospitals. It has, since then, gained importance *pari passu* with the change in doctors' image in the public eye. In the beginning, corporate involvement in medicine was perceived as a boon—since it brought in hospitals with 5-star facilities, international (read JCI [Joint Commission International]) accreditation and several layers of safety checks. These hospitals were gamechangers in terms of quality of care.

Let us look at the issue a bit more closely. The legal dictionary defines corporate medicine as 'a group of physicians who form a corporation in order to practice medicine, but retain their personal liability to each patient'.[8] Corporations, in turn, are 'financial arrangements for a common goal'. Thus, corporate medicine is a healthcare delivery mechanism with two dimensions: clinical and financial. How these two dimensions are balanced in a particular corporate hospital makes all the difference. Today, corporate hospitals are mostly business ventures that either hire doctors to see patients for a fixed salary, or enter into agreements with doctors to see patients on a profit-sharing basis.[9] Doctors have no say in the hospital's corporate policies but continue to have personal liability to each patient.

When corporate hospitals came in the early 1990s, they hired all the big names in academic medicine, luring revered and legendary professors from apex government medical institutions with hefty salaries. They also attracted Indian doctors in the USA and the UK, who started migrating back. These hospitals were an instant hit with those who could afford them, as they gave luxurious facilities combined with excellent results. They also started inviting medical tourists, which was claimed to be helping the Indian economy! Soon, these corporate hospitals became the benchmark of healthcare and a yardstick to measure other hospitals' performance. The government hospitals desperately tried to emulate their ambience and equipment, albeit with partial success.

With dismal funding for health in India, the government was never serious about upgrading healthcare services in public hospitals.[10,11] The private sector is anyway better, faster and more efficient than state-run monoliths in every sector. Over time, corporate hospitals proliferated, converting healthcare—what was once a vocation—into an 'industry'. Private involvement in healthcare is replete with the risk of excessive medical intervention and iatrogenic harm. Corporate hospitals, just as the pharmaceutical industry, are obsessed more with 'innovation'—an euphemism for marketing newer, costly technology—than with community care using established and inexpensive techniques and drugs.[12]

Let us look at the anatomy of a corporate hospital. Doctors form only 10%–15% of their workforce, with nurses, technicians, secretaries, managers and staff for marketing, finance, housekeeping, security and legal services forming the rest. The hospital administrators often draw salaries that are higher than that of the average doctor working at the same hospital. Where does the money for the infrastructure and salaries for all these people come from? Obviously, from patients! Moreover, who has the honour of taking it out of the patients' pockets? In the patient's eye, however, it is the man in the front line—the doctor—who has taken the money. It is not unusual for a patient to pay a hospital bill of ₹1 million (₹10 lakhs) on discharge, which may include only ₹10 000 as the doctor's fee. However, in the patient's mind, it is the doctor who has charged him ₹1 million (₹10 lakhs)! 'These greedy doctors!'

Corporate philosophy is not in sync with the moral duties of a doctor. It focuses on profits and not on the needs of the community. The hospital management provides bonus and incentives to doctors who earn them larger profits. Every doctor who joins a corporate is asked to take an indemnity insurance of at least ₹5 million (₹50 lakhs), preferably more. In other words, the hospital sends the doctor a message that 'every patient is a potential plaintiff—make sure you don't miss anything! Cover every possibility, it is safer to over-investigate and over-treat'.[13]

A few decades ago, there was a public outcry about poor medical care. Today, the people are crying about 'over-care'.[14] Today everyone is prescribed a host of medicines, when probably none (or a few) are needed. One example is the recent report that many commonly used antidepressants are no better than placebos for a large number of indications.[15,16] This knowledge came to light after millions of prescriptions had already been written. Even in the USA, there is a talk of unnecessary surgeries that may not benefit patients.[17] Unnecessary healthcare is a global phenomenon;[18] however, its implications are harsher for a poorer country such as India.

