"If you are not a part of the solution,
you are a part of the problem"
-Eldridge Cleaver

Practicing Responsible Healthcare

Monograph

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Chapter 1: Is the Patient, Just Another Case?

Medicine came out of a lot of pain and suffering. And there was someone who had to offer the hope of a cure to end it. “The suffering has led to the discovery of many medicines, vaccines, technology, instrumentations which have made the quality of health in the country better. But in the recent years, there has been a sharp decline in the image of medical professionals in the eyes of the common man. This is not a hidden factor. Partly it’s because of the materialistic influence which has made its way into the values of this system which is not to be proud of. It is not the isolated reason. That is when the idea sprang up of bringing in a group together to discuss about this issue and come up with new principles which we could all follow.”

To set the context and introduce the problem, **Mr. Thulasiraj Ravilla**, Executive Director, LAICO, comes forward “stimulus came when we looked around the level of malpractice. It is far more deep rooted than it appears.” He categorises the day’s topic into two broad buckets, one relating to practice and the other to design. He painfully talks about the whole issue of transparency and the irony behind the patients being a part of the healing factor. He reads out a mail which he received from a friend who resides in San Francisco. The mail details about how strange as it sounds that getting a vitamin A injection is nearly impossible in the country where he lives. Today the injection costs $1000 “only” in America. He puts forth various questions like **education has become an investment**. After graduating, the fuss is about how to get back the invested money. Like this many who, why, and how questions seemed to creep out. Mr. Thulasiraj sees this as the broad thinking platform for understanding and pondering on the symptom

Chapter 2: Responsible HealthCare or Responsible Medicine?

Prof. Jagdeep Chhokar, one of the founding members of Association for Democratic Reforms and an ex-faculty at IIM Ahmedabad, reads out the title of the summit, "Practicing Responsible Medicine", and strikes a main cord by asking should it be "**Responsible Medicine" or "Responsible Healthcare**." In response to this, **Dr. Para R Pararajasegaram,** a retired Consultant Clinical Ophthalmologist at Eye Hospital, Colombo and a former Adviser at the World Health Organization, says he is for healthcare because "We belong to a caring profession. Not merely a curing one." Mr. Thulasiraj seconds Dr. Para in saying that people in this profession should practice care giving because our ownership is in providing and not in preventing. Prof. Chhokar contradicts them by saying healthcare is important as it goes into the system. Whereas **Dr. B. Soma Raju**, the Chairman and Managing Director of Care Hospitals, expressed his concern on medicine being one component of a wider picture we all work for. To him medicine today comprises of **bio, psycho and social**. But **healthcare encompasses of everything, including politics.**

Mr. Gopi Gopalakrishnan, the President of World Health Partners, places his view on how vast the whole of healthcare was and time may not be sufficient to discuss it throughout. Medicine seems to be something practical and useful which can be implemented for discussion. **Prof. D V R Seshadri**, a faculty at IIM and ISB seconds Mr. Gopi's views on the wideness of the topic healthcare which triangulates to medicine. He suggests picking and choose topics to discuss as healthcare involves everything and everyone calling it a juicy topic. **Mr. D. Nagarajan**, a Seva - Arvind Volunteer, seconds Dr. Para on choosing healthcare as the canvas. **Dr. Jayaprakash Narayan** (IAS), Founder of Loksatta Party gave his consent on the existing title "Responsible Medicine" but going wider and deeper into the cause will be productive is what he opinionated.

At this point, Prof. Chhokar came out with a specific issue to be discussed. He pointed out that doctors are being constrained by so many other issues. They are not an alone entity to be focused upon. "**We are treating the symptom rather than the cause.** This is the same with education system. We cannot isolate the medical community. Medicine is too narrow whereas Healthcare is too wide to be discussed in this platform. Dr. Devendra has been a good example – a dentist joining healthcare." **Prof. T.Sundararaman**, Dean of School of Health Systems Studies, TISS, suggested zone of influence and zone of concern and how to

plan the individual concern, while he preferred medicines to be the topic of the workshop. Dr. Para quoted a Sanskrit saying, “Our eyes do not see what our mind doesn’t want to know” stressing on ‘Responsible Medicine’.

Chapter 3: Hospital, an Abyss?

Prof. Chhokar began the discussion by calling if today's doctors were really bad. Which other profession is more charitable than medical profession? It is tough to answer. In a society filled with corruption, how can this profession alone escape its influence? In these two days we will have to find a care which is available, accessible and affordable. We have to look at the good and bad examples and dissect them. We are here to add whatever we have to life not take away from life. People who teach have no idea of this. Interrupting Prof. Chhokar, Dr. Soma Raju stresses "**things are not as bad as it sounds**". Medicines never live up to the expectations of the people. Why does it look bad? It is because the media today and the internet look bad at medical system.

Dr. D. Bachani, who is currently working for MOHFW, Govt. Of India, Delhi, interestingly points out that even after so much of technical advancement, medicine is the only profession where there is consumer ignorance. Literate people are aware but still doctors prescribe anti-biotic and the consumer does not care. Responsibility is on all. There should be reformation in the medical education system itself. Politicians are investing in medical colleges and hospitals. It is a business. Student fee is very high in private colleges because of this.

Dr. Namperumalsamy, one of the founding members, is currently the Chairman – Emeritus, of Arvind Eye Care System; talks about mal-distribution in service providing. In Private sectors service is high. We should bring uniformity in service providing. Developing a proper doctor and patient relationship is very necessary. He suggests topics for discussion like urban/rural, public/private partnership where problems are prevalent. Insurance is one which is becoming communal.

Dr. Jayaprakash Narayan speaks from a patient's point of view. Patients, who got to the hospital, feel like going into a bottomless pit. The bottomless pit is the billing which is the last month in a patient's life. A patient when he comes to know that he is sick, he goes to the hospital hoping for the best. But there the scene is different. High cost MRI and CT scans, billing runs, necessary or not. Patient looks for the best, cost effective care. Are the procedures really needed? We need to ask ourselves. Ultimately the doctors become unpopular agents in this profession. Hospital care should become the zone of influence. Hospitals like Arvind should establish good health care. What are the deficiencies and what is

to be done? There should a change in the holistic management. Sympathy is absent. The system is designed to not look at the totality. For the past ten years, doctors' regulation is lost, failed. Professional regulation is missing. Disciplining the black sheep is missing. We should be protecting the society against the system but it is happening the other way round. So how to regulate the black sheep needs to be reviewed. We have Rs.100,000 Crores worth pharmacy system. **Bangladesh has regularised it.** When are we going to do it? India is arrogant about it. No poor country, unlike China has this kind of a body of panel. Pharmacy industry in India is world beater. Educational model has to be improved. Policy makers know nothing. We have to be responsible. India is going the American way in terms of cost and insurance. India cannot afford it at this point of time in history. This is exactly the wrong way. Policy makers are using the American model which will lead to a disaster.

Chapter 4: Conspiracy of Silence

Prof. D V R Seshadri gives the statement of the day, "**conspiracy of silence**". Food processing in the U.S, for example, is a sugar lobby; Muted voices saying about Coke/Pepsi being the reason behind failure of multiple organs. All these are profit oriented. Unless there are some checks and balances, things will go out of control. Rating order of hospital is important. Breaking the conspiracy of silence will remove the ignorance. **Life savings are gone in billing**. Let us break this conspiracy of silence. This exists in every industry. Same thing happened in the automobile industry with Volkswagen. It is happening in many religious groups and food industry. Attempts are to break the silence. Movements like fitness, yoga, and organic food are coming up the ladder. Same is with management studies. IIM's return of investments is high. People like Rajath Gupta are ready to mortgage their soul for money. Regulation is also heading the U.S way. In schools moral sciences are being removed. Prof. Seshadri breaks his silence about doctors who are given daily based targets. So they prescribe scans. **Transparency is the need of the hour. In the internal part of the system there is a lot of angst.**

Dr. Soma Raju, floating in the same direction as Prof. Seshadri, says yes, a lot of money is being spent in the last days of life. There are two types of doctors, he says. One is the kind who keeps giving hope to the family members of the patient and makes money out of it. And the other kind also gives hope. Even though in well meaning, the result is the same. In other cases, doctors will gut out of the situation if the patient is going to die. Another issue is that there are too many choices for the patients. It is difficult to choose. He also focused on how profit oriented industry doesn't make money but non profit make plenty. That is the irony of today's world.

