

NATIONAL BIOETHICS CONFERENCE

Ethics, equity and justice: a view from the belly of the beast

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First of all let me begin by saying that I feel deeply honoured and humbled at being asked to deliver this talk at this inaugural plenary of the NBC 2010.

At the same time, I must confess that I'm a bit nervous and embarrassed, as, unlike many of the other speakers; I am not somebody who has studied, researched or taught ethics to be able to give you the kind of scholarly oration that a plenary session deserves.

So when I was invited by the National Organising Committee to give this talk, a question that went through my mind instantly was: what could the reason be for the organisers choosing me to speak today?

When I mulled over this I came up with two possible reasons. The first could be that I have been associated with the Forum for Medical Ethics and the *Indian Journal of Medical Ethics* right from its inception in 1993. So in a sense, the choice could be due to my historical connection with the organisation.

The second reason, which I suspect is more accurate, is that for the last two decades I have worked as a surgeon in the world of curative, specialty medicine in both the public and private sectors in Mumbai, the capital of India's commerce, and perhaps, of market medicine. In that sense, I have been a part of the beast of modern specialty medicine in its extreme form and, therefore, have had the opportunity to get an insider's view from the belly of this beast. Hence the title of today's talk. In the next 20 minutes or so I will attempt to touch upon the following questions:

1. How has the nature of modern medicine been changing in India in recent years, especially in the context of the new economy?
2. How does the medical profession perceive these changes and respond to them?
3. What is the role of governance and state intervention in healthcare?
4. What does the ethics movement need to do to sensitise healthcare providers to issues like justice and equity -- the theme of this meeting?

Given the limitation of time and the complex nature of these questions, I am afraid I may just be able to flag some of the important issues; this may involve some oversimplification and I apologise for it.

How is the practice of medicine changing in India, especially in the new economy?

Modern medicine has seen tremendous scientific and technological advance in the last few decades and this has found its reflection in India. India's access to scientific ideas and technology has vastly improved and a trickle down has benefited disease control and cure in some areas.

On the policy front, the dominant feature of the evolution of healthcare has been the retreat of public health and the rise of private medicine, a phenomenon that is not new but started in the 1970s. In the last decade though, supported by the liberalisation of the political economy, the growth curve of the private sector has massively widened its sweep, scale and form.

Private medicine is not only established as the dominant form of healthcare, it has also acquired respectability and acceptance and has the tacit support of the state. Private health is now patronised by large sections of civil society. In comparison with public health, it is perceived to be of a "higher standard", "efficient" and "patient friendly"; especially by the middle class, but also by significant sections of the poor.

Medical education, until a few decades back entirely in the public sector, has slowly moved into the hands of the private sector, both at the undergraduate and postgraduate levels. Clinical research (that is, if you can call conducting drug trials at the behest of pharmaceutical companies research) has also moved into the private sector. The pharmaceutical and medical equipment industries have grown tremendously; they have a stranglehold over the profession and can manufacture consent to sell their products at will.

All this is well known to most of you who are keen observers of Indian healthcare, but it needs to be underscored.

In my view, the paradigm shift has been in the parameters of the healthcare policy debate which have shifted from the fundamental question of whether India needs marketised medicine to the question of how to regulate marketised medicine. Thus, the basic question of whether a system based on commodification of healthcare can ever be genuinely sensitive to issues like equity and justice is now often not central to the debate. This shift has also influenced discourse within the medical profession and also in the people's health and ethics movement. Equity and justice, it seems, are old

fashioned ideas being drowned out by the new slogans of regulation, standards and evidence-based medicine.

Against this changing scenario, in the last two to three years, we have also had the entry of new kinds of market players, especially international organisations which are creating their own dynamics.

These include corporate hospitals, especially hospital chains, international tie-ups, the medical tourism sector, clinical research organisations and insurance companies, including foreign players.

On the one hand, they have raised the market stakes and on the other, they have brought in ideas like accreditation, standardisation, professionalisation, auditing, cost rationalisation and cost control. These ideas, in isolation, are laudable objectives; but in the heterogeneous and unequal Indian scenario are leading to confusion and newer forms of internecine warfare.

