Report

Effect of alternative medicinal systems and general practice

Shyam Verma, MBBS, DV&D

From 18 Amee Society, Diwalipura, Vadodara, India

Correspondence
Shyam Verma, MBBS, DV&D
18 Amee Society
Diwalipura
Vadodara 390 015
India
E-mail: vermaderma@rediffmail.com

Abstract

Alternative medicinal systems like Ayurveda and homeopathy are respected and legitimate sciences. The former was born in India. Colleges abound in this country churning out tens of thousands of graduates of these fields. It is ironic that a large number of them pratice allopathic general practice instead of, or along with, their field of specialisation despite laws prohibiting them to do so. Their gross lack of knowledge of dermatology wreaks a havoc. Even GPs contribute to this confusion for the same reason. Pharmacists contribute to unauthorised sale of dermatologic drugs and promote unsupervised treatment flouting the law. The result is neglected and vitiated dermatoses, unwanted adverse drug reactions and resource depletion for the patient. The practising dermatologist in India is unfortunately the one who bears the brunt of the above confusion. However these situations are also contributory to the enviable clinical skills that Indian dermatologists are so well known for.

Introduction

India boasts one of the most vibrant and forward-looking pharmaceutical markets in the world with affordable and low-priced medicines. As of 2003, the Indian pharmaceutical industry was supplying 20% of the world's drugs, and is currently one of the largest pharmaceutical industries in the world. At least 60 manufacturing plants in India have United States Food and Drug Administration (USFDA) approval, second only to the USA. Currently, a dozen top Indian companies are major suppliers to the US and European market, as well as China. Impressive as it may sound, these facts do not impress the practicing dermatologist for various reasons. The health-seeking behavior of the average Indian, especially from lower socioeconomic backgrounds and villages, is not affected beneficially by these impressive statistics. Indeed, they represent a stumbling block for dermatologic treatment in this country. The prevailing health-seeking behavior has direct ramifications on dermatologists, as it makes their task more arduous and complicated than the treatment of a straightforward dermatosis. The side-effects of injudiciously applied and ingested drugs confuse the picture of a given clinical entity, and neglected, difficult-to-treat dermatoses are the main problems faced by dermatologists.

Ayurveda

Let us start with Ayurveda ("Science of Life"), the ancient and traditional Indian medicinal system that is based on the *Vedas* and on a body of medical writing by many contributors, notably Charaka and Sushruta. The pharmacopeia is voluminous, with a list running into thousands. When practiced exclusively after obtaining a formal qualification, Ayurveda is a definite science in its own right. Given its deep roots and popularity in India, coupled with the fact that the large majority of Indian patients do not have access to specialists, this field has the potential for integration with mainstream allopathy to cover more ground. There is a dark side, however, that is significant and is not discussed adequately in dermatology. This unfortunate development is ancient, and has occurred as a result of social, cultural, and economic factors. It is a true example of confusion of systems of medicine and a lack of awareness.

There are hundreds of Colleges of Ayurvedic Sciences offering a formal qualification in the field; however, the overwhelming majority of graduates do not practice pure Ayurvedic medicine! This also applies to homeopathic colleges and homeopaths. Only a small proportion of those qualified in Ayurveda and homeopathy exclusively practice in their own field. This has serious repercussions on patients (Figs 1–7), because these practitioners practice in cities and villages as general practitioners/family physicians and also treat dermatologic disorders! They have no formal education/knowledge of dermatology or pharmacology. They are officially prohibited from practicing allopathy and prescribing allopathic drugs, but they continue to do so with impunity. Their knowledge of the skin care products and drugs used in dermatology originates predominantly from pharmaceutical company representatives who peddle their wares with equal impunity, as there are immense business opportunities in these unauthorized clinics.

International Journal of Dermatology 2007, **46** (Suppl. 2), 46–50

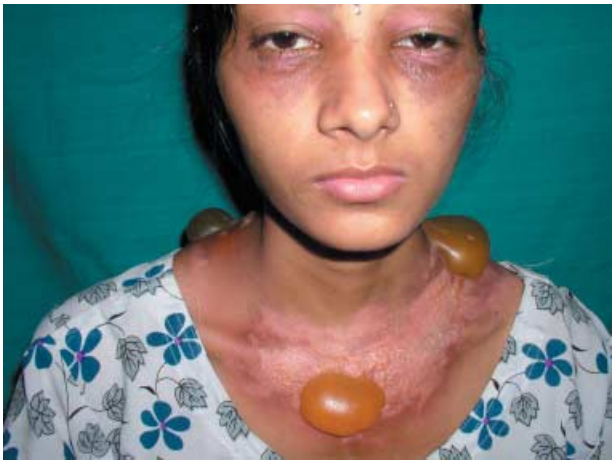

Figure 1 Crushed fig leaf application suggested by an Ayurvedic doctor for vitiligo

