REFLECTIONS

The five hundred rupee note

PRAJNA ANIRVAN

Abstract

This reflective piece deals with the challenges of healthcare delivery in a resource-constrained setting. The narrative is set in an emergency room and the story follows a doctor's desperate efforts to save a young girl suffering from disseminated tuberculosis, whose condition is exacerbated by economic hardships and delayed diagnosis. This story is a compelling commentary on the inequities in healthcare, and the urgent need for systemic change to ensure that all individuals, regardless of their economic status, have access to quality healthcare and health as a fundamental right of the people is established.

Keywords: *healthcare disparities, right to health, socioeconomic circumstances, disease outcomes*

"Doctor, she's gasping!", shouted her agitated father, as I took a fraction of a pause from pumping in the umpteenth ampoule of atropine into the boy who had consumed a can of organophosphorus, to look up at the elderly, hapless person who had stormed into the ER (emergency room) that September night.

On the trolley, lay a seventeen year-old, emaciated, pale-complexioned, dyspnoeic girl who was making laborious efforts at drawing in the last gasp of air that would possibly keep her alive for the next few seconds. In an instant, I assigned my intern the task of atropinising the lad and rushed to examine this girl, who was on the verge of collapsing.

The chest was bad — coarse crepitations, absent breath sounds on the right side, the trachea shifted to the left, and a stony dull note covering the whole expanse of her right hemithorax. She was hypotensive, febrile, and needed help — *real* help. I took a moment to sift through various prescriptions, laboratory reports, electrocardiogram strips, which her father produced from a mucky cloth bag. These were, evidently, done in the preceding month at a local clinic after she had complained of breathlessness and a bout of haemoptysis (coughing of blood). Incidentally, I discovered an endoscopy report among the documents.

Asking for a chest x-ray to confirm my findings was not feasible — the radiology centre was a kilometre away. Having started her on intravenous fluids, antibiotics and oxygen, I put in a 10 ml syringe into the "triangle of safety" and sucked out milky white fluid from her throbbing chest. The massive amount of "milky" fluid that had perhaps painfully accumulated inside the tiny space between the pleurae was slowly drained that night through a water sealed container. I could see glistening beads of sweat appear on her vapid face as she collapsed onto the bed out of sheer exhaustion, and somehow dozed off despite the excruciating pain at the puncture site. She had endured several sleepless nights without a morsel of food, I knew. She would survive the night to tell her tale another day — or, perhaps, to suffer another ordeal.

Somehow, I could not get my mind off the endoscopy report, which I had discovered while rummaging through her documents. Why an endoscopy for haemoptysis? Had her doctor mistaken her blood-stained sputum for hematemesis (blood vomiting)?

During my undergraduate days in medical school, a professor whose astute clinical acumen we admired, used to reprimand us for relying overly on investigations and not spending time talking to the patients and clinically examining them. He used to tell us often of Paracelsus, the "stormy petrel of medicine", who had declared, *"Medicine is not only a science; it is also an art. It does not consist of compounding pills and plasters; it deals with the very processes of life, which must be understood before they may be guided."* Often, the professor would make us imagine how William Osler might have examined patients in his rounds at Johns Hopkins. The fallout was that I developed a kind of aversion for physicians who ordered blanket investigations for patients, unmindful of the economic burden or the inherent dangers of being blinded by reports and missing the true diagnosis. I began to question whether our over-reliance on investigative tools and techniques was robbing us of the basic art of clinical diagnosis.

It was an eventful night, and at 8 am in the morning, as I readied myself to leave the ER, I was stopped in my steps in the corridor by her father. The patient had already been shifted to the intensive care unit (ICU). He thanked me profusely for "saving" his only daughter and kept sobbing. I comforted him in whatever way I could and explained that

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this was just the first step — the alleviation of symptoms, and that a thorough diagnosis would be made soon. We would try to the best of our abilities to improve her condition, I explained. Somewhat convinced by me — in his eyes, I was his daughter's saviour — he left me but only after extracting from me a promise to help his daughter get cured.

I had a seventy-two-hour shift in the ER and could not quite follow up on her. After I had finished with the last ER patient, I called up my colleague posted in the ICU and enquired about her status. I was told in no uncertain terms that her condition was critical, even though a diagnosis of disseminated tuberculosis had been made and she had been started on antitubercular therapy, intravenous steroids and other supportive medications.

I knew she was being attended to in the ICU and the best, in terms of medical aid, was being given. As I went about my daily work, jostling through wards, cabins and ICUs, I used to meet her father often, sometimes near the canteen, sometimes in front of the tea stall and at other times in front of the ICU, with that patient look on his face. The deep furrows on his forehead struggled to hide in their folds years of forbearance and fortitude. I used to pick up a conversation with him now and then, and those sessions of brief exchange of words would not necessarily have a logical conclusion but we always seemed to pick up from where we had left off. One of our brief exchanges ran thus:

"How are you doing, *borta* [uncle]?"

"I am fine, doctor…I just hope she gets well soon….is she slightly better?"

"Yes, a diagnosis has been made and she is being adequately treated…but see, it will take time. *Accha,* tell me…why did you bring her so late? And why is she so emaciated? Doesn't she eat proper meals?"

"(Long sigh)…Her mother died when she was a child. Our son poisoned himself to death. I work in the fields the whole day. She cooks for me and herself. Of late, my earnings have dwindled…I am a strong man…she is however, weak."

"I am sorry to know that, *borta.* The medicines will be provided free under the Revised National Tuberculosis Programme but you will have to improve her nutrition. It is nutrition that is of paramount importance."

