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"THE CHANGING PROFILE OF THE INDIAN MEDICAL PROFESSION: *THE MISSING SOCIAL SERVICE COMPONENT.*"

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Abstract:

Even in today's commercial world, the public image of the medical man is still intact as a person who saves lives. The many changes in India post economic liberalization of India seem to have had a cumulative effect, have resulted changed the culture among the physicians in India, leading to a scenario with increased costs and reduced access to health care for the majority of the population. Indian Medical education system needs to be reconfigured to increase the emphasis on human values and the present system needs a overall restructuring to avoid impacts resulting due to excessive privatization and commercialization of medical education and caring.

Keywords:, Medical Practice, changed culture, Medical Ethics**.**

Introduction:

Currently the healthcare industry is considered the best career choice for young people world wide.[1] That may, in part, reflect assumptions about the social status of a medical career. In the West, the increase in the percentages recommending medicine, nearly doubling for both men and women since 2001, reflects a growing perception that Medical career is also a practical choice. [1] Even in India, as a recession free career choice, Medicine continues to be a valued career choice.[2] However; the focus is on specialisation and superspecialisation within specialist areas. Thus climbing the ladder of success is said to be more complicated than even before. [2]

Prospective Indian medical students and their parents have realised that specialisation is inevitable for the medical student who seeks to carve a niche for himself in this competitive profession. [2] The doctor is respected by people in all walks of life. [2,3] Even in today's commercial world, the public image of the medical man is still intact as a person who saves lives.

This is many times literally true.[3]

One's knowledge and sincerity does make a huge difference to the life of one's patient, and thus brings in a tremendous satisfaction. [2,3]There are many occasions to rejoice, when patients go home happy and eternally grateful, which for most of us is a huge high. The patient trusts the doctor with his most valuable possession: himself. This is indeed a humbling privilege, not experienced in any other profession. [3]

The changing profile of the medical profession **:** [3,4] Eminent medical educationist, K.S. Jacob from India's pioneering medical research establishment, the Christian Medical College,Vellore has recently commented that the changes in the social and financial climate may have also resulted in major shifts within medicine.[4] He writes that the changed culture within medicine appears pervasive and, in many ways, irreversible and that Medicine in India today looks less of a vocation and more of a business opportunity.This, commercialisation of healing illnesses and infirmities, may represent a global trend, or effect of globalization on the holistic aspects of Indian medical vocation.[4]

The complete absence of regulation and audit in these matters often results in unethical practices. [3,4]Profit before service has become acceptable. Business models and wealth have become increasingly the refurbished lofty standards to judge the success of doctors.[4] Hospital and pharmaceutical industries have increased their influence on the practice of medicine.[3,4] The lack of enforcement of clinical guidelines and standards and the direct conflicts of financial interests often result in unnecessary diagnostic tests and medication and increased costs.

The money transactions often said to be necessary for obtaining the regulatory permissions to start and run courses are transferred by medical colleges to students and doctors. [2-4]The need to recoup the investment makes those who set up such facilities and those who pass out of them look at their institutions and careers through a business lens. Many such practices, unethical and some even illegal, appear to be the norm. [4]

Prevention versus cure**:** Diarrhoea, potentially a killer disease among the vulnerable and often caused by unsafe water and poor sanitation, is commonly treated with antibiotics with no provision to address the root causes. [4,5] Another inglorious example is the well known relationship between tuberculosis and poor housing or chronic malnutrition and inadequate nutrition –all being the celebrated causes of Indian infirmities since ages. Much of the effort of today's champions of public health in India, Dr Jacob laments, ends up in provision of curative services, albeit at the small hospital or clinic.[4] Most physicians succumb to the constant demand for better curative services. Such services thwart public health efforts by treating diseases and preventing death, which should have been prevented in the first place using public health strategies. India has been growing economically at a rapid pace particularly

since the advent of its New Economic Policy of 1991.[5,6] Jacob compares that, presently, prior to before economic liberalisation, employing urgency-driven curative medical solutions, instead of even thinking of long-term public health policies, has become the norm ,as in profiteering economies based on health insurance model .[4-6]Cynics among health professionals would argue that there is less money to be made through public health interventions, and such a similar feeling has pervaded most health insurance model based economies like the United States of America [4,7]

