LETTERS

Ethics of pandemic planning in India

Devnani et al discuss various ethical dimensions of the public health measures to be taken when planning for an influenza pandemic (1). In a developing country like India which is diverse, multicultural, over populated and undergoing rapid but unequal growth, ethical pandemic planning must address existing health inequalities.

In India, inequalities in health indicators can be seen according to gender, caste, religion, ethnicity, economic status, and location. To illustrate, children among scheduled castes and scheduled tribes below three years of age are twice as likely to be malnourished as are children of other groups (2). The same is true of access to healthcare. For instance, the rural/urban ratio of hospital beds is 1:15 and the rural/urban ratio of doctors is 1:6 (2). Improving the health of a population and reducing health inequalities will depend upon how effectively the social determinants of health are addressed.

Such disparities pose a greater threat during a pandemic outbreak when there will be increased pressure on scarce resources such as drugs and vaccines. Existing health inequalities are likely to be aggravated if those in power favour their own friends, families or ethnic groups (3, 4).

In India, authorities involved in pandemic planning must be required to ensure that healthcare institutions serving rural, low income, isolated and indigenous communities are well equipped to provide the necessary care, and that existing health inequalities are not exacerbated while putting the pandemic plan into action.

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Problems of isolated private hospitals in a rural setting

In the era of the Consumer Protection Act, doctors running small private hospitals in rural settings face unique ethical challenges, especially in acute medical emergencies. I would like to share a few such cases:

1. A 46-year-old advocate, on holiday at a nearby hill station, was brought to our hospital with backache and radiating pain in the left arm. An ECG revealed a 12-hour old inferior myocardial infarction extending to the entire right ventricle. We advised hospitalisation, at which the patient ran out to his vehicle and refused to be admitted, insisting that doctors tell lies to make a profit. His anxious friends prevailed on him to take the aspirin and Clopidogrel tablets were prescribed. Eventually he was admitted and his intermittent ventricular tachycardia was stabilised before sending him to a tertiary hospital in the city. We had some tense hours wondering what to do if he collapsed.

2. A 35-year-old man came to us with complaints of giddiness, suffocation and palpitation. On examination, his pulse was fast and thready; the extremities were cold, with blood pressure of 90 mm hg. On auscultation, marked tachycardia was revealed with a heart rate of 250 per minute with wide QRS complex. We told the relative that direct current (DC) shock had to be administered to reverse the life threatening ventricular tachycardia. While lifting the defibrillator pads, the relative suddenly stopped me, requesting an injection instead. He then took him to another physician who advised the same treatment. Finally, the relative consented and the ventricular tachycardia was reversed by administering DC shock of 200 joules. The reversed ECG showed recent extensive myocardial infarction.

3. A 56-year-old male was brought dead to our emergency room. He had had recurrent chest pain over four to five days and then been found dead in the toilet. The cardiac monitor showed a straight line, but his family tried to pressurise me into giving him DC shocks. On my repeated refusal, the relatives wept and eventually I gave in but to no avail.

In life-threatening situations, it is not easy to insist that a patient receive rational treatment. The results of management of an acute medical emergency are unpredictable, and sometimes grieving relatives become violent. This kind of problem is aggravated in a rural setting, as the individual doctor managing the hospital becomes a target of public anger and frustration and can face long-term stigma after such incidents. At tertiary