Book Review

Back to the Future

-Dhruv Mankad

What are the historical, political, cultural and ethical dimensions of these (health) problems and of concrete solutions sought out in a day to day medical practice?

Towards the Dilemma of Medical Culture Today *explores the answers, looking through the glasses of kaleidoscopic knowledge, attitudes and experiences of medical academics and practitioners.*

Towards the Dilemma of Medical Culture Today, Edited by Anand Zachariah, R.Srivatsan and Susie Tharu on behalf of Christian Medical College and Anveshi Collective; Orient Blackswan, Hyderabad, 2010, 392 pages, ₹495.00. ISBN 978-81-250-4091-0

We are at the threshold of transition in our health status and health care system – *for the past 64 years*! Infant Mortality Rate in 1950-51 was 165, today it is about 56 per 1000 live births. The prevalence of severely and moderate malnourished children is declining, so is the life expectancy. But, declining sex ratio is showing female feticides or no change in wasting and stunting is pointing towards looming hunger epidemic. The health infrastructure has increased from 725 in the '50s to 170000 now, but its utilization by the poor has declined. Availability of state of art technologies and human power trained for treating patients has gone up. But is it relevant, affordable and based on the needs of the sufferers and our people? Are the number and quality of health care services - both public and private as they exist today appropriate? If the answer is no, then the central question which needs to be answered is - what are the historical, political, cultural and ethical dimensions of these problems and of concrete solutions sought out in a day to day medical practice?

'Towards the Dilemma of Medical Culture Today' explores the answer, looking through the glasses of kaleidoscopic knowledge, attitudes and experiences of medical academics and practitioners. Some doctors had a sense of discomfort about the structure of medical knowledge. They were involved in a consultative process for improvement in medical education initiated by Christian Medical College. Anveshi also participated in the workshop as an observer. The participants of this collective discussed critically history, culture, institutions, assumption behind the theory and practice 'dimensions of a crisis' of medical knowledge. The book is a result of these different, new ways of looking at the crisis. (286)

A Rich Dividend

The book is a collection of essays which look into these 'dimensions of a crisis' which are:

Dhruv Mankad

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- Monetary, institutional and experiential cost of treating patients with tertiary care
- Increasing use of irrational and high cost drugs with a logic which has little to do with patient's needs
- Top down preventive program which are not sensitive for what the people want
- Problems of doctors and academics in providing medical care, teaching and research

These essays are presented in five Sections after a comprehensive introduction. They are: *Genealogies of Medicine in India; Health in the time of Development; Tertiary Care Medicine, Evidence based Medicine, Pharmaceuticals and cost; Thinking with the patient* and finally, *Resources of Practice: Calibrating Medicine to the needs of patients.*

Section I: *Genealogies of Medicine in India* elaborates the history of medicine in context of the health policies and plan of Indian Governments (*Susie Tharu*), the evolution of public health around a disease e.g. Kala Azar, (*A. Zachariah and R. Srivatsan*) role of the government and the biases of the scientific research. It also focuses on how the medicine evolved around the transient results of debacles of government e.g. PTSD with linkages of the medical professionals with the interests of the pharmaceutical companies.(*K S Jacob*)

Section II: *Health in the time of Development: Primary Health Care, Nutrition and Population Control* narrates experiences of the past 30 years of actually working on relevant current issues. Working the Contradictions- Three Decades *(*Sara Bhattacharya) presents the canvas of her working with the community, in an academy and in a health department. Andhra Pradesh: Ground Level Observations (A P Ranga Rao), describes his experience in the government set up. The Career of Hunger: Critical Reflections on the History of Nutrition Science and Policy (*Veena Shatrughna*) outlines critically the development of policies regarding nutrition and food security, in a single stroke showing the bright and dark sides of the 'hunger' epidemic India is on the verge of. Different Readings: Demography and Population Control, (*Sheela Prasad)* talks about why Demography developed in the world and how it deviated the governmental models of health care against the peoples' or more specifically, women's needs. Development *an*d the Administration of Public Health – An Overview of Contemporary History (*R Srivatsan)* questions whether India was a Welfare state at all, dissects the logic of the development state and its consequences. He adds the origins of the politics of health in the twenty first century.

Section III: *Tertiary Care Medicine, Evidence based Medicine, Pharmaceutical and Cost* delineates critically the existing approach diagnosing and treating patients suffering from a range of illnesses. Rethinking Organophosphate poisoning/suicide in India (*Anand Zachariah)* based on history of Organophosphate poisoning in the West (Chemical Warfare) and in India (suicidal attempts), argues that the different treatment protocols need to be developed for different contexts, keeping in mind the contextual evidences. Development of Cardiovascular Epidemic in India and Inappropriate Tertiary Care Treatment Guideline (*Anand Zachariah)* traces the causes behind cardiovascular diseases epidemic in India and recommends that an appropriate treatment guidelines should be developed which is affordable and effective for the large majority of the people who suffer – the poor. Drug Pricing and Access to Health Care: Some Issues and Options (*S. Srinivasan)* covers several

problems the drug market in India faces: asymmetric information, market malpractices, overpricing of brand against generic medicines etc. and discusses options to overcome them.

