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FOUNDER EDITOR
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Death of a doctor at the hands of patients' relatives!

The trust gap between the doctors and patients needs to be bridged

WE strongly condemn the killing of a doctor by the family members of a patient, who also died allegedly due to wrong treatment, in Khulna. The incident took place on Monday night when the relatives of a deceased patient assaulted the attending doctor bringing allegations against him of wrong treatment which led to her death. According to our report, Shiuli Begum, a pregnant woman, was admitted to Dr Rakib's clinic on Sunday, where a C-section was performed on her by him and other physicians. Although the mother and child were doing fine after the surgery, the woman's condition started deteriorating later in the night. On Monday morning, she was recommended to be taken to Khulna Medical College Hospital. After taking her to KMCH, doctors there advised the family to take her to Dhaka and the woman died in the ambulance on her way to the capital. Enraged by her death, her family members assaulted the doctor who later died from brain haemorrhage at a local hospital.

While such behaviour by the patients' relatives is totally unacceptable and they must be held to account for his death, we must also admit the fact that there is a lack of responsibility and accountability among the doctors which often lead to medical negligence. In this case, the doctor had a responsibility to frankly tell the patient's family of her medical condition. Had they done so and directly sent her to Dhaka, the patient might have survived.

We are highly appreciative of what our doctors are doing at this time of a national health crisis. But there remains a trust gap in the doctor-patient relationship which is not healthy either for the patients or for the doctors. This gap needs to be bridged at all costs. At the same time, the government should formulate a specific law which will protect both the rights of the doctors and the patients. We have some laws to deal with the medical negligence cases which are hardly in use.

While we understand the grief of the deceased patient's family members, we believe under no circumstances can the act of assaulting a doctor and killing him for "wrong treatment" be condoned. We express our deepest condolences to the bereaved family of the doctor, and hope that those involved in the incident would be punished according to our law. The reason behind the patient's death should also be investigated.

An unprecedented move by the police

Journalists summoned by police for reporting on police high-up

IN a statement released on June 17, the Dhaka Union of Journalists (DUJ) expressed deep concerns over the summoning of at least 10 journalists by the police, after the publication of a report about the corruption of a senior cop. The DUJ also said that the move goes against the country's law and practice and that this type of letter by the police created a kind of psychological pressure which was inconsistent with the free flow of news.

The summoning of 10 journalists together by the police, relating to a story that involves police high-ups, is unprecedented in our country's history. If police, or anybody else for that matter, sees a report in a newspaper that they would like to object to or enquire about, the first step should be to write to its editor. Then, if they wish, they should get an appointment and meet the head of the organisation. But this direct summoning is not acceptable.

It is the role of the journalists to break barriers of secrecy and inform the public about true and objective information, while protecting the confidentiality of their source(s). When journalists are summoned by the police for reporting on them, on a matter that the public should be informed about—which is their duty—it is bound to seem as if it was done to send a message. And the message, it seems, is that journalists should not be reporting on police high officials.

We think of it as nothing but a subtle way to intimidate the media. And such intimidation is neither acceptable, nor does it serve to help improve the image of the police. Moreover, it is the right of the public to know true information about the police that is meant to serve and protect them. It is unacceptable for journalists to get intimidated for doing exactly that.

It is with that in mind that we call for an immediate withdrawal of this summon letter, and also for an end to such intimidation tactics.

LETTERS TO THE EDITOR

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Murder of doctor unacceptable

At a time when doctors—frontline workers in our battle against the coronavirus pandemic—are struggling to provide healthcare support to the nation, I was enraged by the news that the family of a patient who died after giving birth to a child reportedly killed a doctor in Khulna.

Such criminal-like behaviour must not go unpunished. The doctor, who died of brain haemorrhage after being beaten up, was well-reputed and had kept his clinic open to patients at a time when many other clinics were shut. Members of the family alleged that his treatment led to the new mother's death but reports suggest that the woman died on her way to the capital in an ambulance due to complications caused by her delivery. Our healthcare system is collapsing due to Covid-19 and with the shortage of doctors nationwide, this murder is a terrible loss. The authorities must immediately bring the culprits to justice.

