CASE STUDY

Response: such neat resolutions are not possible in India

GEORGE THOMAS

114J Rostrevor Garden, Teynampet, Chennai 600 018 INDIA e-mail: george.s.thomas@gmail.com

Soon after completing my basic medical degree, MBBS, in 1983, I worked as a house-officer under a physician in a mission hospital in Kerala. One day a patient was admitted with chronic failure of both kidneys. The physician called me and told me that the patient had been admitted for nursing care, and would soon die, and that no attempt should be made to resuscitate him. He told me that the patient had no chance of a transplant and had exhausted all his resources on dialysis. His family had spent as much as they could, and they were heading towards pauperisation. The physician had counselled the patient to accept death to prevent the disintegration of the family. He warned me that the patient had agreed many times in the past and that when the end came near, he would pressure the family members to pay for that "one last" dialysis, and advised me to stand firm. He was right. When the end was near, the family members came to my room in the hospital in great agitation. The patient was pressing them to pay for a dialysis. They were beside themselves with grief, confusion, anger and despair. I did as the physician had advised me and told them to stay away from his bedside, that he would soon slip into coma, and they could then see him. The patient died soon after.

The case discussion by Wells (1) brings out the problems faced by a medical caregiver when the patient has no money to pay for the care. Wells was able to resolve the ethical dilemmas he faced within the system of medical care in the United States without compromising the interests of the patient or that of his employers. Unfortunately in India such a neat resolution is seldom possible. Health care providers, both in the public sector and the private sector, are often faced with a situation when they cannot provide a service to a patient merely because of resource constraints. If the procedure could potentially save or prolong life, or prevent or correct major disability, the dilemma is particularly acute. How do professional caregivers resolve such problems in India?

From informal discussions, I have found that the "karma approach" is the most common. Most people consider that it is just the patients' fate or luck if there is no money to pay. The more sensitive among the caregivers try to arrange free treatment for a few patients from donors. Others overcharge some, especially patients who are insured, to subsidise others. One nephrologist I knew, who was in government service, told me that since dialysis time was limited in the government hospital, it was his (self-created) policy to dialyse only patients with acute kidney failure, who had a disease from which they could completely recover. He would dialyse patients with chronic kidney disease just once and no more, unless they were in a transplant programme—virtually a death sentence.

What is clear from these methods of tackling the problem of resource constraints in India is that the doctor plays god either willingly or unwillingly—surely an unhappy situation. Unless we move to truly universal medical care coverage, unless we are clear as a nation what we will and will not provide in our medical care system, unless we truly see health as a fundamental right of every citizen and move towards a more equitable distribution of resources, medical care providers in India will continue to face the dilemma of what to do when the patient cannot pay. And they will continue to devise ad hoc "solutions" which are surely not in consonance with the four pillars of medical ethics.

Thomas George. Such neat resolutions are not possible in India. Case study response. *Indian J Med Ethics* 2006; 3: 34.

Reference

1. Wells JK. Ethical dilemma and resolution: a case scenario. *Indian J Med Ethics* 2006; 3: 29-31.