MEDICAL SERVICE

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EDITORIAL

Towards a people oriented drug policy

The 41st Annual Convention of the Catholic Hospital Association of India held in Bangalore from 23rd to 26th November 1984 had a special characteristic i.e. the two day workshop on "towards a people oriented drug policy". This issue of our journal is bringing out an account of what has taken place during those days. Due to shortage of space we could not accommodate on account of everything that has happened during those days. We hope to complete it in the next issue.

Dr. C.M. Francis of CMC, Vellore gave the key-note address on the theme on Saturday, 24th November. He gave the participants a very exhaustive picture of the situation in our country. Towards the end of his presentation dealing with other factors that contribute to health or ill health, he touched upon chemicals in the environment. Speaking about pesticides he said "There are an estimated 375000 cases of human poisonings by pesticide in developing countries every year with some 10,000 deaths. Lack of protein in the food of rural workers is an additional factor that makes these chemicals even more dangerous. India is proud to be the largest manufacturer of pesticidal chemicals in the whole of South Asia and Africa, with a licenced capacity of 75000 tonnes. In all of human health is not know". This statement of Dr. C.M. Francis came as though as a pre-monition. Exactly 5 days after that came the biggest human tragedy after Hiroshima and Nagasaki, that struck the city of Bhopal, whose dark nature is still before us. As Dr. C.M. Francis and others have pointed out during the workshop, if human life is to be taken seriously, we need also to look into the various hazards to human life. Will the decision makers come forward to look in to these matters or will the public come forward with their opinion. The answer is not either or, but both and. Let us all take up the challenge and contribute our share for a more qualitative human life.

WANTED

I. An experienced Renal Surgeon for immediate appointment in the following hospital.
Contact with full details: The Administrator
Christian Hospital, Washimpuri
Chandrapur Dist. Maharashtra 442 906

II. WANTED 1. An experienced Surgeon MS or DGO preferably catholic.
2. Assistant Gynaecologist D.G.O. or M.D. Apply to the administrator with terms and bio-data.
Fatima Hospital, Mau Aaimgarh Dist. U.P. 276 101.

III. Dr. Mark D'Souza, MS (Opthalmology)
Zamra, Flat-1, 33, Prof. Alaiyedi Road Bandra, Bombay 400 050
seeks suitable employment. Those institutions interested may contact directly.

Significance of the Theme

The Workshop is to help participants understand the issues relevant to drug prescribing, durg distribution and pharmacy policy in our institutions in the context of the ICMR/ICSSR warning and to challenge them to participate in the growing national response to the problem.

What does the 'abundance of drugs' mean to the millions of the poor in our country who struggle in life to make both ends meet ? Can they ever have access to the modern health care system which has become a business today, rather than remaining at the service of humanity at large ? Do they have essential and life saving drugs at their reach within a price range they can afford ?

Is our drug policy today more profession-oriented, drug industry-oriented rather than patient-oriented ? Whose interests are we serving in our institutions ?

How can we move towards a more people and patient-oriented drug policy ?

These are some of the Questions which we shall respond to in our Workshop.

Objectives

1. **To Create an Awareness of**

The health situation in India, the role of drugs in health care, the pattern of drug production in India vis-a-vis the people's health needs, the dynamic of the drug industry, the pattern of drug distribution and availability in the health system, the national drug policies and laws.

2. **To Create an Awareness of**

Irrational use, over use and misuse of drugs by health personnel.

3. **To Discover**

The Social, economic, political, cultural and other factors responsible for this problem.

4. **To Discover**

How all of us are part of the problem at a personal level.

5. **To Consider**

The various responses at national/regional levels in the areas of :—consumer awareness and people's movements; continuing professional education; pressure group on policy makers; search for low cost alternatives; individual/group action; institutional policy changes.

6. **To Discover**

Ways and means by which we can respond to this situation at individual, institutional and regional/national levels.

Programme Highlights

Sessions on :

Understanding the problem
Drugs and the healing ministry
Towards rational therapeutics
What to do to tackle the problem
Some initiatives in the country
The people's medicine

Group discussions on :

What/Why the problem in our health institutions ?
What can we do to tackle this problem ?

Liturgy

Reflecting on our calling and the faith dimension of our response.

Exhibition on :

Socio-political dimensions Health and Drugs
Rational Drug Therapy
Home remedies and Herbal medicines

Studies on :

Drugs for a Community Health Center
Understanding the injection/tonic culture
Use/misuse of drugs in surgery
Drug situation in small rural hospitals
Cost of treatment

Cultural Programme

Understanding the problem from the poor man's point of view.

Synopsis of Papers

Drugs for Primary Health Care
C M Francis (Full text in this issue)

An integral part of our commitment to primary health care is the provision of essential drugs to all those who need them, in adequate quantity and quality and at affordable prices wherever the person is. The various aspects of the drug problem needing our attention include production, what drugs are required, choice of drugs, National Drug Policy, selection of drugs, drug production and procurement, logistics of supply, quality control, regulating the drug trade, drugs for immunization, drugs for cure, drugs for symptomatic relief, search for new drugs, drug information and the need for evaluation of the efficacy of primary health care including drugs.

The Ten Commandments of the Drug Industry—Augustine Veliyath (Full text will be published later)

1. Thou shalt have tens of thousands of drugs
2. Thou shalt not question the price of a drug
3. Thou shalt not tamper with nature's garden
4. Thou shalt respect they doctor more than thyself
5. Thou shalt betray the people and the nation for petty rewards
6. Thou shalt not covet, court, or subscribe to any other system of medicine
7. Thou shalt never reveal company secrets
8. Thou shalt first seek remedies for fashionable ailments
9. Thou shalt be a dumping ground for banned drugs
10. Thou shalt be a guinea pig for new and untried drugs.

The Ethics of Prescribing
George Lobo, sj (Full text was already published in Oct.-Nov. issue)

Discusses reasons for the unfortunate situation related to drugs prevalent today, viz., technological model of health care leading to manipulation of the patient, search and demand for instantaneous cure of symptoms, mystification of medicine, profit motive and 'free enterpirse' of the pharmaceutical industry, a deep rooted cultural allenation from the people, exploitation of dependent developing countries, decreasing emphasis being given to preventive medicine and other systems of medicine.

The use of drugs should be regulated by the principles of totality (overall good of the

patient) and of double effect (the good effect overriding any harmful effect). It suggests remedies for the development of a person-centred and holistic approach to health care.

Professionals in the Church—an introspections—George Joseph (Full text in this issue)

Serious questions have been raised about the institutional witness of the church in India, particularly its relevance in the social context of today. In the case of the Healing Ministry there is urgent need to critically look at our priorities and commitment and our style of functioning in the light of the gospel. The role of the professionals have to be reassessed as part of an overall effort to bring back the true spirit of 'Diakonia' into this ministry.

The whole issue regarding the need for evolving a 'rational drug policy' has to be seen in this perspective.

What is Rational Drug Therapy ?—Mira Shiva (Full text will be published later on)

Rational drug therapy means practice of socially conscious, relevant, concerned and yet scientifically sound medicine. It recognizes the non-role of drugs in certain conditions, the role of alternative systems of medicine and recognizes the limitations of Western Medicine in our social context.

It emphasises selective use of drugs based on essentiality, efficacy, safety, easy availability, easy administration, quality drugs preferably of indigenous production.

Rational Drug Therapy recognizes the concept of essential drugs and the concept of graded essential drug lists for different levels of health personnel. It recognizes the right of health personnel and consumers to drug information and its effective communication.

It is taking of a conscious decision to boycott certain drugs and use others only when needed. It means prescription with awareness, to avoid as far as possible—iatrogenesis (drug induced problems, drug interactions, adverse drug reactions and emerging drug resistance).

It is understanding the role of drugs and rational drug therapy in the emerging health movement.

What can be done at a pharmacy level—Alan Cranmer (Full text in this issue)

(a) Management of Pha macy Services include involving the users of the service; the Pharmacy Committee—its constitution and functions, viz., implementation of hospital policy, selection of medicines, sources of medicines, cost versus quality, basic drugs and formulations, medicines banned in India and abroad, medicines from other systems; stock control; prescribing discipline and pharmacy discipline.

(b) Good dispensing services involve need for good professional service to patients, proper presentation of patient's medicines, preparation of medicines in the pharmacy compared to purchase, medicines in the pharmacy and at clinic level.

(c) Relationships with suppliers, i.e., with representatives in the pharmacy and an assessment of products offered and their sources.

(d) Educational requirements—basic courses, legal requirement, course content, continuing education for pharmacists.

(e) Relationships with hospital colleagues.

Initiatives in the Country

1. *Arogya Dakshata Mandal, Pune,* has been raising awareness about drug related issues among medical professionals and the lay public since the past 8 years. They publish a monthly—'Pune Journal of Continuing Health Education'— on drug issues and are also bringing out a book 'Rational Drug Therapy' in December 1984.

They launched a movement called 'Operation Medicine' in 1977 against irrational prescription of vitamins, tonics and tinned foods.

2. *All India Drug Action Network* : A number of groups have been working in the field of drug related issues at various levels during the past 3-4 years. They have been in contact with each other and have been working informally together sharing information, putting forward a memorandum (demanding a Rational Drug Policy), participating in campaigns, lobbying with government etc. In August 1984, they left the need to have a more organised base and have formed the All India Drug Action Network. CHAI is also a member of the Network.

3. *Lok Vigyan Sanghatana; Maharashtra* or the People's Science Movement have launched campaigns about anaemia and irrational anti-anaemia drug preparations and also about over the counter drugs. They organize jathas, hold district/town seminars, write in the mass media etc.

4. *Kerala Sastra Sahitya Parishad,* is a voluntary non-government organisation consisting of scientists, doctors, engineers, social scientists, teachers, students, workers, peasants, technicians who are committed to popularising science and channelising it for social revolution. The KSSP has recently decided to take up the Drug issue and initiate a big campaign to expose the anti-people and exploitative tactics of the Multinational Drug Companies. The questions of essential versus non-essential and dangerous drugs, the inadequacy of drug safety control measures, the rising prices of life saving drugs and the non-implementation of the Hathi Committee recommendations are the highlights of the programme.

5. *LOCOST,* or Low Cost Standard Therapeutics is a collective voluntary enterprise for rational therapeutics. LOCOST aims to promote low cost, scientifically tested medicine under generic names. LOCOST is a response to a growing demand and challenge of the voluntary health sector to meet the needs of the deprived sectors of the society for not only low priced but also good quality medicine. LOCOST includes procurement, quality testing and control, distribution and educational efforts, and is located in Gujarat.

6. *Bangarapet Mission Tablet Industry,* in Karnataka is a successful small scale venture providing low cost, good quality formulations to some mission hospitals in the country.

7. *Low Cost drugs and Rational Therapeutics Cell of the* Voluntary Health Association of India, New Delhi, has been instrumental in bringing together various groups in India on the issue of drugs They have been providing informational backing to these groups, organizing meetings, informally coordinating some actions etc.

8. *Medico Friends Circle,* is a group of socially conscious individuals, interested in the health problems of our people. Through their monthly bulletin, they discuss drug issues among others. They have formed a Rational Drug Policy Cell and have launched a campaign on antidiarrhoeals.

9. *The Kurji Holy Family Hospital Formulary,* is the result of the accumulated experience of the hospital over the last 10 years. It gives a comprehensive, list of drugs to treat 98% of the hospital admissions. It also gives the generic name, dosage, indications, contra-indications and side effects of these drugs. Information about comparative cost of treatment is also provided.

10. *State Forums,* During the past year drug action forums have been active in Andhra Pradesh and West Bengal. Drug Action forums are also being initiated in Gujarat and Orissa.

11 *The Pharmacology Department of the Post-Graduate Institute of Medical Education and Research, Chandigarh,* provide unbiased technical information on drugs and therapeutics through a monthly publication 'The Drugs Bulletin'.

12. *Others,* The following organizations have also been involved in drug related issues and are part of the All India Drug Action Network :

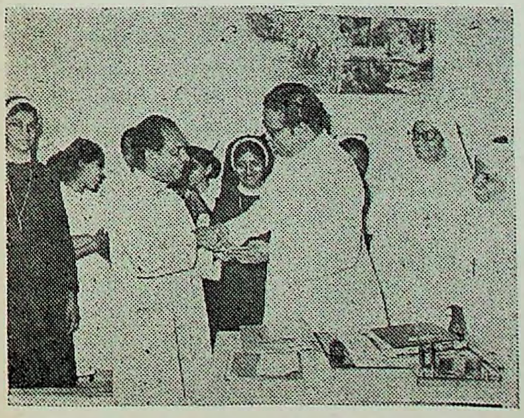
Consumer guidance Society of India, Bombay
Consumer Education Research Centre, Ahmedabad
Federation of Medical Representatives Association of India
Health Services Association, Calcutta
Delhi Science Forum, New Delhi
People's Participation in Science and Technology, Madras/Bangalore
Centre for Science and Environment, Delhi
Centre of Social Medicine and Community Health, J N University, New Delhi

What we can do ?