Saiful Islam, *Chattogram*

All patients are equal, but some are more equal than others

SHUPROVA TASNEEM

OVER 100 days of Covid-19 in Bangladesh have brought with it more than one lakh recorded cases of coronavirus and over 1,300 recorded deaths in the country. All over the world, limited levels of testing have made it difficult to understand the real extent of community transmission of the virus. This is all the more true in Bangladesh, which still has one of the lowest levels of testing in South Asia. Different media outlets have also cast doubt on the official death toll, arguing that deaths at home from coronavirus are not making it to official counts. This suggestion seems to be corroborated by the few funeral service providers in Dhaka who are dealing with burying deceased coronavirus patients. Their records seem to suggest they have already handled 1,000 funerals in the capital alone, although it is not clear whether all of the dead were infected.

Anyone with a family member or a friend who is a part of our collapsing healthcare system must have by now heard of the desperate pleas for ICU facilities in hospitals, public and private, which are full to the brim. All across the city, those who have the means are panicking—stocking up on medicine, pulse oximeters and even oxygen cylinders. The menacing touch of coronavirus is no longer trained only on garments workers, maids, drivers and the "uneducated" classes who were "foolishly" traveling between districts and crowding at bazaars. Now, the net is closing in on all of us.

Against this terrible backdrop, the death of one five-year-old boy from Chattogram may have eluded your attention. A photo of his lifeless body, lying on a gurney outside Chattogram Medical College Hospital (CMCH), appeared in this daily on Wednesday, while his grandfather is seen collapsed on the floor next to him. I don't know what is more heartbreaking—that cold, little form against the cold steel, or the image of that elderly man, clad only in a simple lungi, clutching his head with his hands in a paroxysm of grief.

Shaon was playing on the road next to his house, in the city's Steel Mills area, when he was hit by a three-wheeler. Shaon's father told reporters that the boy immediately started bleeding from his nose, and they rushed him to the CEPZ Hospital in Chattogram, about four kilometres from the scene of the accident, where they refused to treat him. His family then took him to South Point Hospital, another ten kilometres or so away, where he was again refused treatment. They tried the Ma o Shishu Hospital, less than three kilometres away, where they were, once again, turned away. In their final attempt to get urgent medical attention for this injured child, they travelled another seven kilometres to Chattogram Medical College Hospital—the furthest hospital from where the accident happened but the closest public one—where the child was pronounced dead from excess blood loss. Was it the accident that killed him, or that desperate 24 kilometres his family travelled in the hopes of keeping Shaon alive?

Of course, this is not the only such case. When Suman Chakma, a DU student suffering from cancer, died on April 6, after several hospitals in Dhaka refused to admit him, the prime minister herself asked: "Why will patients return? Why will patients die after moving from one hospital to another for treatment?" Her instructions to investigate the involved parties seem to have been ignored by the relevant authorities, since there has still been no reported investigation on the matter. Perhaps the most publicised case was the death of Gautam Aich Sarker, additional secretary to the food ministry, who succumbed to coronavirus at Kurmitola General Hospital on May 9, a day after being admitted with kidney complications. According to his family, he was denied treatment at several hospitals because he was Covid-19 positive, including Labaid Hospital and Dhaka Medical College Hospital. After his death, a common question that was asked was—"how could such a senior government official struggle to get medical care?"

