A campaign to take on corrupt medical practice

We work in community health, and three members of our group have been running small nursing homes in the rural areas of Nashik district. Nashik is a booming city, 200 km from Mumbai and has the latest medical university of Maharashtra state.

In October last year, we had sent a patient to a leading private hospital in Nashik for emergency care. The patient, Ms Mangala Gangurde, was suffering from pre-eclampsia and hails from a poor tribal family in Dindori block. We sent her to the private hospital since people are generally unwilling to go to government hospitals in emergency situations.

In January this year, we received a cheque of Rs 1,941 from the hospital. After our initial puzzlement, we realised that this was a 'cut' or 'commission'. We deposited the cheque in our bank, issued a cheque in Ms Gangurde's name and gave it to her in front of several villagers including two panchayat samiti members. Then we wrote a letter to the hospital saying this was against medical ethics. We sent statements to local papers in Nashik, on the need to act against such unethical practices and to forge corrective mechanisms (two papers, *Sakal* and *Deshdoot*, have carried the statement) Meanwhile, we also met some doctors in Nashik to see if a group can emerge around the subject.

The realities of medical practice today are very harsh. The government health sector is demoralised and is working in tandem with the private sector. The private sector has given up whatever values it had in the 1970s. It is throwing in cuts and commissions, parties, favours, even cash advances to all and sundry, including quacks and rickshaw-wallas, to achieve its targets. Unnecessary procedures are on the rise and 'cutting work' is the buzzword of today. In a rapid survey of three talukas in Nashik we counted 250 private doctors, three of them MBBS, half with ayurveda, homeopathy and electropathy degrees and half without any. Apart from administering injections and salines for guaranteed incomes, they also get their share of cash from speciality and super-speciality hospitals — cuts of anything from 10 to 40 per cent. The cheque we got was just evidence of this deplorable practice.

We could have lodged a complaint with the medical council, but we hope to spark some internal reform in the medical sector by avoiding legal action. The challenge however is daunting.

Are reforms possible? We can roll back the situation as it exists today and bring everything under a public health system; that public systems are also sick in our country is another problem to reckon with. Given the situation, we think there are some ways for reforms. One is to insist on accreditation of health facilities at all levels. This can be either done through existing regulatory mechanisms (Bombay Nursing Home Regulation Act) or an independent body can take this up even as a profitable venture. For the rating system we need to consider the scientific/technical level of the institute/facility, the ethical and accountability standards, the billing procedures and fee rates.

The second step would be to network with accredited institutes in regional organisations like the health maintenance organisations of the USA, starting from dispensaries to hospitals. With a medical financing component and measures to minimise health risks, such an organisation can be a wholesome answer to our current impasse- high costs and no accountability.

Dr Shyam Ashtekar

On behalf of: Dr Shyam and Ratna Ashtekar, Dr Dhruv Mankad, Dr Arun and Jyoti Gadre, Dr Rajendra and Medha Malose, all from Nashik.

In their letter to the president of the IMA, Nashik, Drs Ratna and Shyam Ashtekar note:

"...The name of the hospital issuing the commission is immaterial and the practice is spreading...We are concerned about this matter and its consequences, such as unnecessary referrals and hospitalisations, procedures for favours; monetary loss to the patient/consumer; tie-ups with practitioners who do unscientific practices, and permanent damage to the doctor-patient relationship.

"... Such 'favors' will definitely hurt all honest practitioners if they do not do something urgently to stop the deterioration... We must not ignore helpless patients who in their hours of ordeal lean on us for life and limb.

"Hospitals like ours in the rural areas have to face several odds and limitations. The sole plank of safety for us is the confidence and faith people have in us. The business of commissions hurts this immunity and the spirit of the medical profession. This is a request to the IMA for urgent action. We feel it is a system-problem, not a problem of hospital A or B."

Suggestions for *IME*

I feel bad that the journal, which is perhaps the only representative of any remnants of ethical core of health care in India, is floundering due to problems with funds.

I have thought about it - with empathy born of having to sustain a bulletin on medical education myself - and feel that there are many reasons for this problem.

Your cover MUST look more appealing; not the same sepulchral black border and depressing images every time. After all, two colours are being used on the cover; why not design it better? Maybe a layout artist can help. With a mix and match of the two foreground colours, plus the background white, the cover can really be made attractive and refreshing every time.