Since a corporate hospital's degree of success is measured by its balance sheet, it is commonplace for them to prod their doctors to conduct aggressive screening programmes for the diagnosis of breast, lung and colorectal cancers, even though science says that such screening may not improve overall mortality.[19–21] Agreeing to work for a corporate hospital, to me, has an inherent conflict of interest, if one toe's the corporate line.

PUBLIC SECTOR HOSPITALS

Government policies decide how a public sector hospital will use a doctor's services. Health budgets being frugal, public sectors hospitals are mostly poorly funded. Advanced equipment is often not procured, or even when purchased is not maintained well or repaired in time. Despite these problems, bureaucrats expect these hospitals to function as well as the corporate hospitals. The administrators want to please bureaucrats and may not be aware of the requirements of specialized medicine. Being under pressure to produce results, they set unrealistic targets for doctors and force them to work long hours. Many competent doctors find an easy way out; they leave government service and join a corporate hospital.

The primary interest of politicians in the government is to win votes, and in the process, if possible, benefit the public. They realize that new technology in healthcare is expensive,[22] which even rich countries such as the USA cannot afford.[23–25] The bureaucrats also realize that the government lacks adequate resources to provide healthcare. Hence, they promote Ayurveda, Yoga, Unani, Siddha and Homeopathy as alternatives, allowing their practitioners to use modern medicines for which they have no training, while placing curbs on scientific medicine.[26,27] This diminishes the importance of allopathic doctors.[28] The indigenous medicines, meanwhile, remain unregulated even though there is evidence that these too can have adverse reactions.[29,30]

INDEPENDENT PRACTITIONERS AND FAMILY DOCTORS

This breed of doctors is rapidly disappearing. The family doctors usually provide only basic care. Given the current societal preference for specialists, they often end up referring patients to specialists for further investigation and treatment of serious diseases. When a good laboratory or radiology centre offers them incentives for getting tests done and the best corporate hospitals offer them a service fee for referring patients, they find it difficult to refuse.[31,32] They often do not even look at these 'incentives' as 'cuts', which these are. They justify these as innocuous as 'I would have anyway referred the patient to the specialist'! Pharmaceutical industry has already primed them with incentives for prescribing a particular 'brand'. That is how the rot began a few decades ago and the distinction between 'incentive' and 'cut' got blurred.

PHARMACEUTICAL INDUSTRY

The pharmaceutical industry has emerged as a strong player. It fights the government against price control, while funding political parties. As discussed above, each drug is marketed by hundreds of companies in India and each comes with a different brand name. While the real buyer is the public, companies need to convince doctors to prescribe their particular brands and are willing to spend a large amount of money to get this done.[33–35] With no ethical considerations, their actions are 'no holds barred'! Of course, the final fault is that of the doctor, who has taken the Oath of Hippocrates—but the companies are not blameless.

Associations of medical professionals accept large corporate donations from companies that make and sell medicines, milk substitutes, vaccines and even health foods and colas. These payments constitute a conflict of interest, raising a reasonable suspicion that the associations (and their member doctors) will be tempted to put aside their primary interests (such as advocacy for patients and public health) in favour of secondary interests (financial profit of the association or luxurious dinners/vacations for their members). A physician's commitment to patient and public health is a moral duty and not a mere interest.[36] Such financial transactions erode public's trust in physicians.

BATTLE OF TELEVISION RATING POINTS

Competition in news media implies that each news agency needs to find stories to engage its viewers/readers round the clock. Since healthcare affects and interests all, corruption in healthcare industry is a favourite topic. The prima donna of this industry 'the doctor', is painted as the obvious villain for everything going wrong. If children did not get oxygen, the doctor should be hanged. If a dead body is withheld, it is the doctor who is inhuman. If a beloved leader dies of a terminal illness, it is some doctor's fault. If spurious drugs are given to a patient—it is the doctor who is negligent. High charges for stents—the doctor is greedy. A bill of ₹1.6 million (₹16 lakhs) for dengue fever? Doctors should be in jail.

The media does not try to get to the depth of these stories. No one tries to find out where the money goes. It too paints the doctor as the main culprit, eroding the public's trust in doctors. This raises television rating points (TRPs), but leaves a scar on society—which should have an inherent interest in preserving the doctor–patient relationship.

