Responses to the Letter from Ganiyari: II

Thanks for these reflections. As usual, they demostrate much thought and commitment. What follows is my small contribution to the ideal of 'responsibility' in general, as it arises in the apparently avoidable tragedy of Seema Gond's death, the implications of which are discussed in the cited letter.

In these times of crass commercialization of medical education, it is indeed heartening to see such dedication to the care of the exploited and marginalized. Chhattisgarh (and India) needs many Ganiyaris and committed doctors to deal with the problems people face. One only hopes that at least a small minority of young doctors who have read this Letter are adequately inspired to commit themselves to such a challenging responsibility.

I feel there should be a caution line of the distinction between responsibility and guilt. I say 'caution' out of concern for the well being of that small group of 'rural' doctors who work in difficult circumstances, providing healthcare to those who live in conditions of utter exploitation and marginalization. Similarly, there are many mission hospitals too which perform such difficult and thankless service to those who don't seem to matter. Deep commitment characterizes such people's work in impossible conditions.

The issue with respect to patients such as Seema Gond (or her parents, who brought her to the hospital) is not only whether the poor are informed about what is possible in terms of a disease, but also whether in the final analysis, they decide to, or are able to, come. Given intractable circumstances, people do what is possible. The immediate medical problem is often only a small subset of the larger stakes, however, important it seems to the healthcare person.* Lives as a whole, are also never accessible to the physicians, however much he or she tries to reach out. In my opinion, trying to solve the health problem on an individual basis (doctor-to-patient), will likely lead to

a network of complications that are well beyond medical competence. This will be so at least until such time a democratic politics of health begins to work on a large scale providing the enabling background for such individual intervention. But that is another scenario altogether.

In India today, the lives of the poor are complex, and often the wretched truth is that health is only a staving off of death, a chronic palliation till the end comes.

These are the conditions of exploited lives that committed rural doctors in India have to accept and face if they are to retain sanity.

So my distinction in the argument is: take responsibility for what can be done, in the given circumstances you find yourselves in, with your different limitations and capabilities, but don't feel guilty about what the world is. We are not gods, we are given a set of circumstances to work in and to transform to the best of our different abilities.

Perhaps a more productive and empowering emotion than guilt in such circumstances is *humility:* about one's abilities, about the bitter struggle of life and death before one's eyes, and most importantly, about the patient. This is for a doctor to decide…

Needless to say, a public health system (either state run or community run—to stretch a definition) is incapable of feeling guilty! It is institution of social responsibility to one's fellow human being. It is the prople who work in them who are at risk of burn out, depression and stress because of their personal commitment. I am sure rural doctors who survive have learnt this at a cost to themselves over time.

REFERENCE

1 Culpin I, Rai D. The responsibilities of public health systems. *Natl Med J India* 2015:**28:**251–2.

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* I am indebted for this insight to Lakshmi Kutty's essay 'The intractable patient' in Anand Zachariah, Susie Tharu and R Srivatsan (eds). *Towards a critical medical practice: Reflections on the dilemmas of medical culture today* (Hyderabad:Orient Blackswan; 2010).

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