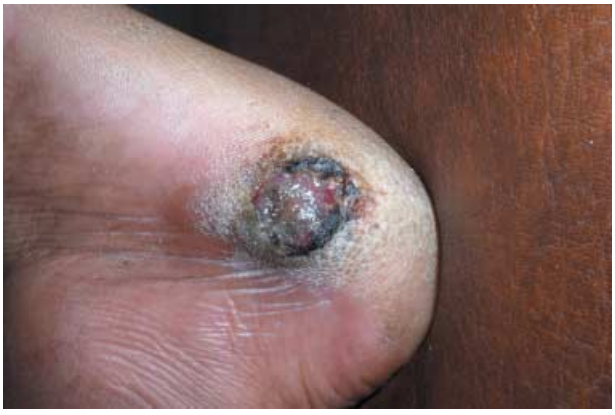

Figure 2 Acral lentiginous malignant melanoma cleaned and dressed for 6 months by a general practitioner

An average dermatologic consultation costs 150 rupees (about $4) in a medium-sized city, whereas a consultation in an "Ayurvedic general practitioner's clinic" costs one-third of this, if not less, and may also include medicines! This is the reason why people flock to these clinics, especially those living in villages and those belonging to the lower socio-economic classes. It is clear that the reasons are predominantly economic. This, coupled with illiteracy and a lack of awareness regarding dermatologic problems, wreaks havoc in dermatologic care. These medical practitioners prescribe oral and topical steroids, antimicrobials, antihistamines, and other commonly used medications oblivious of their adverse reactions. Moreover, drugs are dispensed in these clinics in small paper or plastic packets, and there is no documentation of what drug has been prescribed. Most of these dispensed drugs are given for a period of one to a few days, when the patient is expected to return to the doctor's office for a repeat

Figure 3 Toxic epidermal necrolysis (TEN) after ingestion of "some drug" given for fever and convulsions by a general practitioner

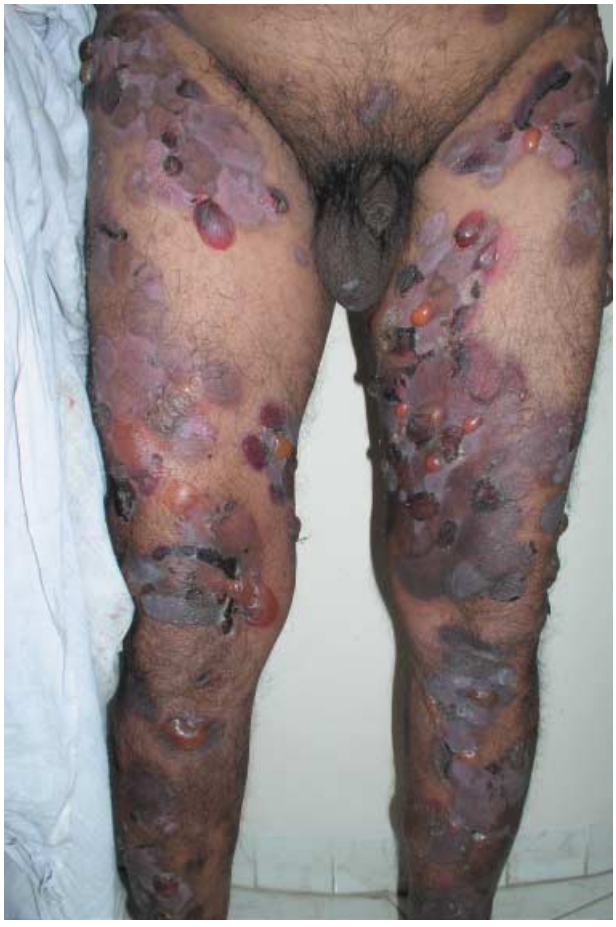

Figure 4 Homeopath-treated bullous pemphigoid where the patient was assured of a cure in 2 months

