

COMMENT

# Making medical care and research rational and affordable.

**SUNIL K PANDYA****Abstract**

*Expenditure on insurance, consultations, the multitude of tests ordered by the doctor, and very expensive drugs make the treatment of illness a great burden. Should the patient need admission to a hospital and, worse, an intensive care unit, the load becomes almost unbearable. Medical research has moved from the domain of the single keen observer to that of highly qualified experts working in laboratories containing costly equipment. The budget for these projects now runs into lakhs or crores of rupees.*

*This essay questions current practices and suggests the need for a return to simplicity without any compromise on efficacy. Placing the patient at the centre of our attention and focusing on affording the best of care at least expense will result in the elimination of unnecessary tests, the use of rational, generic drugs and greater harmony between patients and their medical attendants. It will also help restore dignity to the patient and his family. They can hope for the return of health without a descent into poverty and debt.*

**Introduction**

The escalating cost of medical care, unaccompanied by a corresponding increase in its efficacy, has become a subject of universal concern. In some instances, the efficacy of medical care decreases in inverse proportion to the rise in costs. An obvious example is the rise in the number of tests demanded by doctors and the lack of relevance of the findings of these tests to the care of the patient.

It is especially important for us to try to reach the ideal in cost-effective medical care as we have one-third of the world's poorest citizens. The plight of the sick in villages is, indeed, pitiable. Steps are necessary to ameliorate their predicament.

In private hospitals, the need to show increasing profits conflicts with the aims of humane and effective medical care.

The increasing use of medical insurance, rules devised by insurance companies, development of third party agencies that decide on whether or not insurance claims are genuine, and pressures on doctors and hospitals to maximise their incomes

can lead to irrational practices and escalating costs. Keeping the patient in hospital for a minimum of twenty-four hours in order to validate his claim for reimbursement by the insurance company is an example. A patient who could have been sent home now occupies a bed merely to satisfy the requirements of the insurance company.

Medical research was earlier based on careful observation at the bedside. The progress of disease was recorded, leading to our understanding of the natural history of disease. The effects of a drug were similarly observed and recorded. A fine example is the work of Dr. William Withering on the use of the foxglove in the treatment of dropsy following poor function of the heart (1). The product derived from the study by this 18<sup>th</sup> century country doctor – digitalis – remains an important drug. Current medical research is much more complex, involving as it does detailed analyses and the use of expensive equipment and tests. Costs have rocketed as a consequence. There is need to ensure that expenses are kept to a minimum whilst safety and efficacy are maintained.

This essay attempts an analysis of some deleterious trends and suggests curative steps.

**Definition**

*Webster's New World College Dictionary* defines "cost-effective" as "producing good results for the amount of money spent; efficient or economical" (2). When applied to the care of patients, the definition must also include the satisfaction of the patient and family with the measures adopted.

**Reduction of costs*****Clinical examination of the patient and tests ordered by the doctor******Listening and talking to the patient***

When the priority is seeing increasing numbers of patients in order to maximise income, the first casualty is the time spent with each patient. Most patients leave the doctor's consulting room with feelings such as, "The doctor never told me what I need to know. I could not ask him important questions and clear my doubts." If the doctor were to be questioned, his answer would be simple: "I have to see so many patients. I cannot afford to spare more than a few minutes for each patient."

Worse, the doctor attempts to compensate for his failure to obtain a detailed history and perform a careful examination

Author: **Jaslok Hospital and Research Centre**, Dr GV Deshmukh Marg, Mumbai 400 026 INDIA - Sunil K Pandya (shunil3@gmail.com), Department of Neurosurgery.

To cite; Pandya SK. Making medical care and research rational and affordable. *Indian J Med Ethics*. 2015 Apr-Jun;12(2): 97-103.

© *Indian Journal of Medical Ethics*

by obtaining information through a battery of tests, many of them expensive. In doing so, the doctor violates the hallowed principles of clinical medicine laid down by the great masters. Here are two examples.

- Listen to your patient, he is telling you the diagnosis. – Sir William Osler, Regius Professor of Medicine, Oxford University (3)
- If you have 10 minutes to spend with a patient, spend nine on the history. – Dr Robert J Joynt (4), editor of *Archives of Neurology, Seminars in Neurology*, co-author of *Baker and Joynt's Clinical Neurology*, and founder of the department of neurology at the University of Rochester Medical Center)

Clinical assessment of the patient, when performed well, can help avoid unnecessary and expensive tests, with benefit to the patient. It also helps in building the basis for a good doctor-patient relationship.