Prof. Seshadri shares his personal thoughts on hanging his own will on his wall saying let me die in peace. Prof. Chhokar comes back to the same question as to where do we start. He requests each one to come up with at least three indicators that will help to understand and list out the systematic requirements for **Practicing Responsible Medicine**.

Chapter 5: The key Indicators

Dr. Suzanne Gilbert, the Co-founder of Seva foundation came up with three indicators: **placing the patient first; reach the community; and reaching the needs beyond the walls**. Dr. Soma Raju highlighted the three main indicators according to him as **bio, social/economic and psychological**. He gives an example of his college, Guntur Medical College, where doctors are taught to address the disease first and then the patient. This is just the expansion of Dr. Gilbert's point. Psychology by means he says that it includes the patient, family and the community. Dr. Para added up saying that the patient's **needs/expectations** need to be fulfilled. Whereas **Mr. R D Sriram**, Joint Managing Director – Aurolab, felt that **transparency** to the patient is the most significant of the process. Prof. Chhokar expressed that few patients think that the more we explain, the less we know about it. So transparency is needed for few, not for all. So the degree varies. **Dr. H Sudarshan**, a Social Activist and as tribal rights activist, Vivekananda Girijana Kalyana Kendra seconded Prof. Chhokar's views. Mr. Thulasiraj felt the need to **empower the patients**. Prof. Chokkar once again takes the lead in mentioning why patients get C-section in private hospitals. It is the people's choice to select the date and time by following astrology and numerology. **Dr. Nirmala Murthy**, the President for the Foundation for Research in Health Systems, rejects Prof. Chokkar's point by saying that a majority of people get C- section done because the doctors terrify them with last minute complications. The main indicator she puts forward is to earn the **trust** of the patient.

Dr. Soma Raju leads the discussion panel into discussing the **safest**, **effective, timely, patient centered, appropriate and sustainable healthcare** that can be provided to the consumer. **Dr. Koteshwara Rao**, the Founder of United Hospitals, Hyderabad, added **Standardisation of medicine** to Dr. Soma Raju's list. Prof. Chhokar comments on the point of patient centered, saying that for a doctor, **t**he patient is just another case. But for the patient himself, he is center of his universe. Dr. Para suggests that we should treat the patient with the disease. Dr. Gopi lists his three indicators: the care receivers are more concerned about the distance and the **cost in the receiving process**. He also added like education, **primary medicine** should be the beginning of our concern and thirdly, **reaching the remote rural** to provide should be the criteria. Mr. Thulasiraj to support Dr. Gopi's views, states an example of a General Healthcare Centre he visited in Oman. The working timings end there by 8pm. It was 7.45pm when he entered the Centre and was awe struck to see the responsible staff on

duty to provide care. They even had seven or even more years of complete patient record on tap. So here **documentation at the primary level** needs to be highlighted, he felt.

Dr. Rao says that we as a country often give excuses for maintaining a large population. Instead we have to create ourselves as role model for the rest of the world to show it works in this country. Dr. Narayan says that three things are overlapping; first being **investigative protocol. "Can we standardise it?"** Well, in reality it is not happening. Next is **standardisation of management**. Anti-biotic resistance needs strict protocol. The patient might be happy taking anti-biotic but a strict protocol is the need of the hour. If we are not coming up to the mark then it is not the failure of the doctor but of the protocol. Prof. Sarang Deo speaks in support of Mr. Thulasiraj on dividing the discussion into practice and design. How to practice responsible medicine? Doctors do not have the access to protocols. The practitioner does not know what he is practicing yet tries his best. As Dr. Soma Raju said, there are protocols existing which needs adaptation and adaptation. He specifies on the 'how' factor of it.

A turning point in the whole of the discussion takes place when **Mr. Vijay Poddar**, Member Executive and Finance of Sri Aurobindo Society, takes the level of discussion to a different dimension when he talks about the level of reconciliation. Each patient has to be treated at a different level. Practically it is not possible. He quotes an episode of Yudhishthira from Mahabharata, where everyone goes after the same goal. We should learn to live rather than to die, which is inevitable. This profession is not a curing system but a caring one. Words like caring, commitment, patience, dedication, love are not found in any of the protocols we follow. Another view he expresses is that certain things are not mentioned in the protocol but we still follow. **Spirituality** has to be the foundation, a true sense of reconciliation. He says even Dr. V talked about the divine will, the concept of philosophy to be lived at every moment we exist. He suggests that while we continue this discussion, it is necessary to bring a spiritual dimension to it as well. It definitely needs more time and follow up action. Medical education system should support this dimension and not sideline it. **If you move to the light, you need not move away from the dark, is what he proposes.**

Chapter 6: Incentivization, the root of irresponsible Health Care

Prof. Jagdeep Chhokar begins listing the causes for practicing irresponsible medicine. He put **conspiracy of silence** as the first thing on the list and second one on the list is **Incentivization**. Prof. Sarang Deo adds **lack of appropriate knowledge** that is most updated knowledge as one of the cause. Dr. Sudarshan appends **ineffective regulating bodies** as one of the cause for practicing irresponsible medicine. Dr. Nirmala Murthy talks about the other side of Incentivization that is the performance based payment. She looks at performance based payment from a positive angle. But Mr.Thulasiraj view performance based payment will lead to overtreatment. **Dr.B.Soma Raju suggests instead of performance based we can have pay on outcome based.** Prof. Jagdeep Chhokar asks what does he means by the term outcome in the case of patient. Dr.B.Soma Raju define it as end result, that is in the case of patient, it means the person is doing well and does not need repeated hospitalization. Prof.T.Sundararaman indicates the problem in outcome based payment, he says when you make it as a rule then people will start admitting patient who are little sick, who will fulfill their outcome and will stop taking serious patients.

Then Dr. Sudarshan talks about performance appraisal system in Karnataka, people should distinguish from private and public sector. From his reports there is no performance appraisal in that in public sector Karnataka. The non-operating surgeons in public sector are paid the same money as the person who does operations in Karnataka. Mr. Gopi Gopalkrishnan feels no incentives are also bad. Prof. Jagdeep Chhokar winds up that **Incentivization as one of the main cause for practicing irresponsible medicine.**

Prof. T. Sundararaman mentions that lot of study which done on Incentivization concludes that individual performance based incentives do not work very well whereas **team based incentives** works on certain circumstances. He traces how the system of giving incentives started. In earlier systems people were provided with necessary things, so that they can concentrate on their work. Later this method became a bad logic whether people work or not they get the same salary and therefore incentives were given to make them work. According to him incentive based on performance tends to misfire. On theoretical grounds it might have performed well but in practice they really didn't work. He thinks recognition of people who do work is required but it need not be monitory or financial incentive. He ends, by suggesting that there are different ways to encourage people.

