

What ails India's two-tiered healthcare system? A philosophical enquiry

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Abstract

India's two-tiered healthcare system (viz the public and private sectors) has been suffering from various ailments, and each sector has been criticised for its own set of deficiencies. Against this backdrop, this article explores whether there is any possible commonality between the two sectors, and suggests that the "common logic", or common ground, is the model of biomedical knowledge, which forms the foundation of both sectors. It is to problems inherent in the "model of biomedical knowledge" that certain gaps in each sector can be traced. It is only when we have identified the lapses at the root of the structures of each sector that we can plug the gaps in healthcare. The author suggests that it would be best to analyse the gaps through a philosophical enquiry, and to offer a probable solution, turns to the methodologies of care ethics and feminist standpoint epistemology.

Introduction

India's two-tiered healthcare system – comprising of a private and a public healthcare sector – has long been criticised for its various deficiencies. The private healthcare sector, which has an overwhelming presence in the urban pockets of the country, accounts for close to 80% of healthcare in India. While the country always had private investors in healthcare¹, the concept of "private healthcare" changed significantly in the wake of the neoliberal market policies of the 1990s. Healthcare is now perceived as an industry where the basic motive of the owners is the same as that driving any other profit-making venture, ie to generate economic surplus to keep the enterprise running, often, at all costs.

The higher concentration of private healthcare ventures in urban and peri-urban areas is explained by the simple fact that such set-ups need to generate economic profit, and are consequently dependent on consumers who are willing and able to pay for it. Since it is the middle and upper classes which are the most compatible with this sector, most private institutions are located in areas populated by these classes: many of the high-end private hospitals emulate boutique hotels with luxury suites, certain private hospitals have their own insurance schemes with facilities for easy instalments, besides add-on services that are offered "free" or at a discount. The growing glamour of the private healthcare sector has led to the formation of a distinct class of patients – the affluent ill, with those outside this ambit constituting the class of the non-affluent or the poor ill.

The poor ill are also marked by their economic buying power, ie the *lack* of it. This allows them to access only the public healthcare sector, in which costs of treatment are subsidised by

the state. However, the standards of care and service in public hospitals are usually abysmal, bearing out the well-known adage that "services for the poor are poor services". In India, the concept of "healthcare as service" has long fallen out of favour, and the state's role in providing basic curative and preventive care diminished significantly between the 1950s and 1990s (1:pp 1–34).

While the two healthcare sectors are distinct in terms of form, modality of disbursing services, and ideology of care, both have been criticised by dissatisfied patient groups, health rights and human rights activists, feminists and bioethicists.

This article sets out to explore whether the two sectors also share something, ie if there is some *larger common framework* which sustains/supports both beyond their apparent differences. This enquiry is deemed important because we need to examine whether it is this commonality which gives rise to some of the problems that besiege healthcare at large in India, manifesting themselves in different ways in each sector.

The article will consider both sectors to discuss their respective political economies in brief, to review the problems of each, and to get an overview of the criticisms they have been subjected to. It will then attempt to reach a philosophical understanding of the larger problem, arguing that such an understanding hinges on the model of knowledge of biomedicine.

Apathy and other deficiencies: healthcare in the public sector

Approximately only 20% of healthcare in India continues to be in the public domain even as it is accessed by more than half the country's population (2). Medical students too are reportedly keener to undergo their undergraduate and residency training in government medical colleges (3) because of the sheer volume and variety of cases from which they can learn. However, when it comes to serving as medical professionals, they mostly view a stint in the rural areas as a punishment and there is a general reluctance towards rural postings (4). It is alleged that many medical professionals would rather pay the fine (imposed by the Medical Council of India) than serve in a rural area (5, 6). It is due to this reluctance that the physician–patient ratio in rural areas is skewed, and the few doctors who do serve their postings get overburdened and overworked, resulting in early burnout (7, 8). It is also alleged that in public healthcare institutions, even basic medical and surgical items, such as essential medicines and sutures are in short supply (9), and have to be purchased by the patient's family.

