Health Issues

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Dr. Arunabha Sengupta

In Mikhail Bulgakov's story 'The steel windpipe', in a small village one night a young doctor is faced with the choice of doing an emergency operation he had never done before or let a child die. He dares and the child survives. That is fiction but such and much more complex situations occur across the medical world daily where doctors decide to skate on thin ice to reach a destination than not to proceed at all. At times without happy endings. In an atmosphere of mutual trust and compassion, society for sometime accepted that as a fact of life. That trust is now perceived by the laity to have been breached, giving rise to suspicions of 'crimes' like incompetent and negligent treatment. Growing consumerism in a system of fee for service, where patients expect value for money and feel informed enough to measure outcomes, has aggravated discontent. The state in such a scenario has stepped in with its regulatory role to protect the public by introducing a new law with some modifications of the previous one. Some aspects of which need a debate, from economical and medical points of view. The new law reemphasises that private hospitals cannot demand upfront payment for emergency treatment and should recover their costs later though it does not define the legal route for such recovery and does not promise any government funding. It is difficult to find a parallel for such an act in modern economies for most of the developed countries have a universal health care system covering more than ninety percent of population. The private sector only caters to the ten percent super rich, that too only for simple non complicated procedures, cosmetic surgeries, and never for any emergency treatment. In USA, where for profit private sector occupies thirty five percent of health care, all hospitals are mandated to give free emergency care by Emergency Medical Treatment & Labor Act (EMTALA) but individual states organise several funding mechanisms to meet the cost. The other big country which has now a fee for service system like India is China, where government regulates the fee structure in private hospitals and does not allow restriction

to emergency treatment but makes up for any loss incurred. In India where eighty percent of health care is given through private sector and public spending on health is only 1.4% of GDP (compare USA 8.3, Euro area 8.0, World 6.0, Latin America 3.7, Sub Saharan Africa 2.3, Heavily indebted poor countries 2.5- World Bank data 2014), from an economical point ofnview Government will need to do more than adopting only a regulatory role. The annual health budget of Rs 3500 crore of the whole state of West Bengal itself is way less than the individual annual budget of some corporate hospital groups. From a medical point of view it needs to be pointed out that with an ageing population hospital emergencies are now burdened with more complicated and difficult to treat end stage chronic diseases like hypertension, diabetes, kidney failures, lung problems, and cancer. The number of such admissions is directly proportional to the standard of health care available in the state for which government has some responsibility. Oddly, the bill specifically forbids denial of treatment to road accident, rape, and acid attack victims. A preponderance of which also does not speak well about government. What moral authority a local councillor, who fails to keep his ward clean, will have to judge the local hospital stretched to tackle an outbreak of dengue or malaria? Without a competent first response service, without triage, moribund patients brought on cycle vans can only improve occupancy rates of hospitals.

Adopting a view that ‘health care is not a commercial proposition, it is a service or ‘seva’ and to ensure ‘proper treatment with reasonable cost... and to protect service recipients from unnecessary harassment’ government will henceforth regulate charges in the private sector and impose fines for contraventions. True, private health care here so far has been unregulated, described as laissez-faire, and instances like charging for fictitious visits, unexplained items in bills, holding dead bodies for ransom in gross violation of human rights have put the hospitals on dock for some time. Medical malpractice and devious fleecing of patients is certainly inexcusable. Hippocrates himself advised city-states to devise laws to punish their errant physicians. But that apart, the concern in the medical

community is that this bill will affect more severely smaller setups and centres in the periphery catering to modest and lower income groups. Large corporate hospitals will find salvation by shifting focus to newer costlier procedures and to less risky patient groups and will be able to recover unpaid dues with their efficient back office. These regulations, unless executed very expertly and humanely will stymie medical care, particularly emergency care, outside Kolkata. Government has not published details to inform if it will structure its fees schedules differently for different types of organisations. Government institutions are kept outside the purview of this law but it is not clear how the law will view government employees treated in private hospitals through various schemes. Will a private hospital accept a patient with a thirty thousand rupees package running the risk of a fine of up to fifty lakh if anything goes wrong?

What is more worrisome and needs urgent attention by all is the developing of a "guilty unless proven innocent" attitude about doctors by a section, however minor, of people and their habit of swift and violent retributions at times. The reasoning that a physician gains nothing by willful wrong treatment cuts no ice with them. Neither they are ready to pay heed to several court directives that medicine cannot guarantee immortality and a treatment cannot be stamped as negligent or wrong simply because the end result is unsatisfactory. When Ephraim McDowell performed the first abdominal operation in 1809 on a lady in Connecticut, a mob waited outside with a noose hanging ready from a nearby tree should the patient die. Surely, that cannot be the situation under which doctors should work, yet it is a stark reality that fears of such mob reprisal prevent well trained doctors in district and sub divisional hospitals from rendering their best. Human body being what it is, some medical 'errors' are inevitable even in the best equipped hospital in the world. BMJ has published a study from John Hopkins about medical errors as causes of death in American hospitals. European studies talk of 8-10 percent patients experiencing some form of medical error and WHO estimates at least one error in every three hundred admissions leading to adverse outcome. Best of medicine cannot and does

not promise to be absolutely fail-safe. The honourable Chief Minister has expressed concerns about vandalism in our hospitals. Words now need to be followed up by action.

If it is ‘noblesse oblige’ for the physician, and a vicarious responsibility for whatever happens, rest of the society must also understand the inherent inexactness and limitation of medical science and the prevailing conditions under which he works. The age old covenant of mutual trust and compassion between the doctor and his patients cannot be replaced by any number of laws. No system of medicine can survive without some primacy of the physician.