Correspondence

Private practice in India

I read with interest and dismay the article written by Dr A. C. Anand on private practice in India.[1] The main error made by Dr Anand is to assume that in India there is only one dimension of private practice. His article should have been titled 'Primer of private practice in a large corporate hospital in a metropolitan city in India'. This would have accurately reflected the contents though would not have sounded 'catchy'. Just as one cannot equate various dimensions of medical practice in government service, e.g. a professor at the All India Institute of Medical Sciences, an armed forces specialist or a junior specialist starting in a small district hospital, it is not appropriate to assume all of private practice in India as being under the influences described. As someone who has been in full-time private practice as a gastroenterologist for the past 20 years—and without ever having felt the need to be part of a corporate hospital set-up as described by Dr Anand—I think I should know.

I would like to address just two of the scenarios described by him. The 'restriction' of outpatients works financially only in the set-up described by him. In a city like Visakhapatnam and countless others in India, 80%–90% of all outpatient services for almost all sections of society are delivered by doctors in private clinics. No private practitioner can afford to avoid seeing outpatients during reasonable working hours as they are the ones who form the long term basis of the continuity of his/her practice. Even Dr Anand's composite Dr CS would be applying the same rule at his private clinic.

Referring difficult and complicated cases to government institutions would probably be applicable only in cities such as New Delhi, Chandigarh and Lucknow where suitable centres exist—centres of excellence which are funded and subsidized by the government. In most other regions of India it would be unthinkable for a patient who could afford private medical care to be referred to a government hospital. Most of the time it is the large private hospitals that are obliged to accept critical, complicated or terminal cases from smaller centres.

I can assure Dr Anand that there is more than one path available in private practice. While not all of them will lead to a BMW, it is quite possible to find one that leads to reasonable professional satisfaction—and maybe even a Honda Civic!

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Author's reply

I thank Dr Siva Prasad for his interest in my article. I see no conflict in his opinion and mine, and I agree with him on all counts.

My article is about two contrasting modes of practice; it highlights how different are the considerations for practice in a big corporate hospital as compared with those in a government set-up. I agree that all shades of grey exist between black and white. No attempt was made to focus on all types of private practice. The article is a primer for those who want to switch from government hospital practice to the corporate sector at a senior level. I have no hesitation in admitting that there are many doctors in private practice who are doing a better job of treating patients than many in government hospitals and the article says so as well. It is also equally true that many in government hospitals are providing ideal care despite all limitations.

About restricting outpatients, let me apprise Dr Siva Prasad that the description in the article is the standard teaching in Hospital Administration courses being run in India. I happened to attend one such course by a private (WHO-supported) institute and was equally surprised to learn about this philosophy. All of us (including Dr Siva Prasad) who have trained in government institutes would remember how many patients are transferred to these tertiary care institutes after being kept for 48 hours in a private hospital.

Every doctor in government service retires and moves over to private practice. I am also heading towards that point. Therefore, I am looking carefully all around me at the options available. We all need to find something that gives us a reasonable quality of life and the satisfaction of living by our own principles. I guess there are plenty of options as well as space for everyone.

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Every man has a price?

Marketing is the buzzword these days. Thirty years ago, when I began practice in this city, there were very few private hospitals, nursing homes and laboratories. The few that existed did not feel the need to market their services in the manner it is being done now. Some of us had a small laboratory, an X-ray and ECG machines and these were sufficient for the needs of almost all our patients. The notion that 'more labs, more hospitals, more doctors, more specialists will mean more patients' was unknown to us.

Maybe we lost some patients for want of sophisticated equipment (CT and MRI) and procedures (endoscopy, angioplasty, thrombolysis), but saved many despite not having these. Now it is tough not to do an exercise electrocardiogram or stress test or treadmill test in a young man with indeterminate chest pain or a CT in a person with headache. Added to this is the menace of high-pressure salesmanship. Let me narrate a recent episode.

It was an unusually busy day and the woman must have waited a while before coming in. Smartly attired in a business suit, she said as an opening gambit: 'You have a lot of nice patients.' She must have meant neatly dressed (wealthy?) patients. My reply was a smile. She said she represented a diagnostic service provider and went on to explain the various facilities and services of the many well-known consultants of the city that were available there. Then came the acme of her sales pitch; it was direct and to the point. For every patient sent to them I would get a 15% commission. I had a blank expression. She waited for a minute for a response and seeing that none was forthcoming, she upped it to 20%!

I felt sorry for myself. Despite my best efforts to keep these

executives at bay over so many years, they never take no for an answer and I have this unpleasant job of explaining time and again, why they should not see me. It was now my turn to tell her why I do not take cuts or commissions and thanked her for taking time to come and see me. She looked a bit disappointed but thanked me and went away. As I sat back pondering over this widely spreading malady in the profession, there was a knock on the door and the young woman was back. 'Sir,' she said, 'I just talked to my chief, he has agreed to give 25%, and we cannot go beyond that!'

She must be a firm believer in the dictum, 'Every man has a price.'

My declining even this offer must have made her wonder how and where she went wrong?

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Women physicians in India

Since the 1960s, the number of women entering the medical profession is on the rise in the western world. They account for a larger proportion of medical graduates; 61% in the UK,[1] and 50% in the USA.[2] However, these increasing numbers have not translated into women's advancement in academic and administrative medicine, e.g in the USA nationally, women constitute 15% of tenured medical school faculty, 24% of associate professors, 13% of professors and 8% of medical school chairs.[3] An important reason for this seems to be existent gender roles and sociocultural norms that have put intense demands on the time and efforts of a woman physician to build their family and career concurrently. In other regions of the world, the medical profession remains dominated by men. However, exceptions exist—Mongolia, the Russian Federation, a number of other former Soviet republics and Sudan report more women than men doctors.