Mr. Gopi Gopalkrishnan expresses his notion about the incentive system. Large corporate hospitals give incentives to get their work done. He propounds that why don't we disincentives people for not doing their work rather incentivizing for doing their work. There is no proper system to asses or monitor whether a person is doing his work or not. Prof. Jagdeep Chhokar, from his observation states that majority of individual private medical practitioners have links with hospitals, laboratories, chemists and they get their commission. To him commission is also a kind of incentive. He considers private medical practitioners are not individuals but are actually part of system. Mr. Gopi Gopalkrishnan says that individuals who can't handle certain situation refers to a particular hospital for reference and further treatment, for that they get incentives. Prof. T. Sundararaman talks about the problem faced by individual practitioners. In some cases if the individual refuse to accept commission, then his name will be spoiled by them. By law giving commissions is not illegal, the commissions are legally happening in all the places for the two or three years. Prof. Jagdeep Chhokar says that if it is happening in all the places doesn't mean that we should not deal about it.

Dr. Para reveals that how Indian private practice system is responsible for the raise of incentives practice and there by responsible for practicing irresponsive medicine. In India most of the private practitioners follow a system called fee for service which is really based on incentive whereas in most of the other countries there is no system called fee for services. They are called tag rate that is diagnosing rate, for example if a practitioner is treating a particular disease he have to charge a particular amount only. But in India there is tremendous incentivization to do irresponsive medicine from the bottom clinic to the super. He concludes by saying that incentive system is exists in all levels.

Dr. Sudarshan talks about insurance mechanism in Karnataka. There they give more incentives for a NABH accredited hospital, if they are providing good quality service. Dr. Namperumalsamy states that many private practitioners are not equipped with laboratories and other facilities hence they need it or not they have to refer other hospital or Laboratories. From Prof. Sarang Deo point of view anything that you get in return is also called incentive whether you are providing healthcare service or any other service. To him incentive is a monitory consideration for a service that is provided. Prof. Jagdeep Chhokar questions him whether we should call salary as incentive. Prof. Sarang Deo replies that there different type of incentives some are bad incentive other are good. Dr G. N. Rao reads the definition of incentive as; "incentive is something that motivates an individual person to perform an action". Dr. Nirmala Murthy accepts Prof. Sarang Deo point that salary is kind of incentive.

Dr. B. Somu Raju redirects the discussion to concentrate on how incentive affects giving responsible medicine rather than discuss the definition of the term. Prof. Sarang Deo suggests lay out different types of incentive schemes and listing the merits and demerits then deciding incentives are bad. Prof. Jagdeep Chhokar ends by saying that anything **above salary is incentive.**

Dr. B. Soma Raju tells that individual doctor is not responsible for getting incentive in some cases the whole team is responsible for that. According to Dr.R.D.Ravindran if the doctor himself investigate and treat the disease then it is a fee for service. But in many situations the investigation is not being done by the individual practitioner, he refers to another person for procedure or for diagnosis. At that point it become commercial that kind of incentive is not acceptable and is a kind of irresponsive practice.

Dr. Jayaprakash Narayan says that we have to recognize the backdrop for understanding clearly the reason behind giving incentives. First of all about 70-75% doctors in India have no formal employment whether in corporate sector or in company so the whole issue of salary is not applicable to medical practitioners. The second thing is incentives received by institutions have nothing to do with individual's morality. The third things the cost of establishing a high quality hospital is much higher. The physical cost of equipment and the salary for highly qualified doctors are greater so definitely it's a challenging task to provide high quality healthcare without the support of other systems. He asks everybody to suggest way to manage cost as well as quality.

Mr. Gopi Gopalkrishnan explains how we can deal with the cost factor. When an entrepreneur wants to start a business he looks at the market for what is the demand for their product and then invests. That sort of thing is not happening in healthcare system. He gives examples for that; there are more MRI scan Centre's in Bangalore than in entire U.K. He says medical practitioners who want to provide service should also possess business sense; they need to understand what the actual market demand is. He also suggest that government policy needs to be regulated because in most of the countries a medical practitioner can't start his own hospital in any place whereas he can do in India.

Mr. Thulasiraj express that the whole medical industry is inefficient to handle the situation, on order to fill up the gap in the outcome some are following unethical way. **For example if they have more diagnostic capacity then they unnecessarily suggest for various test to maximize the utilization of their equipment**. The other method they use is

overcharging. On the one hand we have huge unmet need on the other hand we have underutilization of available resources. So we have to find a mechanism to efficiently utilize the available resources.

Prof.T.Sundararaman gives a detailed description about how the management plan should work. In the past the department of medicine and drugs are handled by the department of pharmaceutical and not by the department of health. Today lot of healthcare planning happens in the department of industrial promotion and policy. Industry is defined by return on investment when it comes to healthcare system the entire motivation is not how much health they provide but how much return they can get. So there is largest inflow of venture capital and private equity is put into one of the second largest area that is healthcare industry. He give examples to show how certain hospitals are trying their best to cope with the changing environment. Mission hospitals which are known for maintaining their value are shutting down in many places as they are unable to earn enough to survive and manage the cost. But some are changing their strategy by following the corporate model. In many cases some who decide to stick to values are not able to survive. He ends with the positive note there are exception. Those who able to find the right set of management policy can remain inclusive and survive. It is important to see how these values are worked into management policy so that will lead to the success. Dr. Jayaprakash Narayan tells there are many small hospitals which provide reasonable health care are disappearing. Their charge is also less but increasingly they are reducing in number because the corporate sectors are attracting many and destroying them.

Mr. Vijay Podder summarizes the causes discussed and recommends that the answer for all the problems can be finding from the past experiences. He analyses how the idea of incentive started. In the past also people face similar problem but they handled it well, so wisdom from the past can be used to meet the challenges.

Prof.T.Sundararaman tells that incentives are bad when it is closely linked with commission and plays a major part in decision making. But it does not mean that we need not encourage overall performance. Dr.G.N.Rao says in the case of return on investment the returns could be in any form not necessarily financial. **It could be enhanced public health, could be research product or could be medical discovery.** He adds that most doctor today look for an enabling environment if they have enabling environment they won't look for

money. Dr.B.Soma Raju says in medical field the term return on investment should be defined differently.

Mr.D.Nagarajan put forth the important point, that is, the proper utilization of available resources. He proposes that the unmet need can be done using the available resources without additional installation of equipments. Dr. Para Rajasegaram brings in the issue that if the return of investment is the primary concern then the hospital may force the patient who is unable to pay, in an unethical way, like suggesting a scan where it is not necessary. Dr G. N. Rao's opinion is that if importance is given to quality primary and secondary care, then the cost will come down.

Mr.Thulasiraj explains the reason for incentivization. He says that if an infrastructure is created and if there is no right kinds of system to utilize the resource. Then they may over treat to utilize the surplus. They may suggest some procedure to use the available facility.

Mr. Gopi Gopalkrishnan proposes that to reduce overcharging one need to increase the supply but the quality should also be considered. He also press that primary health should be given importance to reduce the cost. Prof. Jagdeep Chhokar insists that we should not wait for government to do something; we should start doing something and show the government that these kinds of things are possible. Mr. Gopi Gopalkrishnan advocate that role models like CMC and Wardha are available and government can take those models and replicate. Mr.Thulasiraj says that the problem in replicating the role is that they have to replicate not only the physical structure but the values also which is a difficult thing. Prof. T. Sundararaman also accepts that not utilizing the available facility is a big problem. He feels insurance can make a big difference. But Prof. D.V.R. Seshadri feels insurance is double edged weapon and has to used properly otherwise the hospitals may load people with tests.

Chapter 7: Refusal for treatment, whom to deliver care?