"I will do my best but…"

His words had not quite ended and he had now put on that lugubrious look, the expression that suggests less hope and more despondence, when a colleague of mine implored me to come to her aid in getting a patient intubated. Our conversation ended abruptly.

She was shifted to the ward after being kept in the ICU for seven days. Her recuperation was slow and finally, after staying in the ward for twenty-two days, she was discharged. During this period, she had battled bed sores, urinary tract infection, catheter site infection and a host of maladies that hospitalisation brings along with it — the bane of the *nosocomium*.

I had not forgotten the "but" in our last conversation. I asked her father one evening: *"Borta,* you were saying something the other day…"

As if on a cue, he responded, "Yes…but prices have gone up, milk costs eighty rupees a litre, buying meat, eggs or fish is out of the question. How can I manage with my meagre earnings, sir?"

I could not give him a proper reply. To tell him to "still try" would be a mockery of his economic condition. Perhaps he could sense the whirlpool of emotions I was caught in. His eyes conveyed to me a sense of resignation to Fate. I placed my hand on his shoulder and merely said, "you can come to me for help any time you want, uncle. I will do whatever I can."

While leaving the hospital, with folded hands, her father thanked us — doctors, nurses, ward attendants — everyone who had been involved in her care and promised me that he would take care of her to the best of his ability. I knew it would be a difficult task for him but still harboured hopes that he would find some way.

Five months passed. We had not heard from him. One day, I was about to leave my residential quarter for the evening rounds when suddenly, I could discern, in the distance, the outline of a gaunt, slightly bent, person, slowly approaching. I could recognise him immediately. He looked worn-out and forlorn. Someone in the hospital had shown him my quarters. He greeted me with a meek smile. Then came the news. She had passed away. "A fortnight ago, she coughed up copious amounts of blood", he said. "She was weak as well. For the last one month, she was also not taking her tuberculosis medications. I could not bring her for follow-up, too. It was my fault, sir." He started sobbing.

"Borta, tell me what happened." I knew there was something else.

He kept weeping. I took him inside my room and offered him a glass of water.

"I had borrowed ten thousand rupees from the money-lender to meet the hospital expenses", he slowly explained. "The crops failed this year. I was in debt. I worked as a daily labourer to make ends meet. However, I could not find work every day. While I was away either working or searching for work, her health deteriorated. She could not go to the DOTS (Directly Observed Treatment, Short-Course) centre and the DOTS provider had difficulty coming. She missed her medications. I am old and not everybody wants to employ an old man. We had to go hungry for days."

I forgot for an instant that I was his physician. Time froze and

numbed me. Stupefied, I stood there. My clinical acumen, my abilities as an internist, my knowledge and my zeal to excel — these seemed to me infinitesimally small before the words that had just emanated from his mouth.

From the ripped pocket of his tattered shirt, he took out a neatly rolled up five hundred rupee currency note. "That night in the ER, when you saved her from the sure clutches of Death, while you were examining her, a five hundred rupee note had fallen out of your shirt pocket, sir. You did not know but I noticed it and picked it up and kept it. That day, I was penniless…we had not eaten for three days and I…I am sorry sir…." He started sobbing violently. I could realise his predicament.

"I have come to return that to you, sir. I had stolen the money from you. Please forgive me." Tears welled up in my eyes. I told him, "I could not do anything for your daughter. You never stole anything. Please keep this." That night before going to bed, I picked up a book from my shelf. In one of the pages which I had bookmarked long ago, were written these words: *"There is a rich man's tuberculosis and a poor man's tuberculosis. The rich man recovers and the poor man dies."*

They remained no longer words to me — they became tears, sighs and the silent remonstrations of a lost soul.

REFLECTIONS

Public health perspectives on mental health: Reflections from teaching

MUKTA GUNDI, SEEMA SHARMA

Abstract

The mental health discourse in India has been primarily viewed through a biomedical lens that often overlooks the cultural context and social inequalities. To ensure equitable access to preventive, promotive, curative, and rehabilitative mental healthcare, India needs practitioners who combine a social perspective with an empathetic approach. To address this need, we designed a course titled "Critical Perspectives on Mental Health" that aims to introduce the relevant perspectives and community-based approaches to mental health. In this article, we share our reflections on designing this course and facilitating it in the form of a post-graduation programme.

Keywords: *mental health, public health, teaching reflections, pedagogy, inclusive learning*

Introduction

Despite the broad definition of health as *"a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity",* the mainstream public health discourses have largely ignored the mental health-related needs and experiences of diverse communities in the world [1]. While the pandemic attracted our attention to mental health issues, the focus primarily remained limited to individual counselling, coping, and the "illness" narrative [2, 3]. The narrative around mental health has also largely remained restricted to mental healthcare, thus falling short of situating itself in the broader public health domain [4]. There is a felt need to address the social determinants of mental health, to consider mental wellbeing as a spectrum, and to promote socially oriented actions to ensure "mental health for all". The Lancet Commission on Global Mental Health and Sustainable Development argues that mental health is a global public good. The WHO [World Health Organization] Special Initiative for Mental Health [2019-2023] promotes universal coverage of mental health and the United Nations Human Rights Council (2022) emphasises the protection of rights to the highest standard of physical and mental health of diverse populations [5,6,7]. These are welcome additions to the global narrative on mental health. However, to achieve these, there is a dire need for a public health approach [rather than a narrow biomedical approach] to ensure equitable access to a mental healthcare that is preventive, promotive, curative, and rehabilitative. As the biomedical lens has historically ignored the complex role of the various sociocultural, political, environmental, and economic structures in creating and sustaining mental health inequalities, it is necessary to discuss, acknowledge and address these social inequalities in Indian society. Given the stigma around mental health, sustained efforts are required to work with communities to understand how they

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