Announce some prizes (more like a citation or a certificate which costs little but means a lot) for the best letter, the best essay on a topic (for medicos?). The winners could be offered a special subscription.

The content need not be depressingly pessimistic. There are doctors and health facilities all over India doing ethical and humane work. Such positive items could be highlighted. For example, *The Hindu* covered a survey of people's beliefs on corrupt professions (I think in 1998); the medical profession was voted the lowest while the law and politicians

scored highest on the corruption scale!

What I mean is there is a need to appreciate that at least half the cup is filled, even while lamenting that the other half is empty.

You do quite a few book reviews. Most of these books find it difficult to get sold. You can try a symbiotic approach: for subscribers of the journal, offer a discounted sale price of the books. It may help all the three parties concerned - the writer to increase sales, the subscriber to get more value for money spent and yourselves in terms of increasing subscriptions.

There is a need to put on the "what is in it for me" cap and plan out an all-win strategy.

This may be a bitter medicine for you, but I think you can allow sponsorship by ethical firms, just displaying their name and logo without any advertising on their products. It is not unethical to do so.

Finally, I have written a book entitled *Trick or Treat*, to be published with the help of the Consumer International-Regional office for Asia Pacific (CI-ROAP), Penang, Malysia. I can submit one chapter per issue of *Issues in Medical Ethics*; there are 52 chapters big and small, and this could go on for a few years as a serial. I can also work out a big discount for your subscribers. This is the least I could do to support your cause.

Dr K R Sethuraman
PGDHE Professor of Medicine,JIPMER, Pondicherry 605 006.

Ethics and AIDS vaccine trials: a response

With regard to Professor Sanjay Mehendale's valuable article on 'Ethical considerations in AIDS vaccine trials' (1), could I make a few critical comments?

In preventive HIV vaccine trials, any participant who gets infected as a consequence of his or her participation in such a trial deserves the best proven HIV/AIDS treatments, and not only whatever is locally available. In my view it simply doesn't make sense to suggest that triple therapy would amount to undue inducement to join such a trial, simply because before these people joined the trial they simply had no need for any treatment. How could providing them with the best proven treatment possibly amount to undue inducement, given that the participant wasn't in need of any medication before he or she joined the trial?

The claim that providing best proven therapy is not financially sustainable is an empirical claim which, as of yet, has not been substantiated. It is being introduced by various people with an interest in cheap access to research subjects. The recently released latest draft of a UNAIDS document ('Ethical Considerations in HIV Preventive Vaccine Research') essentially supports this line of reasoning, but only after conceding that after several years of consultations with treatment access activists and researchers from developing countries, a consensus could not be reached. The UN organisation has taken a regrettable stance on this matter. It allows Western researchers to avoid providing their trial subjects with the best proven therapies in case something goes wrong during the trials they conduct in developing countries.

Udo Schuklenk, PhD
Associate professor, University of the Witwatersrand,Faculty of Health Sciences
Johannesburg, South Africa

Reference:

Mehendale S: Ethical considerations in AIDS vaccine trials. *Issues in Medical Ethics* 2000; 7(4):13-15.

The views expressed in this mail are my own.

Pinch of salt

I have been following, for some years now, with great interest, and some amusement, the beliefs of Kothari et al in their crusade against oncologists. Let me state right now, that I enjoy reading their theories - but take them with the proverbial pinch of salt. I refer specifically in this letter to their response to Mamdani's letter on their article (1).

They state, in this letter, that there is evidence "as recently as 1975" that removal of breast cancer often worsens it. My point: 1975 is a quarter of a century ago. It would not qualify as recent in most biomedical circles, although, on a cosmologic scale, of course, things would be different. Important advances have taken place in most fields, especially genetics and immunology, in the last 25 years.

"All cancer therapy is glorified palliation." An impressive statement, backed by sufficient references, at first glance. A close look, though, reveals that all six references are to books written by the same team of authors — Kothari and Mehta. If this is not biasing evidence, what is? I might add, that none of the references are in peer-reviewed, indexed journals.

The authors make a reference to a "small controlled trial" of one patient in each arm of the study. Surely, you're joking, Drs Kothari, Mehta and Kothari? Statistics of this sort are only made use of by toothpaste and cigarette advertisers, not by responsible doctors.

Sanjay A Pai
Manipal Hospital, Bangalore 560 017.

