Speaking for Ourselves

Does the insularity of the medical profession threaten its future in national health?

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'Medical progress must be measured by how we treat the least of our brethren.'

– Abraham Verghese, 2006

'An outstanding characteristic (of medical professionals in India) is their self-centredness, the overriding concern with their own ambitions and frustrations... Their involvement in community affairs is limited.'

– T. N. Madan, 1980

The first of these quotations is extracted from an interview given by the noted physician and commentator, Abraham Verghese, to *The Hindu* in 2006.[1] The second quotation is drawn from a critical analysis of the social roles of medical (specifically allopathic) doctors by one of India's foremost sociologists dating further back into history. Do these words hold true today? In this paper, we draw on findings from recent research to reflect on the power of allopathic medical professionals vis-a-vis health systems and societies, and its significance for their roles in the broader agenda of social welfare. We define elements of their vulnerability, as well as their strengths, and highlight avenues of change and the future choices available to the profession and to policy-makers.

It is a widely held perspective that the allopathic medical profession holds the role of *de facto* leaders in national health. Private healthcare establishments, even in an increasingly corporatized environment, typically draw their clientele through the reputation or charisma of the medical professional at the helm of affairs. Public-sector human resource policies give doctors a central position in administration and the provision of healthcare. Doctors enjoy positions of leadership in government health institutions, from the iconic primary health centre all the way up to state departments of health services. The primacy that they have traditionally been accorded in the health establishment has been widely criticised. In a global context, doctors' power has been characterized variously, most famously in terms of their monopoly over the business of legitimized healthcare and their domination of the production of health knowledge.[2,3] In the Indian context, the quotation above from T. N. Madan's landmark book, *Doctors and society*, is indicative of scholarly opinion on the subject.[4] Madan's commentary refers to the allopathic medical profession at large, but by association also reflects the prevailing academic perspectives on doctors themselves—as powerful as they are, doctors are also a widely criticized, even vilified group. There is little doubt that allopathic doctors are a powerful social group in India today. But what is the nature of this power, and what implications does this have for Verghese's vision of medical progress and a predominantly social function of the profession of medicine?

A research study conducted by us in 5 Indian cities in 2006 and 2007 revealed some of the complexities of doctors' power, through our *in-vivo* analysis of the processes of implementation of public health policy guidelines. We found that doctors in government and private hospitals alike had little interest in following national guidelines on diseases of public health concern, especially where they perceived them to conflict with their own interests.[5] Further, we observed that they were generally able to resist the influence of administrators and regulatory authorities to enforce the guidelines. This power dynamic was manifested at various levels: in individual interactions between practitioners and hospital authorities; at the institutional level as government practitioners and private hospitals contested the authority of public regulators; and also at a political level, with professional associations exercising their power through lobbying and representation.[6] In another recent article, Venkatesan describes how a section of the medical community undertook agitations against the government's affirmative action policies for medical education, with the accompanying observation that only their elite social status could have permitted such defiance of parliamentary and judicial diktat.[7] Possibly the most significant reflection on the power of allopathic doctors is that they exercise their power primarily in attempts to insulate themselves from intrusive influences that they consider to be egregious or inconveniencing. Independence and autonomy (for themselves, not for patients) have become the catchwords of the medical profession in India. Doctors strive equally to resist the attempts of the public health system to enforce norms and guidelines, the government's attempt to control their actions, choices and environments, and the attempts of patients to seek information and redress for grievances.

Conversely, however, doctors are also powerless, in many subtle and insidious ways. When a young doctor emerges from an arduous stint through medical college, in most cases, the struggle has only just begun. Remunerative career pathways in government service are hard to come by, and the private sector, driven by the commerce of medicine, offers little by way of intellectual or ideological sustenance. Some migrate to greener pastures overseas. Of those who remain, the private practitioners are consistently subjugated to the irrational demands of health markets, and the influence of corporate and pharmaceutical interests.[8,9] The widespread irrational use of expensive medicines and investigations, and the frequent impoverishment of patients as a result of healthcare costs point to the distorting influence of commercial interests on healthcare