Also, since these institutions are accessed mostly by poor patients, whose literacy levels are often low, providers commonly display minimum accountability towards them (13), and patients themselves are intimidated by the sheer physical space of a hospital (14). To add to this, many healthcare providers believe that patients who come to public hospitals and receive subsidised treatment are being done a favour by the state (13), and such patients are perceived as learning material; consequently, issues such as respecting privacy, obtaining adequately informed consent, sharing details of the diagnosis and prognosis, and involving the patient in decision-making commonly take a backseat (15–18). These various shortcomings, in combination, besides creating an atmosphere of extreme apathy, have also led to a precipitous fall in the quality of healthcare services in this sector (10–12).

High costs and over-medicalisation: healthcare in the private sector

The private healthcare sector, especially corporate healthcare, does not suffer from the problems listed above. To start with, a private specialty hospital is cleaner and less crowded than a public one, better organised and more patient-friendly. Depending on their purchasing power, patients can avail of facilities such as luxury cabins and even spas and theatres (19). The physician–patient ratio is much more balanced in such institutions, and the delivery of services is not disrupted by a lack of basic resources because each item and service comes only at a price. Abusive behaviour on the part of the hospital staff is less common here, and most patients who access this sector are educated and economically secure. Yet, all this notwithstanding, the private sector has also been subjected to criticism.

A common complaint against private healthcare pertains to the over-medicalisation of patients' bodies (1, 20, 21). Most patients are advised to undergo a battery of pathological tests; while some might be medically indicated, some are prescribed because other than offering treatment, one of the imperatives of this sector is to generate revenue and diagnostic testing is one of the easiest ways to do this (22). The health rights and bioethics movement in India has sought state regulation of the private healthcare sector and demanded that checks be put on the ever-escalating medical costs (23), which reflect the growing trend towards over-treating ailments.

For instance, the number of Caesarean section deliveries performed in private maternity hospitals is very high, though the World Health Organization has suggested that the upper limit for medically indicated Caesarean section deliveries should be 15% (24); but in some maternity hospitals, the numbers cross the 50% mark. Besides, women and their families are allegedly coaxed into opting for cord blood banking, genetic neonatal testing and other tests that require technological intervention, all of which imply high costs.

The possible common ground: biomedical knowledge

The stories of each sector are evidently at odds: while in the public healthcare sector the (poor) patient's body is a site for

generating medical knowledge, honing diagnostic expertise and validating surgical skills, in the private sector the (affluent) patient's body is a site for generating economic profits. A space marked by deficiencies, absences, shortages, rudeness and intimidation is pitted against one marked by abundance, capital, excess of technology, over-treatment and over-intervention.

Knowing that both sectors are afflicted by problems, can we discover any fundamental commonality between them? What is the rationale for the basic functioning of the sectors? The author suggests that the rationale is the knowledge of biomedicine, which is the common constitutive base of modern healthcare. What has given rise to different manifestations of this knowledge – in the form of very distinct-looking healthcare sectors – is the structure of ownership, the protocols for disbursing healthcare services, and the philosophy of patient care. However, underneath these coordinates, each sector is ultimately a biomedical space, governed by the larger logic of biomedicine.

Medicine is commonly perceived of as praxis. It is, however, equally important to understand that medicine is also a *system of knowledge* – and the praxis is based on this knowledge. Knowledge needs to be produced, validated and sustained over time. The production of knowledge implies that there is a “producer”, and that the knowledge is produced of someone/ something. This brings us to the concepts of the “knower” and the “known” – the producer of knowledge is the “knower”, while the “known” is the one from whom knowledge is produced. Of the different models of knowledge, one is the “propositional model”, and this is the model we shall examine since it forms the premise of biomedical knowledge.

