LETTERS

Manipulation of prescriptions by patients – what must a doctor do?

Over-the-counter use of medication via chemists, including the use of psychiatric medication, has always been a cause of worry in the Indian subcontinent (1). Over the last two years, the rules on dispensing psychiatric medication have become stringent and chemists have to dispense the exact amount of medicine written on the prescription for the time duration mentioned. The chemist also stamps the prescription with the amount of medicine dispensed so that the patient does not use the prescription at another chemist's or counter to obtain more than the amount prescribed. This means that patients must follow up with the psychiatrist regularly, have themselves evaluated, and get a fresh prescription that must be signed by the doctor and also carry his seal. There are many patients who do not adhere to this rule. Many a time, chemists who have known a patient over the years tend to continue dispensing medication to the patient for durations which far exceed that prescribed by the doctor. This is rather dangerous as the patient may end up taking antidepressants, antipsychotics and sedatives for months or at times, years, without a valid prescription. They may also develop side-effects that could ensue under unsupervised consumption.

At times, patients manipulate the prescription when chemists adhere to the rules and dispense the exact dose specified. They increase the dose on their own so that their medicines last longer and they can avoid follow-up for reasons best known to them. Sometimes, they increase the duration of the prescription on their own and may thus continue with their medication without visiting the doctor. As a doctor, this bothers me as it is the doctor who would bear the responsibility were there some mishap. We are in an era in which doctors are governed by strict rules and are not spared the consequences of the slightest negligence (2). Do we have rules in place for bringing to book patients who take the law into their own hands and manipulate prescriptions? Even though it is their fault, they blame doctors for the long-term side-effects of medication and give excuses for not following up and manipulating a doctor's prescription. These include having to travel long distances, lack of finances and family problems. It has been reported in the scientific literature that patients with a drug abuse problem may manipulate a prescription to procure certain opioid drugs or sedatives (3). When, however, patients who seek help for other psychiatric problems do the same, what are the doctors supposed to do? Should they continue treating such patients with the same vigour even when a patient has threatened the integrity of the doctor–patient relationship? Is there a tribunal or a body where doctors can be warned of such patients? Patients who manipulate their prescriptions are committing a serious ethical violation and this needs to be looked into from the perspective of healthcare.

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What is wrong with the MCI?

In the wake of the Medical Council of India's (MCI) take on the promotion of faculty recently (1), it is clear that the faculty of medical institutions across the country are in a state of alarm. A situation in which the whole onus of research is put on the faculty is quite quirky when there is no consideration of the fact that most medical colleges in India do not have a system of intramural funding, apt infrastructure and a pertinent environment for carrying out good research.

Promotion means a hike in salary, reputation, self-esteem, etc., and people may very well ignore research ethics in favour of survival. Although continuous assessment of the academic achievements of faculty is one of the essentials of maintaining good standards of professional and ethical medical education, in the absence of intramural funding and infrastructure, using publications as a parameter for the same may have serious consequences. If publications are forced on the faculty, in the absence of any funding or research infrastructure, there will be few, if any, concerns about research ethics or integrity. One of the primary objectives of the MCI is "maintenance of uniform (not high) standards of medical education, both undergraduate and postgraduate" and publications are a logically disparate way to achieve the same, at least in non-standard research environments (2). The policy undoubtedly has no implications for the maintenance of uniform standards of medical education.

In India, there is no legislation for research misconduct. Research infrastructure and funding are not essential criteria for the establishment of medical colleges in India (3). India has designated research institutes for funding and conducting health research (4). Most medical colleges in the country do not have research infrastructure or intramural funding for health research and most research is funded by external

agencies. The need for research on a topic is evaluated by the funding agencies. The selection of a research project is governed by the need of the funding agency rather than the interest of the faculty. Therefore, before imposing superfluous rules that are not well thought out on the faculty, the MCI must lay down specific research-related minimum guidelines (if at all it is empowered to do so) for institutions as well, so that some responsibility is shared and meaningful research is carried out. We feel that rather than a healthy initiative for research, the current policy is more of a tyrannical decision that reflects the hypocrisy and ineptitude of the MCI as a national medical regulatory body.

The lack of clear objectivity in the policy document indicates that it is just a desperate attempt to appear professional in the global research scenario and in the process, transferring all the responsibility on to certain individuals so as to create a window of opportunity for shifting the blame whenever the need arises. The institutions and the state governments are totally absolved of their responsibility towards research (3). Looking at the flaws and casualness of the document and the MCI's flippancy regarding a search for a logical and reasonable solution, it seems that the MCI has not succeeded in doing any "original research" on addressing the problem of research in the country. Medical faculty also happen to be doctors with an enormous workload in resource-poor countries like ours and promoting research in such a dictatorial manner will only gradually lead to the demise of medical practice in medical colleges (which are also tertiary care institutions).

The ingeniously percolated idea of perceiving of research as a tool for the advancement of an individual's academic career, rather than a nationalist concept of doing research for the country, could be another reason for regulatory bodies to conveniently come up with such skewed policies. The MCI must take initiatives to instil, in individuals and institutions, the concepts of research integrity and to propagate research as a tool for the nation's development rather than relentlessly trying to create a hostile and autocratic environment in an effort to unnecessarily compete with the West.

Submission of similar work: A letter to the editor of the *Journal of Postgraduate Medicine Education and Research* on somewhat similar lines is under review.

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Should we share the management of acute life-threatening medical emergencies on the telephone?

Daily, I receive 3–4 social media messages regarding the diagnosis, management or clinical dilemmas of acute time-limiting medical emergencies due to snake bite and scorpion sting poisoning. I respond to the caller who has shared clinical signs and symptoms. I also follow up on the progress of the victim. I send pdf files of my publications on scorpion and snake bite.

On the morning of December 13, 2015, I received a phone call from a postgraduate medical student to whom I had already mailed all my publications and also delivered a three-hour lecture on scorpion and snake bite. The case was of a 35-year-old woman, a bakery worker, admitted with a snake bite on her right great toe. The blood clotted within 20 minutes. She had external opthalmoplegia but oculogyric crisis due to autonomic storm which was wrongly diagnosed as external opthalmoplegia and treated as neuroparalytic snake bite poisoning , but no ptosis; the blood pressure was 130/90 mmHg. For neuroparalytic snake bite poisoning, 80 ml (worth Rs 12,000) snake antivenom was given intravenously. But she was still sweating profusely, her extremities became cold, and she had marked tachycardia without any local oedema. She became breathless with SPO_2<90% and pulmonary congestion. The electrocardiogram showed left anterior hemiblock with fascicular tachycardia. Clinically, it was a case of severe scorpion sting with autonomic storm. Within one hour, she developed massive pulmonary oedema with expectorated blood stained froth from nostrils and mouth. She had repeated cardiac arrest, she was resuscitated and intubated and put on a ventilator, with intravenous frusemide, prazosin by Ryle's tube, and inotropic support. Scorpion antivenom of 40 ml was given intravenously in 100 ml of normal saline over 30 minutes. The patient gradually recovered with reduction in heart rate, improved haemodynamically, and was extubated on day 3 without neurological deficit.

In similar instances, I tell physicians in far-off places over the phone the difference between a scorpion sting and snake bite, or the difference between a krait bite and cobra bite (2-5). Villagers, farmers and labourers are more prone to scorpion stings in *wadis* (small hamlets deep inside jungles) where only non-allopathic doctors are available. I have trained these non-allopathic doctors in managing severe scorpion sting, which