Treat the patient, not the lesion

Peeyush Jain speaks out against a disturbing trend in medicine

The young doctor was posted in the cardiac catheterisation laboratory soon after joining a cardiology fellowship. One day, while looking at a coronary angiography film, he asked done of his seniors, "What should be done for such a lesion?" The senior smiled and replied, "We should treat the patient, not the lesion." This statement made a deep impression on the junior.

Eventually, the senior fellow became professor, took premature retirement, said good-bye to academics and became director of interventional cardiology in a major private organisation.

As professor, he was famous for his respect for the rules laid down in the textbook of cardiology. He never recommended angiography without careful consideration. All his angio-films were thoroughly discussed in the morning conference, and further course of action was decided collectively. Some patients were advised coronary angioplasty, others were referred for coronary bypass surgery, while a substantial number continued drug treatment and were followed up.

After starting his practice there was a perceptible change in the former professor's clinical approach. Now he started advising coronary angiography for nearly all patients suspected to be suffering from coronary heart disease. And following angiography, he began advising angioplasty or surgery for almost all patients whose diagnosis was confirmed. It seemed as if he had lost faith in drug treatment. His decision to implement interventional therapy became more *ad-hoc*, prompt and lesion-oriented. A substantial number of such patients had been asymptomatic, detected during routine screening. Lastly, he started taking all crucial decisions alone, as there was no provision for angio-conference or collective decision-making in his new organisation.

The junior fellow came back from a foreign assignment and joined the ex-professor.

Soon thereafter, the junior colleague noticed the drastic change in his senior's approach. One day he could not resist the temptation to ask him the reason for such a turnaround. The ex-professor replied, "Well there are many reasons. The most important reason is economic. When I was a professor, I was not worried about money. I was only concerned about quality. But now, if I don't perform a minimum number of procedures, I will lose my annual raise or even endanger my position as the director. This is a commercial organisation, you see. The other reason is that if I don't perform angioplasty or surgery in most of these patients, somebody else will, so why not me?"

Even though this story is a mixture of fact and fiction, it reflects the overwhelming trends of the day. Institutional medical practice in India today has two diametrically opposite styles of functioning, which bear little resemblance to each other. These differences have become accentuated after the introduction of high-tech medicine.

There is no doubt that many academic institutions in the country are crumbling. Talented people are leaving for greener pastures. The quality of service may be deteriorating due to shortage of funds, large number of patients, lack of vision, slow decision making and corruption. But all said and done, the primary objective of such institutions still remains patient welfare. Therefore, most physicians there find their work satisfying, despite their relatively low wages. Various checks and balances provided by seniors, juniors and contemporary colleagues prevent patient mismanagement. Serious cases and treatment alternatives are discussed on clinical rounds, before major decisions are taken. So the primary objective of optimal patient care is still achieved in the great majority of cases.

There is no dearth of vision, funds, and dynamism in the private medical sector. Such organisations should be able to provide much better care to patients. Alas, this is not always the case. The heart of the matter is that the primary aim of such institutions and the people working there is to provide service for a fee and reap the profits. This by itself may not be a bad idea, provided it is implemented without breaking basic ground rules of medicine. The most important rule perhaps is that there should be likelihood of effectiveness of a treatment and a low probability of causing harm.

Some common practices in cardiology flout the above rule of medicine. Today, cardiologists as a clan are thriving on costly invasive procedures and surgery which may not be indicated in a significant number of cases. Revascularisation of infarct-related territory and surgery for non-critical valve disease are prime examples of such misguided practices.

The problem with private medical care in this country is that there is virtually no control over its style of functioning. Doctors working in these institutions are by and large free to form their own sets of rules, irrespective of textbook guidelines. The lack of regulatory measures over medical care has caused an exorbitant and inappropriate increase in medical expenditure in this poor country. It is high time that some uniform practice guidelines are formulated and enforced strictly to curb this disturbing trend.

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