Using expensive laboratory or imaging tests in preference to the use of clinical acumen in making a diagnosis has become all too evident. Attempts to understand the natural history of the patient's illness are giving way to rapid-fire investigations and gunshot therapy. In part, the use of expensive tests may also be gaining prominence because of the "incentives" offered by laboratories and scan centres. A portion of the fees paid by the patient to the centre is passed on to the clinician. This unethical conduct is camouflaged by the use of terms such as "fees for clinical assessment" or "provision of clinical details". Such sugarcoating appears to assuage the conscience of many colleagues.

### **Tests ordered**

Clinical diagnosis must precede tests. Such a diagnosis is arrived at on the basis of the patient's history and the clinical findings. It is possible that this provisional conclusion may be overturned by the results of the relevant tests.

The test results must:

- a) confirm the diagnosis or shift the focus to another diagnosis
- b) help the clinician to establish the gravity of the illness
- c) form the basis for the treatment or for a change in the treatment when the methods used thus far have failed to help
- d) be used to assess the impact of the treatment and the need for long-term care.

Caution: Do not become "test-happy and technologically-powered". In the words of C. Yeh, "I am afraid that as a result, we may be training a new generation of practitioners to equate high-quality care with conducting a test. Instead of the test being used to discover new information about the patient, it is being used to define if one is even a patient" (5).

Jha points out another danger: "The diagnostic culture of *rule out* is kryptonite to clinical acumen" (6). Ruling out begets more ruling out, more tests and more uncertainty. Here is

an example. The X-ray film shows a patch in the lung of a patient clinically suspected of having pneumonia. Hypothesis: This could be masking a tumour. Perform a CT scan. CT scan: "Doubtful abnormality along the arch of the aorta. Could this be an aneurysm? Perform an MRI scan." MRI scan: "The aortic arch is merely atherosclerotic and unfolded. However, there is a suspicion of haemorrhage in the left adrenal..."

Beware also of the tendency to order tests merely because they are available.

Jha notes that students used to be praised by their teachers when they arrived at a diagnosis. Today, they are lauded for thinking of the atypical instead of the obvious and commonplace illnesses (6).

Tests that do not affect the diagnosis, therapy or prognosis are not worth carrying out.

Tests carried out merely to protect the clinician from medico-legal suits need careful consideration. Maintenance of medical records that clearly show the care bestowed on the patient and clinical findings at each stage of the illness often make such tests unnecessary. Inclusion in the patient's case records of the discussion of the pros and cons of particular tests (coronary artery angiography is an example) and why they were not done will show the care and concern of the clinician for the welfare of the patient.

### **Health insurance**

A variety of health insurance policies are now available in India. The prudent will use one of them for each member of the family. The small investment, a part of which can be used to reduce income tax, will pay huge dividends in the unfortunate event of an illness.

When obtaining an insurance policy, it is incumbent on the applicant to be scrupulously honest, especially regarding illnesses that have been treated in the past and those for which he/she is under treatment. One of the commonest causes of conflict between the policy-holders/beneficiaries and insurance companies is the latter's claim that an honest disclosure was not made in the application.

Greed on the part of doctors, human ingenuity and the desire to be one up on insurance companies often result in the inflation of hospital bills by means of unnecessary tests; the prescription of expensive drugs, the use of which cannot be justified; exorbitant charges; and needlessly prolonged stays in the expensive intensive care unit and in the hospital in general. Such practices are unethical. The increased costs result in increased premiums.

### **Care of the poor patient in the village**

Current deficiencies in the provision of health care to those living and toiling in villages have left them at a severe disadvantage. Poorly functioning primary health care centres make it difficult for them to obtain medical advice and treatment in their neighbourhood. Left to the mercies of ill-

trained, poorly equipped self-proclaimed healers, their ailments worsen and they are compelled to seek treatment in towns and cities at desperate stages of their diseases.

Travel from their villages to urban medical centres entails enormous costs and a total disruption of their lives and work.

Many have cried themselves hoarse at the great need for well-staffed and equipped primary and secondary health care centres to cater to these patients. Till this need is met, the poor sick in rural areas will continue to bear their additional burden of illness under hopeless circumstances.

