

Letter from Mumbai

NON-PAYMENT OF PRIVATE HOSPITAL BILLS OF DYING PATIENTS

From time to time private hospitals face a painful situation—painful to the administration and the relatives of patients alike. Consider the following case.

A patient is admitted for treatment of an acute, severe illness such as myocardial infarction. In view of the emergency, the patient is admitted at once without a deposit, on the understanding that the relatives will make the payment within the next 12–24 hours. Intensive care, resuscitation and all possible therapy fails to help and the patient dies. The relatives wish to take the body away. No payment whatsoever has been made.

The hospital is within its rights to demand payment as agreed upon before releasing the body but an adamant stand can boomerang upon the administration because of the adverse publicity likely to be generated by the family in the media. The hospital administrator is made the heartless and avaricious villain, out to get his pound of flesh from the harassed and bereaved family. Boorish elements make political capital by championing the cause of the family and even insinuating that the death was entirely the fault of the hospital, the treatment inadequate or substandard and attitudes of all staff members arrogant and callous. Demonstration of medical facts testifying to the gravity of the illness, extent of the damage done to the heart by the loss of its blood supply and details of treatment are disregarded as emotion overrules reason in the presence of a television crew.

Experts pondering the issue have made the following suggestions:

1. Public education on the responsibilities of patients and their families to balance education on their rights. It is patently unfair to avail of services and then flee without meeting the costs. Casting aspersions on the treating physicians and the institution without proof and, in some cases, assaulting the former and damaging the latter are indefensible.
2. Improvement of emergency services in public sector hospitals and access to them so that those from the poorer sections of society are confident enough to avail of them.
3. A written undertaking by a responsible relative guaranteeing payment of all dues should precede emergency admissions. The difficulty here is enforcement of the guarantee.
4. Each private hospital should create a fund to take care of such contingencies. Bills not paid under such tragic circumstances should be written off against this fund.

Would readers care to offer their suggestions and views?

STEM CELL TRANSPLANTATION IN INDIA

Many in the Indian medical profession consider stem cells to be the answer to their prayers and those of their patients. Unbridled enthusiasm at the prospect of enabling patients rendered paraplegic by spinal injuries, ridding patients with Parkinson disease of their handicaps and reversing the ravages produced by Alzheimer disease thrill several neuroscientists. The hope of regenerating tissues is truly tantalizing.

Others look to stem cells to study organogenesis and understand what can and does go wrong when malformations occur or diseases strike the organs being created from stem cells.

Hitherto, the principal debate has been over the use of stem cells obtained from the embryo. Experts in biomedical ethics, scholars on religion and philosophy, and regulatory agencies have worried about the damage to the embryo, destruction of a potential living being and the production of embryos merely to obtain stem cells to benefit others.

The recent production of stem cells from somatic cells obtained from the patient to be helped adds a new dimension. This technique requires no embryo. Since the patient's cells are used, chances of rejection of the transplanted stem cells are very low. The risk of inducing tumours may be eliminated by avoiding the *c-myc* gene. These features may lend further impetus to the use of cells from the skin and elsewhere.

Experts on stem cells have expressed concern on the inability to tag stem cells so that their course after transplantation can be studied. Others have favoured directing stem cells into the progenitors of the diseased cells (neurons for example) before they are used.

Such discussions and debates are welcome and form part of the development of any new technique or procedure. The promises held out by stem cells must be validated experimentally, the safety and efficacy of transplantation of these cells confirmed in animals and by staged studies in humans as in any other clinical trial.

To the dismay of many in India, individuals, departments and institutions have jumped the gun in many of our states. Stem cells are being touted as a panacea, desperate patients and their families forming the gullible targets. Huge sums are demanded—and paid—to doctors and clinics for such transplants. Enquiries about earlier work done by these doctors and clinics on stem cells elicit no response or anger at the temerity displayed by asking such questions. A search of the published literature yields no evidence of experiments, techniques used, animal trials and phased clinical trials. The medical profession has no access to follow up studies on the successes or failures of the procedures.

A prestigious teaching institute announced the successful use of stem cells in curing damaged hearts through the national newspapers. Efforts at tracing the background documents have failed thus far. It appears that the institutional ethics committee had sanctioned this project but there appears to be little transparency on the evidence presented to the committee or the discussions that preceded the sanction. A diligent search has led to just one paper on the subject in a scientific journal. This paper—a review of stem cells transplants—blandly reports the 'success' without providing details or evidence.