Five-year-old Shaon lies dead on a gurney at Chattogram Medical College Hospital while his grandfather wails on the ground nearby, on June 16, 2020. PHOTO: **RAJIB RAIHAN**

This simple sentence betrays a grim truth about Bangladesh. Our healthcare system, like so many of our institutions, is in the grip of a structure of power that disproportionately relies on personal spheres of influence, turning healthcare into a commodity for the consumption of the highest bidder, rather than the right of every citizen. Now that the coronavirus has spread like wildfire and we are seeing hospitals buckle under pressure, this has become all the more obvious. Even those who have the means and personal relationships with the relevant authorities are struggling, competing for the rare empty ICU bed. Ordinary people—like school teacher Abdul Gafur from Chattogram's Patiya upazila, whose two-month-old daughter died on June 13 because of the limited ICU facilities at CMCH (after being turned away by a private hospital)—do not have the same luxury. This lack of ICU facilities has become the marker of our public healthcare crisis, created by decades of mismanagement, inefficiency and chronic underfunding. In the direst of times, the people of Bangladesh do not have access to emergency medical care unless they can afford to pay for it. During a pandemic, even money is not enough—you need influence as well.

These spheres of influence are not just limited to patients, but extend to healthcare providers as well. Take for example the case of 22-year-old Habiba Sultana. She was a nurse at the Ibn Sina Hospital. Yet, she struggled to get admitted to her own workplace after a brain stroke, because her Covid-19 clearance certificate had been misplaced. By the time she reached the ICU, it was too late. If this was a member of Ibn Sina's upper management, would this have happened? A lot of the fury sparked by these recent cases of negligence has been directed at attending doctors, but even within hospitals, there are varying structures of power.

This is especially true in public hospitals, which tend to be saturated with politically motivated appointments. Do ward "boys", cleaners or even nurses get the same level of personal protective equipment that doctors do? Can a junior doctor demand to be tested for coronavirus after treating Covid-19 patients? Can even senior doctors protest when their administrations decide to deploy them in the battle against coronavirus without proper facilities? In private clinics and hospitals, healthcare is simply another consumer good in a capitalist economy—if you can't pay for it, you could be on death's doorstep and the hospital has the right to shoo you away. Can a doctor in a private hospital, even if he/she is not morally bankrupt enough to turn away a critical patient, speak up against management without fearing the loss of their jobs, especially when the law does not criminalise their negligence?

A health ministry circular from last month, stating that hospitals and clinics cannot refuse treatment to patients, Covid-19 or otherwise (if they have the requisite facilities or equipment), seemed like a step in the right direction. However, the Supreme Court has recently stayed almost all the High Court directives on this matter. Among other things, the stay applies to the directives on death of or denial of treatment to a patient due to negligence being a criminal and punishable offence, as well as the directives on informing people of the number of ICU beds in government hospitals, making ICU bed management more accountable, and launching an ICU hotline.

Now more than ever, we needed a healthcare system that is open, accountable and accessible for patients from all walks of life. The health inequality in this country is not simply an issue of funding, but also an issue of social justice. We must acknowledge that healthcare is not a luxury, but a fundamental human right. All those who are deprived of this right should have access to some form of legal redress and justice.

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PROJECT SYNDICATE

Firm Priorities for Fragile States

DAVID CAMERON, ELLEN JOHNSON SIRLEAF, *and* **DONALD KABERUKA**

NO country has been spared the impact of Covid-19. But some—the world's most "fragile states"—face a particularly difficult set of challenges. Before the pandemic arrived, Yemen, Sudan, Haiti, Sierra Leone, Myanmar, Afghanistan, Venezuela, and other struggling countries were already beset by poverty, conflict, corruption, and poor governance. Now, these factors leave them especially ill-equipped to deal with the Covid-19 crisis.

What any country needs to withstand a pandemic is precisely what fragile states lack: a government with the institutional capacity to devise and deliver a comprehensive plan of action, effective police to enforce rules, social programmes to deliver money and supplies, and health services to care for the infected.

A lack of state capacity is immediately evident in the domain of public health. Whereas Europe has 4,000 intensive care beds per million people, many parts of Africa have just five per million. Mali has just three ventilators for the entire country.

An effective response also requires trust in government. But, in addition to scarce capacity, governments in most fragile states lack popular legitimacy. In countries recovering from conflict or riven by corruption, many people will be unwilling to follow even a government that proves capable of leading.