Women doctors constitute about 10% of health service providers in Southeast Asia.[4] In India, the medical profession has been held in high esteem as a career for women, apart from the teaching profession. The country has been a pioneer in establishing a medical school exclusively for women, the Lady Hardinge Medical College in New Delhi, about 90 years ago. Interestingly, at the All India Institute of Medical Sciences, New Delhi, one of the leading medical institutions of India, women have formed 20%–22% of the intake in undergraduate and postgraduate medical courses in the past 5 years. They occupy 26% of faculty positions—36.5% are senior and 63.5% are junior faculty, and 8% are heads of departments. In basic and non-clinical sciences, they form a major chunk of the faculty (48%). While 22% of the faculty in the department of medicine are women, they comprise 35%–50% in endocrinology, neurology, haematology, psychiatry and paediatrics. After excluding obstetrics and gynecology (66%) and ophthalmology (32%) from the surgical branches, only 5% are women, whereas anaesthesia has 39%. There are no women faculty in the administration, examination and research sections, forensic medicine, hospital administration, orthopaedics, neurosurgery, nephrology, gastrointestinal surgery, gastroenterology, oncology, oncosurgery and nuclear medicine. In departments headed by women, 49% of the faculty constitute women in contrast to 19% in departments not headed by them.

In the West, attention has shifted to feminization of medicine and its impact on the practice of medicine in future. In India, since the 1990s, after liberalization of the economy, an increasing number of women are taking up male-dominated careers such as the armed forces, engineering, business administration, etc. However, medicine as a career does not attract many women although the number of women faculty remains in consonance with number of women medical graduates and postgraduates. In India, at least at one of the premier institutes, they continue to be in branches which are less demanding in terms of time spent on administrative and emergency duties except for obstetrics and gynaecology.

Policy-makers need to focus on and rectify the reasons for fewer women medical graduates as increase in the medical work force is essential in view of inadequate medical resources vis-à-vis needs.

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Molecular profiling of tumours by immunohistochemistry

This is with reference to the letter from Dr Sanjay A. Pai[1] commenting on our editorial.[2] The role of *p53* mutation has been widely studied in prognostication of colorectal carcinoma. Kahlenberg *et al.* have studied *p53* status in 56 patients with sporadic colorectal cancer, and described *p53* mutation as a significant negative prognostic indicator for overall survival.[3] In a similar study by Caldes *et al*. on 72 patients with colorectal carcinoma, *p53* immunoreactivity in tumour cells was on univariate anlysis found to be a significant postoperative prognostic indicator.[4] In a study by Houbiers *et al*. on *p53* antibody in sera of 255 patients with colorectal carcinoma, a significant association was shown with histological grade, tumour shape, lymphovascular emboli and lymph node metastasis.[5] Erhan *et al*. showed that p53 protein expression correlated with recurrent and/or metastatic cancer.[6] Thus, *p53* has been shown to be a poor prognostic factor in colorectal cancers in a number of studies.

Similarly, the role of targeted therapies such as Rituximab against CD20 protein expressing lymphomas, as well as the use of imatinib mesylate in CD117 protein expressing gastrointestinal stromal tumours are well recognized. We have referred to more than 15 situations where immunohistochemistry contributes in clinical decision-making including the role of signal transduction inhibitors, which includes imatinib mesylate.

Regarding the statement 'practised in the West and is not yet the standard of care in India', it should be understood that due to the ease of use of immunohistochemistry compared with complex molecular techniques, the former technique is most likely to be useful in the Indian situation. Though it is presently not the standard of care in

India, it is most likely to be available in the near future when we take into account the rapid global advances in medicine. The essence of our editorial was to provide an overview of the current global situation and the state-of-art which we should strive to achieve in India.

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Protecting authors?

I welcome your decision to publish the letter on authors' protection.[1] A rejection letter from a journal is often difficult to accept. One might even be angered by comments from experts and get the feeling that they are reluctant to provide a fair review. More charitably, one might feel that they are too wedded to their own beliefs to be able to understand another viewpoint. The history of medicine is replete with instances of manuscripts that have been initially rejected but have later been published to become path-breaking work.

This is particularly true when the work challenges established scientific understanding. In the early 1980s, it was believed that *Helicobacter pylori* (*H. pylori*) was a commensal in the stomach. Challenging this view, Warren and Marshall proposed that peptic ulcer disease was associated with *H. pylori* infection. The communication of these findings was not even accepted for presentation at a conference. However, in 2005, the same research was awarded the Nobel Prize.

A recent survey has identified that incompetent review (61.8%) and bias (50.5%) are common problems experienced by researchers in the peer review process.[3] These can again lead to authors of manuscripts being left with a feeling of their work having been dealt with in an unfair manner.

The peer review process relies on trust between the two parties. Misconduct related to peer review is a difficult area for editors. It is often impossible to prove or disprove misconduct. I suggest that for a fair resolution of problems that may crop up during the process, an independent group of people should evaluate the identified problems and a mechanism be evolved for authors to appeal directly to such a group.

While the process of peer review has pitfalls, in its absence the whole process of scientific publications would have no basis. Indeed, peer reviewers too are not given the credit they deserve. This important contribution deserves to be appreciated and rewarded as no high quality journal could have achieved its stature without the priceless efforts of peer reviewers.

The public trust in science depends upon the honesty and integrity of all those involved in the process of scientific publishing—the authors, reviewers and editors. It is therefore important that better mechanisms are established to enhance the transparency of the process.

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