**SLUG: COMMENT**

**TITLE: Emergency care in rural settings: Can doctors survive and be ethical?**

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***Abstract***

*We describe below the pressures of running a small private hospital in an under-served rural area, while providing emergency healthcare for victims of poisonous stings and other acute health conditions. Both ethics and law demand that payment is not asked for upfront in emergency cases. Yet patients and their families often fail to pay normal dues for months or even years. In these conditions can one be true to ethical principles and ensure one’s own survival?*

We have been running a small private hospital in rural Maharashtra since 1976. Medical management in such settings involves several difficulties, coupled with the high expectations patients and their relatives have from the treating doctor. Patients and their relatives are unaware of the difficulties of treatment with restricted resources such as trained staff and modern gadgets, and the shortage of electricity. Patients invariably compare rural facilities unfavourably with those of tertiary care hospitals in the big cities. Besides providing treatment, we have to update the relatives on the patient’s health and investigations. Sometimes, these relatives come from cities like Mumbai, and have little actual knowledge, but take great pride in their “Google knowledge” regarding a disease. One has to remain calm while they keep lecturing us, no matter how irrationally! In addition, doctors today suffer great stress because of the hanging sword of the Consumer Protection Act and the aggressive responses of patients’ relatives to an adverse result. We elaborate below our experiences regarding patients in a rural setting.

**Case 1**: In 1986, a 38-year-old woman with red scorpion stings was admitted to our hospital at Mahad. She suffered an autonomic storm and we closely monitored her vital function taking repeated ECGs. She took 72 hours to recover. She was from a poor family and her husband told me he would sell her *mangalsutra* (gold necklace) to pay the hospital bill. Horrified to hear this I offered him one month’s time to make the payment. He gave us his statement in writing but did not respond to reminders for a whole year. Much later, another patient from the same village told us the man had deceived many with such methods. Eventually, he turned up only in 2018 to make the payment.

In those days*,* nobody was ready to admit patients with severe scorpion stings. I became popular for successful treatment of the lethal condition. Mahad, where I work, being a small town, there is no question of refusing to admit such emergency cases. Refusal has a very demoralising effect. Even patients from the government hospital are referred to our hospital for further management. Poor farmers and labourers are more prone to scorpion sting and snake bite. So, we have trained several doctors in the periphery regarding management of severe scorpion and snake bite envenomation. Since 1990, we have voluntarily been visiting and treating all such cases at the local government hospital. There is no question of payment and we too, get esteem, mental peace, and satisfaction without burn out.

**Case 2**: A 68 year- old female patient suffering unstable angina was brought by her son to hospital. She was admitted and treated with intravenous nitroglycerine drip, beta blocker and low molecular heparin for eight days. She underwent coronary angiography and cardiac bypass surgery. However, for a whole year no family member turned up to pay her hospital dues.

**Case 3**: A bank employee brought in his mother with acute chest pain, suffering an acute myocardial infarction. She underwent an angioplasty and was later transferred to a tertiary care hospital for further management. The patient’s son was known to my son and requested me to accept a down payment of Rs ten thousand, and the remaining amount after receiving his salary. After several visits to his residence by my wife, Dr Pramodini, he issued a cheque which was returned due to shortage of funds. This happened twice, but we decided not to take police action as he is the main support of his family and may lose his job. His close relative told us he was a regular gambler. Eventually, he paid our charges only after we complained to another patient, a local politician, about his conduct.

**Case 4**: On November 15, 2016, a 40-year-old male was brought in, complaining of severe chest pain radiating to both arms, and sweating profusely. His ECG showed an acute inferior wall infarction. In acute myocardial infarction “time is muscle”, and the longer the infarct time, the greater the damage to the myocardium. To avoid delays, we always keep two vials of tenecteplase in the hospital. After explaining to his relative that tenecteplase is expensive but essential to revive the heart muscle, we obtained his consent and agreement to pay at the time of discharge. His acute infarction pattern was aborted and subsequent angiography was normal as recanalisation occurred due to tenecteplase being given in time. He paid us by two different cheques both of which bounced. We then issued him legal notice and he promised to pay within fifteen days. However, this did not happen. Ultimately, we gave up on this payment, as it meant regular attendance in court by the doctor, which was not feasible.

Both government regulations and medical ethics demand that in emergencies, victims should be given proper treatment in time, without asking for payment. In rural areas there is no established system of payment of advance deposits. Even if we ask for a deposit, the public responds with remarks like “We are not going to deceive you”; besides which few have abundant financial resources. These are the reasons why specialists do not want to go to rural areas. Medical insurance has low penetration among the majority of rural people. There has been no improvement in rural government hospitals for the last 30 years. In a life threatening medical emergency, the poor patient has no alternative to private hospitals. To pay for treatment at a private hospital, poor people have to sell their ornaments, pieces of land, or cattle. This has resulted in excessive indebtedness leading to numerous suicides. To avoid this, we never pressurise patients for payment. However, there is an urgent need for improvement in terms of qualified staff, specialists and modern investigation facilities like Computerised Tomography (CT) and Magnetic Resonance Imaging (MRI), etc. Government should pay for the widest possible health insurance coverage of the poor.

Irrespective of our untiring efforts, if something goes wrong and the patient dies, there is every chance that the relatives may blame and harass us. Patients and the public in general have the prejudice that doctors charge excessive fees. On the other hand, they forget how many years of one’s life are spent in preparing to become a doctor.

In the circumstances outlined above, kindly tell us how we can both survive and observe ethical principles!

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