A Substantive Account of Medical Malpractice in India

ANANT PHADKE

Healers or Predators? Healthcare Corruption in India edited by Samiran Nundy, Keshav Desiraju and Sanjay Nagral, *New Delhi: Oxford University Press, 2018; pp 657,* ₹*750.*

Those who have doubts about the extent of corruption and medical malpractice in India, this book can offer a few revelations. This volume penned by 41 leading medical and other experts across India constitutes an internal, whistle-blowing critique of the very extensive and intensive spread of medical malpractice in India. Among the authors and editors, majority are doctors and leaders in their respective specialities, reputed for their honesty and integrity. They have decided to publicise various medical malpractices occurring in India as they have painfully seen from closer quarters. Other doctors as readers should not ignore the book merely because the title is unnecessarily provocative.

One attractive feature of the book is the foreword by Amartya Sen. Predictably, before getting into the issue of medical corruption, he appropriately refers to the broader canvas of overall dismal failure in the field of health and healthcare in India, because of the neglect of public health, and of primary healthcare. However, coming from a Nobel laureate who has been writing extensively for the lay people, the foreword is a little disappointing. When a layperson would read Sen's comment: "India spends a much lower proportion of its national income on healthcare than do many other nations with comparable achievements in economic development," they may not realise that this criticism is about low proportion of government expenditure on health and not about the total expenditure on healthcare, private and public included.

Similarly, when Sen refers to the fundamental problem of private healthcare, he refers only to the information asymmetry between doctors and patients. Writing for a lay reader, it is equally important to mention the crucial fact that in addition, the patient may be in acute need of relief from some physical, mental distress, and that their well-being, sometimes their life may be in danger; hence the patient remains in a vulnerable position vis-à-vis the doctor. This fact is equally, if not a more important reason, for the inherent market failure in healthcare.

Medical 'Corruption'

In the first section of the book, four essays discuss the overall background and causation of widespread medical corruption in India. In the opening essay, "Structural Basis of Corruption in Healthcare in India," Ritu Priya and Prachinkumar Ghodajkar attribute high level of medical corruption in India to five key factors: colonial legacy of low level of public provisioning of healthcare continued in independent India by making health a commodity; "design of a doctor and hospital-centred health services structure, based primarily on allopathic system"; absence of accountability of the professionals and hence socially alienated health professionals; emergence and domination of commercialised bio-industrial complex which has corrupted the medical professionals; and lastly, the delegitimisation of peoples' knowledge resources and medicalisation of health.

This is an insightful, wholistic, structural analysis. However, it overlooks one important point, that is, in Western European countries also, healthcare is a commodity and yet corruption and malpractice in healthcare is much less. This is because in India the patient as an individual buyer of healthcare is far

more helpless and vulnerable, compared to the patient in Western and European countries where healthcare is bought on behalf of the patient by a third party, funded through public money on terms of "standard rate of payment for standard treatment." Adoption of Standard Treatment Guidelines by doctors and hospitals is a precondition for being paid from such a third party. In the public health system, healthcare is not a commodity, but in India because of lack of accountability, there is a lot of corruption there also. Thus, not only commodification of healthcare alone, but also lack of regulation and accountability are responsible for such extensive corruption and medical malpractice in India.

In this first section, in the essay, "Globalisation and Corruption in Health Sector," Amit Sengupta argues further in the same vein as Priya and Ghodajkar. His central argument is:

> neo-liberal policies in their essence involve a transfer of power from public institutions to private enterprises and hence it can be argued that if corruption is "illegitimate use of public power to benefit a private interest" (Morris 1991), then neo-liberalism is the epitome of a corrupt social system.

In other words, privatisation of healthcare implies systemic corruption. Sengupta argues that this occurs through three pathways: redefining the role of the state to benefit private interests; restructuring of global governance by including private interests in its structure; and by regulatory capture. The three together "enlarge the scale of operations and the power of the private enterprises, thus opening up new forms of corrupt practices." One would tend to agree, given the fact that corruption and medical malpractice in healthcare in India has grown exponentially after neoliberalism from the 1990s onwards. My only rider is: the fact that the virtual absence of regulation and accountability in healthcare has continued in this neoliberal era needs to be taken into account in addition to neo-liberalism, to explain the level and extent of corruption and medical malpractice in Indian healthcare.

In general, in this book, the term corruption has been used in rather too broad a sense. The dictionary definition of corruption is: "dishonest or illegal behaviour especially by powerful people (such as government officials or police officers)" or "illegal, bad, or dishonest behaviour, especially by people in positions of power." Similar definitions have been quoted in various chapters of the book. Only some of the chapters in this book are of the nature of how some public health functionaries and regulators get directly or indirectly bribed and misuse their authority to favour some vested interests. The essay of S Srinivasan on the "unholy nexus" between medical professionals, pharma companies and drug regulatory authorities, is one such. There are others, such as the two classical stories of corruption included in section seven of the book—the "glycerol tragedy" in J J Hospitals, Mumbai due to corruption in Maharashtra Food and Drug Administration, as documented by the Lentin Commission and the "Vyapam scam" of "deadly corruption" in medical college admissions in Madhya Pradesh.

