COMMENT

To talk or not to talk, that is the question

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One of the major ethical issues that I face very often in my practice is whether to criticise my colleagues or not. Complaints, criticism and condemnation lead to terrible consequences and never help anyone, they say. I am told that my colleagues are to be treated like my siblings and I should never criticise them in front of patients.

That seems logical enough. We may or may not agree with a particular diagnosis offered by fellow physicians, and it is not necessary that either of us would be right every time. But to criticise him or her in front of the patient would degrade the whole medical community. Even the patient would be in doubt about whom to trust. Moreover, very often, this criticism is fuelled by competitive one-upmanship. Rather than bettering our performance to get ahead, we use the tactic of putting the other fellow down. The medical community's stature is touching the abyss.

While reading a treatise on the Consumer Protection Act of 1994 (CPA), I stumbled upon a statement that said that behind most medico-legal cases there was a doctor who talked too much. I found the idea of blaming a doctor for the CPA cases shocking. We have interpreted the "sibling" theory to mean that the doctor is my brother but the patient is not. While we must have loyalty to the profession and to the medical community, what about our loyalty to patients? That was when I started thinking about it: to talk or not to talk.

I am treading difficult terrain here and may find it difficult to communicate what I mean. So let me illustrate what I mean by sharing certain incidents that occurred in the course of my practice. Sometimes I spoke out and made myself unpopular, and sometimes I did not, and hated myself for it.

The first case is of a 22-year-old patient with secondary infertility who visited me for her other routine illnesses. She had showed me her documents, which said she had a tubal block, for which she had been operated upon in Kolkata. The doctor had told her not to worry too much, wait for six months and then report back. The following month she conceived, and was thrilled. Three months later, however, she started bleeding. Since her husband was not at home her brother-in-law took her to a gynaecologist who advised an ultrasonography. The sonographic diagnosis was "dysfunctional uterine bleeding and ovarian tumour" and she was told by the gynaecologist that she needed to be operated on immediately to remove her uterus and save her life as the ovarian tumour had grown too big and could burst any time. She was also told that while the uterus size was only 13, the ovary size had nearly doubled to 25.

Fortunately, her brother-in-law did not have enough money for the operation so they waited till the husband returned. He called on me to inquire which nursing home would be a better option, since I was their family physician. I asked for the ultrasongraphy plates. What I saw floored me. It was a simple case of incomplete abortion. The uterus size was written in centimetres (13 cm) and the ovary with the follicle size was written in millimetres (25 mm). I was no sonologist, so I rang up a senior radiologist friend of mine and sent the film to him. He concurred with my diagnosis. I sent the patient to a gynaecologist, who did a small procedure, and she was fine.

The second case was of an old man, a retired judge, who was admitted to a government hospital with severe dyspnea at 2 pm and died at 9 pm the same day. His relative, a lawyer, had a suspicion that something was wrong, so he collected all the documents and brought them to me and asked for my opinion. Now, if one scrutinises a medical document with the intention of finding fault, one will certainly succeed. But the faults I found were fatal and could have been avoided even with minimum care. Here is what I found:

The patient was a known case of chronic obstructive pulmonary disease, not on inhalers. Immediately after admission, he was given a deriphylline injection -- three such in a span of three hours. What I noticed was that every time a new doctor visited the patient, he prescribed another injection of deriphylline. No one bothered to check whether the patient was already on long-acting deriphylline. The patient's pulse rate doubled, became irregular, and he received another deriphylline injection.

Though the hospital had a nebuliser, it was not used. Five hours after admission he went into shock. That was when he received the first dose of steroid injection -- after five hours, and after he went into shock. He was put on IV dopamine, at a very high dose, without monitoring. No one examined the patient after starting dopamine. When he stopped struggling for breath, anxious relatives were told not to disturb him because he was apparently improving and resting. He was found dead in his bed at 9 pm.

Two years ago my middle finger was crushed in a mixer-grinder

in the course of a culinary experiment. Half the nail had gone and the bone was in three pieces. The pain was excruciating. I called some senior surgeons, colleagues of mine, and went to a nursing home. I said that as the pain was very severe, could they please anaesthetise the finger before they did any procedure. Both the surgeons in attendance had at least 25 years of experience and were from reputed universities. They agreed to my request, but the moment one of them tried to inject lignocaine into my finger, I knew he had never done it before. The finger remained painfully sensitive when they stitched it up. I did not scream but a witness later told me that I nearly kicked the ceiling fan off every time they put the needle through my nail and when the thread flowed through the nerve endings and when they tightened the grip.

All three cases presented me with a dilemma. In the first, two doctors worked in tandem to remove the uterus of a young girl desperate to have a baby, just for a few thousand rupees. They are probably doing similar things every day. The patient had no way of knowing what was going on. Most likely, she would have believed that the doctor saved her life and would have thanked him for it. So should I tell her the truth and warn her about the two doctors? If I did so, would I be doing something that was ethically wrong vis a vis my colleagues? It would have been difficult for a non-medical person to detect such a disgraceful act, so should I just keep quiet and let Nature prune its weeds?

As for the second case, what should one call it -- medical negligence, ignorance, or criminal negligence? I have no way of knowing whether the patient would have survived had the treatment been systematic. But does that matter? The doctor should treat the patient with reasonable competence with the facilities available. The case papers screamed of the callousness of the doctors and other staff. No one thought about the patient. I was professionally consulted and asked for my opinion on the case sheet. Should I tell the truth as I knew it, or should I keep quiet?

I asked one of my teachers what I should do. He said, "As long as you give a receipt for the money you receive as consultation fee, show it in your income tax returns, and as long as you are honest and unbiased about your opinion, it is okay." So that is what I did. Now, if and when this case comes up in court, someone will say that behind every CPA case there is a doctor talking too much.

The third case, my own experience, was disheartening. It is easy to find ignorance, negligence being committed on others but when it happens to you, you remember God. I learnt the art of dressing and local anaesthesia as a house officer; as a matter of fact that's what we learnt in the first six months: to take the patient's history and keep the patient ready for the boss to see, and after the senior's treatment, to follow up with a dressing and write the discharge slip. We were lucky enough to also stitch the odd RTAs and other injuries, drain the odd abscess, and assist in semi-major surgeries. Somebody somewhere told me that there is something called pain that a patient usually feels and there is some logic in making an attempt at relieving it. How come my surgeon friends did not know this? Should I protest? And if I should, how and to whom?

In another instance I read an article in a well-known Bengali health magazine in which an internationally known orthopaedic surgeon from Kolkata advised readers that to reduce acute pain in gout, they should take allopurinol. I protested in a letter but the magazine refused to publish it until I sent them a semi-legal notice. Though they then published my letter, no further discussion on the subject was allowed.

What's going wrong? Or am I wrong? Am I behaving like an old man critical of everything new and young? Surely, the need to treat a patient with empathy cannot change with time. If Hippocrates ever saw the prescriptions of some popular doctors, he would cringe in his grave.

Maybe there are some doctors who have found fault with my prescriptions. How do we find out our own faults? Do we deserve to be so free and uncensored?

And, finally, what is the solution? Should we have an ethics committee in every medical college, or town, or *taluka* to which all complaints and doubts must be referred before making them public? If so, who controls the committee? In the present scenario, it is likely to be hijacked by bureaucrats or politicians. Even if doctors head it, I am not sure the right man would be in the chair.

The fact is that everyone is suffering, patients and doctors alike, and something must be done about it.