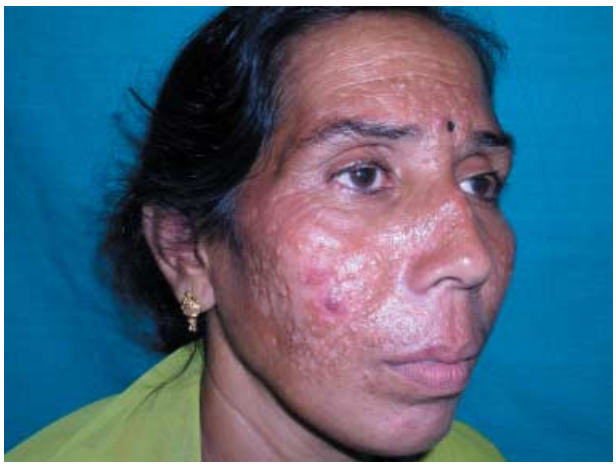

Figure 5 Clobetasol cream applied for over 3 years for correction of complication. Patient advised to apply it two to three times daily

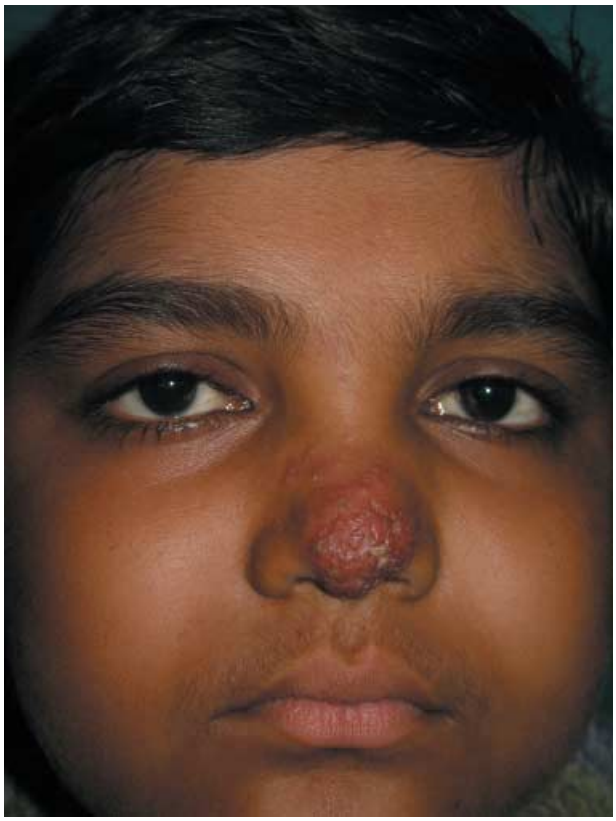

Figure 6 Oral prednisolone, 20 mg daily, given by a general practitioner to a 9-year-old boy with lupus vulgaris. Note the mooning of the face and hypertrichosis

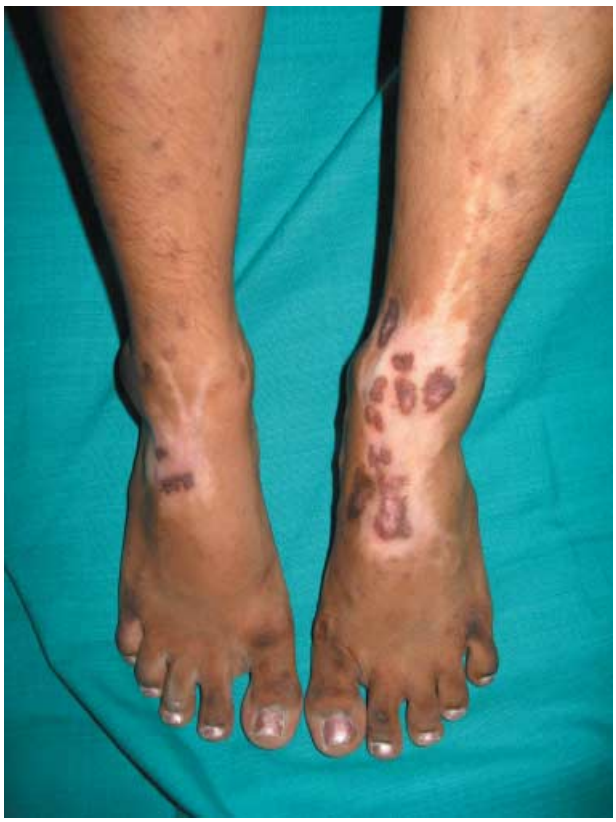

Figure 7 Depigmentation caused by intralesional steroids given by a "quack" in a village. He gives more than 40–50 injections per day to people from surrounding areas and is known as the "injection doctor"

prescription of the drug. Intramuscular injections are given freely on any pretext and are considered a panacea for any difficult-to-cure illness. So prevalent is this concept, especially in individuals from the lower socioeconomic classes, that they actually visit dermatologic clinics asking for an injection! When there is an adverse reaction to any drug dispensed, most of the time it is very difficult to identify the drug responsible, because there is no documentation of the dispensed drug with the doctor or the patient. It is a sad fact that these prescribing and treating patterns are seen even amongst many general practitioners with valid medical degrees.