— Support them
— Join them
— Keep them informed about what you are doing

CHAI—CORPUS FUND

Towards its self-reliance programme, CHAI has started a Corpus Fund. Donations, big or small, are requested towards this Fund. It should be remembered that donations made to CHAI will be exempted from income tax as per section 80G of the Income Tax Act 1961. Please send your donations to *CHAI-Corpus Fund* only. —Executive Director, CHAI



President CHAI, Dr. Ferdinand Kayavil inaugurating the CHAI-Corpus Fund by handing over a cheque to Fr. John Vattamattom SVD, Executive Director, CHAI at Benziger Hospital, Quilon, Kerala.

41st National Convention and Workshop

St. John's Medical College, Bangalore 23-26, Nov. 1984

Theme : "Towards a people oriented drug policy"

General Report

[It is customary that the issue of the journal Medical Service following the convention contains the convention proceedings. This is the only way that the proceedings can reach every member institution as it is possible or feasible for every institution to send delegates to the annual convention. I appeal to all to go through it seriously and make definite plan of action for your own institution along the lines proposed in the workshop on the theme. —Editor]

The concept of convention in our mind was always linked with the exhibition and the 'glamour' connected with that. Though it was decided last year that we will not have convention every year, what was meant by that was we will not have the usual exhibition etc. However, the annual general body meeting or convention as it was called in the beginning is a constitutional requirement. This year's convention in a sense was a follow up of last year's. This year's theme and the workshop on it was a concrete follow up of "Respect-Life". After this year's convention many a participant made the remark "now we find meaning in CHAI convention". Let us hope that we will be able to keep up this spirit by giving more importance to essentials than accidentals in the future.

It was after 11 years we had a convention in Bangalore. As usual a local committee was in action since quite few months. If popular opinion is an indication again this years convention was a great success. But the success of a convention should be measured not by what happened during the convention days, though that is also important, but by what is going to happen in all our institutions, following the convention. Let us hope and pray that this year's convention will be a success in the real sense as mentioned above. In spite of the fact that this year there was no exhibition connected with the convention, a factor that usually attracted the crowd, the participation was beyond our expectation. There were more than 500 participants for the workhop, including local participants. These came again from all over the country including far and remote areas of Assam. By morning of November 23rd, St. John's Medical College premises were full of delegates to CHAI convention, mainly sisters.

A concelebrated Eucharistic Sacrifice headed by Archbishop P. Arokiaswamy of Bangalore, at 3.00 p m. under a beautifully arranged vast "Shamiana" (Pandal) marked the beginning of the convention. Also present for the concelebration were Bishop Gilbert Rego of Simla-Chandigarh and Ecclesiastical advisor to CHAI, Bp. Abrose Yeddanapalli of Bellary and several other priests. The entire liturgy was prepared based on the theme, organised and sung beautifully by the Franciscan Friars under the direction of Fr. Sydney Mascarenhas, not only for the inaugural day, but also for all the days of the convention.

Archbishop P Arokiaswamy in his homily during the Mass emphasised the need for taking care of the sick unconditionally. Explaining the parable of the Good Samaritan, he urged all health care personnel to serve the sick with christ like love and commitement. After the Eucharistic celebration tea and snacks were served to all the participants and guests.

Then followed the inaugural session at 5.30 p.m. Dr. Thimme Gawda, Minister for Health, Government of Karnataka was the Chief Guest. Meeting started with a beautiful invocation song by "Janadhare" a cultural troupe of twentyfive youngsters who are a talented lot and socially involved. Bp. Gilbert Rego, the Ecclesiastical advisor to CHAI presided over the function. Dr. G.M. Mascarenhas, Dean, St. John's Medical College, Bangalore accorded a warm welcome to the Chief Guests and the delegates to Bangalore and particularly to St. John's. He welcomed the Chief Guest Dr. H.L. Thimme Gawda in a special way to the function and to St. John's. Thereupon Fr. Ferdinand Kayavil, the president of CHAI welcomed everyone and introduced the Chief Guests. In this welcome address he emphasised the need for bringing drugs within the reach of the poor where it is not today. The full text of his welcome address is printed separately.

Thereafter the inaugural address was given by the Chief Guest, Dr. H.L. Thimma Gawda, Minister for Health, Government of Karnataka. He appealed to the doctors in the State to desist from over prescribing drug as it could prove to be dangerous for the patients in the long run. He lamented that over prescribing had become a fashion for most doctors as was the prescription of 'glamerous' and expensive drugs. The minister lauded the services rendered by the Catholic Hospitals which were far superior to those in other hospitals. He also lauded the dedicated services of the sisters and others in Christian Hospitals.

The theme and convention highlights were then presented by Fr. John Vattamattom SVD, Executive Director, CHAI. He emphasised the need for working towards a people oriented drug policy and taking up this challenge by all concerned. (Cf. the full text).

Bp. Gilbert Rego, ecclesiatical advisor to CHAI, in his inaugural address expressed his happiness to be present for the workshop which he felt would be most valuable and relevant in the realm of medical profession, especially in the context of the health services of the Church which are primarily to respond to the needs of the poor. He congratulated CHAI for taking this bold step and wished the workshop and convention every success.

The next item in the agenda was the inauguration of the exhibition by Mr. J. Alexander, IAS, Excise Commissioner, Government of Karnataka, who is a good friend of CHAI. This was another speciality of this years convention. The exhibition was not of the usual type, but pertaining to the theme. Presented by means of charts, drawings etc. The exhibition had 3 parts i.e, that which pertaining to the theme prepared by Drs. Ravi & Thelma Narayan and their team; pertaining to the Herbal Medicines prepared by Fr. Joseph Chittoor and Sr. Innocent from Gudalore diocese of Mananthavady; and pertarning to the analysis of the present health care system by Fr. Chacko Paruvanani and his adult education team from Berhampur, Orissa. The exhibition wes very informative, enlightening and thought provoking and most of the participants benefited much from it.

After the inauguration of the exhibition there followed the cultural programme, again

based on the theme, by Janadhare. Through a play depicting the present health care system and the plight of the poor people in it, and through songs etc. the group was able to make the participants aware of the gravity of the problem in the system of health care. A powerful message was put across by this simple means.

The inaugural function and the day's programme were over with Fr. Joseph Kavalipadan, Vice President of CHAI proposing the vote of thanks'.

Workshop

On the first day of the workshop, 24th November 1984, the first session on 'Understanding the Problem', was chaired by Prof. S.V. Rama Rao, formerly head of Community Medicine department at St. John's Medical College. Dr. C.M. Francis, Coordinator, Continuing Medical Education, Christian Medical College, Vellore, introduced the theme by giving a comprehensive coverage of the theme in his paper. He mentioned about the Hathi Committee report, which recommended 116 drug formulation as essential ones for the Indian situation in the place of 30,000 different drug formulations available in the country today. He drew the attention of the participants to the initiatives made by various organizations to combat the exploitation of the drug industrialists. Domestic production of drugs in the place of imports at exorbitantly high rates, effective price control measures, promotion of man research, promotion of drugs in the Indian system, effective monitoring and standardizing, making available essential drugs at affordable prices, tax exemption of vital drugs, production by generic names, exploitation of the public by advertisements, the doctor-drug producer axis that exploits the people, etc. were some of the areas touched in the paper. The solution for the ill-health of the India masses is basically linked with the unjust distribution pattern which makes people poor and denies enough food, safe drinking water and healthy living conditions. Smoking and alcoholism makes the situation worse. Massive pollution of the water and air by chemical plants, especially pesticide factories erodes the health of the public. All these too are certain areas of vital concern.

This was followed by a paper presented by Mr. Augustine Veliyath of Voluntary Health Association of India, New Delhi. Through his presentation of the 'Ten Commandments of the Drug Industry' he exposed to the participants the exploitative practices followed by the drug industrialists to maximize the profits at the cost of the life of the people. The third world countries give the grave picture of being the dumping ground for banned and hazardous drugs. People of the poor countries are compelled to pay high prices for essential drugs which are available in rearer as compared with tonics and vitamin formulations. Doctors, through over prescribing, lack of understandable communication with patients, and through prescription patterns that are not at all in keeping with economic situation of the people, become part of drug issue and generally they make themselves fit for making profits for the drug industrialists-multinationals and large scale domestic producers. This part of the paper was presented quite sarcastically and strikingly as 'Ten diseases of doctors'.

Now it came to the second session of the forenoon, 'Drugs and the Healing Ministry', which was presided over by Bishop Gilbert Rego. A paper on 'Ethics of prescribing' was presented by Fr. George Lobo of Papal Seminary, Pune. While making his presentation he mentioned about the attitude of the people in taking medicines and situated

this in the context of the capitalistic and consumer oriented values. This acts counter to the health of the people. It makes the health care dear and unapproachable to the underprivileged masses. Widespread conscientization is the only answer to the existing pattern of overprescribing and over use of drugs which is coupled with an attitude of the public to support these unethical practices.

Prof. George Joseph, Executive Director, CSI Council for the Healing Ministry, Madras, made a presentation on 'Professionals in the Church—an introspection'. He raised the basic question—why we are involved in health services !? Definitely the answer would be to serve the least of the brothern in whose face we should see Christ. But in concern of time where have we landed up : Through his paper he tried to help the participants to pose these question against themselves and make an effort to rededicate and commit themselves to the actual cause for which we initiated our health services.

Before the afternoon session there was Eucharistic celebration. The liturgy for the mass was also selected to be in line with the theme discussed on the day. This was the practice followed each day.

The afternoon session started with small group discussion—the participants were divided into 15 groups with 4-5 facilitators distributed in each. The group discussion was an attempt to develop more understanding about the problem in the light of the paper presented and identifying the different dimensions of the same in ones own hospitals and dispensaries and thinking about each ones responsibility as persons, professionals and institutions in the creation of this problem. Each group prepared its own reports of the discussion, and putting together and consolidating, one common paper was prepared at the close of the day. This was done by all the representatives of the 15 groups together.

The next session during the afternoon was on 'Towards Rational Therapeutics'. Dr. Prem Pais, Physician of St. Marthas Hospital, Bangalore presided over. A group of interns and students of St. John's Medical College had made 4 studies in the city and outskirts of Bangalore to asses how our hospitals and dispensaries are part of the problem of drug issue, and how they could come up to life above and contain the issue, giving practical concrete suggestions. Thus, Dr. Navin Machado, Dr. Srinath, Dr. Ravindran and Mr. A.J. Perumpanani presented their studies. Dr. Ravi Narayan gave the summary and conclusion of all these four studies. He then spent sometime on rational therapeutics. He explained that rational therapy is a dynamic concept based on our any local situations. He reminded that effectiveness, availability, and accessibility and acceptance to the medicine should be certain words while prescribing a medicine. Most important of all it should be affordable by the patient, Extravagant, over-prescribing, in-correct prescribing, multiple prescriptions, under prescribing and useless prescribing (of medicines whose expiry date is over) are certain thrusts to rational therapeutics. He shared certain criteria for rational therapy—it starts from a good diagnosis, prescribing the efficient, safest and lowcost medicine which is easiest to administer, educating the use of the medicine with an interest to follow up the prescription, and educating patient and the preventive steps for remaining healthy. The influence of the drug company should never play a role while prescribing and it should be the independent decision of the medical practitioner.

In the evening there was a cultural programme presented by the students of Jyothi Nivas College, Bangalore.

If the thrust of the first day's session was attempts to understand the problem the second day, 25th November 1984 dealt with "What to do to tackle the problem?" Dr. George Joseph chaired the first session. Mr. Alan Cranmer, CMAI consultant Pharmacist, Mysore, shared with the group what could be done at the pharmacy level towards purchasing, stocking and administring of drugs. It starts right from following a rational purchasing policy to giving medicines to the patients against prescriptions. Dr. Quasem Chowdhary of Gona Swasthya Kendra project of Bangladesh shared briefly the progressive and rational policy adapted by the government of Bangladesh to curb the unethical and exploitative production practices of huge companies and the, unchecked import of bulk medicines. He mentioned how a voluntary organization as Gonaswasthya Kendra was instrumental in pressurising even a military government to come out with a progressive policy controlling and standardizing drug production and how the Kendra is now actively involved in the production of essential drugs at considerably low cost.

