

## COMMENT

# Day-to-day decision making as a physician in India

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Moral perceptions and judgments are based on a society's values. Professional ethics generally complement social codes and reinforce moral perceptions. In the area of health care, the doctor-patient relationship is inherently unequal, placing added responsibilities on those providing care. In countries like India where practice protocols and referral pyramids are not defined and where patient awareness is rudimentary, the obligations on a physician increase manifold. This is further complicated by a healthcare system that includes both sophisticated, multi-specialty corporate hospitals providing excellent care for a premium to chaotic, under-staffed and under-equipped government services that do not have the will and resources to provide adequate healthcare.

There are many moral and ethical implications of everyday decisions faced by a specialist working in India. The scenarios below were faced by me every day while practicing in India for a period of two years as a neurosurgeon. I describe how I responded in such situations. I conclude with the reflections of a colleague; I have found these valuable in dealing with such situations.

### Seeing a self-referred patient

About 60 per cent to 75 per cent of new patients seen in specialty outpatient clinics in India are self-referred. Most are unaware of the probable source of their health problem and are ill-equipped to choose the right specialist. It has been shown that "misdirected self-referrals by patients to self-chosen specialists can sometimes lead to misdiagnosis resulting in unwarranted delays in getting the right treatment" (1). Should specialists insist that all new patients be referred by general physicians, or should they see self-referred patients?

Some academic institutions insist that specialty outpatients obtain referrals. In the private sector, though, self-referred patients are generally welcome. Some argue that patients will have to pay consulting fees to a general physician before obtaining a referral, which in turn may be tainted by kick-backs to the referring physicians (2,3). If I refuse to see self-referred patients they will probably go to another specialist with different standards of practice. In this situation, until the system is changed, I believe it is ethical to see self-referred patients because it enables them to get into the system and receive care.

### What if another specialist is more competent?

All practicing specialists will do certain procedures less often

than others. I may be confident and competent to do these procedures, but there may be other specialists who do the same procedures more often. It is in the patient's best interest to know this. But practicing specialists do not always volunteer such information. Is this ethical?

One way out is to inform the patient of the number of procedures one has done, with the complication rate, and also provide information on more experienced colleagues, and let the patient decide. On the other hand it can be argued that there is always someone who does a procedure more often and/or better – and referring every patient to a more competent person can also harm the patient who must then wait to see 'Number 1'.

I believe that as long as I feel competent to do a certain procedure I need not discuss these details.

### Witnessing corruption in medical practice

I sometimes see patients who have been wrongly diagnosed and harmed by unnecessary investigations and interventions. Should these misdeeds be brought to their notice? Should the authorities be alerted? If I do neither, is it unethical behaviour or professional solidarity?

Will speaking up against erring doctors help patients get justice? The chances of justice in India's medico-legal scenario today are bleak. Medical councils and the courts fail to deliver justice in medical malpractice cases (4). On the other hand speaking up creates enemies.

If there is incontrovertible evidence that an indiscretion has occurred one does have an obligation to report to the patient and possibly to the authorities. It is important to report to the proper authorities and not to the media. But the evidence must be clear that an obvious deficiency in duty has led to damage or injury to the patient. Sometimes negligence can be presumed. But when it is not obvious one must not criticise a colleague just because one has a different opinion.

### Should one offer expensive options with limited impact to poor patients?

In patients with glioblastoma multiforme, chemotherapeutic drugs like temozolamide offer a few weeks of survival advantage but are prohibitively costly. Should one even mention this option to a middle-class patient? Patients' families desperate to save their loved one's life will sell their home or land to pay for such therapies.

On the other hand not to inform them on the presumption that they cannot afford to pay for the treatment is paternalistic and robs them of their autonomy. Also, on the practical side, they will be upset if they find out from someone else about an option withheld from them.

### Should one offer aggressive treatment for patients who might be a liability to their families?

There are no few or no long-term rehabilitation centres in India providing affordable care. Families face a severe burden in patients with poor neurological outcomes. Consider a patient with high cervical injury with complete quadriplegia who is on ventilator and the family cannot afford to pay. Should one treat the patient regardless of the ability to pay? Does one advise the family to take the patient to a government hospital or home when in both cases one knows the patient will not improve (5). Unless long-term rehabilitation becomes available in the Indian healthcare system these are going to be agonizing decisions for the treating specialist. The guiding principles must be to protect the dignity, comfort and rights of the patient. The mistake that must be prevented at any cost in these scenarios is to compromise patient autonomy either by being paternalistic or by putting the family's interest ahead of that of the patient.

It might help to refer to guidelines for decision-making. The British Medical Association's guidelines "Withholding and withdrawing life-prolonging medical treatment"(6), though they are based on a different practice and cultural setting.

### Do you tell the patients if there is a mishap during the treatment?

Many things can go wrong while a patient is in medical care. Some are beyond the doctor's control – the staff may have given an incorrect medication or a power failure has affected the patient on a ventilator – but the consultant in-charge of the patient is still responsible. Other things like surgical accidents are directly the surgeon's responsibility.

Whether or not the patient's condition is affected by the mishap, it is ethical to tell patient about it. As long as one's relationship with patients is of mutual trust they and their families will

understand and appreciate the honesty and the measures taken to counter the effects of the mishap (7).

### Conclusion

I have found the guidelines suggested by a colleague, extremely useful and reproduce them in full below:

*"1. The golden rule: Do unto others, as you would have others to do unto you... 2. The patient comes first. The raison d'être of our profession is the patient. We are here to serve him. The sick patient, often in physical pain and always in mental distress, deserves our fullest attention and calls for the best qualities of our mind and heart. His interests and decisions must prevail above all else except when the patient is non compos mentis. In the latter instance, the decisions of his family must prevail, 3. The poor patient deserves special consideration. He has nowhere else to go. He does not possess the means to command or demand. In our milieu he is often reduced to seeking help with bowed head and hands folded together. And he is ill. Medically malpractice against this group is particularly abhorrent, 4. Ensure that your decisions and actions are scientific, humane, effective and in the best interests of the patient and his family. Record them. Once this is done, you need fear no individual, administrator or tribunal."* (8)

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