There have been examples galore, in the recent past, of such conflicts flaring up and hitting media headlines. Recently, there has been a bitter and intense struggle between hospitals and the insurance industry over fee structures, with the industry stopping payments to a large number of hospitals. In another, interesting fallout of the same issue, the Association of Medical Consultants, a large body of specialists in Maharashtra, has asked its members to boycott insurance companies as they are insisting on fixing limits on fees.

In another example of such turf wars, plastic surgeons, dermatologists and beauticians have publicly sparred in the media in Mumbai over who should have the prerogative of performing cosmetic procedures and have threatened to take each other to court. With a large number of players vying for what is essentially a limited market space, many such contradictions and internecine conflicts will emerge in the near future.

How does the medical profession perceive these changes and respond to them?

The medical profession has largely embraced the rise of private medicine with enthusiasm and open arms. There is no large-scale opposition to the collapse of public health. The profession is upbeat about the increased opportunities and monetary benefits this has created. Also, the private sector offers a certain freedom from the bureaucracy of state institutions and a feeling of independence. In fact, a new entrepreneurial spirit has swept sections of the profession. Witness how every large metropolis has its own form of the glamour boys of Indian medicine -- cardiac surgeons who have essentially turned medical entrepreneurs and have created huge specialty institutions which are constantly in the public eye.

The opening out of the economy has also increased access to the latest technology, and the equipment industry now competes with the pharmaceutical industry as a major player in shaping medical opinion. There is increased international

collaboration and exposure, which is exciting for a large number of professionals. This has led to the emergence of new areas of specialisation which are driven by a grand alliance of industry, media and sections of the profession. A classic example of this from the field of surgery is the emergence of "obesity" surgery which has manufactured a market based partly on a notion of body image and partly as a quick fix for what is really a lifestyle disease.

Against this background, however, the contradictions and conflicts which I have mentioned before are also leaving healthcare providers confused and insecure.

For example there is growing discontent in civil society about what are perceived as "unethical" practices, manifested in increasing litigation in courts. In a bizarre and perverse manifestation of this anger, there have been an increasing number of direct, violent physical attacks on healthcare workers and institutions. In Mumbai, a leading cardiologist was shot dead by an aggrieved patient's relative a few years ago, and a big hospital in the suburbs was ransacked and burnt down and had to close down. And in another strange fallout of this violent manifestation of the anger of civil society, the Maharashtra state legislature recently passed a bill called the "Violence against Doctors" bill which was hailed by medical associations as a "major victory".

The "no holds barred" market philosophy of the new players in the market is also beginning to suck healthcare workers into its vortex. Healthcare workers are being sacked at short notice, targets are being set and employees in the same organisation are being paid differently based on the returns they get. Doctors working in private institutions can be sacked with a day's notice without any process of enquiry and this makes them extremely insecure.

Some of the new areas of conflict which we are witnessing, which are likely to get sharper in the near future, include turf wars between corporate hospitals, between big corporate hospitals and small hospitals, and between hospitals and nursing homes. At another level, we also witness turf wars between super-speciality medicine and speciality medicine, between specialist practice and general practice (paediatricians versus family physicians) and between allopathic practitioners and alternative systems practitioners

What is the role of governance and state intervention?

As we have noted before, the state in India has retreated from healthcare to the point that it has often become a bystander to a complete free-for-all in the health education and delivery market. Whilst this is in tune with current political thought, which believes that the logic of market medicine will somehow provide healthcare to our people, its implications for the costs, quality and the ethics of healthcare are often not appreciated.

This is especially so, since self regulation by the medical profession, historically regarded as one pillar of control, has largely failed. In many parts of the world, such self regulation

has been in the form of medical councils which are quasi-judicial bodies, and professional associations which act as peer groups. Unfortunately, both these forms have been corroded in India and have therefore lost their credibility in the public eye. It may be pertinent to note that as a result of this inaction and also as a response to media and public anger, we have seen increasing judicial intervention in areas which should have been internally regulated. The Pre Natal Diagnostic Techniques (PNDT) Act and the Human Organs Transplant Act are examples of this intervention.