Mr. Thulasiraj correctly points out that the most common statement has been: **whom to deliver care?** Whereas: who do not receive care, the left out population; should be the main focus. The malady lies out there. The question seemed wide and unending. Dr. D. Bacchani concludes the session by listing the causes that leads to irresponsible medicine. In many states allowing Government doctors to carry out private practice leads to difference in services, he considers that as an irresponsible medical practice. Secondly, he thinks the increase in the number of cases in outpatients department may lead to poor quality of care, the time devoted by the doctor is less and that leads to irresponsible medical care. His final suggestion is **in case of emergency nobody should refuse, refusal for treatment is also considered as irresponsible medicine.**

Chapter 8: Corruption, the endemic disease

Dr. Sudarshan gives a presentation and shares his experience of working in Karnataka Lokayukta. Lokayukta institution is one which is implemented in 18 states. Karnataka Lokayukta is the one that is progressing well. Karnataka government is the one that really brought in the Lokayukta institution. Dr. Sudarshan says that he was mainly in the primary health care, covering nearly 1.5 million populations in 6 different states.

He was called by the then S.M. Krishna the principle secretary and said they would have a health task force and he was made the chairman to look after the entire health sector and make complete recommendation to improve the health. He and others in the Lokayukta have listed major issues of concern and they have put corruption on the top of the list. Karnataka Lokayukta was formed in 1961.He worked as the honorary chairman of the taskforce and he wanted to work as an honorary in the Lokayukta. Then he was forced to take one rupee salary because he had to be salaried person to get judicial immunity to work in Lokayukta. It had been one of the progressive one; any public servant can give any complaint even against the chief minister; it has so much power so the government has taken away, and finally they took away the element. When they started visiting various districts and talukas, for the first time in history they made the doctors, nurses to payback the bribes taken, in front of the media. Initially they were booking cases then they found that doctors were very happy if they charge Lokayukta case because they got their full salary after three months and they could continue their practice. So they stopped booking cases and suspending doctors. **Therefore publically shaming** was the target and that happened. Dr. Sudarshan called it an epidemic of corruption, an illness initially he thought it was something which can be eradicated like smallpox but now he called it a chronic disease like tuberculosis as he thought that he could not completely eradicate.

Drugs control department is supposed to provide good quality drugs to people of Karnataka. On 2,268 samples tested none of them were of standard qualities; files were opened but not a single case was booked on them as bribes were taken. The DCPO has the first control order but they allowed the company to sell the drug at higher price and finally they sacked the drug controller. Today, Karnataka have a much better drug controlling system. The bribe for drug controller officer was 18 lakhs but today it is all merit. It took him 2 years to understand the mafia working in it. The procurement of drugs, the Nimesulide was

banned in Europe and America but 18% of Karnataka drug budget went for Nimesulide, because that company gives the maximum kick back. Then he talked about Equipment procurement, dialysis machine worth 5 lakhs are bought for 12.6 lakhs. Then he asked if anybody got any machine for removing cholesterol from the blood. Then he said In Body hospital in Bangalore have one for which they spent 60 lakhs. Every patient has to spend 75 thousand rupees to undergo that procedure. Then he explained about the corruption in the hospitals; from ayyas to specialist, everybody was involved. Then he talked about bribes for services from admission, issuing medical certificate and so on. Then he presented the corruption among private practitioners; there were no operating surgeons; there were 110 of them who had their nursing home, referring to private hospitals for operations. Then he talked about the corruption in administration in recruiting, posting, to get a posting near Mysore city, transfers, promotion. Medical policy corruption was also there in private medical college, a student has to pay 30 thousand rupees, it has to be paid by all the 100 students, this was called not to fail amount ,a mediator collects all this money and distribute it among the examiners. Corruption in procurement, recruitment and in all the corporate sectors, he found that Toshiba, Philips, Siemens all of them were supplying equipment. They had middle men and there were lot of deals; Wipro GE is the only one who has ethical marketing principle.

There is commission for diagnostic in Bangalore today, MRI cost 16thousand rupees but for prescribing, a doctor gets Rs.4000. Laboratories are very clever if there are 10 lab investigation, they test 3 put the normal value for 7 and charge for the 10.He said he got opportunity to go to other countries and study the NH system, he observed that they also have a counter fraud and security managing system. In Hong Kong they have the very strong anti-fraud structure. Private sector corruption is also there so there is no use in blaming only the public sector. Health sector in India is the second most corrupted according 2005 report telecom was the least corrupted. Money demanded in the northern states is less compared to the southern state, because the money giving capacity is less in Uttar Pradesh and Bihar compared to Tamil Nadu and Karnataka. In ranking, India is one of the most corrupted countries; it is in 76^{th} position in corruption. Looking at the states corruption perception study Kerala has the best health indicators least corrupted and Bihar is the most corrupted according to the study

Prevention of corruption is what he tried, in order to bring in some systemic changes that they brought in integrity pack; he called in all the drug manufactured and assured them that there will be no bribes next year so they brought down the prices**.** Now they give

counseling; counseling is the best method. Transfer policy act had been done and it will bring down corruption in the transfers. They tried to have a system in place but it is an individual based but the corruption in procurement have come down. What they also tried was that they wanted to cancel the license of the people who involved in fraud. But then they realized that Karnataka Medical council had not cancelled a single license in the past 15 years; they gave the evidence and succeeded in cancelling a license of a doctor who involved in corruption.

Then Prof. Seshadri asked him how you would protect yourself. For that Dr Sudarshan replied that we have police protection and states that people are ready to accept the reality and they wanted to change, he feels there are some efforts but still need to go a long way. Then Prof. Seshadri inquired him what interested him to take these kind of high risk job and how he got the courage. Dr. Sudarshan explains that the inspiration he gets from **Aurobindo or Mahatma Gandhi, the inner spiritual strength he had, they inner motivation gave him courage. He concludes by saying that the values have tremendous effect** and gives him inner joy, fulfillment for taking up these challenges.

Prof. Jagdeep Chhokar continues the discussion by raising the question how the new laws or polices can be implemented. He alludes from the preface of the second book of Indian constitution which states that constitutions are inert statements which do not work. Later he asks who have the power to implement these policies and then he expresses his view about leadership. Finally he asks Dr. G.N. Rao to present a framework to make things work practically.

Chapter 9: Awareness

Mr. Thulasiraj gave a brief introduction about the three major points that are emerging; one of them is about the changes happening in the field of the medical education in terms of its quality, content and the corruption around it. He said that there is a major policy shift happening and feels that the coming of **NMC** will make things better. Then he talks about the two types of Insurance -the private and the state insurance; the second one seems to have a wider reach according to his experience. The third thing he mentioned about is quality. He feels that certain quality measures will definitely improve the quality and he also insists that the push towards quality will consume some of the resources.

Prof. Seshadri proposes that somebody has to break the conspiracy of silence and he suggests that social media can be utilized to bring a change in the healthcare system. If people flag a particular doctor in the social media, that a particular doctor is a cheat then, people can't escape. He suggests that social media would be a good platform for people to share their experiences, if two or three committed people manage that platform.

For Prof. Seshadri proposal for using social media, Dr. Koteswara Rao replies that we have to be cautious in flagging people in social media, as sometimes it will be difficult to conclude which procedure is necessary and which is unnecessary. His perception is that a lot of harm could be done. For this opinion Prof. Seshadri mentions that we can draw out bad experience alone. Mr. Gopi Gopalakrishnan also agreed with Dr. Koteswara and says that lay person making a comment on medical procedure would be a dangerous one. He also adds using social media to flag is far more dangerous, as lot of abuse is happening in social media. His view is that these things have to be deal in a judicious way. Then Prof. Jagdeep Chhokar warns that we have to be more careful about these things.