Moreover, even legitimately used drugs belonging to Ayurvedic or homeopathic disciplines are not always identified when there is an adverse drug reaction. It is generally felt by patients that adverse drug reactions are a phenomenon exclusive only to allopathy, and that fields such as Ayurveda and homeopathy are free of side-effects. There have been numerous examples of severe adverse cutaneous drug reactions to Ayurvedic or homeopathic drugs, but, unfortunately, they have been documented inadequately. It is a well-known fact that some legitimate Ayurvedic drugs contain heavy metals. Authentic Ayurvedic texts recommend elaborate

precautions for detoxifying heavy metals, but it is doubtful whether they are carried out in the current scenario of the mass manufacture of Ayurvedic drugs. Time and again, one hears of homeopaths mixing oral steroids in drugs dispensed from their offices. Moreover, unfortunately, it is only rarely that an individual will seek redress in a court of law against these practitioners, and this happens only when there has been a serious lapse in the care provided, leading to severe adverse reactions or deformity.

Another issue that has not been discussed so far in any of the dermatology journals to the best of my knowledge is the problem of unnecessary restrictions on diet suggested by these practitioners. According to Ayurveda, there are three different pillars of constitution in an individual, namely "*vaata*", "*pitta*", and "*kapha*". Diseases of the skin are caused by an imbalance in the "*pitta*" constitution of the individual. In Ayurveda, diet and food play a pivotal role, which explains the concept of hot (*ushna*) food or cool (*sheet*) food, with an emphasis on the avoidance of hot food in patients with skin disorders. Spicy, hot, and sour foods are, according to Ayurveda, aggravating factors for a patient with a "*pitta*" constitution, and are therefore best avoided. So popular and deeply entrenched is this perceived importance of food and dermatologic disorders that almost every patient in India asks the treating physician, irrespective of his field of specialization, about what food should be avoided and what is allowed! It is such a pervasive phenomenon that, if a physician does not place any restriction on the diet of a patient, it makes the patient wonder if he or she has gone to the right doctor! The Ayurvedic association of food and digestion and the concept of cold and hot spill over into allopathic prescriptions as well, and it is common to see restrictions being placed by the treating physician on what the patient should eat and what to avoid, restrictions that have no scientific validity in modern medicine. The concept of hot and cold even extends to medicines, where many pain killers, antimicrobials, etc. are considered to be hot and hence dangerous! These notions, which are misplaced in the context of allopathic medicine, play a role in a failure to comply with the intake of drugs, their doses and duration. It also hampers advice on healthy eating. Many good, nutrient-rich food items are often summarily dispelled in many dermatologic conditions with a label of "sour", such as yoghurt or lime, or "hot", such as eggs and meats. Although these restrictions may have their own place in scientifically practiced Ayurveda, they do not stand much ground in the context of allopathy, and just contribute to the confusion. Ideally, the role of the treating dermatologist should be to ensure that such dietary myths are not perpetuated, as they directly affect the health-seeking behavior of the patient.