One area where such intervention has actually made a difference is in curbing, if not eliminating, the patently unethical and socially dangerous practice of sex selection. In the context of the PNDT Act, a combination of activist pressure, state and judicial intervention and implementation has reduced what was once a huge industry perpetuating a socially dangerous practice. What this experience has demonstrated is that if the state is keen and willing to act on a matter of public good, it is capable of doing so.

There are several such areas in healthcare which are waiting for urgent intervention from the state and its arms of governance in the interest of public good, justice and equity. One such area is the issue of the rising costs of healthcare. Although classic market economics dictates that market mechanisms level this out, it has time and again been established that in healthcare, this does not and has not worked in the interest of the community. Even if the state does not desire to strike at the fundamental concept of market medicine what it can, and needs to, do is to look at unfair trade practices bordering on corruption which aggravate the costs of healthcare. For example, the practice of commissions and fee splitting that is rampant in the profession is a concrete area where the state can intervene as this is an illegal activity. It would be fairly accurate to say that today a large majority of referrals from family physicians to specialists, by specialists amongst themselves, and from doctors to diagnostic centres involve some kind of what is euphemistically called a "referral fee" but actually constitutes a kickback. If non-receipted cash transactions in any trade without transparency constitute corruption, this is an area that demands suo moto action from the state's enforcement agencies.

What does the ethics movement need to do to engage with healthcare providers in India?

Finally, I come to what is, perhaps, the most difficult part of my talk, which attempts to address how the ethics movement can engage with healthcare providers to sensitise them to issues like equity and justice.

I think the biggest failure of the ethics movement in this country is the inability to mainstream the ethics debate amongst health professionals. I am afraid that currently those raising the issue of "ethics" are perceived partly as the lunatic fringe and partly as idealists who have a political or moral agenda. All of us in the ethics movement must contemplate whether we are guilty of shying away from consistent

engagement with coprofessionals and organisations of healthcare workers. As I wrote in a recent editorial in the *IJME* on the Ketan Desai and Medical Council of India affair:

Individuals like Desai can survive and thrive only due to a certain permissiveness and complicity on the part of their constituency, subordinates and peers. The Indian medical establishment and the profession (which includes all of us) have therefore to take part of the blame for Desai being allowed to run amok all these years. In the case of the Medical Council of India, one can argue that he could have bulldozed or bought people; but what about organisations like the Indian Medical Association, whose national president he was for three years? As a large, democratically-run body of professionals from the entire country, how did it accept Desai as its president when it was common knowledge that he had a tainted past? It is also a reflection of a certain tolerance that we, as a society, have developed towards corruption as an issue. It is also a reflection of a certain ambivalence that many medical professionals have towards mainstream medical associations and their activities, with the result that they are prone to easy capture by vested interests. Many senior professionals who have the capacity and credibility to take on such elements have chosen to remain silent or to work outside the sphere of mainstream organisations. The very basis for the formation of the Forum for Medical Ethics Society which runs this journal was an attempt to contest the Maharashtra Medical Council elections in 1993 on the platform of "ethical practice". However, many of those who rallied around during that effort have moved away out of despair, and buried themselves in professional work, in academic writing or in nongovernmental organisations.

So all of us who see ourselves as part of a broad, loose coalition, of a network promoting the idea of ethics in its broadest sense, have a tough job on hand in the current Indian healthcare scenario.

On the one hand, we need to constantly flag the fact that the root cause of unethical medicine in India is the monster of market medicine which has been allowed to go berserk and that any serious attempt to change things will necessarily have to bring public medicine back on the agenda. In a sense, by focusing on issues like equity and justice, this NBC is reclaiming a basic issue.

On the other hand, we need to support and strengthen attempts at regulation, for this will get us allies, and for this we will need to work with the state as well as with professional agencies.

And finally, while doing so, we need to create a critical mass of supporters amongst healthcare providers including medical professionals who are willing to join hands with us.

