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Medical pluralism in India

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ARTICLE

Medical pluralism in India: patient choice or no other options?

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Abstract

The maldistribution of biomedical services creates a dilemma for Indian patients. They encounter a bewildering array of medical services, ranging from qualified traditional medical practitioners to untrained, self-taught purveyors of medicines and cures. Research on Indian healthcare has decried the inefficient distribution of services in rural and urban areas. The studies discussed here reveal the ground reality of the consequences of limited choices for patients, characterised as "forced pluralism," with no state regulation of type of care, quality of care, or credentials of practitioners.

Introduction

My first encounter, 40 years ago, with the use of traditional medicine, was seeing a green paste covering a small child's leg wound in a village near Vikarabad, Andhra Pradesh. As a young American working in a health and nutrition programme, I was mystified at the paste, convinced that the child would suffer terrible infection from it. However, I witnessed that child, and many others, healed by these homemade, herbal pastes. These experiences formed the beginning of my intrigue with traditional medicine, leading to graduate studies in health and medicine and research on patients' use of Ayurveda and Unani in Hyderabad City (1). Today, Indian traditional medicine, such as Yoga and Ayurveda, are popular health and wellness options in western societies, and continue to serve health needs in Indian society. For the urban, middle class Indian patient, traditional medicine may serve as a healthcare option that addresses socio-cultural beliefs. Moreover, its recognition outside of India may add to its cachet and positive valuing of national culture (2). For the poor, rural Indian patient, traditional medicine may be the major option to meet health needs.

Thus, the interest of social science and medical researchers and patients in the traditional systems of medicine has been persistent, if changing, over the years that I have been an observer of these systems. When I first studied patients' use of traditional medicine in India, social scientists were researching the socio-cultural explanations for the persistence of traditional medicine, even as programmes to support biomedicine were promoted. Banerji (3) criticised these social scientists for diverting attention from the failures of the health system. He argued that the inadequacy of the primary healthcare system, in particular, was the reason that rural Indians and others turned to traditional medicine. As Beatrix Pfleiderer later noted of Banerji's observations; "He reasoned that it was not the

belief in the smallpox goddess that prevented Indian villagers from accepting vaccination programme, but the fact that the governmental services were miserable, and wholly inadequate to community needs." (4: p. 415)

Since Banerji's review in 1974, studies of traditional medicine by social scientists, health planners, policy makers and scientists have continued; support by policy makers and patients for traditional systems as part of the Indian healthcare system has continued. A recent issue of the *Economic and Political Weekly* containing six articles on traditional medicine is typical of the on-going research on the history, policy and contemporary use of these systems (5).

Here, I will not address efficacy, as efficacy may be (and needs to be) determined by clinical trials or observations of the outcomes of drugs and treatments. The development of clinical research on traditional medicines, important to establishing beneficial treatments and medications, is in its early stages; it receives limited financial and institutional support. Strengthening research capacity is a necessary objective. If provided by practitioners of traditional medicine or their patients, testimony on efficacy may be considered "anecdotal". Compilation of drugs and treatments from sources such as traditional medical texts is a project now underway in India (6). Ways and means of studying efficacy are undertaken within the Department of Ayurveda, Yoga, Unani, Siddha, and Homoeopathy (AYUSH) (7, 8). In addition, cultural and social beliefs and expectations of patients, their families and communities may identify satisfactory outcomes in medical encounters that do not necessarily conform to biomedical standards.

In connection with concerns in the field of ethics in medicine, I examine the troubling intersection of the need for healthcare, especially among the poor, rural, semi-rural populations, and women and children, and the existence of a large, unregulated, unqualified medical cadre of practitioners meeting these needs. Included under the umbrella terms of "private practitioners" and "traditional practitioners," these practitioners detract from the contributions that qualified traditional practitioners may make to the healthcare system. And, while one may echo Banerji's stance of 30 years ago, that a robust and effective health system would dispense with a need for traditional medicine or leave it serving specialised needs, the dilemma of unmet health needs, documented over and over, persists. Patterns of high demand for healthcare by Indians of all strata support the widespread

network of private health practitioners, and are likely to do so in the future.

