

Editorial

Theorizing Medical Practice for India

Modern scientific medicine originated in the West. Its emphasis on empiricism, experimentation and evidence resulted in an explosion of knowledge, increase in technology and had a major impact on health and disease. Its philosophy, methods and solutions quickly traversed international borders and have been accepted across cultures and countries.

Modern medicine is firmly established in India. Medical schools and tertiary care facilities have wholeheartedly adopted the scientific system; specialists practising out of tertiary hospitals not only advocate the philosophy but also are experts in the field. International medical theory is avidly followed in India, the technology quickly imported and its complex and expensive interventions widely used in the country.

Nevertheless, the success of modern medicine in India is not without its challenges and contradictions. Despite the transformation and the availability of international quality healthcare for the rich, the healthcare scene for the majority of Indians is bleak. Inadequate public health infrastructure, overburdened primary health systems, absence of universal healthcare and the lack of a social security net have resulted in poor health indices, high out-of-pocket expenditure for healthcare and indebtedness for the majority.¹⁻³ While tertiary care and private health facilities are thriving, public health sector, primary medical care and population-based strategies are in a state of decline.

Poor fit

The wholesale and uncritical transfer of knowledge, technology and specialist approaches has not done justice to India. The healthcare industry, with its specialist focus and emphasis on individual-based curative interventions, has a narrow vision of health and disease; it fails to focus on the fact that many causes of disease and illness are produced by social determinants of health.⁴ There are many examples of the absence of a goodness of fit when international specialist medical theory is applied to the Indian context. Some examples are:

The cultures of cholera. Cholera is endemic in India. However, seasonal epidemics are quickly managed using curative treatments, i.e. hydration and antibiotics. Their reporting in the media is often used to beat the government, who deftly transfer the blame to unhygienic practices among the poor. The media soon move on to the next crisis and the provision of clean water and sanitation, essential to the prevention of the disease, are soon forgotten resulting in periodic outbreaks. Diarrhoea, gastroenteritis and typhoid are other examples of water-borne infectious diseases, which present with similar and recurring patterns of transmission and illness in India. Medicine with its curative framework does not fight for public health approaches that prevent infectious disease epidemics.⁵

Malnutrition and crisis of hunger. The nutritional status of India's poor continues to be alarming and confirmed by many indicators such as adult weights, heights, body mass index, percentage of undernourished children, mean birth weights, infant mortality rates, dietary intakes and unconfirmed starvation deaths.^{2,6} A simplistic classification of foods and indices, the search for low-cost diet and an undue focus on calories have resulted in cereal overload, nutritional depletion and the current crisis of hunger.⁶ Children unable to eat the amount of cereals required to even meet the daily calorie requirement, let alone ingesting a healthy balanced diet, end up with childhood under-nutrition. The cereal overload leads to obesity and metabolic syndrome in adults in addition to lowered immunity, making them prone to infections and chronic disease.

Cardiovascular disease. Two different types of epidemics of cardiovascular disease

have been described in India.^{7,8} Ischaemic heart disease (IHD) seems to differ among the rich and the poor in India. Studies have documented much higher rates of smoking and hypertension among slum-dwellers than among urban middle-class residents.⁹ Urban migration, poverty, smoking, higher calorie intake, sedentary work, social stress and increased rates of infection seem to combine to produce IHD in the urban poor. Standard treatments for IHD derived from research conducted by pharmaceutical companies support expensive technological solutions, often out of reach of the poor. While the WHO emphasizes cost-benefit approaches and recommends primary prevention through the early detection of diabetes, hypertension and smoking, it does not question the structure of pharmaceutical-driven scientific research that results in inaccessible treatments, support for the tobacco industry or the effects of development.

Anaemia and category fallacy. The different referral patterns of patients to primary, secondary and tertiary care mean that different types of anaemia present to different settings. Diagnostic algorithms employed in tertiary care are often inappropriate for primary care. Diagnosing anaemia using elaborate schemes is also dependent on sophisticated technology, unavailable in primary care.

Assuming similarities of anaemia across settings is a category fallacy. The socioeconomic-cultural contexts have a major impact on clinical presentations, particularly in primary care compared with specialist settings, which see a much higher proportion of biological-genetic causes and severe disease. Consequently, practice guidelines developed and taught in particular settings will be inappropriate when used in others.

Absence of the post-traumatic stress disorder (PTSD) tsunami. Many international authorities had predicted PTSD after the natural (e.g. 2004 Asian tsunami) and human-made disasters (e.g. Bhopal gas tragedy) in India. While there was much loss of life and chronic physical morbidity, the absence of insurance and social security also meant that most people had to get back to 'normal' life. The PTSD tsunami failed to materialize.¹⁰ While psychiatry in India has bought into the category, it is not a common clinical presentation in practice.