During the next session presided over by Dr. Daniel Isacc, General Secretary, Christian Medical Association of India, certain initiatives in containing the drug issue were shared Dr. Vincent Panikulangara, lawyer and general cenvenor of Public Interest Litigation Society, Kerala, shared the advices by him in fighting legal battles in the high courts and supreme courts against drug industrialists and reminded about the need and relevance of the church health services to emerge as a corrective and porphetic force to contain the exploitative practices followed by the drug industrialists and commercially motivated health institutions. Dr. Mira Shiva, Coordinator, of the All India Drug Action Net work, narrated the evolution development and activities of Drug Action Net Work' at generating awareness at different circles—policy makers, professionals and general public about the existing irrational drug policy and practice. Fr. Joseph Chittoor from Kerala showed how herbal medicines and home remedies could be widely and successfully applied in dealing with many of the common diseases of the rural areas. His group has been actually practicing that in the villages, Dr. Manunath of Vellore Medical College explained the effectiveness and relevance of Ayurvedic Medicines and the need to integrate scientific traditional practices with Allopathic medicines in the treatment of diseases. Mr. John Barnabas narrated the success story of low cost health care using essential drugs through village health centres. Activities of 'LOCOST' voluntary agency engaged in the production drugs at remarkably lowcosts were shared. This approach could pase a meaningful challenge to the increasing pricing policy of the large industrialists.

After the Eucharistic celebration and lunch break the participants went in small groups to discuss what could be done at the individual, institutional, diocesan, CHAI/ National levels to deal with the drug issue. Concrete suggestions were brought out by all the 15 groups. These were consolidated and read out at the concluding session. Following this, there was concurrent programmes with video films on drug issues and a demonstration class on herbal and home remedies referred to on "People's Medicine". The participants were to choose which programme they prefer to attend.

In the concluding session, as mentioned earlier, the consolidated paper on what could be done at the individual, institutional, diocesan, CHAI/National levels were shared and approved by participants. (A detailed note on this will be published in the next issue of our journal). The workshop had also drafted

a rosolution expressing the concern over the scarcity of life saving drugs, the excessive enormity of 30,300 and old drug formulations etc. The full text of the resolution is published in this issue.

The last day, 26th November 1984, was the day of the General Body. The day began with the Eucharistic Sacrifice at 7.00 a.m. with Fr. Percival Fernandes, the Secretary, CBCI Society for Medical Education in India as the Chief celebrant. At 8.30 a.m. the General Body meeting was held with Fr. Ferdinand Kayavil, the President of CHAI presiding. In his introductory remarks, dwelling on the various deliberations that took place during the previous three days, he called upon all the members of CHAI to take the deliberations of this years convention seriously. (Full text of his concluding remarks is published separately).

Thereafter the Secretary Sr. Isabella Mary presented the report of the General Body meeting held in Bombay on 9th November 1983. After that Fr. John Vattamattom SVD, Executive Director, CHAI presented the annual report of the association. Thereupon Fr. Thomas Joseph, Programme Director, Community Health Department of CHAI presented the report on the activities of the department. Then the treasurer Fr. Antony Samy presented to the General Body the audited statement of 1983 and the proposed budget for 1985. Some clarifications were made and the proposed budget was accepted by the General Body.

Thereafter the final declaration and resolutions from the workshop was officially presented by the Executive Director and unanimously passed by the General Body. Following was the declaration :

We the 500 delegates to the 41st Annual Convention of the Catholic Hospital Association of India (CHAI) on the theme "TOWARDS A PEOPLE-ORIENTED DRUG POLICY", consisting of doctors, nurses, pharmacists, hospital administrators and health activists representing around 1900 member hospitals and health care institutions, assembled at St. John's Medical College, Bangalore (23rd-26th November 1984) to express for deep concern over—

1. the increasing scarcity of essential and life saving drugs as against wasteful abundance of non-essential drugs and formulations;

2. the excessive number of over 30,000 drug formulations—as against the Hathi Committee and WHO Expert Committee recommendations of 116 and 200 respectively.

3. the continued availability of Banned Durgs in spite of the Government orders of bans;

4. the continued availability of bannable and hazardous drugs in spite of the mounting scientific evidence and even directives of various courts in this country;

5. the spiralling cost of drugs as against the decreasing purchasing power of people;

6. the continuing domination by the multi-national drug industry as against the National Policy of self-reliance; and resolve—

1. to fully endorse the Government of India's list of banned drugs and here-

by accept to implement the same in our institutions forth with and urge all our sister institutions also to do the same;

2. to prepare a list of essential drugs along the lines of Hathi/WHO Committees for immediate adoption in all our institutions;

3. to urgently take steps to reduce the present unhealthy and unethical influences of the drug industry on the medical and allied professions;

4. to mobilise public opinion against the apparant lack of concern of the State Governments and professional and expert bodies on this vital issue; and further resolve to appoint an expert body to formulate a rational drug policy which is people oriented within the context of a health care strategy and policy, befitting the National Committment to Health for all by 2000 AD.

We also authorise the Executive Board and the Executive Director to take adequate steps to implement the above.

Thereafter the Executive Director presented the revised membership fee on a deck system regarding the bed strength of the institutions. This revised membership fee was already accepted by the Executive Board. After some clarifications, the proposed revised membership fee was unanimously accepted and approved by the General Body. The Executive Director then also explained and stressed the need for organising CHAI in the diocesan level as per the revised rules and regulations of the association and appealed to all to work towards that end and thereby strengthening our association.

The Executive Director then also introduced the subject of the self-reliance policy of CHAI and the establishment of a CHAI-CORPUS FUND. He appealed to all to contribute generously towards this fund and make our Association self reliant.

There followed the election of the office bearer. This year the offices of the President, Secretary and Treasurer were falling vacant. During the election that followed Fr. Ferdinand Kayavil was re-elected as President for another term of three years. In the same way Fr. J. Antony Samy was also re-elected for another term as treasurer, unopposed. Sr (Dr) Fernanda of Mariampur Hospital, Kanpur was elected Secretary for a period of 3 years. She was also elected unopposed. Sr. Isabella Mary, the outgoing Secretary then thanked all. The Executive Director also thanked the outgoing Secretary for all her services for the organisation during the past 3 years. He also welcomed the newly elected office bearers. The President also thanked the outgoing Secretary St. Isabella Mary. The official vote of thanks was then proposed by Fr. J. Antony Samy, the treasurer. He thanked all those who helped to make our this year's convention a success in Bangalore. The Executive Director, Fr. John Vattamattom SVD also thanked individually all those who worked hard for many days to make the 41st National Convention and workshop a great success in all respects.

At about 1.00 p.m. the General Body meeting and also the 41st Annual Convention came to an end.

Welcome Speech Delivered by the President, CHAI, Rev. Dr. Ferdinand Kayavil at the 41st National Convention held in Bangalore

Your Excellency The Rt. Rev. Dr. Gilbert Rego (Ecclesiastical Adviser to the Catholic Hospital Association of India) Honourable Minister Dr. H.L. Thimme Gowda, Mr. J. Alexander I.A.S. Excise Commissioner for the State of Karnataka, Dr. G.M. Mascarenhas, Dean, St. John's Medical College, Your Excellency Bishop Ambrose of Bellari, Your Grace The Most Rev. P. Arokiaswamy, Archbishop of Bangalore, Fr. John Vattamattom SVD, Executive Director of Catholic Hospital Association of India, Fr. Joseph Kavalippadan, Ist Vice-President, Catholic Hospital Association of India, Members of the Executive Board, Members of the Local Organizing Committee, Members of the Press, Fellow Delegates and Friends.

We are gathered here, in this beautiful City of Bangalore for the Forty First National Convention of the Catholic Hospital Association of India. Since 1943, when the Association was first founded, the members of the Association have been gathering together, year after year, from every nook and corner of this vast country, to commit and recommit themselves to the great and noble task of providing Health Care facilities, to the millions of this land, who otherwise would not have had easy and quick access to the much needed basic facilities of health.

For hundreds of years the Health Care Institutions under the auspices of the Catholic Church assisted the nation considerably in providing medical care to the people, especially the poor people of this country. Ever since the formation of the Association, the participation of the Church, in the Health Care System of the country, through her net work of agencies, has become better organized and co-ordinated, more effective and relevant to a considerable extent to the concrete situations of the people, even though there is still a long way to go, before it can be said that we are touching the common man of the land. Dear friends, as of today, there are 1871 member institutions in the Association. Hospitals 499, Dispensaries and Health Centres 1274, Social Service Societies 45, Associate Members 62. This is undoubtedly, a great force in the Health Care System—There are many more hundreds under the Catholic Church Sponsorship. They are not official members. But they too do the same kind of work with the same kind of devotion. We hope, eventually they too will become members of the Association.

Once again dear friends, we have come together for a National Convention. The theme for this year's convention is Drug Issues, rather towards a People Oriented Drug Policy. This certainly is a most relevant topic, in the context of the Nation's Health problems. In 1982 the Ministry of Health Government of India issued a statement of India's National Health Policy. This policy stresses the nation's aim to achieve the Alma-Ata Declaration which wishes for Health for all by 2000 A.D. This policy assigns high priority—to promotion of family planning—provision of Primary Health Care—control of Leprosy, Tuberculosis and Blindness. The Development of preventive, rather than curative measures, is certainly one of the primary objectives of this policy statement. Health

for all by 2000 A D. This in an ambitious goal, though very fundamental and urgent ! —Is it possible of its definition within the remaining short period of 15 years, in a country like ours with 750 million people, 40% of which is still under the poverty line? Most people believe that the magnitude of the health problems of this vast and varied land is too intense and complex to reach the goal of Health for all by 2000 A.D. This may be true. It may not be possible to reach the projected goal within the short period. Obstacles and difficulties are there. But it is also true that the determination of a nation, the collective tenacity of a people, the wise and timely policy decisions of a committed government, should make the goal attainable much earlier than it normally would.

Dear friends, we come together year after year from the breadth and length of this country, in Annual Conventions, to wholeheartedly assist the nation in its determination of bringing Health Care Facilities to every man and woman in this land ! The experts who will be addressing this convention will enlighten us, on most of the issues of the theme—Towards a people oriented drug policy !. Drugs are one of the basic factors in the Health Care System. During the last 30 years drug production in the country has multiplied a hundred fold. In formulations technology, India occupies prime position among all the developing countries. According to reliable sources, there are more than 25,000 drug formulations in India being manufactured by more than 5,000 Drug Industries. The total output of the industry increased from Rs. 100 million in 1947 to Rs. 10,500 million in 1978-79.

Friends, what does this abundance and over production mean ? Does it mean that the poor millions of the country have an easy and quick access to the Modern Health Care System? Does it mean that they have the essential and life saving drugs, at their reach, within a price rance they can afford? The answer is shockingly No No ! Experts in the field have shown with documented evidence that the over production of drugs, most of which is often very costly, is meant for the consumption of the rich and the well-to-do, while the drugs, so desperately needed by the poor millions at cheap rates, are not adequately available.

Social Scientists point out, that this unjust disproportionate pattern of drug production, is only a part of the inequitous social structure, existing in the country, which stresses the production and promotion of luxury goods for the rich and the well-to-do, at the cost of the basic and more urgent needs of the poor.

One does not have to hesitate even for a moment to say, that the Health Care has become part of the exploitative system in our country. The members of the Catholic Hospital Association, inspired and touched by the Association's motto—The love of Christ compels us by the Gospel Values, certainly do not want to be a part in this exploitation, But, unfortunately, we too become. unknowingly perhaps, pushed into this unjust social structure. Often we justify ourselves by saying what can I do, as an individual—what can I do as an individual institution, before the all powerful exploitative axis, prevading the country often protected by an unjust social structure.

During this convention as we become more and more enlightened by the expert team, of the injustices prevailing in the Health Care System, we should ask ourselves, sincerely and humbly—Are we prepared to challenge the injustices perpetuated in the Medical Care System against the weaker section, against the powerless poor man of this land ? Specifically I Are we

willing to take the consumer awareness building process, that will sensitise people to the realities of the drug industry ? Mobilise public opinion ? Educate the patients of their rights ? Influence policy making decisions ? Confront the medical establishment? and Challenge the drug industry ? Friends, what the Indian Council of Medical Research have said in a joint statement must resound and resound in the hearts and minds of our members—"Eternal vigilance is required to ensure that the Health Care System does not get Medicalised, that the Doctor-Drug Producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health." This eternal vigilance demands that we—the members of the Catholic Hospital Association of India—take our position—firmly and uncompromisingly, with the exploited millions until a "people oriented drug policy" bring the modern facilities of Health Care System within their reach. If we are honest fellow delegates with our motto—"The love of Christ compels us"—we have no other alternative.

This convention is being inaugurated by the Honourable Minister for Health, Government of Karanataka Dr. H.L. Thimme Gowda, Dr. M. in his welcome speech has highlighted some of the outstanding qualities of Dr. Gowda. He is a Medical Doctor by Profession. Therefore he is able to understand the Medical problems of the country with a deeper knowledge and a better insight. He is approachable to the common man. That is a quality perhaps most of the high ranking officials do not have. That is what we need most in the country. I extend to you our most cordial respectful welcome. Sir, we are honoured by your presence. Your presence and the words you are going to tell us, will be a motivation and encouragement to us to do our work with greater commitment.