Modern biomedicine was born in western Europe in the 17th century. Biomedicine ushered in a set of conceptual shifts in the perception of the human body, and also in the physician–patient relationship. One of the major shifts was the emphasis on the need to *see into* the patient, which has been called the “medical gaze” by philosophers such as Michel Foucault. Today's high-end private healthcare sector seems to have gone into overdrive as far as the urge to *see into* the patient is concerned, with technology playing the role of an able assistant. Modern medicine warranted that diseases are subjected to optical validation² (25: p xv, p 70) – to see the existence of a disease is to believe it. The power and knowledge to see, to know *what* to see, and to diagnose the seen rests with the “active” end of the physician–patient dyad, ie with the *knower* or the physician; and the subject being *seen into* or the *known* plays a passive role by default.

In philosophy, this kind of relational model in which power and authority rests primarily with one end of the dyad in a non-egalitarian way, is known as the “propositional model of knowledge”, and biomedical knowledge is premised on this. In this model, the knower occupies a higher epistemological position and possesses the power of information over the known (26, 27). Thus, it is only the physician who is in a position of power, and who is expected to have greater knowledge of

the patient than the patient her/himself. And irrespective of whether a patient accesses the public or private healthcare sector, the physician remains in a default position of power – the power of knowledge over the patient.

It can be argued that the problems beleaguering the two healthcare sectors are empirical ramifications of the dynamics of the model of knowledge on which biomedical practice is premised. In both sectors, physicians often autonomously decide what should be done to the patient's body – they believe that *only* they know what and how much can be done. They find it easy to dismiss the subjective experience of patients. In both cases, decisions are taken on *behalf* of patients because as per the biomedical model of knowledge, it is *only* the physician who always knows what is in the best interest of the patient, never the patient her/himself.

A caveat

An important caveat is that not all problems plaguing healthcare in India can be traced back to the model of knowledge; ie, not all problems are ramifications of a non-egalitarian, mono-directional physician–patient relationship. Some are the result of certain skewed and misplaced priorities of the state, besides economic and moral corruption. These problems, such as the refusal of private hospitals to admit poor patients, or the refusal of several doctors to serve in rural hospitals, need to be analysed within a different framework³. However, issues such as lack of adherence to the procedures of informed consent, and unilateral decision-making are manifestations of a model in which the balance of power between physician and patient is skewed. This non-egalitarian balance of power afflicts the everyday practice of healthcare across both sectors and severely compromises its ethics.

How do we then go about making healthcare more ethical in both sectors? Assuming that the problem lies in the model of biomedical knowledge, the search for a solution would have to delve into the realm of philosophy. This is because, neither cosmetic changes in an institution's organisational rules and policies, nor systemic changes in its functioning can entirely address a problem which arises from within a knowledge system⁴; while there could be other methodologies to address the problem, this article focuses on care ethics and feminist standpoint epistemology.

Care ethics and feminist standpoint epistemology in healthcare

Care ethics is based on the notion that an individual is an interdependent being, existing in networks of emotion-based virtues such as mercy, care, benevolence, friendship, reconciliation and sensitivity. In this scheme, the idea of the individual is significantly different from that in liberal philosophy where the individual is seen as an autonomous, isolated and independent being. But care ethics is a philosophy of relationality and imagines the individual as determined by the social, economic, relational and cultural coordinates; care ethics stresses the imperative of developing modes of

attachment, the importance of being attentive to the needs and voice of the "other", and the value of maintaining and strengthening the social fabric of relationships.

Another philosophical possibility is offered by feminist standpoint epistemology: a "standpoint" is the perspective from which a person views the world. It is informed by the social, the cultural and the political axes, and, inasmuch as it offers a view from any one location, it remains essentially partial (28). This means that two people from two different vantage points will see a "reality" in different ways. A common example used to illustrate this is of the auditorium: when a play is being staged, two people, seated across the room in two very different positions (say, one in the middle of the front row and the other in the left-most seat of the last row), will perceive the positions of the actors in different ways. Both will believe that their perception is the "only true" version; however, if each were self-reflexive and took into account the other's reality, they would realise that there can be multiple versions of the reality, since reality is a matter of perspective - standpoint.