Seeking profit out of distress: The medicalisation of distress[8] and monetization of health services has lowered the threshold for seeking help from physicians even in India. It is noted that about a third of people who visit physicians do not have a demonstrable medical disease[4]. Many visit doctors when they are in distress or are unable to cope with life's incessant demands. [4,5]However, recent advances in technology have made diagnosis and cure attractive and profitable for hospitals and medical practitioners. [4-5]Physicians are taught to focus on underlying structural and functional defects and they often tend to disregard the human context of illnesses. [4-5] Many physicians, with their focus on disease and cure, get irritated with patients who present symptoms with no obvious medical causes as determined by expensive laboratory investigations. They dismiss the patients' concerns and rarely focus on the illness or practise the art of healing. [4-5]

The clinical-technology divide: Clinical assessment forms the real core of Medicine. However, the phenomenal improvement in medical technology, while revolutionising the practice of medicine, has come at a price even in the developed countries. [4-6] The cardinal feature of US health care system has been its reliance on advanced medical technology, in the form of new drugs, procedures, medical devices, medical documentation and diagnostic equipment. [4-7]The demand for innovations that might enhance or prolong life seems insatiable, and vendors pour a steady stream of new products and services into the health care marketplace to meet that demand. Many patients look to new medical technology as the answer to their health care problems; it also is a primary driver of health care cost increases. [4,5] Some people believe that there is always room for new innovation in medical care: others feel that more effort should be devoted to making the current technology accessible to more patients.Improvement in medical technology has also challenged and changed medical traditions. Conservative medical thought and thorough decision making process has been replaced by explorative American style medical examination and decision making.[4-7]Among the patients and public, there is a naive belief that improvements in medical technology will provide answers to every medical problem; that its widespread and indiscriminate use will do away with

the need for clinical judgment. [4-6]The sole reliance on technology has also resulted in a devaluation of clinical skills and the failure of the younger generation of doctors to understand its role in medical diagnosis and management. [4-7]

Technology in certain situations is crucial for diagnosis and management; in others, it can complicate matters. Many diagnostic tests and screening strategies [4-7]are not absolute and when applied in low prevalence situations, produce false positive results leading to further testing or unnecessary medication. For example, the electroencephalogram (EEG) is only an adjunct in the diagnosis of epilepsy, a condition that should be diagnosed based on history and clinical examination in the vast majority of patients. The EEG's moderate diagnostic sensitivity and specificity[4,7] for the condition means that it may record "abnormalities" in normal people when employed indiscriminately and be negative in those with genuine seizures. The inappropriate use of technology will mean costs in terms of not just finances but also psychological stress. The focus on technology to the exclusion of clinical assessment as practiced, for example, in the United States, has resulted in an expensive and grossly iniquitous health care system.[7-9] American health care has always been a bit of mystery to the rest of the developed world. Certain questions have been asked-Just why does the richest country on earth have an immunisation rate worse than Botswana's? [7] Why do 38 other countries have lower infant mortality rates? And why are there 47 million people out of a population of 300 million without medical insurance? [7,9]

Generalist versus specialist approaches: Over the years, the general trend has been to seek specialist advice even for minor illnesses. [9]The absence of a generalist who can act as a gatekeeper means that even simple problems are seen in tertiary care centres and viewed through a specialist's lens. The specialist, with his or her perspective of excluding the rarest of rare conditions in the field, usually ends up over-investigating even the most innocuous of symptoms. [10,11] In addition, the specialists' compartmentalised view of the body often does not allow them to see the big picture and tie up multisystem problems. The lack of confidence in the basic doctor and the absence of family medicine as a speciality compound the problem.[9-11]

In every other developed country, except the United States 50 to 70 percent of the physicians are generalists.[12] In the United States, however, the proportion of generalists (family physicians, general internists, and general pediatricians) has declined from 42 percent in 1965 to less than 30 percent today. [12]What is wrong with a system of medical care dominated by specialists? Specialty care epitomizes the strengths of the U.S. health care system, with its lavish use of the latest diagnostic and therapeutic techniques. [12] That abundance, however, is a major reason health care consumed 14 percent of the gross national product in 1992, when in the other developed countries -- which depend

much less on specialist physicians and their accompanying forms of technology -- costs hovered around 8 percent. [12]