Private Practice

It may, however, be noted that many other essays are about medical malpractice (violation of scientific, and ethical principles in healthcare) in which private medical practitioners exploit patients in an unregulated market of medical care. In these essays, we read about how a lot many doctors do take undue advantage of the patient's vulnerability and indulge in unnecessary medical or surgical interventions or charge excessive fees to earn easy money. To call all such medical malpractices as corruption is to make an unjustified and specious interpretation of the definition of corruption. Yes, when the doctor under the corrupt influence of the pharma industry prescribes unnecessary medicines, it is because of corruption. So is the case with unnecessary interventions fuelled by commission practice. But many unnecessary medical interventions are made without any such "external corrupting" influence, without the involvement of any third party.

The special feature of medical care is that the patient is inherently vulnerable vis-à-vis a doctor primarily because of the fact that doctor is approached when a person's physical, mental, or emotional health, sometimes their life is in jeopardy, and because many a time urgent action is needed, for which they are quite dependent on the judgment, skill, and motives of the doctor. Other professionals also have an upper hand vis-à-vis their clients with regard to relevant knowledge, especially when the skill/knowledge is in somewhat short supply. Moreover, sometimes a lot of investment/future direction, etc, also depends on the advice of the professionals.

In healthcare, the inherent vulnerability of the patient is unique due to the patient's acute, sensitive need. That is why the Hippocratic Oath is needed. It mandates the doctor to put the patient's interests above the doctor's interest and thereby makes it a noble profession. Commercialisation of healthcare creates a strong tendency to ignore this oath. But even where the commodity character of healthcare is absent, the patient's vulnerability remains and can be misused. For example, the doctor in the public health system can indulge in an unnecessary caesarean for their convenience, or push a particular contraceptive method or unjustifiably withhold abortion services to needy women merely because of the dictate of the state. It is, therefore, not appropriate to put all malpractices under one category by converting the word corruption into a "catch all" or a "hold all" term.

The second section of the book "Corruption in Practice" is the biggest, and contains a wealth of authentic information about how corruption and medical malpractice occur in India. Penned by leading experts in respective fields, this section shares with us narratives (based on first-hand knowledge and substantial number of references) about corruption and malpractices in many fields in Indian healthcare—ranging from the role of Medical Council of India in malpractices in medical education and clinical practice; malpractices in clinical practice ranging from independent consultants to high-tech speciality fields like organ transplantation; corruption in the drug regulatory system at the expense of the common people; corruption in medical research and clinical trials. These

are all revealing, disturbing, sickening accounts of crass commerce eroding medical ethics.

Public Health Services

Among these, two chapters need special mention as unlike others they deal with corruption and the public health system. In the chapter "The Public Sector and Corruption in Health Services," S V Nadkarni, the renowned surgeon and administrator from Mumbai, talks primarily about the weakening and gross inadequacy of the public health services due to the privatisation policy. He talks about various problems of the public health services like gross underfunding, the attitude of the government bureaucracy, the inappropriate structure and functioning of the medical college hospitals, etc. He emphatically argues that it is because of the absence of "cost analysis data analysis" (as he calls it) that doctors in public hospitals are not aware of and sensitive to cost-ineffective, wasteful practices. Overall, this chapter is more about the overall problems of the public health system rather than about corruption as such. Notably, Nadkarni asserts that improving and strengthening of the public health system and not privatisation, is the answer to these problems.

The essay by Yogesh Jain, who leads the renowned Jan Swasthya Sahyog in rural Chhattisgarh, shares a view from the grass-roots reality of India. He narrates a couple of disturbing cases to make the point that when the resources for rural healthcare are already low, misappropriation and stealing of these resources leads to denial of healthcare to the poor. Secondly, in his field area he finds that corruption has spread among auxiliary nurse midwives (ANMs), and *anganwadi* workers also and argues for strong accountability mechanisms to curtail corruption among public health workers.

Remedial Measures

The fifth section of the book—"Governance and Healthcare Corruption"—indicates aspects of remedial measures. One of these has achieved concrete results. Meeta and Rajivlochan report about the successful experiment in Maharashtra, that made the use of mandatory standard treatment protocol under the government-financed health insurance scheme—Rashtriya Swasthya Bima Yojana (RSBY). For taking a decision to do an angioplasty under this scheme, an algorithm developed by Indian experts for such cases was made mandatory. This mandatory standardisation reduced the proportion of angioplasties by 12.3% in a year, compared to an increase in this proportion in a comparable government-funded programme in Tamil Nadu. This welcome example confirms the experience elsewhere that regulation and standardisation of clinical decision-making reduces the malpractice of unnecessary interventions.

While regulation and accountability is one path towards curbing corruption/malpractice, the non-profit framework is the second route. This is well illustrated by the innovative social experiments in healthcare reported in the last section "Beacons of Hope." The common feature of the seven social experiments included as the chapters under this section is of a clean and humane healthcare of a non-profit nature. This feature of these seven experiments supports one of the basic tenets of this book that commodification of healthcare is at the root of corruption and malpractice in healthcare in India. Overall, this book is a very important, much needed, and very substantive contribution to the literature on healthcare in India.

Anant Phadke (*anant.phadke@gmail.com*) is associated with the Jan Swasthya Abhiyan, the People's Health Movement in India.