LETTERS

Medical insurance: promoting unethical practices?

We appreciate the authors of your illustrative and interesting articles (1,2,3) on health care insurance in India for their lucid handling of issues in the medical insurance sector. While the health insurance sector in India is still at a nascent stage and has to meet enormous challenges, insurance policies must be transparent and standardized, and made clear to both patients and medical practitioners.

It is a distressing truth that the ethical values in medical practice are deteriorating day by day. But this is not always the case. There are plenty of complaints of denial of insurance claims on trivial grounds (patient not on parentral medications, flaws in documentation etc). This prompts the doctor to modify the treatment plan in favour of the patient. In order to reduce the risk of such denials, the physician is indirectly forced to treat the patient unethically. The patient may be put under unnecessary medication, which is not justifiable even though the intention is to facilitate the payment of a rightful insurance claim. Can we completely blame the physician for this? Doesn't this unfortunate situation arise from the ambiguity regarding the requirements of insurance claims?

There is a definite lack of transparency in the health insurance sector and most physicians and consumers are uninformed regarding the 'do's and don'ts' of these policies. Practitioners should, essentially, be trained in the proper documentation of the mandatory pre-authorisation form. The form carries details of current and past illnesses, the proposed line of management, the expected duration of hospital stay, and the approximate cost of treatment. Any flaw or mismatch in this documentation can result in delay or denial of a claim, adding to the patient's suffering.The client should be fully aware of his rights as also of ethical responsibilities. There are cases of people who get admitted to hospital for minor illnesses just to receive insurance payments. On the other hand, there are cases where insurance has been rejected even in emergency admissions. The reason for denial of claims, is, most often, not even communicated to the patient. The insured person should be provided a comprehensible written explanation regarding the reasons for denial, preferably in the local language.

Community based insurance schemes are doing well and the number of subscribers is increasing particularly in rural areas. The majority are illiterate and poor. Marketing agents highlight the advantages of insurance schemes and consciously underplay the complexities in availing the claim. Many succumb to the lure of cashless private health care schemes, only to be frustrated when their insurance claims are denied and they are unable to pay the heavy medical bills. This highlights the urgent need for an efficient grievance redressal system.

Though medical insurance can be a boon to the consumer, it is promoting unethical practices among treating physicians. This trend is unacceptable and measures should be taken to curb it.. Health authorities, the insurance regulatory agency, the Indian Medical Association and the Medical Council of India should take the necessary steps to establish a transparent health insurance and a proper monitoring system to ensure good, evidence based clinical practice, doing no harm to the patient and protecting his rights as a consumer.

References

1. Mathur V. Ethical questions regarding health insurance in India. *Indian J Med Ethics*. 2011 Jan-Mar; 8(1):23-27.
2. Duggal R. Private health insurance and access to health care. *Indian J Med Ethics*. 2011 Jan-Mar;8(1):28-30.
3. Kasaragod A. Health insurance in India: the need to come together for a common good. *Indian J Med Ethics*. 2011 Jan-Mar;8(1):49-50.

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Euthanasia: ethical risks

I have read the review of the film *Guzaarish* by Dr Natasha Anwar in *IJME*, January 2011. I have not seen the film but would like to put forward my views on the subject of euthanasia, taking off from the concluding sentence of the review.

I am a proponent of euthanasia and saw it being implemented in Australia, when I was in a Sydney hospital. However, its application, particularly in this sub-continent, is liable to be misused and, therefore, likely to have unwanted consequences. This is because most of our doctors, who would decide the merit of a case for euthanasia, are without integrity. In my opinion, almost every doctor (with some exceptions) issue false medical certificates for the availing of medical leave, even though the patient is fit. This can stretch to years of leave. Such doctors issue bogus medical certificates to persons involved in criminal acts to help them avoid going to jail, or attending court. How many court cases are adjourned on the basis of false medical certificates?!

