EDITORIALS

After the floods: health services' responsibilities in a crisis

SANDHYA SRINIVASAN

8 Seadoll, 54 Chimbai Road, Bandra (W), Mumbai 400 050 INDIA e-mail:sandhya_srinivasan@vsnl.com

Starting on the afternoon of July 26, 2005, Mumbai was hit by the highest rainfall ever experienced anywhere in the country. Hundreds of people lost their lives; hundreds of thousands lost their homes, property and livelihoods. Though the municipal and state governments had apparently been apprised of the crisis by 2 pm (1, 2), the authorities did nothing to warn the commuting public, minimise the risk of travelling, and provide shelter and food to stranded women, men and children (3).

If this was not bad enough, the public health system's response to the aftermath of the deluge highlighted well-known flaws in the health services. It also drew attention to some important ethical concerns about health systems – when dealing with a crisis or otherwise. These include the ethical responsibility to provide preventive and curative health care, to provide essential, truthful and useful information to the public, and not to suppress information that reflects poorly on the system.

The second disaster

Immediately after July 26, the authorities should have launched preventive measures – such as purifying water, spraying for mosquitoes, and informing people on how to protect themselves from falling ill. The health services should also have been prepared to handle an increase in out-patient and in-patient visits. In an epidemic, even governments withdrawing from public services must take responsibility to provide preventive and curative health care to all, free of cost.

Instead, hospitals soon became overwhelmed by crowds of people seeking treatment for fevers and severe diarrhoea. Over-worked health care personnel in public hospitals tried hard to cope. As many people were forced to go to private hospitals, there were reports of communities organising public collections to pay for the treatment of flood-related illnesses. Even those in public hospitals were forced to pay for drugs and tests. The government announced reimbursement of such expenses (4) only after the media reported such cases.

Some health units were set up in the city, but there were complaints that government staff were sent to the field unprepared, and without concern for their welfare. Voluntary organisations struggled to provide services in the less accessible areas where the government declined to go. Questions were asked about the quality of preventive measures; there were reports of people being given bleaching powder tablets without instructions on their use.

Media coverage

Health care professionals routinely chastise the media for inaccurate reporting. Much press coverage during this time did little to change that view. While there was intelligent reporting focusing on the overall problem and the lapses in the system, there were also alarmist headlines on the numbers of people ill with, and dying from, leptospirosis, cholera, dengue and so on. The daily tables, in the newspapers, of hospital admissions and deaths did not educate the reader on whether there was an increase in these cases compared to previous years.

Newspaper reports were often confusing and sometimes contradictory. Did the city have the facilities to test for leptospirosis? Should people who had walked through the floods take prophylactic antibiotics? Many reports fuelled a panic and drug stores were emptied of antibiotics. (Private initiatives contributed to this chaos. At least one major company sent out emails to all staff to take prophylactic antibiotics. Text messages with similar advice reached the entire cell phone-using population.)

But should the media be blamed? Were they given the information required to inform the public properly?

The ethical responsibility to inform

The government did not publicise important information until quite late in the outbreak. For example, it did not state that antibiotics had no prophylactic value for leptospirosis, thus contributing directly to the panic buying of antibiotics.

Some of the steps advocated were just plain unrealistic. People were told to purify water without being given the means to do so. The poor who are at most risk for water-borne diseases from contaminated drinking water cannot afford to boil water.

A question on many people's minds was: "Is there an epidemic?" But the government was apparently reluctant to make a statement on this question. A number of doctors report a distinct increase in the number of people seeking – and needing -- health care. But

this was downplayed by the government. An epidemic was announced, then denied (5, 6) and then finally announced once more (7) Authorities argued that there had actually been a decline in malaria, jaundice and typhoid cases compared to previous years; the increased numbers of hospital admissions only reflected increased public awareness (8)**.**

(Separately, it is worth noting that even one case of any of these diseases was unacceptable, as they are preventable with basic public health measures. There is no longer any alarm over the now annual surge in cases of diseases like leptospirosis, gastroenteritis and dengue.)

All this should expose the abysmal quality of the surveillance system that is based solely information from public hospitals and clinics – though private services see the vast majority of people seeking care. Private hospitals and clinics do not follow the law on notifiable diseases, apparently in order to avoid the associated red tape. While private hospitals ignore this legal and ethical responsibility the government does not even acknowledge this critical weakness in the surveillance system.

It is another matter that leptospirosis became a notifiable disease only this year, though there have been reports of leptospirosis cases and deaths every year for the last five years.

With such scanty information, the authorities are in no position to deny – or assert – the existence of an epidemic of gastroenteritis, cholera, leptospirosis, dengue or malaria.

The pressure to conceal information

It is also worth noting that while official records will contain no information on, say, the number of cholera cases from the private sector, the private sector may be more likely to report deaths from any of these notifiable diseases.

On the other hand, public hospitals are in a position to collect accurate morbidity and mortality statistics and may report morbidity due to notifiable diseases as this is built in to their system. But they may be pressurised not to report such deaths as they reflect poorly on the municipality's work and its public health services.

Indeed, government doctors have stated that they were told not to speak to the media, leaving this work to a designated media spokesperson. This would be fine, except that the media spokespersons sometimes withheld information from the public – on drug shortages, on the cost to poor patients, on numbers of cases, on deaths, and so on. In at least one instance the spokesperson denied that there had been any cholera cases even as hospital deans confirmed their existence (9).

The system did more than withhold information from the public. It even withheld critical information from treating doctors. At least one doctors has reported that culture reports of very obvious cases came back negative. When asked, the laboratory staff indicated that they had been instructed not to disclose positive tests.

We often hear of doctors' and health services' responsibility to protect the privacy and confidentiality of patients. We must also talk about their responsibility to make relevant information public -- to protect the community, not the system.

This editorial is based partly on interviews with health care staff who do not wish to be named.

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