His excellency, the Rt. Rev. Dr. Gilbert Rego is presiding over the meeting. Bishop Rego is the Bishop of Simla and he is here today primarily in his official capacity as the Ecclesiastical Adviser to the Association. The Association, by its constitution, is an autonomous body. But, by tradition and practice the Association works under the guidance and supervision of the Ecclesiastical Hierarchy. We are happy that such a link is established between the Association and the Hierarchy. Without the timely advice, guidance, supervision and control from the part of the Hierarchy, our work will be less effective and less fruitful. We are thankful to Bishop Rego for his help, on behalf of the Hierarchy. To you, Your Excellency, our loving heartfelt welcome to the convention!

Mr. J. Alexander IAS : The exhibition will be declared open by Mr. J Alexander, I.A.S. Mr. Alexander needs no introduction to the public of Bangalore and the Karnataka State. At the moment, Mr. Alexander is the Excise Commissioner for the Karnataka State. Earlier he worked as Collector in one or two Districts of the State. He has been the City Commissioner of Bangalore. He has been labour Secretary, Social Welfare Secretary, Health Secretary Labour Secretary—He served the Government in many other capacities. Mr. Alexander is reputed to be an efficient, conscientious hardworking administrator. Being an intellectual genius, he is knowledgeable on practically any subject. He is deeply religious! He is a powerful speaker. He is universally acclaimed to be a public officer of impeccable professional honesty. People who know him will not hesitate to say that Mr. Alexander is rare acquisition in the public life of this country To you, Mr. Alexander, a friend and well-wisher of the Association, and an Adviser to us—an affectionate welcome from each and every member of the Association.

On the Dais are : Dr. G.M. Mascarenhas, Dean, St. John's Medical College, Fr. John Vattamattom SVD, The Executive Director, Fr. Joseph Kavalippadan, Ist Vice-President, welcome to you friends, dear colleagues! Welcome to all our friends, who are here graciously responding to our invitation to grace this occasion. Welcome to the local committee without whose devoted hard work, it would not have been possible to have this convention in Bangalore. Members of the press are here! Hearty welcome to you. Welcome to all those who have contributed to the holding of this convention here. Finally, welcome to you, dear delegates and co-workers! Without you this Campus would be just a wilderness, a garden without flowers—you and beauty, to this place! if women make any place beautiful, sisters make it hundred times more beautiful and attractive. You make the Convention! You take the message across the country, you are the Convention, without you there is no Convention. To you all, delegates and co-workers —hearty welcome to this August Assembly!

Thank you !

Have a nice stay !

Theme Presentation and Convention Highlights

—Fr. John Vattamattom SVD

The Catholic Hospital Association convention in Bangalore seems to be historical. Eleven years ago in 1973 when we had the last convention here, we discussed about the importance of Primary Health Care. One of the concrete result of that convention was the wellknown programme of 'Health for a Million' by the Archdiocese of Trivandrum. Today as we are beginning the 41st convention of CHAI here, we are again at a historic point. During this convention we are going to deliberate on a number of issues that have been agitating the minds in many a people and organisation since some years i.e. how to work towards a people oriented drug policy. After the Alma Ata declaration in 1978 of Health for All by 2000 AD, the 1980s is going to be a historic period in the health care ministry and medical profession.

As we are gathered here, representatives of more than 2000 health care institutions directly run by the Catholic Church all over the country starting from a small health centre in a remote corner of this our vast country to big institutions like St. John's Medical College Hospital and a few others, together with various resource persons and friends and also officials from the Government and the Church, it is a time for us to reflect seriously our role in this one time noble profession and ministry which, of late, unfortunately has assumed a business nature. It is also good to be aware of the warning given by the Indian Council of Medical Research and the Indian Council of Social Science Research in their health for all report—"One of the most distressing aspects of the present health care situation in Indian is the habit of doctors to over prescribe or to prescribe glamorous and costly drugs with limited medical potential. It is also unfortunate that the drug producers always try to push doctors into using their products by all means—fair or foul . . . . If the medical profession could be made to be more discriminating in its prescribing habits there would be no market fot irrational and unnecessary medicines."

What is to be happening during the coming couple of days should be a sole searching exercise by all of us here : decision makers from the Government, from the Church, from the Medical profession, from the teaching and training institutions, from the aid giving agencies and above all from the common man, to see where we stand, to examine our attitude as to whether we are pro-life or anti-life in our practice etc. etc.

It was Hypocrities, the father of Medicine who said "for the sick, the least in best". Is that the policy we adopt in our prescribing pattern ? We need to discuss many things during these days and discuss them seriously with an open mind always keeping the good of the people before our eyes. We need to discuss about the pattern of drug production purchase and distribution. Here the guiding principle for issuing a license for drug production, or purchasing and distribution of medicines should be the life of the people rather than the size of the donations or gifts the decision makers receive. We need to discuss the ways and means how to make our health care less expensive in terms of medicine and otherwise. We need to assure the availability of essential and life saving drugs to every one particularly those in the remote rural areas where vast majority of

(*Contd. to page 40*)

Concluding Speech delivered by Rev. Dr. Ferdinand Kayavil at the 41st National Convention

Your Excellency Bishop Rego, Members of the Executive Board, Fellow delegates and Friends,

The 41st National Convention of the Catholic Hospital Association of India is going to be over with today's business meeting. We have been here for the last three days. We have been listening, reflecting, sharing, discussing and deliberating on the various aspects of PEOPLE ORIENTED DRUG POLICY. To be frank, when we came in for the convention, we were not fully aware of the magnitude and intensity of all the problems associated with a People Oriented Drug Policy.

During these three days of study, and reflection, stimulated by well prepared scientific papers presented by experts in the field, we have focussed our attention on : The Health situation in India, role of drugs in Health Care, pattern of drug production vice-versa the People's Health Needs, the dynamics of the Drug Industry, the pattern of Drug Distribution and availability in the Health Care System, the National Drug Policies and the laws and many other related topics. We have broken together the Lord's Bread—the token of his love and the source of our life and our strength. We believe that the celebration of the Eucharist these three days will keep us together in our resolve to share the concern of the poor millions of this country.

We have been told with documented evidence how the people in the country are exploited—by the proliferation of unessential drugs—by the outrageous pricing of drugs—by the excessive blatant over production of drugs for the well-to-do and the consequent under production of drugs desperately needed by millions in the country. We have further seen, how this exploitative structure thrives on the unholy collusion between the industry and the profession ! We have seen how people are confused and exploited by the mindless mis-information that prevades the scene. To our great surprise and shock we understood that the mighty developed conutries dump, in the developing poor countries of the third world, what is unwanted and useless in their own countries. We have observed that most of the poor countries do not have adequate laws to control production and sales of medicine. In the context of this alarming situation, we have identified, through serious thinking and study, aided by masters in the field—most of the problems prevailing in the medicare system—at the Individual level, and at the National level.

Having identified the problems, we have been able to come up with solutions to most of the problems, again at the Individual, Institutional and National level. We are now ready to get back home. My dear fellow delegates, all that we have deliberated here, during these three days of the convention, will be of no use, absolutely no use, if we are not convinced beyond any doubt that there is something seriously wrong with our Health Care System and that we, as Christians, inspired by the gospel values can't simply stay unconcerned. We have therefore resolved to take up the cause of the poor and exploited, no matter what the cost we will be required to pay.

I think the greatest contribution of the convention is that an awareness has been created in us that there is something seriously wrong with the Medi-Care system in the country, and that we, knowingly or unknowingly, are a party to the perpetuation of the evils of the system, and that we, as Christians inspired by the gospel values, can't simply stay unconcerned of the situation. Friends, in the beginning of the world we hear God's voice resounding the universe with two questions ! When Adam and Eve wanted to run away from God's presence God's resounding voice was heard—"Man ! where are you ? "Man ! where are you ? Later when Cain killed his brother Abel, again God's voice was heard—Man, where is your brother ? Man, where is your brother ? From the beginning of creation, until the consumation of the world—God's voice will continually resound in the universe with these same questions—Man, where are you ? Man where is your brother ? Our eternal reward will depend, my friends on the kind of answer you and I will be able to give to these two questions ! Man, where are you ? Man where is your brother ? When your brother was denied a human existence, when your brother was exploited to extend of making his life inhuman, Where were you ? !

Towards a people-oriented drug policy

Dr. C.M. Francis

The Government of India had enunciated a New Drug Policy in 1978, based largely but diluted to a great extent on the Hathi Committee Report of 1975. Many of the objectives of that Policy could not be realised for a variety of reasons. Now there is a move to have a newer Drug Policy. The Government had appointed the National Drugs and Pharmaceuticals Development Council. Its report is available. Most of the recommendations seem to be a departure from the major social objectives of the 1979 Drug Policy, with pressures and threats from the manufacturers. Health is a fundamental right. For the achievement of that health for all, many steps have to be taken. One of the first requirements is to set our goals, enunciate unambiguously the policies and initiate appropriate steps to reach the goal.

2. *Drug policy*: Along with nutrition, water supply, sanitation and housing, the provision of standard drugs of good quality in adequate quantities is a must for the protection, maintenance and restoration of health[1]. There is need for a rational and optimal therapy and therefore the need to have a rational drug policy. This policy must be an integral part of the new National Health Policy. Some groups of active citizens, aware of the need to popularise the demand for action by Government, have come together to form the Drug Action Network. Among them are the Voluntary Health Association of India, Medico friend circle, Delhi Science Forum, Kerala Sastra Sahitya Parishad, Arogya Dakshata Mandal, Lok Vignayan Sanghatana and others. Now the Catholic Hospital Association of India, with its large network of Hospitals, health centres, dispensaries and community health work, and a host of personnel working in the Healing Ministry has taken up this problem of making available to the large masses, seeking health care, essential drugs of good quality at reasonable prices. The problem of drugs can be solved only if concerted efforts are made by the people and the Government, both central and state. There is an imperative need for a comprehensive National Drug Policy, based upon the socio-economic, political and other options and the practical implications of that policy.

2. 1. The present drug policy initiated in 1978 had the following *objectives*[2] among others :

1. Drug availability at reasonable prices
2. Indianising the industry
3. Leadership role for the public sector
4. Self-reliance in drug technology.

We are nowhere near the achievement of these objectives. There has been a noticeable drop in the growth rate of the industry during the last 5 years. The production of bulk drugs has increased by 70%, while the imports have doubled. The sixth Five Year Plan production target for bulk drugs was Rs. 566 crores ; this has been slashed to Rs 500 crores ; so also the target for formulations has been reduced from Rs. 2,450 crores to Rs. 1,950 crores. Even these reduced targets are not likely to be met. What is worse is the fact that the limited resources are often wasted in the production, distribution and consumption of non-essential and useless drugs,

a large, proportion being vitamin combinations and tonics.

2. 2. Shortages have been felt in many essential drugs. The industry had imported 75 tonnes of rifampicin in 1983 against the normal requirement of 35 to 40 tornes and yet there is a serious shortage for this drug, which is important in the treatment of leprosy and tuberculosis. There had been a fall in the international price in rifampicin (it has gone up again) but the import price was calculated on the basis of higher price and costing done on that basis ; the public had to pay more. There have been a number of questions raised in the Parliament and on that basis the firms have been asked to refund "the unintentional profit", which comes to more than Rs. 3.5 crores. But most of the larger firms are refusing to give even the date, inspite of the Government reminders, let alone refund the excess profits.

Some progress has been made in the Indianisation of Drug industry ; there has been abject failure in the leadership role for the public sector and in self reliance in technology.

2. 3. The recommendations of the steering committee of the National Drugs and Pharmaceuticals Development Council are likely to revise, adversely for the public, the national policy :

— Price controls for only 95 drugs ; 265 drugs at present on the price control list to go off it.

— Higher "mark ups" (trade margins, promotional costs and profits for the manufacturer) on the production cost of even these 95 drugs.

— End to the present ceiling on company profits.

— Automatic price increases every year based on a price index mechanism.

— Regularisation of excess production capacities installed

— No price control for 5 years on any drug introduced for the first time.

2. 4. Our closest neighbour has tackled this problem differently. In declaring the bold New Drug Policy of June 1982, Bangladesh followed 6 precepts[3].

(1) Elimination of harmful and useless drugs. As follow-up, 1,700 such drugs were banned. (Similarly, in Philippines, about 6,000 out of an estimated 15,000 drugs in the country would be phased out during this year. In Mexico, over 10,000 drugs have been closely evaluated and many duplications, obsolete products and those with limited or doubtful benefits have been eliminated, reducing the number of drugs available to 329, in 583 combinations.)