MIDDLEMEN APPLICATIONS

The ongoing revolution in information technology has led to the development of convenient 'computer applications for business'. We have app-based aggregators for taxis. And now, we have a host of similar middlemen 'apps' that bring together a doctor and a patient.[37] These apps charge money from doctors and diagnostic laboratories to promote them to potential patients. They also often charge patients for suggesting a doctor or directing them to a diagnostic laboratory. The principle is that each party pays for 'convenience in business', except that medicine is not really a 'business'. These apps also keep a record of each transaction—breaching the ethical principle of doctor–patient confidentiality. Despite this major flaw, their popularity is increasing. They also allow patients to rate each doctor, based on their experience and outcome. It is possible to game this system. Patients may write negative (perceived as honest) reviews if the doctor does not do what they want him/her to do. A doctor can pay the app owners or some 'patients' for getting positive reviews or removing the negative ones. Ultimately, in the name of convenience, the patients can be directed to doctors who pay to lure patients.

A similar phenomenon operates with interpreters for foreign patients.

CONCLUSION

The worsening of the doctor–patient relationship over time can be attributed to several factors. Among these, the deteriorating moral standards of doctors and rising expectations of patients are well known. Aggressive marketing by and competition between pharmaceutical companies are of concern. The influence of corporate medicine, the role of private medical colleges and inadequate governmental interventions are discussed. Media, middlemen and other factors have also contributed to the growing lack of trust. Having reached the current nadir, is there something we can do to restore the public's faith in medical profession? We will examine this aspect in the final piece in the near future.

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REFERENCES

1 Anand AC. Indian healthcare at crossroads (Part 1): Deteriorating doctor–patient relationship. *Natl Med J India* 2019;**32:**41–5.
2 Berger D. Corruption ruins the doctor–patient relationship in India. *BMJ* 2014;**348:**g3169.
3 Nundy S, Desiraju K, Nagral S, (ed). *Healers or predators? Healthcare corruption in India*. New Delhi:Oxford University Press; 2017:1–692.
4 Nagarajan R. High MBBS fees leaving many doctors in debt trap. *The Times of India* 22 July 2018:1. Available at *www.epaper.timesgroup.com/Olive/ODN/TimesOfIndia/#* (accessed on 2 October 2018).
5 NEET: Zero marks in physics, chemistry could still get you a MBBS seat. Available at *www.indiatoday.in/education-today/news/story/neet-zero-marks-in-physics-chemistry-could-still-get-you-a-mbbs-seat-1287180-2018-07-16* (accessed on 2 October 2018).
6 Bindu SP. No country for generic medicines. *The Hindu.* Available at *www.thehindu.com/news/cities/Delhi/no-country-for-generic-medicines/article 26977692.ece* (accessed on 10 Feb 2019).
7 Rabeprazole price of 582 brands. Available at *www.medindia.net/drug-price/rabeprazole.htm* (accessed on 2 October 2018).
8 What is corporate medicine? Available at *www.thelawdictionary.org/corporate-medicine/* (accessed on 2 October 2018).
9 Anand AC. A primer of private practice in India. *Natl Med J India* 2008;**21:**35–9.
10 India's healthcare in dismal condition: Report. Available at *www.business-standard.com/article/news-ians/india-s-healthcare-in-dismal-condition-report-114092401264_1.html* (accessed on 2 October 2018).
11 Jain D. Budget 2018: India's health sector needs more funds and better management. Available at *www.livemint.com/Politics/drnszDrkbt418WpuQEHfZI/Budget-2018-Indias-health-sector-needs-more-funds-and-bett.html* (accessed on 2 October 2018).
12 Spence D. Medicine's leveson. *BMJ* 2012;**344:**e1671.
13 Vaughan D. The dark side of organisations: Mistakes, misconduct and disaster. *Ann Rev Sociol* 1999;**25:**271–305.
14 Harikatha R. Defensive medicine as a bane to healthcare (Winning essay one). *Asian Stud Med J*. Available at *www.asmj.netFullMiscarticle. aspx?id=8* (accessed on 2 October 2018).
15 Hastings G. Why corporate power is a public health priority. *BMJ* 2012;**345:**e5124.