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practice. Nowhere are the failures of unregulated health markets more apparent than in doctors' collusion in sex determination linked to sex-selective abortions.[10] Government practitioners, on their part, must battle rigid and unresponsive bureaucracies, and poor working conditions. Baru has documented the deep demoralization of government health doctors in an elite tertiary hospital, confronted with a declining institutional base and the rapid growth of competing private institutions.[11] Poor living and working conditions in villages keep doctors from feeling interested in joining rural service, and this contributes to a considerable urban skew in the distribution of medical professionals.[12]

It is critical to note that doctors are generally secluded from the types of influences that would help them to develop their social roles and improve their capacity for the management of diseases of the poor. In our 2006–07 study, we observed that in spite of often possessing important perspectives and convictions that diverged from the nationally sanctioned guidelines, government and private practitioners alike were not able to communicate these ideas effectively or introduce them into mainstream public health discourse—a sign of intellectual disempowerment.[6] Private practitioners with an interest in the care of diseases of public health significance decried the lack of opportunities to develop their skills in these subjects. Plausibly, what allopathic doctors consider their greatest strengths—autonomy and political obduracy—are actually indices of vulnerability. Medical insularity protects their pecuniary interests but simultaneously shields them from the types of influences that would facilitate a transformation in their roles. In particular, their resistance to the influence of public institutions isolates them from, and prevents meaningful engagement with, collective goals of the kind that Verghese would have them serve. Instead, their frustrated contributions to the public good can only be expressed in the limited terms of their participation in flawed healthcare markets and, in the case of most government doctors, the narrow vision of hospital-based care.[6]

The medical profession (for its insularity) and policy-planners (for their reluctance to confront medical power) must be held equally responsible for the widening gap between the profession and their idealized roles as agents of social welfare. As a result of this phenomenon, allopathic doctors are rapidly losing ground to other providers, in their purported role as health leaders. Hamstrung by the unwillingness of allopathic doctors to provide services in rural areas and in primary care, government initiatives are now looking to replace doctors with non-professional cadres of health workers. The informal sector is making deep inroads into neglected primary healthcare markets. Doctors trained in Ayurveda, Yoga, Unani, Siddha and Homoeopathy (AYUSH), who are seemingly less burdened by the need to insulate themselves from change, are increasingly seeking a greater role in government health services and in public health leadership. The most significant avenue for medical professionals to enter the ambit of national health is through contracting arrangements which emphasize financial emoluments rather than shared values and common purpose, possibly a reflection of a wholesale change in the status of allopathic medicine from a profession to a trade.

We argue that the truest locus of a sustainable change in the social role of doctors may be in their interface with public institutions—departments of health, regulators, educators and government health services. It has been contended that many public institutions suffer from corruption and deep inefficiencies; however, this is not an argument to reject them, but to reform them. Worldwide, public institutions have played foundational roles in nurturing and developing collective goals of social welfare. European health systems and recent imaginative Thai and Brazilian experiences have demonstrated that publicly mandated institutional structures can be valuable repositories and propagators of social values and knowledge. The process of reform cannot be quick or simple—national development is a commitment across generations and lifetimes. Nobel laureate Elinor Ostrom wrote that in the context of governance, complexity should not be equated with chaos.[13] The public sector is not one entity; it is important to recognize the diverse strands of functions and organizations it contains, and their interconnectivities, and address development and innovation in each strand independently.

In the context of engaging medical professionals, government health systems must construct and facilitate meaningful career pathways for graduating doctors, focus on building capacity in public health and general practice, insist on continuing medical education norms, and institute binding mechanisms for regulatory control. Empowered community-based and civil society-led frameworks for accountability and local health governance may also have a vital role in forcing medical professionals to confront their social roles and accountability. It cannot be expected that these interactions will be free of conflict. On their part, doctors still have opportunities to reinvigorate their roles as agents of social change. Changes in international laws and macroeconomic transitions, globalization, commoditization and deprofessionalization of medicine are powerful trends. The profession can resist these influences by rationalizing its role, appointing a leadership which emphasizes Verghese's axiom of service to the poorest, and reaching out to participate in broader social and political reform processes. Ongoing initiatives to set up an integrated national health system for Universal Health Coverage offer one such opportunity. Will doctors accede to a role in a unified and regulated health system with shared goals, or will they continue to seek autonomy and, in doing so, relinquish their moral authority as leaders of national health?

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