(2) Increased domestic productions of essential drugs.

(3) Public distribution system of essential drugs.

(4) Bulk importation of pharmaceutical materials from different sources at competitive prices (Many countries have been able to do this, achieving economy. Tetracycline which used to be imported at 102 U.S. dollars per kg. before the Policy was imported at U.S. $ 27 per kg.).

(5) Use of generic names.

(6) Encouragement of locally organised applied drug research.

Mr. Vasant Sathe, Minister for Chemicals said at the meeting of NDPDC earlier this year that the motto of New Policy will be "Medicines for the masses". This must be seen in action.

3. Drug scene in India

The total production of pharmaceuticals in India is estimated to be Rs. 2,005 crores in 1983-84. This includes both bulk drugs (Rs. 345 crores) and formulations (Rs. 1,660 crores). If we compare our production with the world-wide production, it is extremely low. The world consum ption of pharmaceutical products was estimated in 1981 to amount to Rs. 763 billions. India's share comes to about one in fifty, while her p opulation is about one in six. The growth of the drug industry in India had been remarkable earlier. From Rs. 10 crore in 1947-48 to Rs. 1,545 crores in 1982-83, from being a mere trading industry to a manufacturing industry, the growth had been good. But in recent years stagnation seems to have got in. The growth in 1983-84 is only half of what was achieved in 1982-8 3, leading to shortage of many vital drugs[4]. The Sixth Five Year Plan had envisaged an annual growth rate of 24% in bulk drugs (achievement in 83-84 : 6%) and 16% in formulations (achievement 4%). The manufacturers are reluctant to go in for bulk drugs ; the profit margin is smaller. There are about 25,000 formulations in the market in India, whereas many of the advanced countries have only one-tenth of it.

4. Drug Industry

There are different types of companies :

(1) The Public Sector—Central, State and joint enterprises.

(2) Those with large foreign shareholding, being part of the transnationals. The shareholdings have been diluted or, are being diluted in the majority of cases to 40% but there are still some with more than 40% shareholding. The foreign controls remains. It was expected that these subsidiaries of transnationals will bring in their complex, up-to-date technology developed by their parent companies. Against this has to be considered the inhibitory effect on the development of technology in India.

(3) Large Indian companies. These are very few but they have a number of benefits. There is a controversy between the FERA companies who now claim to be Indian Companies and the Indian Drug Manufacturers Association. The FERA companies with high technology are given a production ratio between bulk drugs and formulations of 1 : 5, whereas, it is 1 : 10 for Indian companies. 1 : 5 ratio has not been reached in most cases, being on the average 1 : 11, as the FERA Companies and the India manufacturers find it more profitable to produce formulations.

(4) Small scale units which constitute about 92% of the manufacturing units. The SSI units are exempted from the 1979 Price Control Order. But this had led to misuse. Many foreign owned companies and the large Indian companies set up associate small scale firms, with marketing tie-ups.

Because of pressures and for promoting competition, more and more units have been created ; we have over 5000 manufacturing units, many of them uneconomical or substandard.

There are illegal expansions of production capacity in areas which are highly profitable, with reduction in other areas (production of essential drugs, where the price control works).

5. Public Sector

The public sector was to play a leading role in pharmaceutical industry but its performance has been disappointingly poor. The prices are often more than the price charged by the private sector. Even since its establishment in 1961, the Indian Drugs and Pharmaceuticals limited has been running at a loss,

the loss in 1983-84 being Rs. 21 crores ; out moded technologies are being used. The capacity utilization has been poor, being about 55% of the installed capacity. There are plans to improve the performance and to break even by 86-87 ; this is yet to be seen. The picture with the states pharmaceuticals is also not bright. Even with preferential margins, many of them have not been able to do well.

It is necessary to tone up productivity in the public sector industry, with better technology and utilization of capacity. All essential and life saving drugs must be produced by the public sector on a priority basis.

6. Research and Development

There is a great need for developing new drugs and improvement of technologies for production. The pace of innovation in Indian drug industry has been totally unsatisfactory. Innovation can be for new technologies, modification and adaptation of imported technology and for import substitution. Incentives must be provided for research and development; guidelines must be set for stimulating R & D activity; priority areas must be identified, and there should be co-ordination of research, monitoring and evaluation.

6. 1. Indigenous technology should be developed With sufficient number of scientists and technologists available in the country, there is no reason why we cannot be self-reliant in technology. We have to be very careful in technology transfer from advanced countries, as very often we pay exhorbitant amounts for obsolete technology. IDPL resorted to the purchase of technology from an Italian consortium for 5 antibiotics. While preliminary results were good, it was finally a failure. How does one get the latest know-how from abroad if we are paying for it ?

World's leading pharmaceutical firms set apart 10% of their turnover for R & D.[5] The search for new drugs being very expensive and time consuming, it is concentrated in the hands of the large transnationals, with commercial exploitation on a world basis. Various steps are involved in the development of a drug; synthesis (or isolation from natural sources), biological screening for activity, preclinical studies for potency and toxicity, pharmacokinetie and metabolic studies, development of appropriate formulation, pharmaceutical development. clinical trials, and development, of technology for production and surveillance. In 1980, 83 out of the 100 leading medicines in the world were developed and produced in just 5 countries—U.S.A., Japan, Switzerland, W. Germany and U.K.[6] Our expenditure on R & D is very low, being only 2% of the sales turnover. It is essential that we step it up. It must be made mandatory that provision should be made to meet the recurring expenditure on R & D on a percentage basis of the turnover; this should be increased progressively to reach a figure of say, 7% by the end of the Seventh Five Year Plan, irrespective of the category to which the industry belongs.

6. 2. Our R & D should also concentrate on the search for newer drugs required to tackle diseases of relevance to us. The transnational firms are often not interested in such drugs because they do not have a ready market and high profitability. We must also catch up on the newer natural products of "biodrugs". These drugs could be manufactured with the level of technology available in our country.[7]

6.3. The Central Drug Research Institute, Lucknow, the National Chemical Laboratory, Pune and the Research Laboratory, Hyderabad are doing some work. 73 pharmaceutical industrial units have been recognised by

the Department of Science and Technology. But the quantum of research done is totally inadequate and the results not worth mentioning. A larger research base is needed. The Government must actively stimulate and encourage research into pharmaceutical preparations, essential to combat the diseases most important to our country. Sizeable grants should be given to Research Institutions, Universities, Medical Colleges and Colleges of Pharmacy for search for new products, processes and technology. Incentives for research must be provided to the firms:

(1) Pricing mechanisms should include research costs

(2) Waiver of customs duty on import of capital goods specifically for research

(3) Weighted rebate of income-tax for sponsoring research in approved institutions and in-house research units.

7. Drug Evaluation

Drug evaluation is the procedure by which the true value of a drug is determined. Many westerners believe that Third World Countries lack in men and resources and therefore the pre-clinical testing cannot be done in such countries[8]. With its vast potential of scientists and advances in Technology, this cannot be held against India. We must insist that the transnationals carry out the pre-clinical testing in India in some drugs, at least proportionately to their sales here. This would provide development of some expertise and knowledgeable experienced persons who can help the Indian Drug Industry.

8. Indian systems of medicine

All that has been said will apply to the pharmaceutical industry involved in the production, distribution and marketing of drugs for the Indian systems of medicine. Most people use these traditional remedies[9] and there is need to ensure good, potent, genuine unadulterated drugs at affordable prices. There are about 2,700 pharmaceutical belonging to the Ayurvedic, Unani and Siddha systems of medicine. The total number of practitioners is also very big (institutionally qualified or otherwise trained). The old practice of physician manufacturing his own medicines has become unworkable. In the preparation of these drugs, it is necessary to follow the traditional pattern also, in addition to the modern methods of processing. There is need for enquiries into the availability of raw meterials, collection and sale, as also the cultivation of reputed plants of proper species through the forest departments and drug farms.

If quality can be assured, there are possibilities of export, especially to our neighbouring countries. Standarization, safety evaluation and clinical testing must be carried out properly. We have to take special care of efficacy, toxicity, quality control, keeping qualities and packing and handling.

9. Quality control

Quality control is of paramount importance in the drug industry, because the very lives of the people depend on it. Unfortunately it is not being exercised to the extent it should be. Industry has to be self-disciplined and responsible. High quality starts with good manufacturing processes—established and approved procedures and policies that are adhered to in the production of drugs. The proper norms must be adhered to. Registering and licensing authorities have the responsibility to ensure that the drugs offered to the public meet acceptable levels of safety and efficacy. Standard procedures of testing and monitoring should be carried out frequently and corrections applied as necessary.

Counterfeit and substandard drugs are plentiful. Their production and distribution must be stopped, stringent measures taken and exemplary punishment given. The Public Accounts Committee of Uttar Pradesh found some of the products of the Public Sector Unit (UDPL) adulterated and substandard.

10. Pricing

In a poor country like India, it is necessary to ensure that essential drugs are available to the people at prices they can afford. The Drug Prices Control Order, 1979, placed the drugs in 4 categories and the price was fixed on the basis of essentiality and cost. Medicines in the fourth category were free of any price control: other drugs have different make-up values.

Government is planning to revise the drug pricing policy which will mean that the public will have to pay more for the drugs. The mark-up for essential drugs is to be raised to 75% and all the rest will be for open marketing.

Vital drugs may go tax free-central excise, customs duty, sales tax and octroi, which together now come to about 40% of the retail price. This is a step in the right direction.

11. Foreign exchange

Situated as we are, with all the advantages, our pharmaceutical industry was expected to earn foreign exchange. But there has been only net loss and what is worse, the loss is increasing. These losses are through the import of raw materials, capital goods, royalties and dividends from profits by the manufacturers with foreign shareholdings.

11.1. One area which requires consideration is the transfer pricing. This has often been misused, boosting up the price of the raw materials and intermediates. German Remedies imported dipyradimol from a Spanish company: the price was marked as three times the price other companies were paying. Hoffman-La Roche had to pay back an enormous amount to the British National Health Service because it was found that the transfer price charged for the raw material for Valium was very much higher than market price in other countries.

12. Different standards

Other countries believe and our Government agrees that some harmful (or potentially harmful) drugs could be marketed and consumed in India. Is Indian life less precious than the lives of ofher country men? Drugs not approved for use in the United States could be exported to other (third world) countries[10]. They would even consider giving technical assistance to Governments of developing countries to aid decision making process! India should not allow, under any consideration of the so called benefit-risk ratio, the import of any drug which is not freely registrable, licensed and marketed in the country where it is developed and produced. They should not even be allowed to be submitted for clinical trials or marketing in india.

13. Brand names

The drugs should be known only by the generic names. The argument that the physician, patient and public would like to know the names of the firm which has produced the drug can be satisfied, if the name of the company is also printed. Giving brand names confuses everyone and can lead to mishaps. The pharmacist should be in a position to substitute a quality drug produced by another manufacturer, if the product of the particular manufacturer is not available.

14. Promotion of products

Social and economic damage is caused by the indiscriminate advertising and marketing activities[11]. There is no need for high pressure salesmanship, with a large number of salesmen, free samples, gifts and free travel within the country and abroad for conferences or pleasure for those doctors who push the products. These should be banned; so also the advertisements in media for the public. Even in advanced countries, where regulatory measures are much more effective, promotional activities sometimes go far beyond what is reasonable, eg., the Benoxaprofen affair of the Opren scandal[12]. "A combination of an unscrupulous pharmaceutical firm; feeble watchdogs and gullible doctors had been responsible for the use of an unnecessary and unsafe drug...key figures were extravagantly entertained at sponsored conferences in attractive venues".

15. Drug information

Every drug is a poison. Drugs are prescribed because they give more benefit than harm. One must be careful of the adverse reactions and be especially watchful in infants and children (particularly small-for-date babies, protein-calorie malnutrition, infections), elderly patients and pregnant women. Adequate information should be given to the patient about the drug. These would include.

What is the dose; frequency of use; route; relations to meals ?

Does it cure or give symptomatic relief ?

What to do if the drug is not working ? Is there a lag period ?

How long to take ? When to discountinue? What are the side-effects ? adverse reactions ?

What are the precautions during work in the field or the factory ?

How is it to be stored ?

16. Ethical and legal problems in therapy

16.1. *Doctor*: Therapy may result in injury to the patient: physical, mental, financial and others. A large number of patients are treated in hospitals because of iatrogenic diseases. In our country, almost all such mistreatment goes scot-free. But there are possible avenues of punishment :

(1) Professional discipline—the doctor may be reprimanded and even deprived of his right to practice, by the Medical Council.

(2) Proceedings for damages—civil law.

(3) Criminal negligence.