Feminist standpoint theory questions and dismantles the modernist–positivist position which claims that there is one meta truth and one reality, and, endeavours in its place to develop a theory of knowledge which identifies hitherto marginalised subject positions, ie, "standpoints", as potential starting points for producing knowledge. This "cognitive diversity" is expected to help produce knowledge which will be far more inclusive of existing marginalised and suppressed subject positions and voices.

Feminist standpoint epistemology is not just about envisioning a world from the woman's perspective, but about acknowledging *located-ness* in the world (28:pp 575–9). It is about realising that knowledge is marked by social determinants and about understanding our positions in the present context vis-à-vis the positions of others around us. Feminist standpoint epistemology interrogates the ways in which knowers are enmeshed in social relations that are often hierarchical, besides being historically and culturally contingent.

The philosopher, Sandra Harding, takes the lives of women as the point of departure towards examining the politics of, and redefining the process of production of knowledge (29). In the context of our present concern, however, we could take the standpoint of the patient as our point of departure, and focus on working out a physician–patient relation from the patient's vantage point, from her/his located-ness within healthcare. Feminist standpoint epistemology also helps shift the discursive focus from the interplay of power to the subject, who in this context is the patient. We could thus conceptualise an ethical worldview of caregiving from the standpoint of the patient, something which would represent a paradigm shift from the existing biomedical model with its power-imbalanced relation between the knower and the known.

This takes us closer to formulating the idea of "ethics as care". Bidisha Mukherjee writes: "The feminist scholars are of the

opinion that the concepts of justice, freedom, autonomy and reason are no doubt important for the survival of the species, but they *do not* constitute the foundation of ethics.” (30). Explaining the feminist position on the definition of morals, Mukherjee says, “For the traditional absolutist ethical position, morality is predefined and imposed from outside. The feminist view, however, holds that morality is defined within the parameters of the lived experiences of individuals, and *decisions are made from a given context* ... [This mode] upholds a feminine viewpoint, where an attempt is made to balance reason with a sense of care and concern for members involved in the ethical dilemma. This approach combines reason with emotion and holds that we *should do what is most appropriate within the particular circumstances of the case*. This ethical mode stresses responsibility to people in need; *its central moral principle is care* rather than justice.” (30: p 104, emphasis added)

Re-articulating the “care” in healthcare

Where do we then stand? Standpoint theory offers the possibility of different vantage points and corresponding multiple ways of accessing reality; it offers patients a legitimate chance to perceive, comprehend and interpret their illness and unease on their own terms, and not merely play the passive role of recipients, as they are expected to do within the modernist liberal framework of biomedicine. Care ethics underscores relationality and care rather than autonomy and justice; and by weaving feminist standpoint epistemology and care ethics together, we arrive at a framework in which care-based ethics has the potential to offer a standpoint for the patient.

We proceed to see how the concept of “care” – an integral part of healthcare – gets re-articulated in this frame. The carer-and-cared-for model marks a shift from the knower-known relational frame, since the former is characterised by a higher degree of relational attachment than the latter. The philosopher, Nel Noddings argues that it would not be fair to make a fixed, agenda-based statement on what constitutes “care”. In her book, *Caring* (31), she suggests some modes of relationality between the carer (in this case, the physician) and the cared-for (the patient). Noddings argues that the carer must exhibit engrossment and motivational displacement, while the cared-for must *respond* to the caring. The concept of “engrossment” signifies thinking about someone in order to gain a greater understanding of her/him. Engrossment is a prerequisite for caring because carers need to understand an individual’s personal and physical situation before they can determine the appropriateness of their action. Engrossment is not a fixation on the other, but helps understand the position of the other. However, mere engrossment cannot constitute caring since logically, someone might have a deep understanding of another person, yet could act against that person’s best interest. Instances of this form of misplaced engrossment can be seen in several physician–patient relations wherein the physician believes s/he is acting in the best interest of the patient but ends up causing more harm than good.