## Care of the patient in the hospital

### *Intensive care units*

There must be clear guidelines on who can be admitted to the intensive care unit and on when the patient must be shifted out of the unit.

Here are two examples of questionable admissions.

- a) Patients with advanced cancer, widespread metastatic disease and a hopelessly poor prognosis are admitted to the intensive care unit either to tide over an immediate crisis (such as pneumonia and drop in blood pressure), or because the patient is very rich or politically powerful. Even after the crisis is over, they are retained in the intensive care unit for days or even weeks.
- b) It is not uncommon to find patients in persistent vegetative states or severely handicapped patients who are clinically stable in intensive care units. Such patients are often retained in the intensive care unit for long periods on a variety of pretexts. An oft-used argument by doctors is the pressure exerted on them by the patient's family to ensure that the patient is retained in the intensive care unit. Similar pressures are also used to keep the patient in the hospital when care at home might be in the better interest of the patient. The motives of the family may vary from avoidance of taking responsibility for patients, even in their terminal stages, to the demonstration to their peers that they are doing their best and sparing no expenses. The wise physician will spend time discussing these issues with the family. Such discussions, may on more than one occasion, go a long way in resolving conflicts in the minds of relatives.

Such misuse of intensive care unit beds has two harmful consequences. First, life-saving beds are blocked to the detriment of those who need them. Second, the expenses incurred by patients unnecessarily retained in intensive care units continue to rise.

### *The use of antibiotics – the best of the latest syndrome*

Another area to which we must pay careful attention is the use of antibiotics.

It is imperative for the treating physician to justify the use of such a drug on each occasion. The prescription of an antibiotic is unscientific when the illness is of viral origin. Further, microorganisms develop resistance to the antibiotic as a

result of this practice, to say nothing of the added expenditure involved. There is wisdom in the wisecrack, "In 80% of ailments, cure follows in seven days if an antibiotic is used and a week if it is not used."

The urge to bring the patient's temperature into the normal range prompts the use of the latest antibiotic. This antibiotic is likely to be the most expensive drug in the market. It is also intended for the treatment of infection by organisms resistant to the commonly used antibiotics. As the fever persists, this antibiotic is jettisoned and substituted by another "very powerful" antibiotic. Such rapid change of antibiotics is certain to generate resistance to new drugs in microorganisms.

The rational use of antibiotics, based on proven sensitivity of the causal organism in the laboratory, is often ignored on the ground that the patient is in a critical state and the infection must be controlled at once. Were this so, it would make sense to use an antibiotic to which most of the common pathogens encountered in that intensive care unit over the past week have been shown to be vulnerable. Unfortunately, few intensive care units regularly keep themselves up to date with this important information.

### *Purchase of equipment, drugs and consumables*

We have several chains of private hospitals. The success of the first hospital in the chain – judged by the income generated – prompts the promoter to set up another hospital. Further success follows and in a few years, hospitals are set up in other cities.

The establishment of the chain of hospitals necessitates the purchase of several computerised tomography and magnetic resonance units, cardiac catheter units, radio-isotope scanners, sonography units, heart-lung machines, dialysis units, monitors, operation theatre lights, operation theatre and laboratory microscopes, endoscopy and other instruments.

These hospitals also make recurrent purchases of a large number of expensive items, such as stents, heart valves, arterial and venous catheters, drugs and intravenous fluids.

The chain sets up a centralised purchase agency, wholly owned by the promoter. Given the massive bargaining power of such an agency, it obtains significant discounts on all purchases. It then sells the purchased goods with a mark-up to each of the hospitals. The hospitals, in turn, add their margin of profit when billing the patient. The consequent increase in the promoter's income is considerable.

Patients wishing to purchase expensive drugs and other items from the manufacturer or retailer in the open market are often denied this opportunity to cut their costs. Generic drugs are frowned upon.

The purchase of expensive machines results in an escalation of the costs incurred by the patient in other ways. The clinician who demands a particular machine is under pressure to generate revenues from the use of that machine so as to recover the cost and make a profit. There is evidence of such

pressure leading to the illogical use of machines. The use of a gamma knife machine to treat cancer with multiple metastases is an example.