PTSD was created after the Vietnam war, its political context rendered invisible, its criteria loosened and it was moved into the civilian sector. Its usefulness in the American context lies in its reimbursement potential for those who cannot cope with life after traumatic events; they are able to access healthcare, avail insurance, disability benefit and social security. The pathological environment (war) and the political-military-industrial complex are cleared of all responsibility, which is then transferred to individuals, who are considered sick, requiring treatment.¹⁰

The lack of social security and health insurance in India also means the rarity of classical PTSD presentations. The persistence of physical and structural violence against women, lower castes, sexual, ethnic, religious and other minorities also means the persistence of threats. Distress under these circumstances is normal reaction to continued stress.¹⁰

These examples argue that specialist cultures shape our concepts of disease, their explanations and our approach to managing illness; education set in tertiary medical settings will not empower physicians working in primary care and secondary health facilities nor provide the skills to identify common problems and manage them.

The practice-theory gap

It is generally believed that theory drives practice. This is a simplistic interpretation of ground realities. In fact, practice defines theory. The distinction between justice and law is an example. Justice is an agreed concept/value, which is implemented through law. However, laws often fall short of delivering justice and need to be constantly interpreted and rewritten to provide justice.

Similarly, the relief of distress, healing and cure are agreed aims of medicine. They are implemented through different practice guidelines. However, many of these recommendations fall short of the ideal and need to be re-examined and reworked. This is particularly true of using tertiary care standards for the diagnosis and management of common disorders in primary medical care in India.¹¹ There is a need to rework the current international specialist approaches, keeping in mind the reality in India.

Inappropriate setting, unsuitable approaches

Patients attending primary and secondary care settings present with conditions, which are commonly prevalent in the community; they are often different, milder, mixed, sub-syndromal and non-classical presentations. On the other hand, specialist referral pathways

result in severe, complex, chronic and rare disorders presenting to tertiary facilities, i.e. medical colleges. The differences in patient populations and settings result in medical theory that is suited to tertiary care but unsuitable and inappropriate for primary medical care.

Medical education currently situated in medical colleges, uses specialist theoretical framework, perspectives and practice and is unable to produce graduates who can practice independently in primary and secondary care settings. In fact, today's medical graduates are only fit to write entrance examinations for postgraduate courses, having been trained in theoretical knowledge without acquisition of skills and confidence necessary for independent clinical practice. Training in specialist settings with weak inputs from community health, primary care and family medicine departments, compounded by their lower social standing within the medical community, also steers graduates to choose specialist careers rather than vocations working as doctors in smaller, general and rural hospitals.

Situating medical training within tertiary care also translates to step-motherly treatment of primary medical and secondary hospital approaches, which are mandatory, if healthcare is to be delivered to all people. In addition, the archaic examination system, which tests knowledge of rare and severe conditions and exotic and complex presentations commonly seen in tertiary settings, drives student learning; such education makes them less competent, without the necessary skill and lacking in confidence to manage common medical problems in primary and secondary care.

The way forward

Medicine in India needs to theorize medical practice, which is relevant to healthcare needs of the country. It needs to change from its present position of practising medicine based on international tertiary care frameworks. Diluted specialist approaches adapted to primary medical care do not provide a good fit for the reality of general and family practice.

Medicine in India needs to address the felt need of the vast number of generalists who work in primary and secondary care and general medical settings.¹² Unlike standard textbooks that adopt international theoretical frames to medicine, academics, teachers and practitioners should theorize medical practice. They should make a theoretical shift from a 'diagnosis–drug treatment approach', to a broader framework of 'caring for illness', understanding illness in context and taking care of the person who is sick.^{12–14}

They need to emphasize clinical practice and highlight steps that often remain at the subtheoretical level, learnt by trial and error and long years of experience.¹² The hallmark of a good teacher is to be able to explain and accurately describe good/ideal practice suited to the patient's context; they should identify crucial components of medical practice that skilled practitioners find it hard to explain.

However, doctors are constrained by evidence-based medicine, doing only what the evidence allows them to do within specialist theoretical frameworks. There is a need to highlight the fact that practice is far greater than making a criterion-based diagnosis and prescribing evidence-based treatments.¹² There is a need for physicians to exert their full role as doctors, going beyond the evidence and taking care of the sick person. There is a need to open the door of the theoretical frame and encourage doctors to write down their lessons of practice in a way that can be learnt by other students, teachers and practitioners. India needs to theorize its clinical practice.