Mr. Gopi Gopalakrishnan implies that we have to bring our focus into primary health. He put forth the idea that people never got a proper primary health care. For that Prof. Jagdeep Chhokar gives a mischievous comment that there was never a primary care. Mr. Thulasiraj implies that we have to redefine our primary health. Here Dr. Sudarshan points out that most of the people can't access the available care.

Dr. Para presents an index of things that have to be implemented in healthcare. He expresses that in reorienting medical education, significant change is needed not only in

education but also in assessment. He added that though everyone knows everything well in training but they have to implement it. The second thing he mentioned is the system; a proper system is necessary for implementing proper responsible healthcare. He stresses that patient is also equally important.

Dr. Nirmala offers a suggestion that if we provide a model on **value based responsible medicine** then people will know that there are alternate successful models. Then Mr. Vijay Poddar expresses the difficulty in defining a responsible medical care. He recommends that one of the ways to define responsible medicine is to take an example of responsible medical system and show what happens there. Then he put forward the point that **spirituality is the foundation** for all system, process and structure. He insists that however demanding the situation one must find a way of moving forward. The second thing he mentioned is about innovativeness. According to him inspiration for innovativeness comes from higher will. He asserts that we have the capacity within us to face any demanding challenge. He offers his help to implement these things on the spiritual side.

Mr. Gopi Gopalakrishnan expresses his view on the importance of standard which a quality medical practitioner should possess. With his experience of working in the very poor states like Bihar and Uttar Pradesh, he claims that there are more **than 8 lakhs of informal medical providers who have direct contact with rural people**. He says that the cost of medical consultation of these medical providers is low compared to the charge in urban areas and hence the quality is highly suspected able. He believes that there is no uniform system and considers that as a critical issue because under qualified medical provider are highly dangerous.

Chapter 10: Doctor-2.0, a version update

Continuing medical education is what is done in the lot of medical conferences but ironically these conferences are sponsored by various pharmaceutical companies. The doctors have no other means to keep updated and get information. Once the doctors finish their education there is no other way for the doctor to be updated and know what is happening in his own field. The only way they can update is through the meetings sponsored by the pharmacy companies. One of the suggestion which the doctors has given is the medical colleges in which they studied should hold every year refreshers course to know whatever is happening in each field. So that doctors could attend those meeting and these kind of meeting won't need heavy sponsorship. Dr. Sudarshan says the central government should make the **medical council to make it mandatory that every 5 years there will be re-registration**. He states before re-registration they should have some credits and they should make it compulsory. No state has made it compulsory. In U.S the doctor has to earn some credit points to renew their license. Pharmacy council is the only one which has made it mandatory. Dr. B.Somu Raju's opinion is that continuing education is important for a doctor and says inside an organization continuing education is possible. He also feels there are some issues in sponsorship. Dr. G. N. Rao thinks there are lots of opportunities existing in this country, for example LVPEI as an educational system is open to for use for whole medical fraternity but rarely people utilize this. He thinks people don't need sponsors. With minimal fee good continuing education is possible. In U.S they have the recertification exam once in every five years.

Prof. Sarang Deo comments about two things, first one is about the online open course and books the second thing is ,the is gap in education so he says it is good to focus on continuing education. He feels there should be some kind of mechanism to train people in their daily operating setting. Dr. G.N.Rao says the spark reality is that our medical education is bad and post-graduate medical education is very bad. He advocates first the quality of medical education has to be improved. Dr. Sudarshan concludes that we should not work in the clutches of pharmaceutical companies, we should learn from the **evidence based medicines.** Mr. Gopi Gopalkrishnan winds up the session by mentioning that we should

empower the clients and use insurance as a way to pressurize the providers to give quality medical care to seekers.

Chapter 11: Getting it to work

Dr. Rao expresses that all are looking for Formal Universal Health coverage which is the aspiration of most of the countries also. But how can we attain that in an ethical fashion is what we are addressing yesterday and today, the two fundamental factors that seem to be the basis of the discussion was values and standards. As Mr. Vijay Podder pointed out unless one has strong foundation of values the other structures may not sustain. He examines what we can be done immediately with the current system of problem in the medical care, what can be done in the intermediate term within next 5 years and what are the long term propositions. He adds that we have talked much about values and how to inculcate; by catching the students while young and giving them classes in ethics in medical school. He voiced his discontentment in the way the medical students are recruited today, he finds that scoring method in our system of selection in medical schools and engineering schools don't look at the comprehensive development of the individual.

Second thing he talks about is propagating role models both at the medical school level and among the practitioners. Then he proceeds by mentioning about the importance of continuing education and he is unsure whether they will have any influence on changing the values. Finally he asks everybody to suggest for immediate and longer term solution for the existing medical practitioners.

Mr. Thulasiraj shares some of the information, he mentions that the same kind of discussion happened many years back in the business community. World Economic Forum had drawn out a document on ethical way of doing business, which Mr. Thulasiraj believe helps in forming a clear understanding of what it is ethical and unethical. He put forward the idea of modeling a charter and making it available, he feels this will give some clarity of what to do and what not to do. He expects that this will help to move in a direction.

Prof. Jagdeep Chhokar proclaimed that if we give charters and if, all the companies signed on those ethic documents but how many of them implement them practically is a big question. He indicates that if nothing changes on the ground, it is of no use. He is skeptic about the fact that, how many people are hacked for violating this ethical norms.

Dr. Rao indicates from the information he read somewhere a few years ago that only value based organization can sustain in the long term. He was suggested by a person to

identify top 5 values and use them in the recruitment process and also emphasis some of the values on the staff both on existing as well as the newcomer. The other thing that he advocates is role models, Values are very important at **every level unless the leader lives the values**, it is meaningless to expect the rest of the people to follow the values. Then he brings in the topic submitted by Prof. Seshadri breaking the conspiracy of silence.

Second thing which he seems to emerge from the discussion is **cost factor.** He draws from Mr. Gopi's point that if we give more emphasis on lower level primary and secondary care the cost automatically goes down. He advocate that the models developed by Dr. Sudarshan and many other models developed in Bihar can be replicated, to reduce the cost factor. About Insurance he accepts the view of Mr.Thulasiraj that it is important to empower the consumer for the proper utilization of insurance.

Third thing he put forth is the proper utilization of available resources there are many available infrastructure across the country if utilized properly automatically cost will come down. He winds up by saying that once the cost is controlled, some of the financial fraud that is happening in our system can be controlled.

About applying standards he thinks, insisting on checklist won't be practiced by many. He feels that if accreditation is not taken seriously and is not implemented uniformly across the country then there is no point in talking about standards. While expressing his view about role model leading by example he finds that the quality of faculty members in medical colleges is very low. According to him they should inspire students and be a role model to students. He wrap up by saying that unless we have them and even if we artificially change certain system, the thinking of the student is not going to change. **A good efficient faculty will not only teach how to diagnose and treat but will teach the whole system of medical care including ethics which is what lacking in our medical education system.** Dr. Rao welcomes the view expressed by Mr. Nagarajan about the issue of continuing education. He says that in the western countries that it is mandatory to spend certain number of hours on continuing education. He suggests that there are lot of materials available online and offline. Finally he proposes that there should be a policy framework unless there is a strong policy framework in the government there won't be a huge impact across the country.

Dr Sudarshan refers Mr. Madan Gopal who brought tremendous changes and the reason he finds behind his action is the spirituality. **He thinks spiritual values really transform** and can have tremendous impact. To counter his statement Ms. Rema Nagarajan

retorted that having involved or being a member of any spiritual movements will not cease the corruption. She says that if you belong to a sect or spiritual group you will have value system is wrong that is not necessarily true. Prof. Jagdeep Chhokar accepts the views proposed by Ms. Rema Nagarajan. Prof. Sarang Deo claims that there are different types of values, spiritual values, moral values, professional values and also aligns with Ms. Rema and Prof. Jagdeep Chhokar view and conveys that value need not always be a spiritual value.

