Peripatetic Commentary

Ethics in Medical Practice

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There is a feeling among the lay people that doctors have gone increasingly commercialised. Gone are the days they were on a pedestal, and considered Messiahs and even like God. They now carry a poor image. Some people even call them thugs and looters. Why?

Of late doctors have been reported for molesting, rape, perjury falsifying evidence and even house breaking. It must be realised that doctors are derived from the rank and file of todays public. They have todays values. Fortunately such doctors are only a small lunatic fringe. Most members of the profession remain honest gentlemen. Secondly charges for medical treatment have sky-rocketed. For an appendix operation, a hysterectomy and even a cataract operation; you pay close to a lakh. Of course there is Insurance. But they do not defray the total bill. Besides only about 20% population is insured. The corporate hospitals spend a lot on ostentation. Fully air conditioned, glazing tiles, carpets and even chandeliers are not required to treat diseases but to attract patients. Who pays for it? Of course the patient. Medicine is getting increasingly technology based. Costly investigation like CT / MRI. Laparoscopic (now Robotic), Laser surgery have made medical treatment very costly. Middle class patients have to sell their assets to pay for supra major surgery, or even major surgery.

Ex. Hon. Paediatric Surgeon, Bai Jerbai Wadia Hospital for Children, Parel, Hon. Surgeon, Arogyanidhi Hospital, Juhu and BARC Hospital Deonar, Mumbai.

If they happen to get admitted to a Corporate Hospital, it is a total rip-off. Most will be admitted in the ICU, on the excuse that no bed is available. Others will be shepherded into higher class than they can afford. A whole battery of tests are done, some not required. Some are even repeated and re-re-repeated. Outside reports are looked down upon and often derided. In a surgical case, peaens are sung in favour of Laparoscopic (now Robotic) approach. Open surgery is rarely mentioned. Between cashless and non cashless insurance cashless is preferred. Patients with no insurance are often advised to take an insurance and then come (in planned surgery). Every patient is seen by multiple consultants even if the complaints are trivial. Consultants are often rude and unapproachable. In such a scenario, where does ethics come in?

Fortunately there are still a few who care about ethics and morality. Others can look at my suggestions and see if it helps?

1. Informed consent must be taken. It must be explained that most of the complications are notional and may never happen. There is some risk in everything; even flying.
2. Suggest cheaper hospital or treatment if patient wants.
3. Give receipt, if patient desires.
4. Prescribe minimum number of medicines. Explain side effects if likely.
5. Charge less for repeat visits.
6. Don't hesitate to advise on phone,

especially if you have seen the patient before.

7. Keep note of patient's illness.
8. Don't blame patients e.g. you have come too late.
9. Don't run down other doctors. Don't say treatment was wrong. Just get on with the job.
10. Offer open operation, if patient has poor paying capacity.
11. Don't argue with patients. Let them feel free to choose another doctors, if they so desire.
12. Be honest with your failure. Covering up will cost much more and will involve other people. They may not be your friends.

Offer to put it right on your expense. In my experience most irate and intimidating patients settle down if you own up.

I might be creating a controversy by offering these suggestions. But each must judge for himself.

Regarding the Doctor-Pharmaceutical -Instrument maker axis, much has been written in the papers. The public is aware that a nexus exists. My answer to it is that it cannot be curbed. It is a global phenomenon. Bribing, incentive, inducements are similar terms only one is open and the other are subtle. Children don't go to school, babies don't drink milk, dogs don't learn tricks without an incentive. Inducements, threats persuasion are all similar. I agree that money bags and cash incentives look vulgar. That is wrong. But supporting conferences, CME and medical educational lectures are not wrong.

One can not be too moralistic in todays world. One has to be pragmatic.

Role of Bronchodilators in Management of Cough

In particular, in cough variant asthma, cough responsive to bronchodilator treatment can be the principal or only manifestation of asthma, especially in young children.

Morice and Kastelik have omitted atopic cough, a bronchodilator-resistant non-productive cough that has been defined as an isolated chronic cough with no variable airflow obstruction or airway hyperresponsiveness and one or more objective indication of atopy as identified by blood or sputum eosinophilia, elevated total or specific IgE or positive skin tests.

Vinay Naik, Supplement to JAPI, 2013, Vol 61, 20

Thrombolysis in acute ischaemic stroke: time for a rethink?

As the UK regulator reviews alteplase in ischaemic stroke. Brian Alper and colleagues question the evidence for its use beyond three hours

Use of alteplase 3-4.5 hours after stroke is supported by guidelines and meta-analyses based on analyses that do not directly examine treatment in this time frame. Direct comparisons of alteplase with no alteplase at 3-4.5 hours after stroke suggest an absolute increase in mortality of 2% and no clear benefit.

Recommendations to use alteplase 3-4.5 hours after stroke should be re-evaluated

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