Cross-subsidy in public hospitals

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It is interesting to note that ethics in medicine has different connotations to different people. What some believe to be ethical, others may call unethical. This is illustrated by the following examples drawn from my own experiences as a trainee in general medicine in one of the teaching hospitals in Pune.

As a first-year resident trainee, the duties that one was expected to perform included venepuncture (letting blood through skin puncture) for laboratory investigations. As in most government hospitals, the facilities were found wanting as far as provision of disposable syringes, needles, sterile cotton swabs and gloves was concerned. The sheer number of admissions would deplete government supplies.

After exhausting all methods of procuring these materials through government sources, one had no choice but to ask patients to get them from private pharmacies. A significant proportion of patients who needed these services were too poor to buy them. In such situations we turned to 'richer' patients for these things. It was left to the resident doctor's imagination to decide which of these patients and their relatives were ' rich'.

Many relied on the patient's occupation as a guide. Some went by their conduct and demeanour. A few of the relatives who were perceived as arrogant and uncouth were also made targets for this charitable work.

The patients and their relatives were tricked into believing that the purchases were for their own good. Little did they realise that a surplus of these materials was bought to replenish the ever emptying stores in the hospital.

One of the other duties for a first-year intern was to arrange CT scans for poor patients, which in those days were carried out at private hospitals. This would involve negotiation with managers of these firms, for a rebate on these scans, as most patients couldn't afford even a tiny proportion of the scan fee charged. It was not uncommon to plead with the managers to have scan fees waived in exchange for ampoules of the contrast dye used in CT scans. These dyes would cost about Rs 200 in the market.

Acquiring these ampoules posed problems for the residents. The price of these injection ampoules were as outrageous as the fees for CT scans. This ruled out the possibility of getting them even from the richer patients, as was the case with syringes, etc. The solution lay with a very special group of patients frequenting the government hospital — those admitted with complaints of insecticide poisoning. Suicide formed the cause for the intoxication in a large number of these patients. As in most instances, they were registered as medico-legal cases, which prevented them from going to a private hospital.

Stigma and fear of death would make these patients and their relatives receptive to the demands of the doctors who would extract their pound of flesh by way of a prescription including injection ampoules of the contrast dye, and other paraphernalia required in the wards.

In some instances the relatives were told that these ampoules of contrast dye were actually a miracle antidote for the poison. This would send the relatives running to the nearby pharmacy to get the medicines lest the delay should endanger the lives of their dear ones.

As residents we were also told of an incident where a particular doctor had stepped up the dose of Atropine to make the patient delirious, thereby sending a veiled message (albeit untrue) that the poison had affected the brain. The strategy was apparently meant for those who did not comply to doctor's orders. This behaviour was not approved of, by most residents.

Interestingly these ampoules were very similar to the commonly used multivitamin infusions (MVI) ampoules in size and shape. For inquisitive relatives, an MVI ampoule would be broken and mixed with dextrose solution in front of their eyes to reassure them that the 'expensive lifesaving injection' was, indeed, being given. The contrast dye would then find its way to the store of 'loot' gathered over a period of time. This would be used for the purpose of striking deals with CT firms for scans for poor patients.

The onus of collecting these materials for patient use was on the first-year trainee doctor (JR or the junior resident) who was assigned the task of amassing syringes, gloves and other paraphernalia well in advance to avoid a scramble on admission day.

Each medical unit had its small storehouse in the form of a cupboard. It was not an uncommon sight to see junior residents of different units talking about their prized collections. Camaraderie between JRs would also help the less fortunate borrow from those with a better stock.

For the smooth functioning of the ward and prompt and efficient management of the patient, it was deemed necessary for the unit to keep a good reserve of these materials. More seriously ill patients would have prolonged hospitals stays if one depended solely on government supplies which were not only of an inferior quality but also available in inadequate quantities.

All this had the tacit support of seniors in the unit. Although the practice was not endorsed by those in administrative or academic bodies, nor was it ever condemned. Perhaps endorsement would mean acknowledging the constant shortage of supplies; this would expose administrative failings in ensuring a steady stock. At the same time, the practice could not be discouraged because then the normal day-to-day chores of the wards would come to a grinding halt.

This account paves the way for some questions. Where do we draw the line? Are we right in labelling a person rich or poor for the purpose of extracting supplies for the hospital? After all, it is very relative. We are also guilty of deceit. Can

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one small wrong be justified because it is helping us prevent a bigger wrong arising out of a problem which is not the doing of the doctors? Do these actions subvert established codes of ethical conduct? Are the residents not guilty of deceiving one set of patients and relatives? Do they merit a reprieve because their actions were guided by the sole intention of serving the poor?

Resident doctors would argue that such Robin Hood antics were needed to ensure that the system did not collapse. Surely, this was the least pleasant way of addressing the issue of lack of basic amenities in hospitals.

Let us not forget that such undignified methods were resorted to only after more acceptable measures of addressing the problems failed to elicit a response from the authorities. What happens if a poor patient with a potentially curable head injury is left to be managed without a scan because he is unable to afford the fees charged by the CT firm?

One also has to ponder over the fall-out of this practice. Some critics would argue that the silent approval of one's actions paves the way for deceit of larger magnitude later in their careers. In an era of falling ethical standards in public services could such practices lead to more serious problems? Does the end always justify the means in such circumstances?

Commentary: living by deceit

Thank heavens we did not have similar moral dilemmas when we were residents.

Much has changed since the time of my internship nearly three decades ago. The private sector in health care has grown disproportionately and has better health care facilities than in public hospitals, specifically in terms of access to newer technologies. However, this advantage is denied to most of our people because they have insufficient means to meet the escalated treatment costs.

A caring, concerned and compassionate physician today habitually confronts the setting in the case study presented here. In finding a solution he is often in conflict with the dictates of his conscience. The necessity of speedy action forces one to follow one's nose. At times of relative leisure he ruminates over the ethics of his deeds and often takes refuge in the maxim: "The end justifies the means."

The problems narrated in the case study are not rare; they are unlikely to be resolved in the near future. The callous response of administrators and the mute endorsement of deception and wrong-doing by seniors in the profession reflect their inability to grapple with such disturbing issues and find appropriate solutions. However, their lack of concern cannot legitimise such unseemly acts by subordinates. Impropriety does not merit a reprieve. Robin Hood antics may occasionally be condoned in exigent circumstances, but they cannot be approved as a rule.

The essence of the vexatious instances cited in the case study is scarcity of money in public-funded hospitals. How often, and how seriously, have medical professionals deliberated to find means to prevail over administrative apathy, and to discover novel ways of mobilising resources for such institutions? There is no dearth of funds when meetings are to be arranged, when financial support has to be found to attend conferences far and wide, and for other private activities of doctors. Why do the beneficiaries not contribute a small proportion of their extras to a permanent patient care fund in their own hospitals? Suppliers to hospitals can also be approached to donate a small share of their profit to the same fund every time they procure an order from the institution. These voluntary grants are ethically more acceptable than robbing rich patients through deceit or bartering in violation of the law. Honesty and trustworthiness are vital in health care.

Lest one forget, "*There is none so cruel as the lying ascetic who lives by deceit. A weakling's philanthropy is a sword in a eunuch's hand.*" (Tiruvalluvar: *The Kural*).

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