DISCUSSION

Emergency care in rural settings: Can doctors be ethical and survive?

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Abstract

We describe below the pressures of running a small private hospital in an underserved rural area, while providing emergency healthcare for victims of poisonous stings, accidents, and other acute health conditions. Both ethics and law demand that payment is not asked for upfront in emergency cases. Yet patients and their families often fail to pay normal dues for months or even years. It is disturbing to encounter such behaviour even in villages; and doctors in small communities are easy prey. In these conditions can one be true to ethical principles and ensure one's own survival?

Background

We have been running a small private hospital in rural Maharashtra since 1976. Medical management in such settings involves several difficulties, coupled with the high expectations patients and their relatives have from the treating doctor. Patients and their relatives are unaware of the difficulties of treatment with restricted resources such as trained staff and modern gadgets, and the shortage of electricity. They invariably compare rural facilities unfavourably with those of tertiary care hospitals in the big cities. Besides providing treatment, we have to update the relatives on the patient's health and investigations. Sometimes, relatives who may not be properly informed or have come from a big city, have difficulty understanding the constraints under which rural doctors provide treatment. In addition, doctors today suffer great stress because of the hanging sword of the Consumer Protection Act and the aggressive responses of patients' relatives to an adverse result. To save lives and carry on original research in these conditions is indeed difficult. We elaborate below our experiences regarding treating patients in a rural setting.

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Case 1

In 1986, a 38-year-old woman with red scorpion stings was admitted to our hospital at Mahad. She suffered an autonomic storm and we closely monitored her vital functions taking repeated ECGs. She took 72 hours to recover. She was from a poor family and her husband told me he would sell her *mangalsutra*[1] to pay the hospital bill. Horrified to hear this, I offered him one month's time to make the payment. He gave us his statement in writing but did not respond to reminders for a whole year. Much later, another patient from the same village told us the man had deceived many with such methods. Till date, we are awaiting payment from him.

In those days, nobody was ready to admit patients with severe scorpion stings. We became popular for successful treatment of the lethal condition. Mahad, where we work, being a small town, there is no question of refusing to admit such emergency cases. Refusal has a very demoralising effect. Even patients from the government hospitals are referred to our hospital for further management. Poor farmers and labourers are more prone to scorpion stings and snake bites. Hence, we have struggled for years and found antidotes.

Case 2

A bank employee brought in his mother with acute chest pain, suffering an acute myocardial infarction. We settled her chest pain and stabilised her vitals. She underwent an angioplasty and was later transferred to a tertiary care hospital for further management. The patient's son was known to my son and requested me for a loan of ten thousand rupees in cash, for his mother's further treatment, promising to repay it on his return from Mumbai. I obliged and also deferred the hospital charges. Later, we noticed that his mother had long since returned from Mumbai, but there was no sign of the payment! After several visits to his residence by my wife, Dr Pramodini, he issued a cheque which was returned due to shortage of funds. This happened twice, but we decided not to take police action, as he is the main support of his family and may lose his job. His close relative told us he was a regular gambler. Eventually, he paid our charges only after we complained to another patient, a local politician, about his conduct.

Case 3

On November 15, 2016, a 40-year-old male was brought in, complaining of severe chest pain radiating to both arms, and sweating profusely. His ECG showed an acute inferior

wall infarction. Because, in such situations "time is muscle", immediate thrombolysis therapy should be administered to avoid myocardial damage. In big cities, cardiologists perform immediate percutaneous angioplasty in myocardial infarction. To avoid delays, we always keep two vials of tenecteplase in the hospital. After explaining to his relative that tenecteplase is expensive but essential to revive the heart muscle, we obtained his consent and agreement to pay at the time of discharge. His acute infarction pattern was aborted and a subsequent angiography was normal as recanalisation occurred due to tenecteplase being given in time. He paid us with two different cheques, both of which bounced. We then issued him legal notice and he promised to pay within fifteen days. However, this did not happen. Ultimately, we gave up on this payment, as it meant regular attendance in court by the doctor, which was not feasible.

Case 4

A 65-year-old retired military man who had undergone coronary artery bypass surgery, reported with acute chest pain. We monitored him, administered treatment and took repeated ECGs. We referred him to Mumbai for further evaluation. His wife promised payment of the hospital bill after returning from Mumbai. He did not return. After we sent a message with his neighbour who came in for examination, his son came and abused us, threatening severe consequences if we sent such messages to him again.

However, such demoralising behaviour of patients has not changed our approach to the management of acute medical emergencies. We have trained several doctors in the periphery regarding the management of severe scorpion and snake bite envenomation. Since 1990, we have, on a voluntary basis, been visiting and treating all such cases at the local government hospital. There is no question of payment and we too, get esteem, mental peace, and satisfaction without burn out.

Both government regulations and medical ethics demand that in emergencies, victims should be given proper treatment in time, without asking for payment. In rural areas, there is no established system of payment of advance deposits. Even if we ask for a deposit, the public responds with remarks like "We are not going to deceive you"; besides which, few have abundant financial resources. Also, in small towns, news spreads like wildfire and we have to face constant questioning about hospital adverse events on the telephone or in person. These are the reasons why specialists do not want to go to rural areas. Medical insurance has low penetration among the majority of rural people. There has been no improvement in rural government hospitals for the last 30 years. In a life-threatening medical emergency, the poor patient has no alternative but to approach private hospitals. To pay for treatment at a private hospital, poor people have to sell their ornaments, pieces of land, or cattle. This has resulted in excessive indebtedness leading to numerous suicides. To avoid this, we rarely pressurise patients for payment.

However, there is an urgent need for improvement in terms of qualified staff, specialists and modern investigation facilities like Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI), etc. The government must finance the widest possible health insurance coverage of the poor. The present government has planned a health insurance scheme for vulnerable families of up to Rs five lakh per family per year for secondary and tertiary hospital care, which we hope will work successfully. However, a majority of the poor are from rural areas and can only visit the primary health centre and primary private peripheral hospitals, which, unfortunately, are not covered by this insurance (1). This scheme may result in unnecessary referrals to secondary and tertiary care hospitals.

Irrespective of our untiring efforts, if something goes wrong and the patient dies, there is every chance that the relatives may blame and harass us. Patients and the public in general have the prejudice that doctors charge excessive fees. On the other hand, they forget how many years of one's life are spent in preparing to become a doctor. We have noted that many super specialists spend half their life in education and medical training.

These may be some of the reasons why so many doctors want to leave India or why doctor parents do not want their children to become doctors. The future is even more uncertain, with the cut throat competition for survival between MRI - CT scan centres, and multispecialty hospitals. Patients and relatives are preoccupied with extra charges, commissions, and unnecessary investigations.

In the circumstances outlined above, kindly tell us how we can both survive and observe ethical principles?

Note

[1] *Chain, often of gold, gifted during marriage ceremony by the groom*

Reference

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