Chapter 12: Building the Value System

Mr. Thulasiraj on the ways to proliferate values recommends that value should be embodied in the system and we should constantly check whether we are following it properly. Prof. Jagdeep Chhokar expresses his view that it is difficult to work against the society as the society is more valueless today.

Prof. T. Sundararaman who has a positive outlook propound that we are moving forward in terms of gender, caste and racial discrimination. He feels that the society has progressed a lot and everyone should understand and take confidence from that and give positive examples. Mr. Gopi Gopalkrishnan tells the ways to functionalize the issues of values. He says that in about ten years we will get good doctors if we do what we are doing now, he wraps up by saying **we talked about the quality and patient centered value based health system,** we have to empower the community and appreciate the institutions that are practicing values, which are patient centric. Finally he says we should push the institution to practice values. Dr Nirmala Murthy proposes that there are various systems which have used these values and if we take that example and look forward to show how the value based system are working will have an impact on the society.

Mr. Gopi Gopalkrishnan brings about the complication in applying the values. He finds that the problem is when these set of values clash with other set of values from other institutions, he put forth the question how will we have to align our values with others so that there will be some level of compatibility. Mr.Thulasiraj suggests that if we design the system and put the values as the substructure will help.

Dr. Narayan, points that Mr. Vijay has showed us the right path to walk ahead. He says spirituality and knowledge are not antagonists. Practically speaking, there are certain systems working against the two. That's when Dr. Devendra insists in bringing purpose to medical education. In dental colleges, the 'why' question is frequently asked by his seniors. The most common answer from the students would be to serve the community but seniors' rubbishes this answer. If any student says that he wants to earn good money through this profession then the seniors appreciate it. Ultimately, the student's purpose with which he enters is misplaced.

Mr. Thulasiraj proceeds with Mr. Vijay's cue, stating that there are two distinct components: healing and dealing that we have to look into. Desire is there but no action is being taken. Education is supposed to deal with knowledge skills and attitude. Though we have addressed areas of knowledge and skills; attitude or character building along with knowledge is difficult to achieve. Medical profession is largely accountable for what happens in the protocol. The drive for outcome is amiss. Mr. Nagarajan comes up with an example of China. China to protect them decided to build the Great Wall of China. But after that more invasions happened. Invaders did it by bribing the guards. Walls were strong and huge but guards guarding them lacked integrity. So it is must to start character building along with the structure. **Ms. Rema Nagarajan,** a Senior Assistant Editor at the Times of India, Delhi, stresses on the value system. She says value system fit is missing in our medical education system. While hiring people for constructing the Delhi metro, the chief person said when asked that he looked for people who had integrity and not just degrees. That is the reason behind the metro project was completed in a short period of time than it took in the other parts of the country. We have to inculcate value system to build an institution. In Aravind, she says the staff has no incentives. They work on the fixed salary. In private sector, everything is based on incentives. The tragic part of this is that nobody is coming forward and saying that this system is wrong. This is the conspiracy of silence. This she says is a huge problem. Taking public stance even when it is unethical creates a lot of confusion. An example for this is the pricing of medicines at hospitals. This is the revenue system for the hospital. Selling medicines at a high price is unethical. Aravind knows that this is wrong. At this juncture we should come together and point out that he/she/they are wrong.

Dr. Bachani suggests that the system should be team oriented, like what is to be done and by whom. We have to start seeing a person in *Toto*. Dr. Rao intervenes by sarcastically saying, 'the system will not survive if incentives are not given'. This is the advice given by the management and vice versa. Ms. Rema compliments Dr. Rao's statement by saying that the alarming thing happening right now is that Hospitals are run by MBA's and not by doctors. MBA's do not have concern or the patience needed in this profession. All they know is return on investment, profit and loss. Prof. Chhokar hilariously but correctly points out that not only medical profession, but journalism is also heading towards the same goal of measuring profit and loss. Educational system too cannot be looked at as a profit making system just like medicine. The core system is clogged if this is the scenario. Profit motives have ruined the profession. We talked about the value system. Medical educational system

needs a lot of upkeep to be done. This is the larger issue to be dealt with. Value inculcation is a large topic. This group cannot do it alone. Policy regulation is required. We are not an isolated entity. We have a group following us whom we can influence. He raises a question, what we can do.

Mr. Gopi proposes to establish institutions to prevent this profession from turning into profit gaining activities. Dr. Para says that in medical education system, the major role is on who educates the younger generation. The attitude is lacking. Attitudinal misbehavior has many outcomes. At the educational level, this can be corrected. At the primary level, he recommends the educators to give attitude and knowledge skills. The educator should be a role model whether it is the teachers or parents. Correct attitude is important which is not available in school books. So setting up a role model has to be necessitated. Prof. Sarang Deo comes up with a slightly modified idea about value education. He says it is a problematic discussion. It tends to put people in shame or embarrassment. It is unreasonable to ask people to create values in institutions when it should start at home. Being a father of a 10 year old at home, he says that is where he can make a difference.

Dr. H. Sudarshan talks about introducing policing system. To substantiate his idea, he gives an example of himself. The Karnataka Medical Council is not aware of his license expiring date. They have no idea whether the person is alive or not. State Medical council is corrupted. It is more interested in medical colleges where money flow is high, as a result of which there is no policing. While he was submitting his proposal on the problems faced in the healthcare system, corruption was in the first position. While handing it over to the government, **the first thing they asked him to change was to put corruption in third or fourth position**. This kind of attitude needs to be changed, he says. The reason for all this, Dr. Rao says is the generational shift. His father was a doctor. Doctors then never compared their income with businessmen friends. This generation is doing it. This is getting worse. **Will this discussion have an effect on the societal change?** He questions. Prof. Seshadri intervenes by saying that Narayan Hrudayalaya did well until hiring four IIM's toppers. The luxury lifestyle of chairman is from sucking blood out of the patients. Entering a graded business school or hotels or engineering colleges has no grading for the common man. He suggests that there should be a forum of people who have a deep knowledge of how hospitals work. An indicator for hospitals like a score card is desperately needed. Dr. Nirmala Murthy insists on the need for checklists. She questions Prof. Seshadri on how far can transparency work and how to rate a score card. Transparency does not work on all levels. Ms. Rema takes

CMC Vellore as a role model for having values installed. It has made a difference in the educational system it follows. Teachers have the responsibility to create that difference. Dr. Rao on the other hand states that the well-known names in ophthalmology to students are the ones who are the most unethical ones. We glamorize the lifestyle. These names are stuck to the memory of youngsters. How are we going to change these mindsets, and **present good role models to the younger generation is what we should be headed to.**

Prof. Chhokar states that there is a societal decline. Globally, we are moving towards capitalism whereas communalism is dead. He accepts the fact that values are inculcated at home. Institutions can reinforce or balance the values inculcated at home. "There is more to money". This message often does not come out. There are things to be done for short term and long term. Change in the medical education system is a long term need. How it is to be done is different. Legal education is even worse in our country. Influencing the government, he says he is not for it. Today government will agree, tomorrow it will change and disagree. So it is better to do it individually. Definitely, a watch dog is needed. A body or group is needed who are not willing to be corrupted. Ms. Rema seconds Prof. Chhokar's thoughts adding up that if the vision is strong then the M.B.A's will follow the good vision. A good example is Arvind.

Mr. Thulasiraj before going for a lunch break sets the stage for further discussion on mandating things**. Change happens only when it is mandated**. It is a powerful tool which can be used for a good purpose.