At the Second National Conference on Bioethics in Bangalore, a session on 8 December 2007 featured a discussion on stem cells. Speaking in this session, Dr Bernard Lo, professor of medicine and director of the programme on medical ethics at the University of California at San Francisco, offered comments that are relevant here. He took pains to emphasize that our knowledge on the use of stem cells to treat diseases and spinal cord injury is evolving and that we are far from the stage where we can start treating patients even on an experimental basis. He went on to add that he was aware that such usage had already started in India but did not possess details.

A member of the audience had an interesting question: 'Dr Lo, we are aware of the fact that we need to learn more about stem cells

before using them in clinical practice. Let me put before you the plight of a young patient who has been rendered paraplegic by an accidental spinal injury. Lacking social services and rehabilitative measures, the fate of such a patient is usually sealed as pressure ulcers, urinary tract infection and eventual pneumonia take their toll. Is it unethical to use stem cells to try and benefit such a patient?’

Dr Lo replied: ‘I fully sympathize with the plight of the patient you refer to. Under such circumstances, the experimental usage of stem cells must be under strictly controlled conditions and at a few, carefully selected centres. The procedures to be followed must be standardized and approved by an authoritative ethics committee. Meticulous records must be maintained. There must be total transparency at every stage. The patient and his family must understand that an experiment is being conducted which may help but which is also fraught with several uncertainties including the possibility of complications such as the development of tumour. The patient must be carefully observed and followed up over a long period after the transplant. The records on the patient should be available for scrutiny by the medical profession. Since the treatment is of the nature of a clinical trial, the patient should not be charged for participating in the experiment.’

Dr P. M. Bhargava, founding director of the Centre for Cellular and Molecular Biology, Hyderabad—a member of the audience—gave us the benefit of his observations on the subject. He acknowledged several instances of unauthorized and unsupervised use of stem cells in patients in India with no transparency. He bemoaned the lack of any statutory agency that could act in such cases. He pleaded for a national council of senior and experienced scientists who could foresee developments such as those on stem cells and formulate and table legislative measures to ensure that unscrupulous individuals or clinics did not jettison science to enrich themselves at the expense of desperate patients and their families.

The Indian Council of Medical Research (ICMR) has proposed the formation of a National Apex Committee for stem cell therapy with ICMR itself as the Regulatory Authority. To the best of my knowledge this has not yet been legislated.

A PLEA FOR THE INCLUSION OF AYURVEDA INTO MODERN MEDICINE

Dr M. S. Valiathan delivered the inaugural address at the above conference. He chose the subject *Bioethics and Ayurveda*. While describing the very perceptive and thought-provoking instructions on ethical medical instruction and practice in the *Samhitas* of the schools of Charaka, Susruta and Vagbhata (to name but 3 of the great teachers of the past), Dr Valiathan referred to the ‘missing domain’ in most modern Indian medical conferences and meetings.

He pointed out that India produces over 15 000 Ayurvedic doctors every year from over 200 colleges. He quoted estimates of 60% of our poor villagers depending more or less on Ayurvedic practitioners for their basic healthcare needs. ‘To survive and flourish even after 2000 years of varied fortunes, the traditional system must surely have intellectual and ethical vitality and its claim to consideration in a national discussion on bioethics would seem self-evident.’ This claim can be extended to all branches of healthcare.

To exclude such a large number of physicians catering to a vast segment of our population from our deliberations and the planning and execution of healthcare programmes can only be to the detriment of our people.

He pleaded for an effort—however difficult and time-consuming it may be—to integrate Ayurvedic experts and practitioners into modern medicine.

WE ARE PLUMBING EVER FURTHER DEPTHS IN MEDICAL MALPRACTICE

The Times of India (17 December 2007) informed its readers in Mumbai of ‘a case of autopsies being conducted on the basis of instructions given over phone by the doctor on duty’.

Representatives of the Police Surgeon have been placed at some of our large public hospitals. They are required to perform autopsies for medicolegal purposes. Since the scrapping of the Coroner’s Act, they represent the law in these hospitals and their findings are crucial in all legal hearings on these deaths.

At the Bhagwati Hospital, run by the Municipal Corporation in Borivali—a suburb in north-west Mumbai—Dr Abhijeet Gawde was the pathologist on duty to perform autopsies on 21 November 2007. He did not report for work. Worse, ‘when the bodies started coming in for autopsy, he issued instructions over the phone’ to the unqualified staff in the autopsy room. Still worse, ‘the doctor would give (the unqualified staff) necessary instructions to list the cause of death and issue certificates’ without his ever having seen the body or witnessed the autopsy findings.

