

CONTROVERSY

The right to refuse treatment

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In recent years, a disturbing trend has crept into health policy. This trend is being seen not only in India but also in the West. In fact, it appears that we are only imitating this trend without considering the larger interests of our country and society. This is the trend of prioritising the rights of some people or patients over the rights of society at large. Ironically, this is being ushered in under the garb of human rights, while it is actually compromising the collective good for the convenience of a few. Whereas many within the government and even among the intelligentsia are concerned about the negative fallouts of such laws, the halo around the human rights concept has forced them to be silent spectators to this retrogressive trend. The financial implications of such an approach also need to be kept in mind. The belief that this financial burden will not affect the poorer sections of the society, since it will fall on the private health sector, is more than a myth. Seventy per cent of the population in this country seeks medical help and even inpatient care from the private sector.

Harmful law

The proposed Maharashtra Clinical Establishment Act is in the stage of finalisation. The Act envisages regularising the standards of health care in the state. The need to regularise the standard of health care and establish certain basic norms cannot be disputed. There are, however, certain contentious issues in the Act. For example, one provision of the Act reads: 'the clinical establishment shall not refuse admission of any patient suffering from HIV infection or AIDS.' This provision may sound holistic but it is almost surely going to prove retrogressive. It makes the rights of HIV-positive patients, for mysterious reasons, more important than the rights of the rest of the population. Such a turn-around in the approach to communicable diseases defies logic. Such a legislation is likely to harm the normal population as well as the HIV-infected one, besides causing inconvenience to clinical establishments.

The fallacies of such a legislation are many. I list them below:

The phrase 'right to admission to a clinical establish-

ment' is vague. There may be various reasons for which the clinical establishment is unable to admit the patient. This provision seeks to ensure health care to HIV-positive patients, for which there cannot be any dispute. However, it completely overlooks the right and duty of the clinical establishment to take a judicious decision according to the circumstances. For example, the consultant of the relevant specialty may not be easily available, there may be a shortage of beds, the patient may not be able to pay for the expenses of the establishment, and so on.

The patient may also be harbouring communicable infections besides HIV, which may necessitate isolation. Opportunistic infections in the immunocompromised host are known to be very virulent and also resistant to standard treatment schedules. The susceptibility of HIV-infected people to opportunistic fungal infections and resistant varieties of tuberculosis-causing microorganisms, which do not respond to the primary line of treatment, is well established. They would thus infect the normal population if not adequately protected or isolated, and even non-HIV-infected patients would get infected with these virulent infections, necessitating a secondary line of treatment. Such isolation may not be possible every time in small establishments.

There is no doubt about the need to take special precautions while handling such a patient due to the possibility of infection to the health care worker and also transmission to other patients. The argument that all patients should be treated as if they are HIV positive is unreasonable because that would send health care costs shooting up astronomically. One disposable kit used for the operative treatment of an HIV-positive patient costs approximately Rs 1,300. Even a minor surgery requires a minimum of three such kits. This will increase the cost of all surgeries by about Rs 5,000.

If the HIV status of the patient is not known, the treatment plan cannot be formulated because most such patients are likely to be resistant to routine antibiotics, and precious time may be lost while treating them with the primary line of treatment. How will a clinician decide the level of aggression he has to use for the opportunistic

infections in these patients without knowing their HIV status?

At times, the patient may be better treated in a specialised set-up where it may be possible to monitor such patients more effectively, especially in the presence of virulent infections. Often, for reasons of their own convenience or the short-sightedness of relatives, they may not heed medical advice. Such relatives may now be able to impose their conveniences over the good of the patient himself.

Short-cut policies

HIV infection is a social problem and laws have a limited role in its eradication. Experiences with similar such problems as the Dowry Prevention Act, which has been blatantly violated by a large section of society, are proof of the futility of such laws and the ineffectiveness of the legal processes. Medical establishments could (and should) be encouraged to look at these patients sympathetically. They should be relied on to render medical advice in the best interests of the patient and society. Social commitments cannot be enforced legally. HIV-positive patients would be better served by intensifying the efforts on the ground level to facilitate the treatment of these patients, creating awareness to prevent their ostracisation, and promoting efforts to control the spread of this disease at the earliest. Short-cut policies will only serve self-seeking policing authorities. The discriminatory attitude of the bureaucracy of this country is obvious by the fact that the various professional indemnity policies offered to doctors and medical establishments

by state-owned insurance companies specifically do not cover the treatment of HIV-positive patients.

Independent India's history of more than 50 years has documented that the policies of reservation have only served the self-seeking promoters of these policies. They have done little to help the lot for whom these reservations were designed. The intelligentsia and non-governmental organisations (NGOs) need to learn from this. An increasing number of laws and control on private health care will be detrimental not only to the welfare of the medical community but also to the more needy sections of society. Private clinical establishments in our country are self-financed, non-aided institutions. The rising costs of health care infrastructure have already overburdened them financially and their economic survival is under threat. Their financial depletion will lead either to their closure or their seeking supplementary and tangential methods of income. Either scenario would be detrimental to the health care of the community.

The fabric of health care is delicate, even in the most well-developed economies of the world. Soaking it in the muck of vendetta, abnormal levies or unrealistic expectations would only make it more friable. There is an urgent need for progressive, realistic and honest legislation to protect the health of the country. We plead with the Maharashtra government for its preliminary efforts to evolve a consensus on the Clinical Establishment Act. Suggestions have been made by the medical and anti-medical community. Hopefully, wiser counsel and pragmatism will prevail in the final draft of this Act.

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