Some institutions, such as the Sanjay Gandhi Postgraduate Institute in Lucknow, have implemented measures to reduce the costs that patients have to bear. The institute obtains drugs and other consumables at a considerable discount on the maximum retail price (MRP) (7). The discount can be as high as 60%. The institute adds 5% of the cost to the discounted purchase price to cover its service charges and passes on the rest of the discount to the patient. This results in a saving of anywhere between 30% and 55% of the MRP. This and similar measures need to be implemented in all our hospitals.

### **Waste**

Given the extent of poverty in our country, it appears illogical to exclusively use disposable items. Almost all our hospitals have forgotten the age-old practices of cleaning certain instruments and articles after each use, and sterilising and re-using them. This used to be done in the case of glass syringes, metal needles, latex gloves, endotracheal tubes and even arterial catheters for angiography, with proven efficacy and without complications.

The twin principles of convenience and reduction in labour have overthrown the consideration of thrift and cost-saving for the patient. In the process, we generate huge volumes of waste, which is not always dealt with scientifically. Willy-nilly, there are unscrupulous individuals and groups who bring many "disposable" items into re-use, without bothering about cleaning and sterilisation. This is to the detriment of patients.

Paperless and filmless facilities must be used extensively. Computer terminals in all operation theatres, intensive care units, wards and outpatient services display, on command, the complete case record of a given patient, the laboratory and imaging findings, drugs being prescribed and other relevant data. Inter-departmental and administrative correspondence, notices, announcements and memoranda are transmitted similarly. The savings from these measures are considerable.

Another example of waste is the manner in which medical conferences are organised. In the past, medical colleges were the preferred venues for these conferences and provided rich fare for the intellect. Whilst gastric needs were not ignored, they were accorded second place. Inexpensive and simple business lunches were the order of the day. Postgraduate students and junior teachers could easily afford the registration fees for the conferences. Those who attended the meetings did so to learn. A respected teacher inaugurated the conference. The presence of pharmaceutical companies and manufacturers of instruments was felt only in the exhibition hall, where they displayed their wares in modest stalls. They did not intrude into the conference.

Conferences are now held in starred hotels. Lavish meals are the rule rather than the exception. Delegates cannot escape the all-pervasive presence of companies manufacturing

drugs and instruments. Slides that advertise products are projected between successive talks. We are constantly being told which company has sponsored breakfast, lunch and dinner. At one meeting, the biscuits served at tea were embossed with the brand name of the drug being sold by the company paying for them. Senior consultants and their families are flown in and housed in starred hotels by the companies. They have chauffeured cars at their disposal all the time. Small wonder, then, that whilst the dining halls are crowded all the time, the lecture halls become progressively less peopled as one proceeds from the inauguration of the conference to the last day.

The conference is inaugurated by a powerful politician and the inauguration is often delayed till this "dignitary" arrives. The display of sycophancy by the senior conference officials when he arrives would sicken any thinking observer. Since up-and-coming doctors attend these meetings, the effects of the current mores on them can only further demean the professed goals of such conferences. They are quick to learn that to rise in the hierarchy of officialdom of societies or associations, it is necessary to cultivate those in power, and that commerce must dominate over academic excellence. The humble researcher is consigned to oblivion. It is the flashy star performer on whom they model themselves.

### **Research**

Research is distinctly different from re-search. The creation of a new chemical that eliminates a disease is much more important than merely confirming that a drug tried and tested abroad is effective in India as well.

The annual sums disbursed by governmental grant-giving agencies, such as the Department of Biotechnology, Department of Science and Technology and Indian Council of Medical Research (ICMR), are huge (8). The Plan outlay for medical research in the Expenditure Budget for 2014–2015 is Rs 726 crore (Union Budget 2014–2015) (9).

Pleas for retrospective studies of the cost-effectiveness of the many research studies sponsored by them have fallen on deaf years.

If one analyses each research project sanctioned by these large funding agencies on the basis of the following questionnaire, it will perhaps yield information that will help weed out the chaff and result in research that is both relevant and meaningful.