Objectives

Reflecting my training as a sociologist, as I began research for this paper, I had planned to focus on the socio-cultural foundations of traditional medical systems, showing their meaning for patients and, thereby, providing explanations of patients' behaviour. I intended to point to these concepts as important to understand as India develops its foundation for bioethics; I had planned to argue that a narrow medical, scientific, and legal perspective, such as often utilised in western bioethics, is not an ideal model for others to emulate. However, as I began reviewing recent studies of traditional medical practitioners and their patients, I was diverted by the problematic role now being played by traditional medicine as a provider of healthcare. It strikes me as a key ethical dilemma in healthcare provision. Unqualified practice threatens the reputation of both biomedical and traditional practitioners; it also provides sub-optimal, often costly and dangerous, treatment for patients (9). Today, although exact numbers are hard to come by, traditional medicine, or a facsimile of traditional medicine, is being widely practised. The anticipated demise of, or lesser role for, traditional medicine has not taken place, especially in rural areas and small towns.

First, I will discuss the policy decisions about traditional systems at central and state government levels. Second, using findings from a series of field and anthropological studies, I will discuss the issues that emerge as patients' use of medical systems is identified. These findings show the presence of unqualified medical practice as a challenge to both biomedicine and traditional medicine. Recent studies portray the role of unqualified practitioners as providers of healthcare to the poor, the rural, semi-rural, and urban slum populations. Within the conundrum of qualifications lies the knotty problem of the term: "private practitioner." Frequently referred to in health documents and studies, the term is elusive as the actual qualifications of practitioners are often not specified. A study by Bhat of private practitioners in West Bengal specifies that up to 65% of "private practitioners" identified in their study were not qualified in any medical system (10). Dugger, reporting on absenteeism at rural health posts in India, interviewed villagers who "turned to amateur private 'doctors' who have regular hours and plentiful medications to sell." (11: p. 1)

Legislation against unlicensed practice and cross practice (practice using medications and treatments in which one is not trained) exists (9). However, it would seem that legislators and health ministries must again address the ethical question of licensing, certification and other regulatory measures regarding medical practitioners in order to ensure the safety of patients, by the Indian Medicine Central Council Act of 1970 (8). Some states like Andhra Pradesh and Maharashtra have undertaken legal initiatives to ensure regulation of medical practice. Of added interest and in a broader theoretical vein, in the context of India's rapid economic growth and the increased

prosperity of the middle class, is the observation by societal analysts that as divisions between the haves and have-nots widen, the differentiated services of all types available on either side of the divide may emerge (13). Thus, an inadequate level of health services for the have-nots, described by Sen, Iyer and George in their study of healthcare inequities in Koppal District, Karnataka, may be characterised by "an unaccountable government health system and an unregulated private health system..." (14: p. 688)

The Indian systems of medicine and homeopathy

Ayurveda, Unani, Siddha, and homeopathy are identified as Indian Systems of Medicine (ISM & H) by the Ministry of Health and Family Welfare and, since 2003, as Department of AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homeopathy). Full discussion of the history, theories and methods of these systems is of academic, medical and scientific interest and may illuminate contemporary interest in complementary and alternative medicine. However, this paper highlights the dilemmas of on-the-ground use of traditional medicine. At the time of Independence, in 1948, the Bhoré Committee established the direction of India's health system without examining a role for traditional medicine, as has been frequently noted (15). Nonetheless, individual states continued support for traditional medicine and, by the 1960s, political activism on the part of leading Ayurvedic and other traditional practitioners led to the establishment of a central government ministry for the Indian medical systems. The physicians, colleges, research institutes and hospitals supported by this ministry may be identified, as Leslie called them, as primarily "urban" and "elite." (15: p. 313)

From this stratum have emerged trained traditional practitioners who work in the Indian medicine institutions as physicians, researchers, and teachers; who establish private practice; or who accept positions as staff doctors in the many new urban corporate hospitals (15, 16) While numbers of practitioners and facilities of ISM&H often vary widely, data provided by a WHO report in 2001 estimate that there are approximately 590,000 registered medical practitioners of ISM & H, qualified and unqualified (17). Another WHO report (18) estimates that 70% of the population in India uses traditional medicine. Based on a survey covering 35 districts over 19 states, a total of 45,000 sick persons in 45,000 households were surveyed by the Institute for Research in Medical Statistics, at the request of the Department of ISM&H. It was found that 14% of patients used ISM&H (19). Thus, one may refine the large percentage identified by WHO by identifying the situations in which patients resort to the use of traditional medicine, as was done in this study (19). This study identifies reasons given for using traditional medicine as showing "no side effect" and "low cost of treatment." (19: p. 137) Thus, the 70% figure represents both patients who may use traditional medicine exclusively, as well as those who may use it only for certain medical problems.

Since the central government and many state governments, like Andhra Pradesh, oversee the functioning of these ISM &

H facilities, for the purposes of this discussion, we will assume that guidelines establish proper patient care and treatment practices. The Indian Medicine Central Council Act of 1970 and subsequent acts reinforce standards for education, registration, and licensure (8).

