Training and Education of Health Care Professionals:

Indianization of Allopathic Medicine

Consistent with the Economic Realities of the Indian Population

-Dr. S. V. Nadkarni[1]

The allopathic medical science is based on the Physics, and Chemistry of the body function. Being a science, it is pure and extremely definitive; there cannot be any error in the conclusions drawn through this science. Now technology has added more precision to the already precise science of allopathic medicine. But though Allopathy is a pure science, the clinical practice of allopathic science is NOT a science. As with many other fields, application of any science brings in Art and Commerce. The mixture of the Art, Science and the Commerce in clinical practice makes it a new product—a variable product for that matter—which MUST differ from place to place, depending on the exact needs of the place. Even in the same place, the needs of the various strata of the society could be different and, therefore, the product suitable for one may not suit the other. **This is the fact not realized by most of the followers of the allopathic clinical practice and a standard format/menu is served to all**, irrespective of the actual needs of the local people. Unfortunately, too, it is the Western model which is advocated blindly, without realizing that this Western model is proved not to be suitable even for their own people who belong to the poor and lower middle class strata. ANSWER? **We must formulate our own model suitable for our own needs. This is what I call Indianization of Allopathic Medicine.**

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Are the health needs of the poor any different from those of the rich? I would say "Yes"; in fact, I dare say that the needs of the middle class are also different from those of the poor or the rich. So, broadly, the three strata of society have different health needs and that difference is due to the economic status of each strata. **This is a fact most people are not willing to accept.** How can the needs be different? It is because of their economic compulsions. Their expectations are determined by what medical assistance they are presently receiving and their knowledge about the health and disease. The poor do not understand an early disease; forget about the need to prevent the pre-disposing factors that can lead to disease. So, they usually come late when the disease is fairly advanced. The clinical manifestations are very clear and diagnosis is relatively easy without too many modern investigations. They need to be treated fast as it is difficult for them to take treatment for a prolonged period, even if it is "free"; there are ancillary expenses and other logistical problems. Fortunately, they are satisfied with immediate relief and some prolongation of life or productivity, as they do not know that better results are possible with modern methods. Not knowing much, they have to depend on the opinion of the doctor and accept the protocols prescribed without much questioning. They have to depend on the public sector - good or bad - as they can never afford the charges of the private set-up. The science remains the same, but the Art and the commerce differ; hence the "product" offered is different. Efficiently managed, this product can give equally good results at a very low cost. Due to efforts of NGOs and the various "awareness Programs", some of these poor are becoming aware of their health needs and have started demanding better health care. That is good, but when it leads to expectations beyond the financial capacity of the health centers, and the "awakened Poor" demand better service "FREE", grave problems arise; often the services deteriorate, as the medical professionals go on the defensive and send the patients to higher

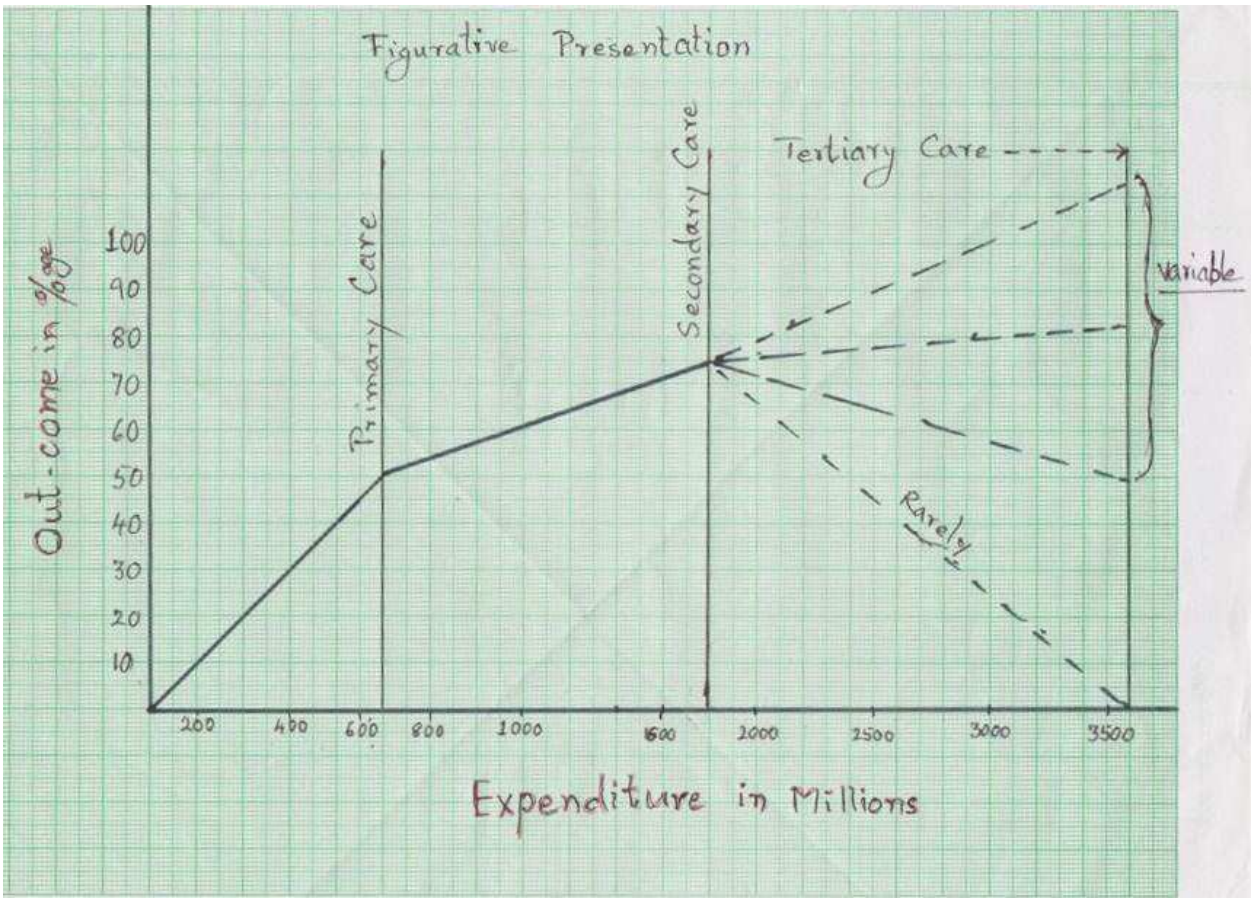
centers for “better Treatment” and there is paucity of “better centers.” This attitude immensely helps the “shirkers” in the profession while the socially oriented “enthusiasts” who are willing to do their best under the prevailing facilities are totally discouraged; there rises a hanging sword of assaults or complaints /actions against them, if things go wrong.The community has to realize that Better treatment is bound to need higher costs, and the medical professionals have to be taught to improve their Skills to give better results without raising the costs**.** The rulers will have to do the balancing act.

