

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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References

1. Devnani M, Gupta AK, Devnani B. Planning and response to influenza A (H1N1) pandemic: ethics, equity and justice. *Indian J Med Ethics*. 2011 Oct-Dec; 8(4): 237-40.
2. Deogaonkar, M. Socio-economic inequality and its effect on healthcare delivery in India: inequality and healthcare. *Electronic Journal of Sociology*. 2004.
3. Kumar S, Quinn SC. Existing health inequalities in India: informing preparedness planning for an influenza pandemic. *Health Policy Plan*. 2012 Sep; 27(6): 516-26.
4. World Health Organization. Addressing ethical issues in pandemic influenza planning. Discussion Papers [Internet]. Geneva: WHO; 2008 [cited 2012 Sep 19]. Available from: www.who.int/csr/resources/publications/cds_flu_ethics_5web.pdf

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

hospitals the responsibilities are shared.

The fear of such reactions and of prosecution makes doctors lethargic and passive in such emergencies and a majority of them develop an unwillingness to be proactive. We appeal to your readers to send in their experiences of how they have faced such ethical problems.

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Ethical aspects of operating on seropositive patients.

Infection with blood-borne pathogens has long been recognised as an occupational risk for healthcare workers (HCWs), particularly surgeons and anaesthetists whose work often involves breaching the cutaneous or mucosal barrier, exposing them to blood and other body fluids and putting them at risk of acquiring HIV or other blood-borne infections (1). However, in spite of these risks, systems to protect HCWs are not in place.

More than 5% of patients with AIDS require surgical procedures, most commonly in cases of peritonitis, non Hodgkin's lymphoma, Kaposi's sarcoma, and appendicitis, and in situations requiring splenectomies or in deliveries requiring a caesarean section.

Exposure to an infected needle, blood or body secretions carries a risk of infection with Hepatitis B (9-30 % with a single percutaneous exposure), Hepatitis C (1-10 % with a single percutaneous exposure), or HIV (0.3 % with a single percutaneous exposure; 0.09% with a mucous membrane splash to the eye, or oro-nasal exposure) (2).

Despite following 'universal precautions', accidental exposure may occur while performing invasive procedures and handling body fluids. Our ART centre has more than 9,800 seropositive patients registered, and over five years, more than 60 HCWs here have been given post exposure prophylaxis (PEP) (2).

The risk of occupational transmission of HIV, HBV or HCV is likely to rise among HCWs in resource-poor settings where universal precautions are not practised and patients may not disclose their test reports even if they know their positive status.

Certain policies must be followed strictly regarding management of positive patients.

1. Immediately after exposure, the HCW should notify the designated supervisor for help in completing the incident report.
2. The patient's blood should be tested for HIV, HBV and HCV (after pre and post test counselling) even if a patient refuses consent, and the results should be kept confidential.
3. Five doses of PEP should be kept in the operating theatre (OT) to be administered within two hours of exposure, routinely, without any panic or delay.

4. If an HCW tests positive, s/he should be allowed to continue working in a different area and receive a special benefit package to cover expenses for treatment, disability and possible loss of life.

Certain general policies must be followed. HCWs with a positive status for HIV and HBV should not work in an OT, or in any department where blood-to-blood contact is likely, to avoid the chances of transmission of blood-borne infections to patients. Although this is not a legal requirement, HCWs must be encouraged to know their HIV status. They should also be vaccinated against HBV and the records maintained confidentially

All OT staff should have a good understanding of risk of contracting infection in the theatre. Simultaneously, special ventilation systems for OTs must be used, and all standard precautions regarding patient preparation, use of protective kits and waste disposal must be implemented.

When operating on known positive cases, separate theatres should be maintained if possible. If not, a minimum of experienced staff should be deployed, excluding students and trainees. Surgical techniques may also be modified to minimise the use of sharp instruments.

No surgery should be postponed on grounds of HIV or HBV positivity test reports. But post-exposure prophylaxis should be available for all HCWs working in the OT, irrespective of their designation. If the patient is seropositive and on ART, his/her viral load and CD-4 count should be retested for better post-operative management. If the patient is diagnosed preoperatively, then after surgery, s/he should be advised to get registered in an ART centre. There may be delayed wound healing in such situations. ART should be re-evaluated and HIV co-infection should be ruled out.

While HCWs must be educated about the protocols to be followed, the importance of being tested when exposed, accepting a positive finding, reporting to superiors, and following up treatment till completion cannot be overemphasised. This applies particularly to new recruits who may be enthusiastic and incautious. There is a considerable lack of awareness among medical and dental postgraduate residents about PEP (3) against accidental exposure to HIV, suggesting a need for training and awareness programmes.

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References

1. National AIDS Control Organisation. Antiretroviral therapy guidelines for HIV infected adults and adolescents including post exposure prophylaxis [Internet]. New Delhi: Ministry of Health