The average medical professional is going through a strange kind of duality. On the one hand, there are the exciting commercial and technological possibilities and opportunities created by the new economy, as well as the growth in the science of modern medicine. On the other, is the increasing hostility and scrutiny of civil society and the fact that the

profession is accountable to and controlled by the new market forces, on whom it is now dependent.

This, in my view, creates an opportunity for the ethics movement in India to engage with the profession on a few new platforms. One is the reassertion of the historically independent ethos of the medical profession, which feels intimidated by the juggernaut of market medicine, with the hope of forging more sustained ties with some of them. The other of participating in the process of restoring its credibility in the public eye by working on a joint programme which respects the rights of patients as well as of health professionals. The time may be ripe for opening a dialogue with professional bodies on these premises, and a beginning has been made by our friends in

the People's Health Movement in Maharashtra with the Indian Medical Association.

I would like to end my presentation on a personal note by sharing a dilemma. I have often wondered whether individuals like me are, by being in the belly of the beast, contributing to the growth of the beast in its present form. Perhaps some of you in the audience may be able to identify with this sentiment when I say that this results in an almost schizophrenic existence. But then as I said earlier in the context of the Medical Council of India scam, the need for alternative viewpoints within the profession today is greater than ever before.

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Ethics, equity and genocide

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With its declaration that social injustice is killing people on a grand scale, the World Health Organization, through its report of the Commission on Social Determinants of Health, has brought the issue of equity and health right to the centre of the stage. How do its prescriptions fare when examined against the backdrop of the Indian situation?

India is one of the most inequitable societies on earth, and certainly when its size is taken into consideration, we are responsible for a sizeable proportion of the sum total of human misery on this planet. As health professionals, we have access to data that goes beyond the Dandekars and Tendulkars and Arjun Senguptas, and which we can read off the bodies of our study subjects. We have become inured to the knowledge that, in India, 47% of our children under the age of five are malnourished by weight-for-age criteria. In the last six years, more children have died, across the world, of malnutrition-related causes than the total number of adults who died in the six years of the Second World War. But let that pass. The next datum that I will place before you is this: 26% of our newborn babies are low birth weight for gestational age. Please remember that this 26% is not randomly distributed across the population, but occurs far more commonly in specific communities, obeying the pressures of inequity and social injustice. And then project Barker's hypothesis - no longer just a hypothesis, alas - onto their future trajectories. See if it helps you sleep at night.

Coming now to the adults, childhood malnutrition is a complex pathophysiological entity, in which the lack of food is only one among a complex of factors. Adult malnutrition is simpler - it means you didn't get enough to eat. The National Nutrition

Monitoring Bureau tells us that 37% of adult males and 39% of adult females in India have a body mass index of less than 18.5, signifying chronic undernutrition. If we disaggregate these figures, we find that this includes 50% of scheduled tribes, and over 60% of scheduled castes. More than 40% of the adult population of Orissa is also below 18.5. The population of Maharashtra, which is considered to be a relatively "developed" state with a high per capita gross national product, has 33% below 18.5. Now the WHO categorises these proportions and says that any community with more than 40% of its population below 18.5 should be regarded as a community in a critical state - amounting to famine.

So now we have a population of which significant and identifiable subsets live in a state of chronic famine from year to year - what I call walking through time with famine by your side. As if this weren't enough, Utsa Patnaik, one of our senior economists, says that from 1993 to 2004, the per capita yearly grain consumption has declined from 178 kg to 156 kg-- that is by 22 kg. Since this is a mean figure, and richer people have actually increased their consumption, the decline at the lower end of the scale is even greater.

So, now we have an ongoing famine, and it's getting worse over time. But, as my friend the Bengali poet Gazi M Ansar puts it, "Here, twilight descends over a vast hinterland, like a tiger's paw: the mullahs' houses are stuffed with grain. The famine is only in our neighbourhood." It is precisely this "neighbourhood", these sections of the population, that are being targeted by the State, which stands guarantor under the doctrine of eminent domain, in a countrywide process of expropriation of natural resources and primary accumulation, including, in the words of eminent