16 Spence D. Bitter sweets. *BMJ* 2008;**336:**562.
17 Krumholz HM. Cardiac procedures, outcomes, and accountability. *N Engl J Med* 1997;**336:**1522–3.
18 Unnecessary Health Care. Available at *www.en.wikipedia.org/wiki/Unnecessary_health_care* (accessed on 2 October 2018).
19 Spence D. Greed isn't good. *BMJ* 2011;**342:**d524.
20 Woloshin S, Schwartz LM. How a charity oversells mammography. *BMJ* 2012; **345:**e5132.
21 Mayor S. Expert group advises separating risk and benefit information from cancer screening invitations. *BMJ* 2012;**345:**e5322.
22 Anand LC. New medical technology and cost effectiveness. *Med J Armed Forces India* 1996;**52:**181–3.
23 Chin M. 1 in 4 Americans refuse medical care because they can't afford it. Available at *www.nypost.com/2017/06/07/1-in-4-americans-refuse-medical-care-because-they-cant-afford-it/* (accessed on 2 October 2018).
24 Garson Jr A. Half of America skimps to pay for health care. The only fix is to cut waste. Available at *www.usatoday.com/story/opinion/2017/10/23/cut-health-costs-put-doctors-on-salaries-arthur-tim-garson-jr-column/777179001/* (accessed on 2 October 2018).
25 Over 40 million in U.S. can't afford health care: Report. Available at *www.reuters.com/article/us-usa/over-40-million-in-u-s-cant-afford-health-care-report-idUSN0343703420071203?sp=true* (accessed on 2 October 2018).
26 Bhuyan A. 'As of Now the Standards for Licensing Proprietary AYUSH Drugs Are Pretty Lax'. Available at *www.thewire.in/featured/ayush-ministry-interview-ajit-sharan* (accessed on 2 October 2018).
27 Budget allocation of AYUSH ministry hiked by 8%. Available at *www.livemint.com/Politics/tr8SA0OgI7ibU8mPFLOs4J/Budget-allocation-of-AYUSH-ministry-hiked-by-8.html* (accessed on 2 October 2018).
28 Bill Introduced in Lok Sabha Seeks to Allow Ayurveda, Homeopathy Doctors to Practice Allopathy. Available at *www.thewire.in/health/bill-introduced-in-lok-sabha-allowing-ayurveda-homeopathy-doctors-to-practice-allopathy* (accessed on 2 October 2018).
29 Ekor M. The growing use of herbal medicines: Issues relating to adverse reactions and challenges in monitoring safety. *Front Pharmacol* 2014;4:177.
30 Gorski D. Death by "alternative" medicine: Who's to blame? Available at *www.sciencebasedmedicine.org/death-by-alternative-medicine-whos-to-blame/* (accessed on 2 October 2018).
31 Anand AC. Manjunath. *Natl Med J India* 2015;**28:**93–5.
32 Anand AC. Evidence-based or evidence-biased medicine? *Natl Med J India* 2006;**19:**100–3.
33 Anand AC. Professional conferences, unprofessional conduct. *Med J Armed Forces India* 2011;**67:**2–6.
34 Anand AC. The pharmaceutical industry: Our 'silent' partner in the practice of medicine. *Natl Med J India* 2000;**13:**319–21.
35 Anand AC. Using generic drugs in India: Some thoughts. *Natl Med J India* 2017;**30:**287–9.
36 Erde EL. Conflicts of interest in medicine: A philosophical and ethical morphology. In: Speece RG, Shimm DS, Buchanan AE, (ed). *Conflicts of interest in clinical practice and research*. New York:Oxford University Press; 1996:12–41.
37 Anand AC. Medical practice management: An update. *Natl Med J India* 2017;**30:** 163–6.

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