Pharmacists

The other issue that plagues dermatologic care in India is pharmacists, known in India as chemists. There are laws that make it mandatory for a qualified pharmacist to run a pharmacy. Despite this law, many pharmacies are managed by unqualified individuals. Drugs such as oral steroids, isotretinoin, etretinate, and methotrexate can be purchased without prescription. The law prohibits pharmacists from selling any prescription drug without a prescription. It insists that drugs should be dispensed according to the quantity and duration specified by a qualified medical doctor. This law is only "on paper" for the majority of pharmacists, especially in smaller cities, towns, and villages. Any drug in any quantity for any given period of time can be purchased. There are many instances of patients buying these drugs simply on the basis of a wrapper, cardboard box, or container with the drug's name on it. The concept of "refilling a prescription" is therefore nonexistent! Oral and topical steroids are indiscriminately sold, with or without prescription, prednisolone, dexamethasone, betamethasone valerate, and clobetasol being favorites in many parts of the country. There are instances of young boys taking a combination of cyproheptadine and dexamethasone tablets to put on weight! These drugs are actually sold over the counter. Recently, I was told of a town in Gujarat state which is known for its educational institutions, and where there is a large population of young students from all over the country. A well-known company's ear drops containing chloromphenicol, lignocaine, and dexamethasone were being promoted by many pharmacists of that town for the topical treatment of acne. Thousands of units of the drug were sold without prescription for the treatment of acne! Pharmacists/chemists are welcome alternatives to doctors, as individuals describe their symptoms and a drug recommended by the pharmacist is sold to them, of course without a prescription. This is common practice for the treatment of common dermatoses, such as urticaria, acne, pyodermas, and fungal infections. There are many over-the-counter drugs which have become household names, and many have led to severe adverse cutaneous drug reactions. Another curious phenomenon is the purchase of drugs through the recommendations of friends, relatives, and others in a given social network. Prescriptions are recommended and individuals, especially in smaller towns and villages, take prescriptions belonging to others and buy drugs. Some individuals just take the package inserts or package and buy drugs. One shudders to think of the possibility of isotretinoin pills being "popped" by young women with acne purely on the recommendation of friends. Fortunately, in this regard, premarital sexual activity and procreation are culturally and socially frowned upon, and hence these practices are not as prevalent as they are in the West.

Effect on dermatologists

In the final analysis, all of these unfortunate practices drastically increase the burden on dermatologists. Severe irritant dermatitis caused by various topical agents, severe disease

flares caused by inappropriate medication, diseases modified by inappropriate topical agents, especially steroids, and severe side-effects of topical steroids, etc. are seen. It is not uncommon to encounter patients who nonchalantly reveal a carefully folded strip of steroid drugs which they have been taking for months, or even methotrexate which they have been taking for long periods of time, without the supervision of a dermatologist and of course without any follow-up investigations. "Cleaning up" the mess that has been caused by unauthorized medical practitioners is not an enviable task! This is further complicated by the fact that patients are not willing to return for regular follow-up as they have to pay for consultations and drugs. There is always a great sense of urgency in obtaining relief and being cured, leading to doctor shopping, i.e. the patient going from one dermatologist to another in the hope of obtaining a rapid and miraculous cure.

This article is a reflection of the economics, lack of awareness, and cultural factors that govern the prescription of dermatologic drugs, and their effect on a patient's wellbeing. This ultimately translates into an increased burden on dermatologists. At the cost of appearing immodest, I salute the responsibility that an Indian dermatologist shoulders against these odds, and the clinical acumen that he or she develops in the light of the prescribing pattern and socioeconomic and cultural milieu described above.

Access to essential drugs

This article would not be complete without mentioning, in brief, the issue of access of the average Indian to essential drugs. The pharmaceutical market is vast and is growing rapidly in India. In 2005, India's drug prices were amongst the lowest in the world. As of 2003, the Indian pharmaceutical industry was supplying 20% of the world's drugs and, in 2005, the sales of Indian pharmaceutical companies touched a staggering Rs. 40,000 crores! There is a paradox in the availability of essential drugs in India, however. The laws are lax and unimplemented, and there seems to be easy access to the drugs of choice; however, there is always a price, which the majority cannot afford! Thus, there is an inherent inadequacy amongst plenty. The lack of access to essential dermatologic drugs is most severe on the Indian subcontinent and in Africa. Indeed, 38% of individuals who have inadequate access to essential drugs live in India. Another 15% without access to essential drugs live in African countries. Although the sales of pharmaceutical companies are estimated to be around Rs. 40,000 crores, including exports, the total government expenditure on health is a mere Rs. 3000 crores! Although some southern states of India spend 15% of their total budget on health, states in the north and east spend only around 5%! Indian per capita annual drug and other medical expenditure in rural areas is around 300 rupees (approximately $7.5). Further reading of the excellent "Report of the National Commission on Macroeconomics and Health" of September 2005, and later similar reports, is recommended. This article ends with a reminder that the overwhelming majority of the Indian population has no health insurance, which represents a serious impediment to the practicing dermatologist. It is safe to assume that these impediments are reflected in most developing countries. It is my humble belief that these nondermatologic issues need to be discussed on such reputable platforms time and again. Failure to do so will give them the status of "*vox clamentis in deserto*," a voice shouting in emptiness.