While many problems beset basic health services in India, the single change in emphasis, which will have a major impact on healthcare and its current culture, is to locate medical education away from tertiary care to primary and secondary care centres. Medical education set in primary and secondary health facilities should be taught by generalists from internal medicine, general surgery, obstetrics and gynaecology, paediatrics, orthopaedics, psychiatry, dermatology, etc. It will provide for a contextual understanding of health and disease for both students and teachers and increase collaboration between primary and secondary physicians and specialists. Relocating medical education will also simultaneously reduce reliance on expensive technology and will consequently reduce the cost of healthcare. It will also focus attention on the need for public health approaches and population interventions, which are currently on the back burner. Producing competent basic doctors will go a long way in improving healthcare delivery in India.

Many medical schools in the West already train their doctors in primary medical care.^{13,14} The power to situate medical education within primary and secondary healthcare departments and facilities is clearly within the control of the medical fraternity in India. Such a change will not have massive financial implications and will make an important

impact on the competence of medical graduates. It will ground doctors in the local context and reality. While it may be difficult to completely shift out of tertiary settings for training physicians, a gradual and phased move to primary and secondary care facilities, already available within medical colleges, is clearly feasible.

Context and local knowledge are critical to understanding illness. Universal abstractions may not fit local reality and may artificially force structures. Healthcare in India should be able to choose a different framework for the management of common problems. Contexts should not only change medical practice but also should be able to change medical perspectives.¹²

Seeing the biopsychosocial world through the 'practice lens' will allow academics and teachers to understand the complex dynamics of health and disease in communities. There is a need to rethink medical practice and for critical reflection on the medical culture in India. The current specialist/tertiary model places an ideological bar on the discussion of alternative approaches. There is an urgency to narrow the practice-theory gap. The medical fraternity in India needs the political will to theorise medical practice rather than practice theory that is contextually not appropriate for the country.

Conflicts of interest. None

REFERENCES

- 1 Jacob KS. Mental health services in low-income and middle-income countries. *Lancet Psychiatry* 2017;4:87-9.
- 2 Naandi Foundation. *The HUNGAMA Survey Report – 2011*. Hyderabad:Naandi Foundation; 2011. Available at www.hungamaforchange.org/HungamaBKDec11LR.pdf (accessed on 15 Mar 2017).
- 3 World Health Organization. Global health expenditure database. Geneva:WHO; 2014. Available at www.apps.who.int/nha/database (accessed on 15 Mar 2017).
- 4 Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva:World Health Organization; 2008. Available at www.apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf (accessed on 25 Mar 2017).
- 5 Tharu S. Medicine and government: Histories in the present. In: Zachariah A, Srivatsan R, Tharu S, on Behalf of the CMC-Anveshi Collective (eds). *Towards a critical medical practice: Reflections on the dilemmas of medical culture today*. New Delhi:Orient Blackswan; 2010:69-92.
- 6 Shatrugna V. The career of hunger: Critical reflections on the history of nutrition science and policy. In: Zachariah A, Srivatsan R, Tharu S, on Behalf of the CMC-Anveshi Collective (eds). *Towards a critical medical practice: Reflections on the dilemmas of medical culture today*. New Delhi:Orient Blackswan; 2010:116-35.
- 7 Zachariah A. Development of cardiovascular epidemic in India and inappropriate tertiary care treatment guidelines. In: Zachariah A, Srivatsan R, Tharu S, on behalf of the CMC-Anveshi Collective (eds). *Towards a critical medical practice: Reflections on the dilemmas of medical culture today*. New Delhi:Orient Blackswan; 2010:187-200.
- 8 Prabhakaran D, Jeemon P, Roy A. Cardiovascular diseases in India: Current epidemiology and future directions. *Circulation* 2016;133:1605-20.
- 9 Ramachandran A, Snehalatha C, Vijay V, King H. Impact of poverty on the prevalence of diabetes and its complications in urban southern India. *Diabet Med* 2002;19:130-5.
- 10 Jacob KS. Post-traumatic stress disorder: Psychiatric management, atonement and justice. *Natl Med J India* 2015; 28:198-200.
- 11 Jacob KS. Reclaiming primary care: Managing depression and anxiety in a different framework. In: Zachariah A, Srivatsan R, Tharu S on behalf of the CMC-Anveshi collective, (eds). *Towards a critical medical practice: Reflections on the dilemmas of medical culture today*. New Delhi:Orient Blackswan; 2010:311-19.
- 12 Jacob KS, Kuruvilla A. *Psychiatric presentations in general practice: A guide to holistic management, 2nd ed*. Boca Raton, FL:CRC Press, Taylor and Francis Group, and Byword Books, New Delhi; 2017.
- 13 General Medical Council. *Tomorrow's doctors: Recommendations on undergraduate medical education*. London:GMC; 2003.
- 14 Pearson DJ, McKinley RK. Why tomorrow's doctors need primary care today. *J R Soc Med* 2010;103:9-13.

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