The medical maze facing the patient

Once outside of this framework of government-sponsored traditional medicine, however, the ability of individual practitioners to establish their own, often eclectic, practice is unchecked. Thus, traditional practitioners, as D'Cruz and Bharat (20) suggest, take on the appearance of biomedical practitioners, by the use of stethoscopes and modern drugs like antibiotics which they are often ill-equipped to use. As a recent study of practitioners in Mysore shows, the incorporation of modern medical instruments and treatments in traditional practice is expected, but often serves as symbols, which are not used, or used incorrectly (21). The reality on the ground is that a cadre of ISM & H practitioners serves as a secondary part of the health system, "a health reserve" to which urban patients turn when biomedicine fails to cure (21: p. 207). In the situation faced by rural patients, such as those interviewed in a study conducted in rural Orissa, the reputation, proximity, and affordability of the medical practitioner explain their use of both biomedical and traditional services (22). However, in the rural areas, most practitioners are unqualified practitioners, and when the monsoon, or lack of funds, prevents access to more distant or costly health services, these are the practitioners of resort (22). Thus, there is a need for regulation of medical practice, and of the use of drugs and treatments not within the ISM & H repertoire. And, as discussed below, there is a need for strategies to strengthen availability and access to efficacious medical care.

As stated at the outset, recent research identifies a critical sub-theme when patients resort to a variety of practitioners. These studies reveal an end result of the stresses in the healthcare system, long identified and decried—scarcity of health personnel and resources in the rural health sector, in particular. I referred to Banerji's (3) critical identification of this problem, and more recent research shows the contemporary dimensions of the issue (23, 24). In the absence of services, and in the presence of need and demand, unqualified practitioners have emerged as routine providers of healthcare in rural villages, small towns, and urban slums (9, 11, 14, 21, 25, 26, 27). In their research in Karnataka on health inequities, Sen and colleagues identify a system of "forced pluralism" in which they found "spiritual and traditional healers, shopkeepers selling tonics and tablets, traditional birth attendants and RMPs (registered medical practitioners). Our provider survey interviewed 548 providers working in the 60 villages covering a population of about 82,000 people. This included 35 spiritual healers, 133 traditional healers, 178 traditional birth attendants, 47 RMPs, one qualified ayurvedic doctor, 152 provision stores and two medical shops. Although there are a few private specialists in the largest towns, the rural reality of Koppal is ...dominated by informal providers." (14: p. 688) Problems also emerge in the healthcare options available to tribal communities (28) to

rural patients in small, market towns in Maharashtra (24) and to middle and working class patients in urban Mumbai and environs (25). In a study carried out in an urban community in New Delhi, by Das and Hammer (29), an effort was made to determine the clinical decision making of various types of practitioners trained in biomedicine and in traditional systems as well as that of registered medical practitioners with minimal training, when faced with five typical medical problems (ranging from childhood diarrhoea to pre-eclampsia). The researchers found that the clinical competency levels of practitioners with all types of training, working in the public and private sectors, were lower than what standards required. Patients in poorer neighborhoods faced choices of less qualified and less competent physicians than did patients in richer neighborhoods. This study, although not solely focused on the traditional systems of medicine, again highlights the dilemma of forced pluralism, and also points out the socio-economic divide evident in patients' choices and their access to competent physicians.

In these cases discussed in recent field studies, the important social and cultural underpinnings of the ISM & H, which contributed to patient, family, and community understanding of illness and disease, identified earlier in numerous social scientific and historical studies, are less evident. The dire lack of qualified health providers in impoverished localities or failures on the part of biomedical practitioners frequently account for this type of patient use which may be described as "forced pluralism," (14: p. 688), or used as "a health reserve," (20: p. 207), and for provider practice that is "unethical and dangerous" (26: p. 885). This by-now entrenched pattern of inappropriate medical practice and patient use calls for a review of policy, a plan for regulation, and action against unqualified practitioners who can bring harm to patients through inaccurate diagnosis, inappropriate drugs, and harmful treatments. Moreover, the valuable socio-cultural and medical services provided by the Indian traditional medical systems, potentially important contributors to a sound bioethical policy, are eclipsed by this moral dilemma of unqualified, unregulated medical practitioners, sought out by unsuspecting, misguided patients.

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Editors: Sandhya Srinivasan, George Thomas

Published by: Forum for Medical Ethics Society and Centre for Studies in Ethics and Rights, Mumbai. December 2007. 288 pages. Rs 200

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Published by: Forum for Medical Ethics Society and the Centre for Studies in Ethics and Rights, Mumbai. November 2005. 248 pages. Rs 150.

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