1. Names and affiliations of the principal researchers
2. Title of the project
3. Time from submission of the project proposal to approval and actual start of work
4. Summary of the aims and objectives of the project
5. How many of these aims and objectives were achieved
6. Reasons why the rest were not achieved
7. Whether the research resulted in one or more patents

8. If patents were obtained, what was the subsequent fallout in terms of:
  - a. income to the funding agency
  - b. income to the researchers
  - c. commercial exploitation of the product in India thus far (give details)
  - d. commercial exploitation of the product abroad (give details)
9. Publications on the project, with bibliographic references
10. Time within which the project was to be completed
11. Time taken to actually complete the project
12. In case of delay, reasons for overshooting the time
13. Cost of the project according to the initial project proposal
14. Actual cost of the completed project
15. Reasons for extra expenditure, if any
16. Feedback from the researchers on:
  - a) whether they encountered any difficulties in getting their project proposal approved
  - b) whether they encountered any difficulties in getting their funds at the start of each financial year
  - c) whether their communications to the ICMR were dealt with promptly and efficiently
  - d) whether they encountered any difficulties in patenting
  - e) whether they encountered any difficulty in getting their patented product into commercial production through a third party on the payment of royalties
  - f) whether they are satisfied with the returns from such commercial exploitation
  - g) any other observations they might like to make
17. Report of those monitoring the scientific and social aspects of the project from its commencement to its conclusion

### **Well-meaning but poor diktats**

Owing to lack of monitoring and poor standards, a variety of practices were being followed earlier in the various hospitals and clinics. Many private hospitals and clinics made high investments in expensive equipment and gadgets, and then tried to recover their costs and make a profit at the expense of patients. In many instances, patients paid for unnecessary tests and treatments. In order to circumvent this, the Government of India decided on an accreditation policy and formed The National Accreditation Board for Hospitals and Healthcare Providers (NABH).

NABH issues dictats that must be complied with before it recognises a hospital. Private hospitals are especially keen on recognition by NABH so as to attract a larger number of patients.

The Board appears to have followed practices in vogue in western countries, regardless of their relevance in our country and overlooking our own experiences over the decades. One

of the consequences of this is that some of the diktats are harmful. Let me give you two examples.

1. In the neurosurgery operation theatre at the King Edward Memorial Hospital in Mumbai, since 1957, preoperative scrubbing of the scalp and skin over the spine was being done using ether, tincture iodine and methylated spirit. Similar practices were being followed all over the country.

Ether was used principally to get rid of the greasy accumulation of sebum and particulate matter. It also took away the remnants of the dense rubber or polymer zinc paste left behind by elastic adhesive tape.

Tincture iodine was applied and allowed to dry, ensuring that there was adequate time for its antiseptic action to take place.

Spirit was used to wash away the iodine and leave behind unstained skin. The incidence of infection following such scrubbing was gratifyingly low.

These three cleansing agents have been abolished from the hospital at the instance of NABH (unpublished hospital rulings based on undeclared instructions from NABH). We are now expected to use "Betascrub" and "Betadine" for preoperative preparation of the skin. These are proprietary items and are expensive. The cost of scrubbing patients is now much higher than it was with our old and effective methods. When patients scrubbed with "Betascrub" and "Betadine" return to the ward, their relatives are alarmed by the dark brown stains on their pillowcases and bed sheets – a consequence of the iodine preparations not having been washed off. Those wishing to use methylated spirit are instead asked to use "Sterilium" or other handwash / handrub preparations, which are much more expensive.

2. A few decades ago, we were fortunate to have the eminent German neurosurgeon, Professor H.W. Pia, and his equally illustrious colleague, Dr Ernst Grote, visit neurosurgery centres in New Delhi, Kolkata and Mumbai to conduct workshops on microneurosurgery. The conventional practice was to cover the unsterile microscope with a sterile disposable plastic cover, which had a plain glass window to be placed over the objective lens. The disposable cover, which was not available in India at that time, was expensive. The more important objection to its use was the fact that if it got torn accidentally during use, the microscope could not be used till another such cover was found to replace the damaged one. Finally, the cover restricted the mobility of the unencumbered microscope.

Drs Pia and Grote used relatively inexpensive formaldehyde tablets to sterilise the microscope. These were placed for 12 hours in a plastic bag that enveloped the entire microscope. Microbiology studies carried out following such sterilisation repeatedly showed that no organisms were present on the microscope. The plastic bag was removed carefully, such that no part of its outer surface touched the microscope. The bag was re-used. The sterile microscope could be used freely.

We are now told to discard the tablets and use the expensive disposable cover instead. While the tablets needed to sterilise the microscope cost less than Rs 10, the disposable cover costs around Rs 500!

By using such covers, we are raising costs, augmenting the quantity of plastic waste, using an inferior method of sterilisation, and handicapping the surgeon by making the instrument clumsy to use.