Noddings also draws an important distinction between “natural caring” and “ethical caring”: according to her, caring because “I want” (to care) is a form of natural caring, while caring because “I must” (even if I do not want to care) constitutes ethical caring. The “I must” mode urges the carer to assume responsibility. Noddings argues that a person displays ethical caring when s/he acts out of a belief that caring is *the* most appropriate way of relating to the other/patient; however, ethical caring and natural caring are not mutually exclusive, in fact, one usually builds on the other.

The way ahead

We are poised at a juncture where care ethics, with its emphasis on the component of care and relationality, seems to offer a conceptual gateway to re-think healthcare. Applied to the physician–patient relationship, care ethics would urge physicians to perceive of the patient as a social being and not just as an ahistorical, asocial diseased body. Lakshmi Kutty enunciates the ways in which a patient’s subjectivity is overdetermined by the axes of gender, caste, religion, poverty, desires and expectations (14). Using care ethics to define the physician–patient relationship will open up the identity of the patient through these different routes and thus help to acknowledge and appreciate the located-ness of the patient in healthcare.

A shift to care ethics would allow physicians closer understanding of the lived experiences of patients; it would also help them involve patients in medical decision-making to make it a more participatory process where the patient’s specific located-ness is taken into account. Admittedly, the onus does not rest only with the physician, but given the physician’s inherently more powerful position, the responsibility to make a beginning, to initiate dialogue and work towards a more egalitarian distribution of power does, indeed, rest with her/him. Following up on Noddings’ distinction between natural caring and ethical caring, the author concludes that it is the “I must” mode of caring that should constitute the premise of physicians’ relations with their patients. As the cared-for, the patient will also need to respond to the involvement and the objective attachment displayed by the physician, in an active and responsible way. It is realised that incorporating care ethics into the daily, systemic functioning of healthcare institutions in India would be a formidable challenge; however, acknowledging the significance of care ethics would be the first step towards making both the public and private healthcare sectors more responsible, relational and ethical.

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Notes

1. There have been private stakeholders in healthcare in India for close to two centuries now. Individuals such as Jamsetji Jeejeebhoy, Seth Gordhandas Sunderdas, Bomanji Hormusji Wadia and Neville Wadia in 19th-century Bombay, and Rani Swarnamoyee and others in Calcutta were among those who collaborated with the (colonial) state to set up hospitals, who arranged for funds for building medical college hostels, and founded scholarships for medical students.
2. Michel Foucault argues that modern medicine demands objective specificity in interactions and cannot deal with subjective descriptions of illnesses. So while in the days preceding the birth of modern medicine, physicians asked their clients, "What is the matter?", doctors now ask, "Where does it hurt?" (1973: p xxi); the shift has happened from engaging with the holistic state of well-being or ill-being of the patient, to being concerned only with the exact location of the ailment, not with the wholeness of the patient.
3. To explore what this different framework could be is beyond the scope of this article. However, we could briefly consider the following point: an analysis of class might help to understand these other problems and they could be explored in the light of the ideological structure afforded by neoliberal capitalism. The trope of "class" is absent in the Foucauldian scheme, and in the context of healthcare in contemporary India (and similar developing contexts), it could be effectively used to analyse those problems which do not stem from the model of biomedical knowledge.
4. This is not to underestimate the ways in which we have been trying to address the manifestations of certain problems. Efforts to increase the awareness of hospital staff regarding patients' needs, introduce courses in medical humanities and bioethics to sensitise medical professionals, streamline institutional protocols, monitor the behaviour of medical staff, set up active systems for grievance redressal, advocate transparency, ensure the accountability of the private healthcare sector, regulate its costs, etc., are of absolute and urgent importance. However, these efforts besides, this article aims to examine what leads to the problems in the two healthcare sectors and explore how we could work on the "root" of the problem. The article does not intend to create a false binary between the existing modalities of improving healthcare in India and the solution it advocates; rather, it sets out to emphasise the importance of *also* working at the level of knowledge, especially as a long-term measure.

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