Section IV: *Thinking with the patient* narrates the experiences of patients from a varied background and expresses their feelings about inadequate attention from health personnel and institutions. It underlines what was expressed by the patient activism that there is a gap between healing and cure. 'The 'Intractable' Patient, Managing context, illness, health care (*Lakshmi Kutty*) articulates the feelings of poor patients who were 'falling short of ideal behavior' of health care system. Patient Questions (*Duggriala Vasanta and Seemanthini Niranjana*) attempt to question the official views about doctor-patient relationships. After Ervadi Healing and Human Rights in the Context of Mental Health (*Jayshree Kalathil*) presents thoughts about loss of community support systems to 'mentally ill' patients in case alternative therapy centres like Ervadi or dargas are closed.

Section V: *Resources of Practices: Calibrating Medicine to the needs of the patients* focuses on the medical practice which is sidelined by ever growing medical theories. Rethinking Practices *(Susie Tharu)* points out toward the theory before practice is the conceptual approach in modern philosophy which always considers theory as superior than practice. Practice in the ICU: The case of Organophosphate poisoning (*Sujoy Khan* and *Anand Zachariah*) analyses the varied clinical presentations of pesticide poisoning and the clinical practices evolved out of these experiences, absence of such variation in treatment protocols and importance of dialogue with the patient in practice. People's Struggle Producing a Curative Public Health for AIDS (*Anand Zachariah*) documents how the current understanding about AIDS treatment evolved through negotiations with patient groups, scientists, regulatory agencies and the pharmaceutical companies. What constitutes Evidence based Practice in Rehabilitation (*Duggriala Vasanta*) highlights case by case approach in rehabilitation of patients with Alzheimer's Disease. It discusses the absence of evidences based non-biomedical practices for each patient.

Finally, Reclaiming Primary Care: Marketing Depression and Anxiety in a different framework (*K. S. Jacob*) describes experiences of general practitioners of patients presenting psychosomatic symptoms of common psychiatric problems and emphasizes that at the primary care level, treatment of such illnesses should be based on these experiences.

Ethical Dilemmas in Medical Praxis

Introduction – The Dilemmas of Medical Culture, by Anand Zachariah and R. Srivatsan. presents two cases which frame the fundamentals of the ethical dilemma they, the teachers-activists- researcher-practitioners face in dealing with each patients. According to the authors, these cases raise several questions viz., what was the best line of treatment: at primary level (by a GP) or at the tertiary level? What was the desire of the patient for survival, for treatment? Was clinical diagnosis appropriate on a case by case approach or the protocol must be applied for each patient? Who was responsible for the avoiding the associated causes of illness – the patient or the hazardous products? Who should be responsible to treat when social determinants of ill-health like poverty are the main causes of illnesses like malnutrition, depression etc.?

While going through the absorbing essays/chapters of this book I realized that the collective efforts are pivoted around four central theses. In summary, they are:

Thesis 1 (The principle thesis): Dichotomy in the Modern Medical Knowledge and Medical Practice

- Modern Medicine is based on the agendas of the governing, and not on the patient's sufferings
- Medical knowledge, its perspectives and content are determined by the governing – the state.
- Therefore, it ensures that teachers and the students participate in this mode and act as its agent
- During the practice, doctors apply the logic of the medical knowledge they have adopted, use the protocols directed by the government or professional association etc.
- Also, we have to start a process subtly which does not have the same logic while treating a sick person. It is often contrary to what they have been trained to do and is illogical/ irrational from the perspective the medical knowledge is built upon.
- Thus often the praxis ("a hard theory to put into practice") instead of moving forward to a synthesis, disjuncts what was to be done for the sick patient from a patient-centric logic and what the doctor was directed to do as per the governmental protocol/ medical knowledge.
- This leads to frustration, anxiety and burn out and even conflicts between doctors and patients/or medical practitioners and governmental medicine.

Theses 2: Dichotomy in medical technologies transplanted from the Western context and its efficacy in India

- Growth of Pharmaceuticals and Medical Technologies and Scientific Institutions – the Medical Industry was propelled by increased health expenditure during the post-World War era
- Increased health expenditure inevitably ensured involvement of state by allocating large national budgets
- Specialties developed along with the new technologies
- Tertiary care developed in the western context, when applied in India, turned out to be non-feasible and inappropriate in local context, thus making difficult for doctors to provide cost effective and appropriate medical care
- Doctors trained in sophisticated tertiary care hospital are unable to apply their knowledge in a less sophisticated or almost rudimentary settings

Theses 3: Dichotomy in curative care services and public health services in India

- Government shirked the responsibility of providing curative health care and focused on preventive programmes
- These programmes were designed in 'national interest' by public health experts and administrators
- Curative health care, particularly tertiary care is mostly in the hands of private hospital
- Most doctors find private hospitals in India or in other countries lucrative and in congruence with their background, the investment they have made to get educated
- Only the remaining doctors are available to provide services to rural or urban poor. In addition, they find difficult to relate to community coming from a different cultural, socio-economic background