Reference:

1. Kothari ML, Mehta LA, Kothari VM. Evidence-biased therapy. Letter, *Issues in Medical Ethics* 1999; 7(3):70.

Banned formulations

The government of India has banned certain combinations of medicines as being non-rational and one among them is a fixed-dose combination of dextropropoxyphene with any other drug other than anti-spasmodics and/or non-steroidal anti-inflammatory drugs (NSAIDs).

I came across two formulations being sold under brand names Spasmo-

Proxyvon and Buta-Proxyvon which contain Acetaminophen/Paracetamol which is being termed as an NSAID and my investigation shows that acetaminophen is anti-pyretic and analgesic and not NSAID. Thus, I feel these two brands belong in the banned category of formulations and the medical fraternity should exercise utmost caution prescribing this combination. According to the drugs controller for Karnataka, acetaminophen is basically an anagesic/antipyretic, its anti-inflammatory property is weak and seldom clinically useful and hence it cannot be classifed as an anti-inflammatory drug under the category NSAID.

Further, *Indian Pharmacopoeia 1996*, an authentic reference published by the ministry of health and family welfare, government of India, has classified it as an analgesic, antipyretic, and not as NSAID.

S Ramananda, Bangalore,

Published in *TheTimes of India*,Bangalore, September 1, 1999.

Blood collection in medical practice

Blood collection in medical practice, blood suckers many.
From mammals: Draculas in folklore, vampires or leeches attack at times, even mosquitoes.
There are in reality always medical vampires: students, researchers and doctors from our fellow humans, under the banner of therapy or diagnosis.

Blood letting, known before Hippocrates as removal of harmful humours
Also believed in letting of demons, existed in some countries and communities for the wrong reasons and without benefits.
Medical history has many such stories.

Blood collection for medical practice: each doctor while on service
After a clinical assessment of the patient, recommends blood tests
With or without reason, regularly and repeatedly or at intervals.

Blood collection for evaluation, very often and more, in intensive care wards
And in teaching institutions. The ill effects on patients: anaemia and infection influenced by the duration of hospitalisation.

Multiple pricks for blood collection are made to confirm illness or to make a diagnosis, and to assess the status and progress.
But every now and then through different sites. Is this not an international harm or an avoidable charm?

Blood collection practices need revision in all aspects:
Replacement of old methods, use of multichannel analysers
and small capillary samples.
Refrain from indiscriminate orders
And plan for a collection in appropriate tubes.

Oh, my dear vampires, assess in every case, the cumulative blood loss.
And decide this before an order, never, never routine ones.
Welcome research or thesis works, but all after discussion and rounds.
Blood collection is always more in multispeciality care.
Finalise the order after negotiation with the co-ordinator and take care in flushing lines to overcome blood loss.

Oh, my medical vampires, recall the quantity of blood loss per day
It seems to be litres in hospitals.
Patients lose more but receive less. Is it justifiable or warranted?
Let us be humane and judicious.

P Thirumalai Kolundu Subramanian, Gizan, Saudi Arabia
A Uma, Madurai Medical College, Madurai.

Superlative service

May I join you in giving a very warm send-off to Dr Sunil Pandya who has undisputably rendered a superlative service to the journal, whose evolution from a mere newsletter to a first-class magazine I have been watching with admiration. Let us hope that Dr Sunil will be with us for quite sometime, guiding the journal.

Dr C N Parameswaran,

Aswini Hospital, Thrissur-680020

National workshop on accreditation of private hospitals

The *Journal of the Qualified Private Medical Practitioners' Association*, Kerala, carries a short report of a national workshop organised by WHO, the government of India and the Medical Council of India, to finalise the minimum standards for registration and accreditation of private hospitals in the country.

The need for regulation of hospitals of all types was endorsed by the workshop, though it is necessary to categorise hospitals according to services provided on location, with separate guidelines. Every state shall have an assessment and accreditation council authorised to draw up minimum standards to be adopted by all hospitals in each state; to inspect and recommend to the government regarding accreditation, and draw optional higher standards for grading of hospitals.

Proposals prepared during an earlier workshop were discussed, and the position in each state was described. The Medical Council of India was authorised to nominate a sub-committee of doctors and legal experts to draft rules for the implementation of minimum standards for private hospitals, to be submitted to the central governemnt, which in turn may present this in the form of a bill at the next parliamentary session. The WHO has offered technical and financial assistance to develop packages for information, communication and training, as well as funding some pilot projects.

QPMPA JMS 2000;14 (2): 35, 44-48.