It is quite the opposite with the RICH. They are apprehensive about each and every symptom/health complaint and wish to rule out ***any*** serious ailment which maycause trouble in future or shorten their life-span. They are not willing to accept a 1% error and are willing to spend any amount for investigation and/or therapy. Money is no problem; in fact, more they spend, surer they feel about the management of their symptoms by the specialists. Not that they get a perfect outcome - far from it. The middle class, as in Marxian philosophy, are somewhere between the two. They are health conscious but also cost conscious. They are well read but skeptical and will not swallow all “modern” propaganda easily. The health professional has to really discuss with the middle class patient to convince him about the diagnosis and the management. Personally, I feel he strikes the right balance.

The Health Care professionals need to be re-educated in this direction but that cannot be done unless they are made COST-CONSCIOUS, and that cannot happen, unless we do costing of every treatment protocol. The diseases will have to be classified and graded as Mild, Moderate, and severe in a standardized fashion and then only, it will be possible to co-relate the outcome to the costs incurred. Such a re-education will lead to a search for cost-effective management protocols.The “New Products” could be different depending on the facilities available. The

teaching institutions will have a great role to play by doing research in this direction. Because if such new products were to be developed by the teaching institutions, they will be considered as authentic. The Science is now properly mixed with Art and Commerce to suit the existing circumstances of the local community. Each product is different but it is the most suitable for that particular locality/strata. MADE TO ORDER — so to say.

On a macro level, it is seen that increasing the expenses at the primary level to upgrade them, gives maximum benefits to the community at a relatively low cost; improving the secondary services needs much higher expenses but it improves health care perceptibly. But when we come to the tertiary, high-tech, modern health care, the expenses mount sky high - yet the outcome is extremely variable. Some miracles do occur, but, in general, the real improvement in health care is very marginal for the community as a whole; in the hands of half-trained specialists, the higher expense could result in worse outcome - sometimes disastrous (see graph). The outcome being so variable, it is my considered opinion that the public sector should spend the most minimum on tertiary care and make strict rules about the referral methods. Who should get the benefits of this tertiary service should also be defined strictly in this public sector. All others may have to pay for this service.



How to make common man cost-conscious? For the success of the scheme of Universal health Coverage, it is absolutely necessary that the community becomes extremely cost-conscious; otherwise, the demands mount sky high or the expenditure is easily wasted on wrong priorities. I have suggested two methods in my other articles. One is to give him the actual bill of expenses (it can be called "cost statement" and not a bill). The other- more effective way- is to make every patient in public sector**, beyond primary care,** pay at least10% of the actual bill. In my modified format of UHC, I have made it merely 8%, while local self govt. bodies will bear another 12%. Bothwill become cost conscious. Even presuming that 30% of the people are below poverty line, the scheme is yet possible, **as the government will pay for them — this is the real subsidy which now goes exactly to those who need it.**

It is not only the professionals who need to be re-educated; it is the whole community and their leaders who need to be educated on the real value of Health services.

A - All health services are NOT needs; some are demands; some are sheer luxuries. B **- It costs**. And C - as a corollary- therefore, while essential services must be asocial obligation, other services must be tailored according to the capacity of the individual or the community to pay- individually or collectively. D - All services have to be paid for - public services through Health related taxes with contribution from all, and private services through additional health insurance or personal expenses.The medical professionals, who are going to treat the poor and the lower middle class, need to be educated as to how to treat effectively **at reduced costs within the available facilities by improving one's skills.** (Strong incentives would be necessary for this)

The role of medical colleges is grossly under-estimated. **It is totally wrong to look at the college hospitals as merely tertiary centers for the treatment of complex cases.** The college and its hospital are centers to create competent doctors/specialists for the entire spectrum of health services. Therefore, it must have the widest canvas of diseases and from all possible strata of society. It is then only that the students (and the teachers) will understand the subtle differences in management of early and late diseases in various strata of society. Today, the over-whelming percentage of the poor patients is giving them a distorted training of the art of communication and of dealing with the complaints of the patients. Secondly, we are not training doctors to be family physicians at all. There ought tobe a training course of 2 to 3 years for G.P. or primary health provider, I prefer to call them. The whole time table of hospital working must be looked into to accommodate the complex needs of the nation as a whole but it is a big chapter and cannot be discussed here.

In brief, the socio-economic influences on the actual clinical practice ought to be taken into account at every step from medical education to the formulation of health policies to the actual clinical practice. Unfortunately, vague ideology and euphemism are hindering the right approach and causing untold harm to the health services. We all need to be re-educated.