Theses 4: Dichotomy in the diseases and their manifestation in India and its presentations in classical (western) medical education

- The epidemiological profile of illnesses in historical, cultural and clinical context are different in India as compared to any other countries
- This leads to innovative diagnostic and treatment methods keeping in mind its cost
- Medical education presents illnesses in context different from what exists in India

Theses 5: Dichotomy in medical knowledge and its day to day practice

- The tertiary care diagnostic and treatment protocols are developed on evidence generated in their settings
- Practitioners often compute a different strategies based on their medical knowledge on the local context
- Their contribution to people's health needs is immense

Ethical Issues about the Healthcare Crisis

The essay also lays down (p5) the dimensions of 'the crisis that besieges health care..': the disjunction between scientificity and efficacy (sic), cost that the patients bare due to illness, the treatment and its failure or success, relevance and appropriateness with Indian cultural, socio-economical context, healing - the patient's need versus cure – the outcome of medical treatment and absence of 'an academic orientation the crisis about the relationship between the medicine and the government to understand its form in the postcolonial, 'developing' country like ours.

However, it is true that such dichotomies and dilemmas exist in reality; my contention is that the contradiction remains even if one takes patient centric views. It adds on further ethical issues:

1. **Consent to choose an appropriate treatment source**: Do the patients have the choice of accessing the advance tertiary care as against the residual, primary care that exists even if its governmental approach was dropped. Let us take the example of Hina. It is true that the best psychiatrist could not have done any better to the root causes, but was her access to an unqualified GP out of her choice or out of compulsion? This in a situation when we as doctors have by and large a choice of treating her or not, how and when, of deciding what is appropriate and what is not. She did not have any choice.

2. **Whose interest is served if treated at a primary care – by a GP and not by an expert**? Again, the answer is: neither was serving her interests. Treatment by a GP was giving her some psychological relief and was costing low. However, in case of Suicidal OP poisoning patient, adding the role of psychotherapy at the primary care level may ameliorate the miseries the patient is suffering from. However, does the clinician have autonomy of contextual trial and error in place of a well-tested clinical guideline even if it is developed elsewhere? Particularly, this is so when the situation is an emergency.

3. **'Cost' reduction in a private health care setting is a double edged sword**: When we consider the cost of treatment in any setting particularly in context of private health care, the issue is who gains from cost reduction approaches: Is it the provider who gains – need to spend less time per patient and hence delegated to the primary care provider or an assistant. (In infamous case of Dr Praful Desai, he retained the monetary cost but reduced time and hence the 'responsibility' nonmonetary costs.) Did the private hospital gained 'profit' by cost reduction - using comparatively cheaper treatment protocols (less investigations, less staff per patients, less services?

4. **Conflict of interests:** What is the interest of the various stakeholders involved in deciding the types of public health measures to be introduced? Is it because they have created a model which one side wants replicate on their terms? Particularly, this is more so when the model is competing with another one which has the same intention. E.g the Government of India wants to upscale Kala Azar as a National Programme (hypothetically, because the medicines are produced by a private pharmaceutical company) against say snakebite.

5. **Policy and Guidelines as coercive documents in practice**: If guideline generated by Government of India loses its guiding nature and becomes a mandatory clinical '*fatwa*' then it is certainly a violation of the principle of formal justice of applying it as per the patient's need. Using a single recipe '*Khichdi*' in Supplementary feeding under the ICDS is one such example. The baby may need different feeding not just because of choice but as a patient still suffering or recuperating. Compulsory rural postings of doctors may be in patients' interests and necessary in an 'emergency' but it is a coercion of the doctors.

6. **'Misuse' of Guiding Principles of decision making regarding ethical dilemmas:** The central professional commitment reflected in the book, while finding solution of dilemmas, is being patient-centric. Often, when decisions are regarding

ethical dilemmas particularly in public health, several of these principles are violated or often not used or worse, misused. E.g. Policy and guidelines are documented but not truths are revealed about the participants and the processes. (Principle of Veracity) or compromising the policy in favour of providers e.g. softness toward absenteeism in public health providers or missing social support component from Mental Health Programme for people with mental illnesses.

Back to the Future

In essence, the book is a rich source of theoretical perspectives and practical examples where not just the practitioner and the patients are having a dilemma, it is a presentation of the pitfalls in the future direction medical technology and public health is taking by looking back at the history of medical science, in the political and cultural context of problems of Public Health in India. My hats off to the authors particularly, Veena Shatrughna, K S Jacob, Anand Zacharia and R. Srivatsan for painting almost surrealistic canvas about the healthcare crisis in India and its historical, political and ethical origins. They have exercised their vast knowledge and professional experiences of grappling the crisis ethically in day to day practices.

One may have expected more guidelines, solutions and preventive steps for health practitioners, to tackle the ethical dilemmas they face in medical practice. However, the authors have done an important job in emphasising the complexities and dilemmas of decision making in such situations, and this point is made in the title itself.

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