A strong private sector is also a necessary component of effective, resilient states. People must be able to work to support their families, and governments must generate tax revenues to help those who cannot. Yet fragile states typically lack the formal economy through which to meet these needs.

Earlier in the crisis, there were hopes that some fragile states would escape the worst of Covid-19's health impact, owing to their youth and isolation. But, from our perspective as the co-chairs of the new Council on State Fragility, this has not been the case. In recent weeks, Sudan, South Sudan, Somalia, and Yemen have all had infection and mortality rates rivalling those in more developed countries that were hit by the coronavirus first.

Worse, the economic impact of the pandemic will surely fall harder on fragile states, not just as a result of internal lockdowns, but because of what is happening overseas. Trade with countries like China has declined massively, revenue from remittances has tumbled, commodity prices and oil revenues have plummeted, and deficits are ballooning. Because fragile states rely on imports for much of their food, there is now increasing talk of "hunger" and even "famine."

We should know by now that poor countries' problems tend to become the world's problems, whether in the form of mass migration, organised crime, terrorism, or economic spillovers. Given that half the world's poor will live in fragile states by 2030, these problems will escalate further.

PHOTO: **AFP/GETTY IMAGES**

A medical staff member in Burundi measures a man's temperature.

That is why the Council on State Fragility has made it a top priority to draw attention to the unique challenges these countries face. Comprising former world leaders, ministers, diplomats, business figures, academics, and heads of development organisations, the council will combine cutting-edge research with detailed policy knowledge to influence the global and national decision-makers who will determine how fragile states fare through this crisis and tackle their broader and deeper challenges.

Decentralisation, adaptability, and the savvy use of data will be key. For example, there is ample evidence to suggest that "smart containment" of local outbreaks is often more appropriate than countrywide lockdowns. Such insights could prove critical in fragile states. But we must act fast before the acute phase of the pandemic in the West ends, and the sense of urgency there wanes.

We offer five recommendations. First, social protection must be made simple and fast. Sometimes, that will mean universal eligibility rather than precise targeting. Mobile-phone networks should be used to gather evidence on current needs, and to distribute small, regular (albeit time-limited) payments.

Second, more domestic food production should be encouraged. Sierra Leone, for example, used to grow rice, but it has been becoming increasingly dependent on imports over the last decades. More broadly, Africa has 60 percent of the world's unused arable land. Efforts to produce staple crops locally can and must be scaled up quickly and substantially.

Third, whenever a vaccine becomes available, the international community must ensure that fragile states are not priced out of the market by richer countries. When the threat is a contagious pathogen, no country is safe unless all are. We must encourage and accelerate the production of multiple vaccines to ensure rapid, widespread distribution.

Fourth, businesses in fragile states need direct support. As the best development-finance institutions know, small companies in poorer countries are often overlooked, and tend to suffer from the perverse effects of broader targets and rules (because it is easier to hit a target by investing in big projects in big countries). But it is precisely these smaller enterprises that merit greater investment.

Finally, the G20 should do more to support heavily indebted fragile states that are being forced to choose between paying their foreign creditors and saving their people. Countries receiving bilateral development assistance are scheduled to repay about USD 40 billion to public and private creditors this year alone.

To forestall that fiscal blow, we call on all G20 members to commit to debt moratoriums, not just until next year, but rather for the duration of the crisis. Moreover, it is essential that all fragile states secure emergency funding to support efforts to curb Covid-19 and mitigate its economic impact—including countries that are not ordinarily eligible for funding from the World Bank or the International Monetary Fund.

Covid-19 will deepen existing wounds in all of the world's fragile states. But with swift global action, we can mitigate the pandemic's worst effects. If there is one thing we have learned from this crisis, it is that lives and livelihoods will be saved if we can move faster than the virus.

David Cameron is a former prime minister of the United Kingdom. Ellen Johnson Sirleaf, a Nobel Peace Prize laureate, is a former president of Liberia. Donald Kaberuka is Special Envoy of the African Union's Peace Fund.

(Exclusive to *The Daily Star*)