Chapter 13: The Role Model

Prof. D.V.R. Seshadri suggests that three or four of them can design a course on ethics and values in healthcare and distribute it freely to all medical students. He thinks using technology as a tool we can show people that a good way of practicing is possible

Dr. Devendra Tayade expresses that people need inspiration and that there is a need for good model. He suggests good people can come and share their model in forums. Second he proposes is sharing the available documents about good model and show the students that these kind of practicing is possible and there by inspiring them. Dr. B.Somu Raju says instead of giving lecture on value system we should provide them with successful models based on value system and show them how it succeeds, how it works. Dr. G.N.Rao mentions that models which he is following may serve as a good business model. This can be decoded and show people that this model which is practicing responsible medicine can work well on financial way. Prof. Sarang Deo tells **he has been documenting models on primary care which are sustainable but not profitable.**

Dr. Koteswara Rao advises to bring in uniformity in medical education and training, thereby improving the standards. Dr. G.N.Rao adds on to what Koterware Rao said. What he is looking for is basic minimum standard for care and basic minimum standard for medical education. He thinks this will help to achieve uniformity in care and treatment and these should be given importance in medical institution. His second point is developing integrated primary and secondary care groups with potential and for every ten Primary Centre has to be linked with a Secondary Centre so that the revenue is met. It is like a model of **community hospital linked with several clinics.**

Dr. Para Rajasegaram emphasizes the importance of customer satisfaction. He says customer satisfaction will lead not only to more patients but also to sustainability of the hospital in long run. Then about quality he says it is not just clinical quality, the quality which the practitioners use to satisfy the patient is more important. He proposes that the means to implement these qualities is through education. He stresses that not only quality and skill should be imparted through education, the teacher should also serve as good model. **Dr Nirmala Murthy considers hospital rating system is a good idea worth implementing.** Second point she suggests is educating people to practice responsible medicine. Dr Koteswara Rao asks to define the criteria for rating the hospitals.

Prof.T.Sundararaman suggests there is a need for tool of advocacy, he advocates developing a charter for responsible health care providers. The charter should set out the values, sets out the indicators, and also displaying the features of business models. Then he talks about accreditation systems. There are many quality accreditation systems but he suggests we may create our own scoring system to critically examine to see whether they are taking care for responsible health care provision. **He feels most of the accreditation system are looking at physical standards and are not focusing on value based healthcare system.** He suggests that with our own standards we can intervene and we can advocate. He proposes that we can circulate these **charters in various areas** and make it accessible to everybody.

Dr N. Devadasan thinks that the steps they are taking should reach out wider by using technology and they should bring everybody into the network. Second thing is Health financing, he tells that we have seen how the government and medical council has failed in pushing the practitioners to practice responsible medicine. But at the same time in Karnataka by using financial tool they have made big hospitals to bring down their mortality rate in the hospital from 3% in cardiac surgery to 1%.Using money as legal agenda the insurance company as payer can influence the practitioners. What we can do is document this and educates the insurance companies to force the hospital to practice responsible medicine. Prof. Jagdeep Chhokar from his experience as a patient feels that the Insurance companies extract from the hospitals and practitioners, **so he feels it is easier to educate the Healthcare Industry than the Insurance companies.** Dr Jayaprakash Narayan asks him to explain how they bring down the mortality rate. Dr N. Devadasan explains, the Karnataka government runs the Vajpayee Arokya scheme, so every month they monitor outcome of the scheme. One of the thing they noticed that was the mortality rate in cardiac procedure is 5 % in big hospital, so the organizers of the scheme sent a letter to the hospitals saying for cardiac procedure it should not be more than 1%. Then the mortality rates came down. **They also did death audit.** As the scheme is paying the money the hospitals allows them to check the hospital. About Insurance Mr.Thulasiraj describes the two types of models. One is the U.S model where the power lies in the hands of insurer. The control that they have doesn't seem to be effective. The other Insurance that is used in India are Chief Minister Scheme, ArogyaShri and many others. In these models the power seems to be in the hands of patients and there is fixed prices for procedures. In these schemes the hospitals are not allowed to charge more. I think in principle, in Insurance schemes we should make sure that the power

lies in the hands of consumer not in the third parties hand. There is something new working well and it has to be take care by the academic institutions. The results may vary if it is applied in different places across the country. He suggests study should be done to examine how this schemes works and push the successful model. He says if the decision power is with the patient, then it will help him.

Prof. D.V.R. Seshadri expresses his thoughts on what this forum can do. He says they can document this whole workshop into monograph. He offered his service to be the editor of this monograph. He suggests making a monograph with different versions, a monograph with 200 pages which features different successful health care models and **different schemes and in shorter version with 20 pages.** If these are animated for **3 or 5 minutes** then many people can watch it. We can create element of disturbances in the whole medical field by distributing in various social Medias. We can create some kind of disturbance in the minds of people that there is something which is not correct and makes them think what they can do. He proposes that we can create massive explosion in the media. The second thing he talks about is leadership, as there are so many hospitals in the country and if they can arrange the gathering of like-minded people to forum like this once in three months or six months in regular frequency more and more leaders will come to know that there are other possibilities meeting like this. Many people don't even know that there are other successful models. He suggests why don't we show other models and ask them to try these models. So what we have to do is we have to gather some 20 leaders and they will take this to many people. Another point he talks about is Insurance. He feels the Healthcare costs are increasing because the hospitals think they can get the insurance patient and grab money. The Insurance Company should be deeply concerned as health care is feeding product for Insurance Company. So what we can do is we have to talk to CEOs of Insurance companies how to decrease the cost and increase the profit.

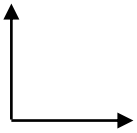
Then Dr Sudarshan gives the difference between health insurance mechanism and health assurance. In Karnataka they don't employ insurance company as the mediator, the government itself manages. They have package of things, costing is managed very well whereas private insurance companies made lot of profit. Insurance companies in responsible health care are very bad. Responsible healthcare model is what is needed for the country. First the individual doctors should practice responsible medicine and then propagate it. His second suggestion is that we need to **improve health establishment act.** Another thing which needs immediate attention is reforming medical council both at nation level and at

state level. Third thing is doctor should regulate their own profession; Self-regulation is best for practicing responsible medicine. He also insists the accreditation mechanism needs to be improved to provide responsible healthcare. **In Accreditation they should follow some protocols and standards have some value system.**

Dr. R.D.Ravindran starts with the values and attributes that contribute for practicing responsible medicine. He discusses what the kind of things that we should add to the system to empower patient and transparency. Rema Nagarajan says lot of medical association has talked about **continuing education**.

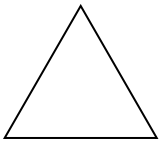
Chapter 14: Painting your child's room

Prof. Seshadri sets up the final table for discussion by introducing Clay Christensen's book, H*ow Will You Measure Your Life?* This book practically intersects life and work. He highlights four important topics discussed in this book: how to find fulfillment with profession; how to find fulfillment with your spouse; how to find fulfillment in your relationship with your children; and how to stay out of jail. Taking each topic at a time, he drew a diagram for better understanding.



The horizontal axis represents motivators, passion and professional purpose. The percentage is very less. Whereas the vertical axis represents the other majority who are after money. The majority who are after money associate it with happiness. This is the malice in the society. It saturates at one point of time. There are a very few who run on the horizontal axis like Dhan and Arvind. Values and greed, he says, are two sides of the same coin. The way one balances is the game. To find fulfillment with profession this balance is important.

Moving to the next topic, how to find fulfillment with children, he draws a triangle representing three different choices made by parents/ the care giver.