It is a telling commentary on the state of affairs in the Police Surgeon’s department that this practice came to light only when a sub-inspector came to the centre to get the autopsy of a relative done. ‘The officer noticed that even though there was no doctor present at the place, the postmortem was being done. The death certificate, too, was issued to him. When he asked the employees what was going on, they gave evasive answers, prompting him to lodge a complaint with police surgeon, Dr S. M. Patil, who is in charge of all postmortem centres in the city. The police surgeon confirmed having received a complaint from the sub-inspector.’ Dr Patil is reported to have said: ‘It is shocking to learn that the employees were allowed to issue a death certificate in the absence of the doctor and even fill in the details, which they are not supposed to do.’ Apparently it was not shocking that Dr Gawde did not perform the autopsy and was not even present when it was carried out.

The news report mentions in passing that Dr Gawde was trapped by the anticorruption bureau the following day for demanding and accepting money from another doctor for writing a favourable report.

Several questions arise. The following worry me most. Are pathologists appointed to these posts carefully scrutinized and periodically re-evaluated regarding their qualifications, aptitude, fitness to work and quality of performance? Are the activities of these pathologists not subject to periodic scrutiny by the Police Surgeon? Is there no system whereby findings at each autopsy are recorded, perhaps on video camera, since they will form the basis of judgments in court? Dr Gawde has probably been misbehaving and showing evidence of blatant malpractice and corruption over time. Are his autopsies, reports and certificates going to be re-evaluated by experts so that the full truth can see the light of day?

If currents trends prevail—as well they might—this unwelcome publicity of Dr Gawde’s activities will blow over as newspapers turn to other news stories and Dr Gawde may return to practice as usual.

S. K. PANDYA

Letter from Australia

A Federal election is due before the end of 2007, but the Prime Minister seems to be holding off announcing any date until the last possible minute. The Opposition has a commanding lead in the opinion polls and a landslide defeat of the government is predicted. Both major parties have been trading blows in the false election campaign for so long now that the population's interest in the outcome is fast waning. Health has emerged as a major election issue. In relation to gross domestic product (GDP), health expenditure is running at close to 10% and rising at a faster rate. Around \$A 4000 is spent on healthcare per person per year. Hospitals consume 35% of the total expenditure but are never able to perform to the high expectations of the community. Australians have universal health insurance under the Medicare system which entitles them to free treatment if they choose to be admitted to a public hospital and also to a rebate covering a proportion of doctor's fees for community-based consultations. All taxpayers contribute 1.5% of their taxable income as a Medicare levy. Many Australians take out additional private health insurance to provide cover in the event of treatment being provided in a non-government hospital setting. The funding for government-run public hospitals is complex with about half coming from the State Government and half from the Federal Government. This generates tension between the two levels of government because, although both contribute to the running costs in roughly equal proportion, the administration of these hospitals is entirely controlled by the State Government. In this Federal election campaign, both major parties have hinted that they would consider exercising much greater control over public hospitals that were not performing well. Apart from this, there have been promises of an additional \$A 2 billion for the ailing mental health system and promises from both sides for additional funds to support services for autistic children.

Some news that is considerably more interesting for clinicians is that two rotavirus vaccines are now registered in Australia. Rotavirus was first recognized by Australian researchers, Ruth

Bishop and Ian Holmes, who carried out electron microscopy studies on faecal material at the Royal Children's Hospital, Melbourne in 1973 and subsequently identified the virus particles in duodenal biopsy specimens. Rotavirus is responsible for 520 000 deaths in infants and children under 5 years of age each year, mostly in developing countries, and for 45% of all hospitalizations in this age group. The first live rotavirus vaccine produced by Wyeth was tested in 1998, but was withdrawn 9 months later when a cluster of cases of intussusception occurred in vaccinated children. Subsequent epidemiological studies suggested that the risk of intussusception was in fact very low—1:32 000 live births—but by then the vaccine was no longer available. Professor Julie Bines and colleagues have studied regional differences in the incidence of intussusception and have been able to confirm that the risk of this condition in Viet Nam is 3.5 times higher than it is in Australia. The increased incidence is not related to rotavirus; instead, the strongest association seems to be with adenovirus infection.

Two other discoveries stand out as landmarks of Australian research success. The first is the discovery made by Marshall and Warren in 1985 that peptic ulceration is an infectious disease, not one caused by stress as was previously thought. The identification of *Helicobacter pylori* in gastric biopsies and Marshall's demonstration of Koch's principles by experiments carried out on himself make classic reading. The second is the demonstration by Professor Fiona Stanley from Perth of a clear association between the risk of neural tube defects and the dietary intake of folate in the first trimester of pregnancy. Stanley's elegant large scale epidemiological studies and the first papers of Marshall and Warren were all published in the *Medical Journal of Australia* and are among the 10 most often read publications from that journal.

GARRY WARNE
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