The doctor may not devote sufficient attention in the prescription of drugs and prescribe :

(1) unnecessary and potentially dangerous drugs. The patient may be treated with a range of drugs which have potential adverse reactions and interactions. Some doctors continue to prescribe drugs, even when the adverse reactions and contra-indications are known generally, because they fail to keep abreast of the literature. Sometimes, the doctor is under pressure from the patient or relatives to prescribe unnecessary therapy.

An interesting question that can be raised is : If drugs banned elsewhere and allowed here by the Government cause any injury which can be attributed to them, who will be responsible?

(2) inappropriate drug. Gross examples can be prescribing aspirin for gastric pain or a drastic purgative for sudden constipation possibly due to intestinal

obstruction. The decision as to whether the physician was negligent would depend on what the physician could have known, should have known and infact did know and acted upon.

(3) careless and inaccurate. The prescription could be indecipherable, there could be confusion between micrograms, milligrams and grains; there could be be confusion between drug names, especially trade names.

(4) fail to prescribe essential treatment

(5) give inadequate or misleading information to the patient, about the treatment.

16.2. *Pharmacist* : It is the duty of the pharmacist to

(1) check the prescriptions before dispensing

(2) dispense the correct medicine. Mrs. Winifred Greig, 64 years old was prescribed pardale, a mild pain killer for her arthritis; she was given Priadel, containing lithium. She collapsed a day after she began taking the drug and died. The pharmacist had misread the prescription.

(3) provide correct and adequate information to the patient.

(4) store the drugs safely and properly, so that there is no deterioration.

(5) ensure that the date of expiry is not exceeded.

16.3. *Drug regulatory agencies* approve new drugs and review old ones. They decide as to what drugs are effective and safe and what information should be available on the package inserts, data sheets and advertisements. They are the people in a position to know; the doctor, pharmacist and the public depend on them. The regulatory authorities are responsible for their decisions. There has been a well-known ruling in Japan ;

"..... in view of the nature of administrative supervisory authority and in all other relevant circumstances, the Government stands in a position of quasi joint-and-several liability with the other defendents who are the direct offenders and therefore should bear one third of the total cost of the compensation that the court determines the defendents should pay".

16. 4. *Manufacturers :* The pharmaceutical industry has to take all precautions to see that only safe (and effective) drugs are released to the market. Pharmaceutical industry should put a product on the market only if due care has been observed in all aspects[13].

(1) The drug should have undergone extensive preclinical and clinical studies.

(2) Good manufacturing practices must have been followed, with quality control at every stage.

(3) The drug should be promoted only for valid indications and in a responsible manner.

(4) Necessary precautions, warnings, indications and contra-indications should be communicated to the doctors and patients.

(5) There must be efficient post-marketing surveillance.

Discussions are going on in various countries whether there should be strict liability or no—fault liability. The New Drug Policy must decide on the liability. In any case, there has to be product liability (and

not merely process liability). The producer shall be liable for damage caused by a defect in the drug, whether or not he knew or could have known the defect and without having to prove that the defectiveness of the product which caused the damage was due to any fault on the part of the producer[14].

17. *Drugs for primary health care* : Primary health care is essential health care made available to individuals and families in the community and has to be

(1) accessible, assuring equitable access to all,

(2) acceptable, based on the life pattern of the people,

(3) effective, in providing an adequate level of care, and

(4) affordable, without the imposition of excessive burden on the individual, family or community.

It is the first contact care, where most of the usual, everyday health care needs can be met. Primary health care is an approach which integrates at the community level all the elements which are necessary to improve the health of the people.

17.1. India, a signatory to the Declaration of the Alma Ata International Conference on Primary Health Care, is committed to provide an acceptable level of health for all by the year 2000 AD. Primary health care has to be defined in terms of function and the scope and quality of care under each function. It is also necessary to decide what proportion of the GNP should be alloted to health care and what part of it to primary health care, though this can present problems.[15] An integral part of this commitment is the provision of *all essential drugs to all those who need them, in adequate quantity and quality, and at affordable prices, wherever the person is.* The ability to meet the cost or to reach the place should not be considerations in providing the essential drugs.

17.2. What are the drugs required ? Drugs are required for prevention, cure and symptomatic relief. The World Health Organization has, in 1983, listed about 250 drugs as essential[16]. This is a large scale modification of the list prepared in 1977 and revised and updated in 1979. The objective of WHO action programme on essential drugs and vaccines is to ensure the regular supply to all people of safe and effective drugs and vaccines of acceptable quality at lowest possible cost in support of primary health care[17]. They have also given a list of 22 drugs for primary health care, which "can be used effectively and safely by responsible individuals with little formal medical knowledge". The report also states "highly trained workers might use a wider range of drugs appropriate to their diagnostic skills" and advocated that where there is no scarcity of medical manpower, many potent drugs could be used. Primary health care is the involvement of the practitioner (doctor, nurse, medical assistant, auxiliary, or primary health worker), to whom a person first turns, when ill or seeking advice. This varies from country to country and even within the country. The W.H.O. expert committee observed "the preparation of a drug list of uniform, general applicability and acceptability is not feasible or possible". The same is true for a vast country like India. In India, there is a reasonable ratio of trained doctors to population in the majority of places; in many situations, they will be the persons for primary contact; in others, these will be trained nurses, community health workers or others. Depending on who provides the health care in the first contact situation, the use of drugs will vary. I shall take the situation where a qualified physician is

available; in other situations, the list of drugs may have to be drastically curtailed, being nearer the twentytwo drugs listed by the expert committee of W.H.O.

18. *Policy* : There is need for a clear decision as to what diseases and symptom complexes come within the purview of primary health care. A purposefully determined regimen of treatment should be worked out for each disease and symptom complex, leaving the rarer treatment regimes to the specialists at the referral care.

19. *Choice of drugs* : The drugs for primary health care must be well-chosen. The choice has to be based on a survey of the mobidity pattern in the area or region. To ensure optimal benefits, the definition and determined implementation of clear national policies are required. The steps to success in the choice and supply of essential drugs have been listed[18]. They are :

(1) A comprehensive National Drug Policy

(2) Selection of essential drugs

(3) Drug production and procurement

(4) Logistics of supply

(5) Proper use of drugs

(6) Quality control

(7) Training of personnel.

19.1. The list of drugs should be drawn up by a regional committee of doctors, pharmacists and others interested and involved in primary health care. Concise and yet comprehensive drug information should accompany the list. The common diseases in our country are infectious diseases, parasitic infestations, acute diarrhoeal diseases and malnutrition. India, in common with other less affluent countries, has a young population with about 40% under 15 years of age. Hence the diseases common among children have preponderance; drugs required for their care must have priority. Periodic revisions must be made to meet the changing needs or based on better assessment of the needs and the availability of more cost-effective drugs. It is better to have only one effective preparation for each indication, avoiding unnecessary duplication. The drugs, where possible, are better supplied in tablet from for ease of administration; they should also have keeping qualities under the existing and often exacting conditions of temperature, humidity and storage. The packing must be efficient but not expensive. The choice of the drug should be based on

(1) proven efficacy; well tried drugs should be preferred to newer drugs whose efficacy, side-effects and adverse reactions have not been fully established.

(2) low cost, commensurate with efficacy; the cost of the whole treatment should be considered and not merely of single dose.

(3) safety in the hands of the user.

20. *Drug costs* : The costs should be kept to the minimum. The country should as far as possible become self-sufficient in the production of drugs for primary health care. Where imports are necessary, they should be obtained on the basis of bulk purchases on global tenders and selection with due regard to quality and cost. Considerable savings can be effected.

Even affluent countries have taken measures to contain the costs[19]. The nine countries in the European Community took steps to reduce the cost of drugs. Among them are

(1) Fixing of prices or limiting profits of pharmaceutical companies

(2) Limiting sales promotion activity

(3) Regulation of retail margins

(4) Circulation of information to doctors to encourage economical prescribing.

21. *Logistics of supply* : An adequate supply of the essential drugs must be ensured at all times, in all places and in suitable dosage forms including paediatric dosages. The challenge is to devise systems that will provide essential drugs where they are needed, matching the supply to the health care needs. It often happens that the essential drugs are not available at all times, leading to shortages. This has happened often to the large scale treatment of tuberculosis, leprosy and other diseases. Sometimes it has happened because manufacturers deliberately did not produce them or retailers refused to stock and dispense them, all clamouring for a larger margin of profit. Villages and regions may be cut off in certain seasons for a variety of reasons.

22. *Drugs for immunization* : High priority must be given for immunization in primary health care. The commonly preventable diseases must be prevented. This is high technology and highly cost-effective. Everyone knows of the success story of small-pox eradication; it is estimated that about a billion dollars have been saved by giving up compulsory vaccination. Infectious diseases take a big toll in our country, especially of infants and children. The cost for treating the patients with these infectious diseases and the complications and sequelae are very high. Among the common infectious diseases which can be effectively prevented today are

diphtheria,
poliomyelitis,
measles,
whooping cough,
tetanus.

Newer effective vaccines may be added, depending on the cost—benefit.

23. *Drugs for cure* : Some of the more essential drugs are listed ; a few more will be needed, based on regional requirements and other factors.

Antimicrobials : Infectious diseases being the commonest, priority should be given for drugs to fight them. The proportion of the pharmaceutical budget spent on antibiotics and antiparasitic drugs was 24% in India, compared to 4% in the Federal Republic of Germany and 15% in Britain. Well-tried, cost-effective antimicrobials from among the many available, should be selected. This would necessarily include the penicillins (crystalline, procaine and oral) and ampicillin; one or two potent and safer sulphonamides could be included. Drugs like chloramphenicol and tetracyclines will also be useful. The misuse of antimicrobials is fraught with danger, especially the development of resistance. *Antimalarials*: Malaria is again becoming a major threat. From an all-time low annual incidence of 100,000 in 1965, it has risen to some millions. Chloroquine is a good drug. Unfortunately resistant strains have developed especially in the northeast and are spreading to other parts of the country. Primaquine may be provided for radical cure; quinine is also included. *Antileprosy* : Dapsone can still be the basis of treatment, though multidrug treatment with rifampicin and/or ethionamide is common now and probably cost-effective. *Antituberculous* : It is estimated that there are about 10 million people in India suffering from tuberculosis with about one-fourth of them being infective. About 50,000 die per year from pulmonary tuberculosis. The

drugs required for standard therapy such as INH plus streptomycin plus PAS/Thiacetazone/ethambutal or the short course including rifampicin must be available. Antiamoebic: metronidazole; Antihelminthic: Mebendazole. Antianaemic : Ferrous sulphate; folic acid. Antixerophthalmic—Vitamin A. Antifilarial : diethylcarbamazine. Antifungal : griseofulvin; Antikala-azar (in regions where kala-azar is present).

24. *Drugs for symptomatic relief* : Analgesic and antipyretic : aspirin; paracetamol; morphine in special situations. Inflammation: glycerine and mag. sulph; ibuprofen. Cough: Noscapine; pheniramine maleate. Diarrhoea: rehydration salt. Constipation: magnesium sulphate; senna. Vomiting: promethazine. Allergy : Chlorpheneramine. Asthma: ephedrine aminophylline and salbutamol; adrenaline injections for an acute attack or status at shmaticus. Angina : glyceryl trinitrate ; propranolol. Hypertension and congestive heart failure : hydrochlorothiazide ; digoxin. Epilepsy and convulsive disorders: phenobarbitonel phenytoin. Sedatives and hypnotics : diazepam. Poisoning : atropine sulphate injections ; activated charcoal ; syrup of ipecac. Antacid : aluminium hydroxide. Colicky pain : Oxyphenonium bromide. Diabetes mellitus : an oral hypoglycaemic like glibenclamide or metformin ; insulin. Uterine bleeding : ergometrine Oxytocin. Urinary tract infections : Cotrimoxazole.

Ear infections : Choramphemicol/gentamicin drops (Other requirements for ear, nose and throat conditions will have to be met). *Skin condition* : Disinfectant : chlorhexidine ; gentian violet ; iodine. Soothing agent ; calamine lotion. Ringworm and other fungi : Whitfields ointment (benzoic acid plus salicylic acid). Scabies and lice : benzyl benzoate. *Eye conditions* : Topical antibiotics : chloramphenicol—1% ointment ; tetracyclines– 0.5% ointment (other materials, including spectacles will have to be provided). *Psychiatric conditions* : Amitriptyline, chlorpromazine, fluphenazine.

In addition to the drugs mentioned, there is need for intravenous solutions like normal saline and 5% dextrose, surgical dressings, suture materials and a local anaesthetic.

25. Other factors

Drugs form only one of the factors contributing to better health. There are other more important requirements for Better Health for All. Among them are health education to lead a normal healthy life, avoiding risk factors, good nutrition, safe drinking water, sanitation and housing.