### ***Jettisoning the principles of medical ethics***

This is a major factor which has adversely affected the cost-effectiveness of medical care over the past few decades. You must have noted that the preceding pages contain several examples of practices that do not stand up to scrutiny if one considers the principles of medical ethics.

Had we been faithful to ethical principles, medical practice in India would have been truly beneficial to patients. Why have so many of us strayed from the straight and narrow path?

The teaching of medical ethics appears to have fallen by the wayside. When teaching courses on ethics at teaching institutes all over India, we are confronted by a common question: "Why is it that the topics discussed in this course have never featured during our entire undergraduate and postgraduate training?"

There are few teachers who can inspire impressionable medical students and young residents. Our youngsters are no fools. They are able to distinguish between the pious verbal outpourings of their seniors and the practices they follow to extract the last rupee from each patient and glorify themselves. Preaching the virtues of courtesy and holding discourses on the rights of patients are followed by rude and rough treatment of the poor patient, and fawning over the rich and powerful. The fact that there are teachers who force their juniors to include their names as the first author of papers for publication when they have done none of the work indicates that "positional" might is right. The influence of example is greater than that of precept.

The mushrooming of private, for-profit medical colleges and hospitals has worsened the situation.

### **Improving efficacy**

The steps suggested so far will, in themselves, ease the burden on patients. Improving efficacy will help in other ways.

Here are some suggestions based on the existing practices in some of our institutions.

1. The late Mr Nani Palkhivala described Sankara Nethralaya in Chennai as "the best managed charitable organisation in India." Its practices are worthy of emulation by other institutions (10).

Patients are attended to personally from the time of their arrival at the outpatient clinic. When it is necessary for the patient to move from one room to another for consultation, tests, minor procedures or the completion of formalities before admission to the hospital, the patient is

personally guided by a staff member of the hospital. He/she need not fumble, search or ask for help. This facility is extended to the poorest patient and there is no cost involved.

2. The patient's level of comfort is enhanced in simple ways. For example, care is taken to reduce the noise level in all areas of the hospital. Maintaining a garden with flowers, shrubs and trees can be very effective in raising the patient's morale.
3. Some Indian hospitals have already started using computer-generated prescriptions, which have several advantages. The computer programme has a feature which ensures that the generic form of the drug is mentioned, the drug interactions are highlighted and the proper dosage has been prescribed. Directions on how and when each drug is to be taken are printed. Illegible handwriting is of no consequence now!
4. Another standard feature at some of our better hospitals is the provision of detailed, printed discharge summaries. These contain a brief description of the clinical features of the case, the results of the tests carried out, diagnosis, findings, procedure at surgery, postoperative recovery, and measures (including drug therapy) advised at discharge.
5. Transparency in all interactions between patients, doctors and the hospital administration (especially its accounts department) helps to raise the morale of the patient and keeps all the staff members in the hospital on their toes. There must be a similar transparency in all the financial dealings of the institution.
6. The establishment of a redressal forum in each hospital would increase the patients' and relatives' confidence in the hospital's staff. The forum must receive all complaints and grievances in writing. In the case of illiterate patients, a scribe may be engaged to first note down the grievances and then read aloud what he/she has recorded. Each complaint or grievance must be recorded in a register and deliberated upon by a committee consisting not only of hospital staff members and administrators, but also a social worker and reputed lay person (perhaps a retired editor or judge). The patient or a representative nominated by the patient must be invited to attend each hearing. The person against whom the complaint has been made and his immediate supervisor must be present at the hearing to answer queries that may be posed by the patient or committee members. The final judgment of the committee and corrective step(s), if any, must be conveyed to the patient in writing. A follow-up study on the implementation of the corrective step(s) must form part of the committee's records.

### **Closing thoughts**

It is high time that corrective steps were taken to improve medical care and reduce costs. Focusing at all times on the welfare of the patient, and providing medical care that is humane, considerate and of the highest quality at the minimum cost, are ideals to cherish and strive for. Every

Indian has the right to be provided with the means for the maintenance of health and the treatment of disease. Universal access to healthcare has long been talked about in our country, but precious little has been done to make it a reality for the vast majority of our population.

A market-driven economy is best left in the market place. It has no place in the healing of the sick and the care of the ill. We must certainly not tolerate any move that smacks of profiteering.

