

Emergency care in rural settings: No easy solutions

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Abstract

Bawaskar and Bawaskar in their paper titled "Emergency care in rural settings: Can doctors be ethical and survive?" in this journal have presented a very real problem faced by small private healthcare facilities in rural areas. They raise the important question of whether doctors can be true to ethical principles and yet survive in the marketplace, with particular reference to emergency care. This commentary seeks to examine the problem and suggest solutions.

Bawaskar and Bawaskar have presented a very real problem faced by private medical practitioners in rural areas (1). They raise the important question: Can doctors be true to ethical principles and yet survive in the marketplace? Ethical behaviour has always been expected of doctors. Even in ancient India, Ayurveda had a code of conduct for the physician (2). The western Hippocratic Oath has been influential around the world for the past many centuries. In modern times, the four principles of respect for autonomy, beneficence, non-maleficence, and justice have become fundamental principles of medical ethics. They have universal appeal and despite differences in individual philosophy, politics, religion, moral theory, or life stance, most healthcare professionals can commit to these principles. These principles can help us deal with most challenges that arise in healthcare (3).

Each of the four principles is binding unless it comes into conflict with another moral principle. If there is a conflict of principles, one has to choose between them. This approach does not provide a method for choosing the principle, so at times we are stuck in a situation where we have to pick one principle over the other. This difficulty makes it necessary to have ongoing discussions on ethical dilemmas we encounter as we are faced with cases and their contexts.

In each of the four cases that Bawaskar and Bawaskar describe, we find they are presented with a problem which has these components.

1. A serious medical condition is present;
2. treatment for the condition is available;
3. the window of time for initiating treatment is short;

4. the treatment is costly;
5. the caregivers did not have enough cash to pay upfront, though they had the capacity to pay the bills if adequate time were given.

In all these situations the impulse to go ahead with the treatment is clearly impelled by the principle of beneficence. If any one of the above-mentioned constraints were removed, it would be easier to deal with the situation. Given that these constraints exist, what are the options available and what are the ethical implications of these options?

Option 1: Refusal of treatment

This option is inhuman even at face value. The Code of Medical Ethics of the Medical Council of India (MCI) states that "...though a physician is not bound to treat each and every person asking for his services, he should be ever ready to respond to the calls of the sick and the injured but should be mindful of the high character of his mission and the responsibility he discharges." It also states that in the case of an emergency, a physician must treat the patient and that no physician shall arbitrarily refuse treatment to a patient (4: p 4). The 201st report of the Law Commission proposed "imposing a mandatory duty on hospitals and doctors to treat persons who are injured in accidents or who are in other medical emergencies." (5: p 89). They are also proposing a statutory scheme for reimbursement by state governments.

There are no clear standards for emergency care. Does emergency care for a patient stop with first aid and stabilisation of the patient before being moved to the nearest publicly-funded hospital or does it mean provision of the whole gamut of services available in the private hospital? It raises an important issue of where the humanitarian response of the hospital ends and its responsibility to sustain itself as a private service provider begins. The lack of clarity is convenient enough for private practitioners to avoid legal trouble but it does not clear the dilemma for the ethically conscious.

Option 2: Separate the pharmacy services from regular service

This is a pragmatic step. Willingness to pay is influenced by multiple factors (6). It is well known that people are more likely to pay for products than services. When life-saving medicines are provided to the ICU directly, the caregivers do not see the product. When they are made to buy the medicines in pharmacy counters close by, they are in a better position to consider the marginal costs and marginal utility. This increases the willingness to pay. In the cases described by Bawaskar and Bawaskar, the problem was apparently not inability to pay but rather unwillingness to pay. This option, however, is

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not a solution for those patients who are and would always be unable to pay. So, if there is no other mechanism to help such patients this option would go against the principle of beneficence.

Option 3: Insist on immediate payment

It can be argued that people who evade payment in hospitals which trust them but are able to pay for ambulance transport to come to hospital and settle bills in other hospitals when referred are exploiting the benevolence of the service provider. So, a case can be made for insisting on payment. However, this overlooks the fact that there are genuine cases of people not having the resources to make out of pocket payments. In such cases, this option seems inhuman as it puts pressure on caregivers when they are already under stress arising from the patient's grave condition. It goes against the principle of beneficence.

Option 4: Take post-dated cheques

It can be seen as a very practical step when people have bank accounts and operate chequebook. When the person signs the cheque he knows by which date he has to maintain the minimum required bank balance and is therefore fully responsible for ensuring that the account has sufficient funds. If the person has not maintained the required balance then the hospital may file a legal case to obtain it. There is an additional cost for the hospital in fighting a case to recover the money. However, not doing so would prove to be costlier for the hospital in the long run. Service providers may think that fighting legal battles with patients might go against the principle of non-maleficence, but that principle is supposed to work together with the principle of beneficence to provide a net gain for the patient in the therapeutic relationship. Avoiding payment altogether is a breach of social contract and getting legal remedy for the same is not in the scope of a therapeutic relationship. The person who is genuinely in financial distress could request the hospital for more time or pay in smaller instalments. It would be sensible of the hospital to allow a grace period. All the more so in areas where penetration of banks is limited, people may not have bank accounts or even if they do, may not be using the chequebook facility.