25.1. *Nutrition* : The most important health-threatening condition in our country is malnutrition, mostly protein—calorie malnutrition, though specific deficiencies are also present. Adequate food intake is the solution. Food production in the country is adequate but there is unjust distribution, poverty and lack of education; health care should ensure adequate intake of balanced food, with easily available foodstuffs.

25.2. *Water supply and sanitation* : Water supply is not safe, especially in the villages. There are still lakhs of villages which are classified as problem villages (those which do not have an assured source of drinking water within a distance of 1.6 km.). Disposal of excreta lags far behind; only 2% of the rural population has been covered by satisfactory disposal, while a neighbouring country like Sri Lanka has had a remarkable progress in this area.

25.3. *Tobacco* : The smoking epidemic should be of great concern in health care. While cigarette consumption is declining in many affluent countries, it is increasing in our country. The tragic effect is increase

in lung cancer and cardiovascular and other diseases related to smoking. A campaign must be mounted as part of health care against smoking.

25.4. *Alcohol*: The alcohol problem is a growing threat to health. Between 1960 and 1980, alcohol consumption increased by 500% in Asia. Alcohol-related problems affect not only the individual drinkers but also their families and the general community and can be physical, mental or social in nature.

25.5. *Chemicals in the environment*: A class of substances are being added to the environment; these are synthetic chemicals. Many of them can be toxic and need to be dealt with in the same way as poisons and infections. Among them are pesticides and insecticides (example : highly toxic organophosphorus compounds); their metabolites; industrial effluents (an example is disease produced in people who ate fish rendered toxic by the presence of methyl mercury); herbicides (Agent Orange); Fungicides. All these call for prevention, recognition and management. There are an estimated 375,000 cases of human poisonings by pesticides in developing countries every year with some 10,000 deaths. Lack of protein in the food of rural workers is an additional factor that makes these chemicals even more dangerous. Agricultural spraying (including aerial) is common in the countryside but its effects are not always known. India is proud to be the largest manufacturer of pesticidal chemicals in the whole of South Asia and Africa, with a licensed capacity of 78,000 tornes[20]; its toll of human health is not known.

The Catholic Hospital Association of India can be a powerful organisation for the good of the people. You can achieve your goal in the Healing Ministry provided you are willing to work a little bit, willing to struggle a little bit and willing to suffer a little bit.

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our people live. We need to revamp our medical education and nurses training system to make them relevant to the situation of our country and the life and culture of our people. We need to focus our attention on the sick person more than his sickness. Hence the need for a proper attitude for our health care personnel which is more person oriented.

Fortunately for us we have of late, sufficient and clearcut directives to do all these both from the part of the government and the church, through the new Health Policy of the Government of India and the various documents from the Church Leadership both national and universal. All what is needed is the political will and commitment to people from part of all concerned, to implement all these and make them a reality.

Hence this convention is going to be a time of challenge for all of us. There is no choice before us in the sense that whether we should take up this challege or not. For, our motto says "The love of Christ compels us" today to take it. What we need to deliberate on these days is as to how we are going to do this. We need to address ourselves to the real needs of the people. Let us hope that all of us together will be able to find our way to give life to our people and to give it in its fullness as Christ wants us to do.

Let me conclude this with another piece of warning from the ICMR/ICSSR report : "External vigilance is required to ensure that the health care system does not get medicalised, that the doctor drug producer axis does not exploit the people and that the abundance of drugs does not become a vested interest in ill-health."

Professionals in the Church—An Introspection

Dr. George Joseph

About a month ago, I had the privilege of participating in a workshop under the CSI on the 'diakonal ministry' of the Church, particularly, viewing it from the angle of its scope and relevance in the social context of today.

Let us examine the formation of the 'diaconate' in the early Church referred to in the Acts of the Apostles. The Church increased and the old patterns of the ministry were found to be not adequate. There was some grumbling about the way the Apostles 'served at the tables' in their service to the widows. The Greeks complained that the Greek widows were being discriminated against, as compared to the native Hebrew-speaking widows. The Apostles therefore suggested a new order to be instituted to deal with this changed situation. The Apostles appointed seven 'deacons' to efficiently organize the service to the widows. For these deacons, the following qualifications were prescribed :

— they should be the men of honest report—of proven integrity and with acceptability in the community

— they should be full of the Holy Spirit i.e. with a sense of call and commitment and motivation to serve

— they should be men of wisdom—the ability to do the work applying their knowledge and understanding.

Seven persons were chosen and anointed and set apart for this task. It is said that the community was very much pleased. The word 'diakonia' is the same as used for the activity of the Apostles, namely, the ministry of the word, and also to refer to the ministry to the widows—i.e., serving them at the table. Interestingly, both are considered as part of the same ministry of 'diakonia'. This is perhaps the earliest reference to the professionals in the context of the Church.

Let us now, examine the role of the professionals in the Church in our own context from this perspective. Let it be clearly understood that their role remains the same today as in the days of the early Church, as seen aganist the overall mission of the Church. It should be a matter of concern, that as time rolled by, the non-pastoral/non-sacramental ministries were no more seen as related to the mission of the Church and as a result, there was no sense of call and commitment on the part of those who served in the service institutions of the Church including that of healing. Examination of a few basic issues appears to be germane to our discussions. Why, after all, are we involved in the ministry of healing ? Whom do we serve and how do we serve ? Answers to these questions, hopefully, will help to throw insights as we grapple with this vital issue relating to a people-oriented drug policy.

Why do we serve ? What is the relevance of the institutional ministry of healing ? The answer is direct and straightforward : we have the master's commission to abide by, and his own example to follow. 'Heal the sick' and 'preach the Gospel'—was the commission given to the disciples. The Gospel is replete with examples of how Jesus dealt with the whole problem of disease. He had compassion on the crowd for He felt they were without leadership—

sheep without shepherd. He therefore taught them and healed the sick—a masterly illustration of an 'educational diagnosis' of the problem at hand followed by a combination of approaches 'educational' and 'service' to solve it.

He has demonstrated several approaches in the healing ministry e.g. 'reaching out' to bring hope and health to people—the oft-quoted incident of how he went out to meet the impotent man at the pool of Bethesda waiting for a cure for 38—long years; bringing hope and health to those ostracised by society as in the case of those suffering from leprosy. He walked through Somaria—no jew with self-respect would like to do that—to meet a group of ten, afflicted with this disease, of whom nine were Jews as they could not have safety and freedom in their own country and society. He used physical remedies, at least once—the making of the mud-paste with spittle and applying it on the eyes of a blind man and making him wash it in a particular pool-symbolic of the use of a physical remedy in the cure of a disease.

Whom do we serve ? A highly searching question! Here we see the Master had distinct priorities—the priority for the least of the brethren of Mine—the poor, the socially disadvantaged, the out-castes. He identified himself with the least of these brethren who have all along been neglected.

How do we serve ? What is the 'model' of service we are provided with ? We find here that the central emphasis is on 'abundant life'—life in its fullness and richness. He demonstrated care of the physical body as well as those of the mind and soul as an integral whole—the concept of viewing health in its 'totality'. We have a remarkable incident to illustrate this : The woman who had an issue of blood for twelve years whom no physician could cure and who in the process had lost all resources, took a bold step, a venture of faith at that, walked through the crowd, and on reaching Jesus, caught hold of the hem of His garment. The story is familiar. She was healed immediately. But the way the Lord dealt with her helps us to gain deeper insight into the wholesomeness of the ministry. To the great horror and amazement of the crowd He addressed her as 'daughter' and by the use of that tender word He had recognised her adoption into the family of God. Jesus knew she was penniless, still ostracised, through she was healed How would society treat her ? How would her family look upon her—and the religious rulers ? Her acceptance back into society was a matter of great concern to him as part of the healing ministry. We have these glimpses into the pattern of the healing ministry of Jesus which provides a model that has an all-time appeal. It has great contextual significance to us who are involved in the healing ministry in one way or the other.

During the last two years, I had occasion to closely observe the activities and the style of functioning of a few 'popular' mission hospitals in my own state of Kerala. The issues regarding drugs in hospital practice may be examined closely without any pre-conceived notion or bias. The issues relate to the selection, purchase and procurement of drugs and medicaments including what is locally compounded for routine use; the discretion exercised by the physician in the choice of the drugs while prescribing, as a part of clinical management, and the dominent influences that guide these two processes.

Most of our institutions do not have a drug purchase policy, not even an approved formulary on essential drugs is available, with the result, the guiding considerations

in the purchase and choice of drugs are purely in terms of financial or material gains accruing therefrom. It is in this context, that our doctors are influenced by the medical representative and his biased literature.

Let us for a moment put ourselves in the unenviable position of the doctor who is working all alone in a remote rural area in charge of a hospital. The communication facilities in the area and the general development are such that he is functioning, as though in isolation. There may be a ricketty bus plying that way, that is more often than not, sick and off the road. The doctor is ungrudgingly and faithfully doing the difficult job of tending to the needs of his poor patients. He is cut away from society and the companionship to which he is used to. Then one day, drops into his O.P. department, a handsome young man, immaculately dressed with a broad and winning smile on his face and extending an unbelievable order of courtesy in his total demeanour. This is his first encounter with this young doctor. He condescends to describe it as an event of great significance and as a matter of pride for him, and worth all the trouble of plying long distances on his motor cycle, on mud roads. The scene is familiar. The doctor welcomes him with all the warmth. Then follows an interesting 'scientific' session, on the new products put in the market by his 'reputed' firm and major claims about their therapeutic superiority—an excellent display in effective communication (though often one-way!) using well-produced, attractive, highly colourful and appealing visual aids (some even excel cine-ads!). The shining leather bag bulging at the seams is laid open and the display starts, of product after product. He is liberal with samples. He also leaves at least a few items which have some attraction even to the doctor e.g. tonics for his wife or parents or multi-vitamin drops for his children (how considerate!). He is also careful to gift-away some trinkets. The doctor is overwhelmed, this being a novel experience. A new relationship is born. The order book is pulled out, concessions are announced which includes 'deferred payment' and 'attractive margins'. The deal is struck.

Let us dispassionately look at the scene. Who is at fault? I would be rather careful in my pronouncement. The ecounter described has social implications more than anything else. For the doctor, this is perhaps the first occasion after leaving the medical college when someone has attempted to talk about the so-called 'recent advances' in medicine and for no fault of his, the academic isolation is going to continue for a long time to come, till he is ultimately branded as a 'back-number' professionally. Continuing education is something we usually talk about during annual conference when the medical educationists and health planners meet, but no serious efforts till now, have been made in this direction. I am certainly aware of some major contributions in recent times in this direction which is laudable. But it calls for a tremendous initiative, on the part of the Government as well as our teaching institutions to become functional and operative. Under the regionalised plan of health services it should be the direct responsibility of medical colleges and training institutes to maintain bridges with peripheral institutions owing and adopting them, and providing professional support which includes continuing education.

Let us look at the issue of drugs as a source which can bring greater monetary gains for the hospital. Let us frankly admit that today success or otherwise of our institutions are measured in terms of material gains and financial stability and not in terms of the quantum or quality of care they provide. No wonder the doctors fall easy victims to the temptation of looking at drugs

from this perspective, in spite of its professional moral and ethical implications. We believe no doubt, that rational therapeutics is based on as accurate a diagnosis as possible. Taking into account the present constraints of diagnostic facilities in our institutions, the doctors, have to place greater reliance on clinic history and physical examination and also depend on the existing lab facilities. Here again we are confronted with the familiar problem about the need and relevance of the investigations usually ordered, for other considerations, need not necessarily keeping the interest of the patient as supreme. We are placed in a rut, where we are ready to sink our values; the doctors are tempted to order investigations with the sole aim of material gains.

We often blame doctors for injudicious use of antibiotics and chemotherapeutic drugs, choice of which is often made through purely arbitrary 'hit and try' methods, often with serious consequences to the patient. How many of our hospitals, even the major ones have facility for performing 'culture and sensitivity tests'?

Let us admit that we cannot put the blame on the professionals alone for the maladies that plague our institutions. Our institutions to be true to their 'first love' and carrying on the unique role of caring and service especially of the under-privileged befitting their calling, need help and support from the church in a large way.

No meaningful discussion on the futuristic role of the institutional ministry of healing can be initiated without a clear understanding of the role and responsibility of the dioceses, i.e., the individual Churches and the congregations they represent, in this whole endeavour. At the outset, let it be made clear that achievement of any measure of success in the attempt to bring about the much-needed awakening and community orientation, depends largely on the positive response to the call from within the Church itself. At present the Church is involved only at the 'decision making level' working through the controlling bodies, i.e. committees and the extent of actual involvement of the congregations in the healing ministry is, at best, only notional. Let me reiterate that the new orientation we want to bring to bear on the institutional ministry of healing calls for a radical departure from the past both organisationally and in terms of values and wherein our congregations have a major stake.