We have all heard of a number of cases regarding the inheritance of property, where our doctors could be manipulated at a price and authorise euthanasia, even to the extent of declaring that the patient has cancer. This loss of integrity and lack of clear medical ethics and conscience is a deficiency in our society. Until that is changed, introducing euthanasia is dangerous to the safety of many defenceless individuals.We can argue that all these cases should be monitored, but those involved in monitoring such cases will be

the same Indians/ humans. And therefore we will need to have monitors to monitor the monitors.

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Challenges of collaborative research

In 2009, as a supplement to a National Institutes of Health (NIH) -funded collaboration between the Indian Council of Medical Research (ICMR) and the NIH, a formative study was conducted with 30 HIV-positive people and 18 HIV-related service providers to understand sexual risk-taking, HIV-related disclosure, and other behavioural patterns among HIV-positive individuals in Baroda, Gujarat. One goal of this research was to determine how to adapt a counselling intervention which had been tested in the United States, in order to make it culturally and linguistically relevant for PLWHA(People living with HIV/ AIDS) here.

We identified several challenges in the course of our work.

Initially it was decided to compensate each PLWHA Rs 1,000 per day for their daily wages and transport expenses. We had to reduce this to Rs 500 per day per participant, following ICMR guidelines. However, the PLWHA with whom we interacted wanted monetary benefits in return for giving in-depth interviews.

Though the study had already been reviewed by the NIH, the University of North Carolina and the ICMR, it had to be reviewed and cleared by the institutional review board (IRB) at the Medical College of Baroda. This took roughly one and a half years. Our foreign investigators came twice to India for this purpose. We believe that this delay was because research is less common at the Indian site and the IRB here met infrequently. Second, the IRB had little experience of reviewing joint/ collaborative research protocols.

A number of our budget items were rejected. For example, a separate private cabin was proposed for taking in-depth interviews, and password-protected computers were to be used for data entry and maintaining records in confidence. However this proposal was rejected by ICMR and so we had to use the institutional investigators' cabin and computers for these purposes. This is not an ideal condition for maintaining privacy and confidentiality. A laptop had to be sent from the US for our research associate to maintain and monitor data. Finally, the ICMR rejected salary support for the principal investigators (Rajendra Baxi and Sangita Patel) on the grounds that they are government employees, and also cut the budget for supplies.

The high levels of HIV-related stigma made it challenging for study staff to record interviews with HIV-positive people, though they were willing to be interviewed.

For extension of this project and to triangulate our findings we proposed a qualitative study on HIV prevention needs in Gujarat. It was approved by NIH but rejected by the ICMR on the grounds that this was not our national research priority, and this type of study could be done locally without foreign funding. Since the NIH cannot release the grant without ICMR clearance, further study is not possible.

However, we learned a great deal from this experience, and communication between the US and Indian collaborators has been very good.

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Doctor v/s doctor: always a lose-lose game

Doctors are only human. On occasion, ethics takes the backseat, sometimes unintentionally, sometimes 'intentionally'.

In life everyone wants to prove his or her one-upmanship. And in this process we spoil medical relations.

Our role as doctors is not only to protect our patients - we must also protect the 'other doctor'. In short, it's important how we talk before our patients.

Let's analyse how we inadvertently start playing the game of doctor v/s doctor.

When a patient who has been seen by a junior doctor comes to our clinic, we comment indirectly about his lack of experience by saying, "He is a budding doctor." Or we show total ignorance of his skills, sometimes even his competence, and say, "He was my houseman. When did he start private practice?" We may even go to the extent of doubting his qualifications, saying, "He is from a 'deemed university'," or "I know how he got admission to medical college. How did you land up in his hands?"

You are in your consulting chamber and a patient tells you that he had been to another doctor earlier. You refuse to even glance at the case papers and tell the patient to forget all about the previous doctor. Or you spend a full 45 minutes in studying the case papers, implying that a complication had occurred, and then say, "I don't understand anything."

Sometimes you even digitally scan the papers, prepare slides and present them in 'scientific' conferences.

If a patient says the other doctor is attached to a big hospital and you have a small set-up, you downgrade his skills by saying, "He has to show a certain number of cases, that's why he must