The Mahatma's words, in a slightly modified form, can still serve as an excellent guide for us (11):

*Recall the face of the poorest and the weakest patient whom you may have seen and ask yourself if the step you contemplate is going to be of any use to him.*

When we apply this test to modern medical care, pride is replaced by humility and a sense of dismay. There is so much to be done for the poorest and the weakest. Are our best minds and finest medical organisations equal to this task? Have they started work on it? Do they even consider this task worthy of them?

A paraphrased passage from the writing of the noted American author, Ms Ursula K Le Guin, is also relevant:

*The profit motive is often in conflict with the aims of medicine.*

*We live in an age of capitalism, its power seems inescapable - but then, so did the divine right of kings.*

*Any human power can be resisted and changed by human beings* (12).

All that is needed is the will to change for the better.

### **Acknowledgements**

*I am grateful to Dr. Sanjay Mehendale, Director, ICMR National Institute of Epidemiology, Chennai, for his prompt response*

*to my request for review of my essay and the many helpful suggestions he made for its improvement.*

*I am also obliged to the two anonymous reviewers who have helped me improve the paper. I have incorporated their valuable suggestions in my revised text.*

### **References**

1. Withering W: *An account of the foxglove and some of its medical uses: with practical remarks on dropsy and other diseases*. Birmingham, UK: M. Sweeny; 1785.
2. *Webster's New World College Dictionary*. Date unknown [cited 2015 Feb 24]. Available from: <http://www.merriam-webster.com/dictionary/cost-effective>
3. The Osler Symposia. About Sir William Osler and his inspirational words. Date unknown [cited 2015 Feb 24]. Available from: <http://www.oslersymposia.org/about-Sir-William-Osler.html>
4. Shoulson I. In memoriam: Robert J. Joynt, MD, PhD (1925–2012). *JAMA Neurology* [Internet]. 2012 Nov [cited 2015 Feb 24];69 (11):1518–9. doi:10.1001/archneur.2012.2265. Available from: <http://archneur.jamanetwork.com/article.aspx?articleid=1389840>
5. Yeh C. 'Nothing is broken': for an injured doctor, quality-focused care misses the mark. *Health Aff (Millwood)*. 2014 Jun;33(6):1094–7. doi: 10.1377/hlthaff.2013.0855.
6. Jha S. Stop hunting for zebras in Texas: end the diagnostic culture of "rule out". *BMJ*. 2014 Apr 7;348:g2625. doi: 10.1136/bmj.g2625.
7. Pandya SK. Personal observation during visit to the Sanjay Gandhi Postgraduate Institute of Medical Sciences on December 14, 2014.
8. Department of Science and Technology, Government of India. *Annual Report 2013–14*. New Delhi: Ministry of Science and Technology, Government of India. Figure 1.2, p 217.
9. Union Budget, Government of India. *Expenditure Budget 2014–2015. Volume 1, Part III – Plan Outlay 2014–15*. p 39. Available from: <http://indiabudget.nic.in/ub2014-15/eb/po.pdf>
10. Sankara Nethralaya: a mission for vision. Sankara Nethralaya triggers interest in high places. 2012 Feb 14 [cited 2015 Feb 24]. Available from: <http://omlog.org/2012/02/sankara-nethralaya-triggers-interest-in-high-places.html>
11. Gandhi International Institute for Peace. Essential quotes of Mahatma Gandhi [Internet] 2012 [cited 2015 Feb 24]. Available from: <http://www.gandhianpeace.com/quotes.html>
12. Le Guin UK. Ursula K Le Guin's speech at National Book Awards: 'Books aren't just commodities' November 20, 2014 [cited 2015 Feb 24]. Available from: <http://www.theguardian.com/books/2014/nov/20/ursula-k-le-guin-national-book-awards-speech>

## **World Association of Medical Editors (WAME) Conference**

The World Association of Medical Editors (WAME, pronounced Whammy) came into existence 25 years ago. One of the key features of this organisation was its virtual nature with communication and interaction mainly by email. However, once in four years, the members attending the Peer Review Congress would participate in a WAME business meeting on the sidelines of the Congress. At the last WAME strategy meeting (the third since its inception), it was felt that the organisation having grown, an international conference for its members should be organised in 2015. This meeting will be held from October 2 to 4, 2015, at New Delhi. For further information please write to: [india.editors@gmail.com](mailto:india.editors@gmail.com) or visit the website: <http://www.wame.org/>