The corners represent resources, values and the process. For example if your child asks for a play house, there are two things to do. One is either you build a play house or you buy a play house. Building a play house involves the process. This may excite the child but at the end, interest is lost. Similarly, buying a playhouse does not involve a process. After buying the play house, the interest is lost immediately. This is the same with painting your child's room. The process involves role modeling your child. For example, lecturing your kids about being compassionate towards old people is not going to be very effective. Whereas taking the child to an old age home on his/her birthday and spending time with them will definitely impact the child. This is shaping. Learning by doing or engaging is what the writer suggests. This is done by placing the role model at the center. Like parents, the founder/CEO is the head of the process. Just like the song goes, 'Hum honge kamiyab ek din', this process will definitely bear fruit in the long term. Assigning a star to hospitals like hotels should be introduced. This

is focused on identifying the best service delivered by the healthcare system rather than degrading anybody. There are many people like **Rajath Gupta who try to cross the boundary once**, make money and then sit on the right side. This cost his career.

Mr. Vijay reemphasizes the points that he made earlier on how important values are and the ways to instill them. Out of the three ways of influences, speaking, writing and role models, he stresses on role models. This type of influence is the most powerful. A spark of divinity is in everyone, be it the Maoists or Veerappan. We are beyond what we are. The way we live communicates everything. He continues to stress on the importance of primary health care in the country. He talks about bringing education and health together by the way in which all educational systems should have a health care component. Parents should be complimenting the school and vice versa.

Dr Rao turns the table to the issue of standardisation. Prof. Sarang Deo says that protocols cannot be binders. They are static. We have to over write it, modify it. The usual excuse heard by the doctors is that they are so busy treating the patients that they find no time to review the documents. This attitude has to be changed. Dr Devadasan suggests that we should take more initiatives to involve both medical and non-medical people and try to work it all out. Prof. Seshadri states that time management is a rare phenomenon. Habits are like a chakravyuha. The more we mandate things, the more loop holes are created. Mandating should be done to a certain degree and autonomy to an extent. Dr. Koteshwar Rao speaks of customising the protocols to the requirements. Dr Para substantiates Mr. Vijay in saying 'do as I say, say as I do' role models won't work. Dr. Sudarshan prefers to list out the good points done by the council, NGO's, etc., after which we can bring in the empathy component.

Dr. Soma Raju explains that only 15% guidelines are available. Whether it is applicable to your patient is questionable. People should learn to do teamwork. **We should inculcate second opinion with doctors**. There is nothing wrong in asking. If a doctor does not have time for reading the he is not a doctor. A senior asking second opinion to a junior should not be looked at like a matter of attitude. Dr Rao shares his experience that happened in the U.S when he had to refer his patient to another doctor for second opinion. The whole process of typing the records took him half a day. How to save the time, another doctor suggested him to dictate the letter in front of the patient so that the patient gains trust over the care giver.

Chapter 15: Implementing Standards

Prof. Sundararaman questions about the standards. If NABH is to attract patients then the nature of standards needs to be constructed. Many good hospitals do not get NABH. One needs to keep in mind the standards inbuilt power embedded motifs. In U.K, NICE institutions elaborate the processing of constant standardization. Embedded values are explicated. Indian experience in building standards, transparency is not considered as an issue. Communication and implementing remains a big problem in standards. Mr. Thulasiraj says that guidelines do not talk about diagnosis. Guidelines are not properly applied. The guidelines are not meant for patients. This should have been the other way round. Prof. Deo mentions ISO, JCI and NABH being standards. These guidelines are formed by experts and are being followed. There is a need for supplier communication. Prof. Chhokar too stresses on communicating with the patient. Mr. Nagarajan correctly says that today we have so many options for treating the same disease. It has become complex. Multiple choices lead to corruption too.

Prof. Seshadri brings back the topic of future course by listing action plan with fifteen topics in five major buckets: **Education in Healthcare, Institution and Individual, Eco-System, Information Democracy and Models**. The first major bucket involves course on values, inspire on different models and improve standards. To take this idea forward, Mr. Vijay, Prof. Seshadri, Prof. Sarang Deo, LAICO, Dr Para and Dr Suzanne Gilbert have volunteered. **The second bucket Institution and Individual involves rating the hospitals,** bringing self-regulation and self-role modeling. The volunteers who will be involving themselves are Dr. Koteshwar Rao, Dr. R D Ravindran and Mr. Thulasiraj. The third bucket is Eco System. Setting up basic practice standards, primary care and clusters, audit charters, reviewing of existing standards to bring responsible medicine, influencing the quality of service, advocacy to government and re-registration are the key issues under the larger topic. The people who volunteered are Dr. Bachani, Dr. Sundararaman and Dr. Sudarshan. The fourth bucket is Information Democracy which involves in creating network, dissemination which is further divided into monograph, white papers and successful models, then score card and setting up a **forum to break the conspiracy of silence.** The people who will be working together are Dr Devadasan, Prof. Seshadri, Ms. Rema Nagarajan and Dr Nirmala Murthy. And finally the last bucket Models aims at cataloguing success models based on values. Dr Gopi, Prof. Sarang Deo and Dr Devendra have volunteered to take it forward. The hosting

duty has been taken by LAICO, CARE and LVPEI. A general concept is being set for all the buckets that values should be the base on which everything is built on.

The title is changed to **"We Practice Responsible Healthcare"** and the group is named as '**Forum for Responsible Healthcare**'.

List of Participants

S. No	Name	Designation and Organization
1	Dr. Namperumalsamy	Chairman- Emeritus, Aravind Eye Care System, Madurai
2	Dr. Soma Raju	Chairman & Managing Director, Care Hospitals, Hyderabad
3	Dr. GN Rao	Founder-Chair, LVPEI, Hyderabad
4	Dr. D. Bachani	communicable -Non) Deputy Commissioner New Delhi ,of India .Govt ,MOHFW ,(Diseases
5	Prof. Jagdeep Chhokar	Founding Member,Association for Democratic Reforms, New Delhi
6	Prof. D V R Seshadri	Clinical Professor of Business, Indian School of Business, Hyderabad
7	Dr. Koteswara Rao	Founder, United Hospitals, Hyderabad
8	Dr. Devadasan N	Director, Institute of Public Health, Bangalore
9	Prof. Sarang Deo	Professor, Professor of Operations, Indian School of Business, Hyderabad
10	Dr. Jayaprakash Narayan IAS	General Secretary, Foundation for Democratic Reforms, Hyderabad
11	Ms. Rema Nagarajan	Assistant Editor, Times of India, New Delhi
12	Mr. Vijay Poddar	Member Executive - Admin and Finance, Sri Aurobindo Society, Puducherry
13	Prof. T Sundararaman	Dean, School of Health Systems Studies, Tata Institute of Social Sciences, Mumbai
14	Dr. Nirmala Murthy	President, Foundation for Research in Health Systems, Bangalore
15	Mr. Gopi Gopalakrishnan	President, World Health Partners, New Delhi
16	Dr. H. Sudarshan	Founder, Vivekananda Girijana Kalyana Kendrara & Karuna Trust, Bangalore
17	Mr. R D Thulasiraj	Executive Director, LAICO, Madurai
18	Dr. R D Ravindran	Chairman, AECS, Madurai
19	Mr. R D Sriram	Joint Managing Director , Aurolab, Madurai
20	Mr. D Nagarajan	Volunteer, Aravind Eye Hospital & LVPEI
21	Dr. Suzanne Gilbert	Senior Director, Innovation & Sight Programs, Seva Foundation, US
22	Dr. R Pararajasegaram (Para)	Former WHO Consultant, Geneva, Switzerland
23	Ms. Sasipriya KM	Senior Faculty, LAICO, Madurai
24	Dr. Devendra Tayade	Manager, Employee Engagement program, Aravind Eye Hospital, Madurai