The tradition and practice hitherto have been to visualise the entire activity of the healing ministry as an exclusive domain and preserve of a handful professionals, both men and women, who ungrudgingly continue to perform their professional role in generating a variety of the much-needed services for the sick. Our congregations, and the members of the church have to visualise a totally different role for themselves vis-a-vis the ministry of healing a role that calls for a sea-change in their very attitudes and conception. From being exclusively the 'beneficiaries of care', and holding a position of advantage at that, or at best being 'passive onlookers' in the total scenario, they are to be elevated to function as 'providers of care' and as 'partners' in the mission of the ministry.

It is said that people of the nations are going to face the Son of man as the King on the final day of judgement, where the only yardstick to be employed is in terms of the individuals' contribution to heal the sick, to feed the hungry, to clothe the naked etc. The 'qualifying service' it is further clarified, is what you render to the least of these brethren of MINE. Let it be understood that even as related to the ministry of

healing, it does not draw any distinction between the role of the professionals and that of the laity, for the King's sacred commission binds all alike.

I have very often felt that we have hitherto failed in putting across this challenge to the fellow-christians in our congregations. Let it be made clear that the responsibility of caring for the sick and the suffering has to be perceived as a joint venture of the laity and of the professionals playing a role complementary to one another and both pooling and sharing their 'resources' towards achieving the same objective. The work and mission of the healing ministry both in breadth as well as in depth has to be perceived in this light, where not only each congregation, but each christian family and each member of the congregation is a share holder in this prestigious gilt-edged security which pays rich dividends.

Towards a people-orientated drug policy what can be done at the pharmacy level?

—Alan Crammer

Underlying what is to be said here is the fundamental principle that the service offered to patients must be a quality service. Striving for a rational drug policy must not go against proper presentation of work which must be the best that can be achieved with the available resources.

To achieve a quality service in accordance with a rational drug policy in the Pharmacy, control of that service professionally and administratively is essential. To achieve success it become necessary not only to involve the Pharmacists, but also the users of the service which in this context means the medical and administrative staff of the Hospital.

The Pharmacy Committee

Of necessity that subject can be dealt with only briefly here. The objective of the Committee is to involve the users of the Pharmacy services, and administration in its control and development. The non-Pharmacist professionals should not be expected to advise on the technical aspects of the work for which they do not have the experience. This simplifies the choice of persons to serve on the Committee, and this we will consider before its functions.

The constitution of the Committee might be in a 300 bed Hospital :

1. Medical Superintendent, chairman
2. Chief Pharmacist, secretary and convenor
3. Medical Specialist
4. Pediatrician
5. One other senior doctor
6. Administrator
7. Other staff by invitation when subjects of special interest to them are to be discussed
8. Where possible, a second Pharmacist

Meetings should be held regularly even if it appears that there is not a lot of business because very often something of importance does come out in discussion. A meeting once a month may be sufficient, but they may be more frequent in the early months of the Committee's existance.

Functions of the Pharmacy Committee in relation to the Drug Policy

1. To implement the medicines policy of the Hospital management.
2. To prepare and publish a Formulary of approved medicines, including the rules for prescribing.
3. Examine requests for medicines to be added to or deleted from the Formulary.
4. To set out the detailed purchasing policy, including :
   a) deciding which medicines are to be purchased
   b) deciding which basic medicines are to be purchased and which fixed dose combinations, if any, bearing in mind the fixed dose ratios and unnecessary ingredients.
   c) deciding which manufacturers are to be preferred bearing in mind quality and cost.

d) considering if drugs banned in other countries should be purchased, for example, analgin and oxyphenbutazone.

e) whether medicines from other systems should be purchased since these are frequently multi-drug formulations and no works of reference about them are available.

5. Producing minutes of the meetings and publishing them and ensuring that decisions made are conveyed to the persons affected by them.

6. In the early days of the life of the Committee much time will be needed to examine the list of medicines stocked and to decide whether or not each one is to be retained.

7. To ensure that proper stock control measures are carried out such as ABC analysis, re-order levels, economic order quantities, etc.

8. Non-Formulary purchases must be kept to a minimum.

Introduction of Changes decided by the Pharmacy Committee

There is likely to be some resistance to changes recommended and such may include.

1. Medical Staff probably will not be of one mind on all the decisions made. For example, adhering to formulary medicines in prescribing may be interpreted as interference in the jealously guarded freedom to prescribe the medicines the doctor considers necessary for the patient. Frequently prescribing non-formulary medicines will make the work of the Pharmacy more difficult, and sending prescriptions outside in the first instance may lead to errors and delays in treatment.

2. The Pharmacists may feel that their volume of work is being reduced and their professional interest lessened with the decrease in medicines being dispensed.

3. Nurses may feel that their work is being affected if medicines prescribed for their patients are not readily available in the Pharmacy.

4. All Staff who attend the Statf Clinic seem to expect that they will receive any medicine that is prescribed for them and not infrequently press the doctors for expensive formulations. If these are not stocked in the Pharmacy and not prescribed for other patients, it will indicate that the rational medicines policy is really being implemented.

All persons working in the Hospital must be kept informed of every stage of the rational drugs policy. This does take time and requires meetings and some printed material from time to time. This investment in time will repay the effort and achieve the understanding and co-operation of most of the staff.

There is going to be a need for a sense of discipline among the medical and Pharmacy staff if the Pharmacy Committee is going to succeed in implementing a rational drug policy. Senior staff will have to take great trouble to supervise properly the juniors in their prescribing, and thus teach this policy's requirements. This should be founded on the Formularly and Prescribing Rules, a copy of which each medical officer should receive, and must read.

The Pharmacists will have to be disciplined in implementing the Policy, and full suppport must be given to them by the Medical Superintendent, and members of the Pharmacy Committee, when it is necessary for the Pharmacists to take any action when the Policy is ignored by other professional staff. In their dealings with the manufacturers and suppliers they must behave correctly at all times.

Dispensing Services

As stated there must be and must continue to be a high standard of professional exellence in the service to the patients. The compoinding activities should be continued and expanded where this is found to be economically feasible. Dispensing of medicines to patients should be correctly carried out including the use of correct containers and seals, packaging, and complete labelling preferably in a language known to the patient, and for those who are illiterate suitable symbols should also be used.

Contacts with the patients gives opportunities to explain the meaning of a rational drug policy, and what it can mean for them in terms of successful treatment and economically. Time thus spent is valuable to try to persuade them that expensive formulations, or a prescription with many items, are not necessarily the sign of a good doctor or a certain cure. To further such efforts a member of staff may be given the responsibility for addressing the patients in groups or individully, and a series of posters giving information on the proper use of medicines, and the dangers of self medication with potent medicines, could be displayed in the waiting areas.

Pharmacists should be encouraged to survey critically the medicines in the Pharmacy, and elsewhere, and to discuss their merits and demerits with their colleagues. Medical staff can help the Pharmacists by explaining the reasons for prescribing medicines in special cases.

Medicines in Community Health Programmes

The medicines to be supplied to the Community Health Workers will have been worked out by the Community Health staff, and the Pharmacists and should be approved by the Pharmacy Committee. The Pharmacists will prepare the indents for the CHW and they will have to take care that there is no addition of unauthorised medicines. It should be clear in the experience of the CHW and the Pharmacists, that the simple medicines they are asked to use for their patients to treat common ailments will also be used for their patients to treat common ailments will also be used for patients who come to the Hospital with the same conditions Too often patients reporting directly to the Hospital get much more expensive medicines which certainly is not national.

Relationships with Suppliers

The Pharmacist's contacts with the suppliers is through the literature they produce and through visits by the companies' representatives. Meetings with the representatives are influenced by what the doctors prescribe or promise to prescribe, and what is stocked in the Pharmacy. The Pharmacist will have his own opinion about suppliers and their medicines and these should be listened to in the Committee. It is not only quality of the medicine about which he will have knowledge, but also cost, delivery time, record of business of which he will have had experience.

In meeting the representatives, the Chief Pharmacist should keep in mind the Hospital Medicines Policy, and make it clear in what types of products the Hospital is interested. Often Pharmacists do not know how to handle meetings with representatives, and they need help, as do the Medical staff, on how to do this. It must be remembered that many representatives are trained in 'high pressure' salesmanship, and the results of this can be seen in many Hospital, where there are excessive stocks of medicines, or unsuitable items have been purchased and then not utilised.

Training in this aspect of Pharmacists' work should include :

1. Making plain the Hospital medicines policy
2. Learning to assess special Offers, and discounts.
3. Learning how to seek scientific literature rather than the glossy, unimformative papers generally offered.
4. Learning the type of questions to ask representatives on pharmacology, and the rationale behind formulation.
5. Learning to make it clear that he has no interest in personal inducements to place orders which some companies unfortunately resort to at times.
6. Learning not to divulge any of the Hospital's private business which may then be used to exert sales pressure.
7. Learning how to terminate an interview. Too much time is taken in many Hospital pharmacies on entertaining representatives, and this time is therefore denied to the patients.
8. Learning not to give orders to representatives since this can become a source of difficulty at every visit.

These points if remembered do help the Pharmacists (and doctors) in these contacts which may be useful in other ways.

Assessment of Sources of Medicines

The Pharmacist will need to assess the medicines that he is being asked to consider recommending for inclusion in the Hospital Formulary. He will have to find satisfactory answers to the following questions, and perhaps to some others in special circumstances :

1. Does it fit in with the Hospital medicines policy ?
2. Does this product merely replace on already in the Pharmacy ? If so is there any valid reason for considering a change ?
3. Did this company originate the medicine ? If not, has any research and/or clinical trials on bioavailability been carried out ?
4. Is there any good scientific literature available for the product ? Does the literature include toxic effects and contra-indications in a clear and complete manner ?
5. What is the experience of the Pharmacy with this company ? Are quality, availability delivery time, etc satisfactory ?
6. What is the appearance, of the product ? Is it satisfactory or does it leave doubts as to quality ? Can any tests for quality be carried out ?
7. What is the pack size ? Is it a normal dispensing size or a bulk back requiring packaging in the Pharmacy ? Are suitable packing materials available ? Is the packaging unnecessarily expensive ? Does it properly protect the contents ?
8. Is there any possibility of compounding a similar preparation in the Pharmacy that would be as good and less expensive ?

Education

This is important for the basic education of Pharmacists in their degree or Diploma courses needs to prepare them for a rational medicine policy. It is doubtful if this is sufficiently emphasised at present. The

majority of diplomates do not go into Hospital service but in to medical shops where the emphasis is placed on the business aspects, and their contacts with prescribers are minimal. Both groups need to be taught the need for a rational drug policy, and to persuade them that the legal requirements relating to the supply of medicines must be strictly followed. The present 'free for all' in the prescribing and supply of medicines must be contained if real progress is to be made in achieving health for all by the year 2000.

It is necessary to stress the same principles in the basic education of doctors and nurses also. The ignorance of, and sometimes contempt in which the law is held is extremely serious, and has moral implications too. All three professional groups must realise that each one is responsible before the law for what he does and writes, and that he alone can answer in the court should a serious mistake be made. Perhaps all should be encouraged to understand this before setting out on a career in medicine, nursing or Pharmacy.

Continuing Education

Already this has been mentioned in the case of introducing the rational drug policy to staff of the Pharmacy. A wider sphere of training should be encouraged by providing opportunities to attend Workshops and seminars to increase knowledge and understanding of their work. It is to be hoped that if there are no sessions on a rational drug policy that it will be an underlying principle of the programme. What the Pharmacists gain from such courses his institution gains in his developing service.

Readin

We expect Pharmacists to know about the rational drug policy and something of the national compaigns to bring this about, and even more to know about the medicines he prepares or purchases and dispenses. Yet how many Hospitals provide any reading material ? Many have books in the Pharmacy which are of historical interest, but of little current value! Books in recent editions must be kept in the Pharmacy for quick andeasy reference, and not in the Hospital library where there will seldom be a chance for the Pharmacist to refer to them. Senior staff must encourage others to read and study what is available.

Relationships with Hospital Colleagues

Some changes are needed here for the rational drug policy really to work. Relationships depend upon individual character, but too often team work is not seen, but rather separate groups working on promoting their own interests. These groups are often protective of professional interests, but some things not directly related to these have effect on Pharmacists :

1. Social differences between different professional groups often makes it difficult for him to express his opinions.
2. His comparitively short course of training and often lack of useful experience do not allow him to give detailed reasons for his opinions

   These cause shyness, often experienced as total silence in meetings where his experience and opinions would be helpful.

   These may also cause him to be under pressure from members of other groups to c ircumnavigate clearly laid down Hospital rules because he finds it difficult to politely and explain and carry out Hospital procedures.

These types of problems have to be worked at positively by all groups involved so that the implementation of the rational drugs policy may be successful not only for the institution, but much more for the benefit of the patients whom we seek to serve.