The US approach consumes resources in the health care sector that could perhaps be devoted to jobs, education, and infrastructure; even if these dollars remained in health care, they could be more wisely devoted to primary care, preventive services, and coordinated care for patients with chronic illnesses -- activities that engender both better health and better quality of life. [12] Blind aping of the United States, availability of diagnostic modalities in every city of India due to medical consumerism and overselling of the medical technology benefits seem to be usual culprits along with physician greed to make a fast buck. [13]From within our own establishment, voices of protest can be heard. *Medicine out of Control – the Anatomy of a Malignant Technology* is the title of a book by Dr. Richard Taylor. [13]If anyone wants to know the inside story of the overselling of modern medicine, over-investigation, super-specialists, coronary care units, unnecessary surgery, screening and medical check-ups, the diseasification of pregnancy and childbirth, and the medicalisation of life, here is a veritable source-book containing some thought-provoking information. [13] .

Because of increasingly market-driven economic forces, students and trainees who may enter medicine with idealism and a commitment to public service are increasingly unlikely to enter primary care disciplines. [13]Perhaps more important, the investment capital that drives service and program development in medicine is generally not being used to develop primary or generalist medical services. Instead, as in every market economy, capital is being invested to expand the more lucrative services. [13]

Ward's medical education as an investment: Today Indian medical education is increasingly seen as a secure method of investing in an Indian student's future with propensity to yield sure returns. The system of capitation fees [14]for admission to private colleges has increased the private investment in medical education. Though capitation fee has been banned way back in 2003 by the apex court in India capitation fees till rules medical seat admissions in private colleges.[14]The merchandisation and commercialisation of Indian medical education system is complete and total in the Indian private sector with no room for the poor intelligent student in private elite institutions of India. The trend is just a decades old phenomena but is likely to persist- and may not yield the intellectual dividend for the country's poor at least.[14]

The issue of capitation fee in many of the southern States revolves around certain core issues: the gradual withdrawal of the State from investing in higher education leaving the field wide open to private players; [14]the dynamics of professional admissions which demand that even students with comparatively higher marks have to per se approach private institutions as too few seats are available in

the government pool; [14]the demands of the market place which creates an exaggerated, unsustainable demand for engineering graduates with plum placement offers, and the pathetic state of arts and science education in the State.[15]Not to be missed is the readiness of the students and parents themselves in giving capitation fees, based on the reasoning that today's investment is tomorrow's dividend. [15]

Profit before service and relevance to India:

The global decline of communism, the rise of capitalistic thought[11-14] and economic liberalisation have had a major impact on medicine and health care in India. The 1990s saw a reduction in the emphasis on public expenditure with an increase in private and out-of-pocket expenses for health care. [14]The persistent poor functioning of government health facilities resulted in private hospitals and medical practitioners flourishing.[13,14] Whilst millions of poor Indians suffer from poverty resulting from bankruptcy due to out of pocket payments, the Indian government claims that Medical tourism to India has become a profitable industry and has become a important foreign exchange source. [14] Meanwhile, performance incentives in the Indian private sector essentially imply a commission for ordering tests or prescribing branded medication and medical devices.[14] Contracts and commissions replacing salaries also mean that there is no limit to the incomes of physicians, laboratories and hospitals concerned.[15] This situation is not far removed from American health care scenarios where similar fee-splitting, fee sharing malpractices are reported, even as the United States claims to be the worlds best health care provider to its masses.[10,13] The advent of the profit oriented model in health insurance provision ,without built in safe gaurds will increase cesarians,surgeries and health care costs manipulations false health claims and similar malpractices for financial gain.[14,15] A definite system has to be worked out to safeguard the poor in the health insurance net while visualising efforts to defeat the basis of health care insurance. [16]