Option 5: Use personal means to recover money

It seems fair for one to use known contacts and relationships to recover the money. Bawaskar and Bawaskar mention that a politician had helped them recover money in one of their cases. It is very difficult for any provider to influence defaulters through such personal relationships. Also, such recoveries would be in serious breach of the principle of non-maleficence, as they would be "successful" in the shadow of a threat of harm.

Option 6: Cross subsidise from other areas of a hospital

There are a few departments like pharmacy, operation theatres,

private wards etc, which are profitable and some departments which do not generate enough money like the general ward, counselling etc. One might cross-subsidise emergency services from other areas of hospital. One can justify a case for cross-subsidy using the principle of justice. It need not be a blanket cross-subsidy for all emergency patients, as that would make it unjust for others in non-emergency situations who are footing the bills. However, practically, this could help cover costs for those who cannot pay. It might marginally increase the cost for others but this could be justifiable in the interest of saving lives.

Option 7: Ignore the money aspect and provide service.

One could take an idealistic stance and say that the principle of beneficence is of paramount importance and preservation of life is an absolute obligation. However, if the money aspect is ignored fully, in the long run the hospital would not be sustainable and would close down. The loss to a community when a rural hospital shuts down is enormous. Sacrificing benefits for many in the community to facilitate benefit for a few patients in emergencies is not justifiable. The utilitarian principle cannot be trumped by ethereal idealism. One cannot ignore the monetary aspect, if the principle of justice is to be upheld.

Discussion

Medicine has become a healthcare industry and the doctor-patient relationship has become a service provider-client relationship. The expectations of people are increasing even in rural areas. They want good quality services with their desired outcomes. They however fail to realise that there is a cost to the running of services. Medical emergencies create constraints requiring deeper thought about the principles we need to follow. It is quite clear that there are no easy solutions. Each option is riddled with complexity. However, we could agree on a few things.

The bottom line is, we have to do whatever is a legal obligation. However, we as individuals and institutions should try to go beyond that and do whatever is possible and feasible. Being led by the principle of beneficence, hospitals should give priority to service to the people especially during emergencies, regardless of the ability to pay upfront.

Those patients who take services from the private sector also have the responsibility to pay for those services and cannot expect or demand all services as a "right." Even considering health as a human right, we should note that the primary obligation of providing healthcare rests with state parties and to a lesser extent with private hospitals. Much more needs to be done towards universal health coverage by increasing accessibility through a network of primary care hospitals with effective referral system, availability of needed services, acceptable quality of care especially in public sector, and affordable care including medicines based on government financing. In the private sector, patients have the right to choose upscale or cheaper treatment so long as they accept

the responsibility of paying the bills incurred and accepting the outcomes.

The service providers should use their judgement to differentiate between those who cannot pay and those not willing to pay, and deal with the situation appropriately. It is not easy to do this and it is never fool proof. It clearly is an art, the skill for which one should hone over time. Providers should realise that patients are willing to pay more during a crisis, and less willing after the crisis abates. They should look for creative ways to get financing. It is unethical to use the imbalance in knowledge to scare patients and make money through needless investigations and interventions; however, it is perfectly acceptable to be paid for appropriate services that were provided.

Private hospitals are seen as institutions driven by profits, when in reality some hospitals may have a vision for education, service and research and not just for generating a surplus. Society needs organisations which practice medicine ethically. If such organisations are pushed to pick the principle of beneficence, they will not be sustainable. If such hospitals close, many needy deserving patients would be deprived of medical services. This would go against the principle of justice. We may have to make tough choices at an individual level so as to sustain our services for serving the larger population.

We should note that government is unable to provide services of the quality and quantity that is required. It is because of this that patients who truly cannot afford to pay for private healthcare services have no option but to go to private providers. They resort to finance from local money lenders during a crisis and then fall into a debt trap. It is to prevent this fate that Bawaskar and Bawaskar had to give treatment on credit and face the difficulty of non payment. They would not have had to face this problem if the government-run health system was strong.

In addition to running robust health services through primary health centres, district hospitals and medical colleges, government can also reimburse private hospitals the bills for certain emergencies, as the Delhi government proposes to do, towards the cost of treatment for medico-legal road accident victims at pre-approved rates (7). Government aided health insurance schemes like Rashtriya Swasthya Bima Yojana should get wider coverage (8). Government should regulate the health sector to make the system ethical and of good quality. It should not shirk its obligations, off-load them onto the private sector and make the private sector unviable. Consider the Delhi government proposal in the new law that a 50 per cent waiver on the bill should be given if the patient dies

within six hours of being brought to the hospital. Even though this sounds very empathetic, it is quite uninformed regarding implementation and long-term viability. The same law however tries to protect hospitals from patients who have not paid the bills by allowing them to take legal action against the family (9). The wider availability of smart-phones, high speed internet, internet banking, mobile wallets, credit cards is bound to make transactions easier for those with money but for those without money, government and a just civil society should provide support.

Conclusion

We do not have any easy solution to the question Bawaskar and Bawaskar have raised. We should be led by the principle of beneficence in providing care even during emergencies. We should try our best to get resources to provide care for those who cannot pay. We should actively find ways of making people who can pay to pay, so that we can do justice to others. We should however stop short of providing services at a cost that could bring an existential threat to our service as a whole.

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