In Chile[17] it was noted that Elective caesarean can, however, facilitate the coordination of the doctoral team in charge of the perinatal caring (and maximize their money earning capacity). Women normally stay in hospital for three days after the birth (whether vaginal or caesarean). [17]Patients incur extra costs, however, as a result of surgery, and hospitals can be expected to benefit from these, as well as from the higher bed occupancy rates that result from programming.[17] Thus, Obstetricians do malpractises to increase their income. Conflicting demands arise from complex peripatetic work schedules and the need to provide personalised care for private patients. [17]These are resolved by liberal use of caesarean section, which permits maximum efficiency in use of time. The prevailing business ethos in health care encourages such pragmatism among those doctors who do not have a moral objection to non-medical caesarean section. [16,18]

Constant specialization, narrowing of the scope of work of specialists, the fact that a precise diagnosis cannot be made only on the basis of personal contact, knowledge, and sympathy, have resulted in a relationship between the physician and the patient which in itself expresses relationships between things to a greater extent than between living people. [18,20]The present-day patient, if he is in a more complex and better-equipped institution, in many respects reminds us of production material which travels on the assembly line. [18]"Undress," "Get dressed," and "Go to the laboratory" are repeated mechanically, data are heaped up, and the picture becomes more and more complete, but nobody knows what has brought the patient to hospital, what is troubling him, and even what his name is. [18]Let us add that the economic factors demand efficiency from medical institutions, that is, rational expenditure of time, energy, materials, the greatest possible speed at work. [18]

The way forward: *Need to end commercialisation of health services*:The relationship between the patient and the physician has become quite impersonal even in India.In the changing social climate, it may be necessary to reiterate the need for social commitment from our physicians. [18] There is need to reemphasize community responsibility, to highlight service to the poor and to provide equitable access to health care for all. [16,18] The special social status accorded to physicians in India necessarily mandates a social serve the people, especially the underprivileged and the marginalised. [16]Such social obligation is necessary from not only individuals but also institutions, professional medical societies, regulatory authorities and governments. There is need for social audits and for greater social recognition for those who live, work and serve in disadvantaged areas. [16,18]

Further, we doctors have to realise that the tradition of medicine and medical education in India is as ancient as any of the traditional cultures of the country and has resisted commercialization since ages. The names of those great teachers of medicine, Charaka and Sushrutha[19] are linked with the age when Indian medical thought dominated the then civilized world four thousand years ago.[19]Charaka laid down four essential attributes of a Physician viz., a scientist, as a specialized technician, as a teacher and as a member and leader of the civilized society. Public Health Foundation of India President, Educationist Srinath Reddy opines that Indian Medical education needs to be reconfigured to increase the emphasis on epidemiology; economics, ethics, empathy and engagement with the health system and the present system needs restructuring [20]to avoid impacts resulting due to excessive privatization and commercialization of medical education. Selection to medical schools should also evaluate social consciousness, a record of such service and

a commitment to serve vulnerable sections. [16-20] In selections for higher medical education, greater weight age should be accorded to those who serve in areas of need. The commercialization of medical education and health care needs to be checked, unethical procedures should be curbed and illegal practices rooted out. [16-19]

Enforce Code of medical ethics: The code laid down by the Medical Council of India is a good but greatly neglected document. Despite debates about commercialization and sensational revelations in the press on various allegedly unethical practices by doctors, very little has been done by the medical associations to popularize and enforce this code.[20]

Summary: The many changes in India post economic liberalization of India seem to have had a cumulative effect, have resulted changed the culture among the physicians in India, leading to an American type scenario with increased costs and reduced access to health care for the majority of the population. [18-22]The cost of seeking health care is known to be the single important reason for indebtedness in the country and needs to be addressed urgently. [21] As a profession intimately connected with life and death and with the well-being of individual and collective life, medicine is obliged to maintain its moral premise, to keep its allegiance to ethical values and principles both within and outside the profession, even within a morally challenged set-up. [22]We have an obligation of a moral nature-to ourselves, our children and families, our society, our profession, our country-that needs to be fulfilled for the sake of everything near and dear to us and considered sacred in life. We need to discipline ourselves and prevent excessive commercialization of the medical education and practice sectors. [23,24]Without waiting fruitlessly and endlessly for a change in the deteriorating ethical climate of Indian medicine, conscientious educators need to go ahead and introduce ethics education, taking small steps at a time, because that is just the right thing to do. It is time to take the challenge head-on.

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