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EDITORIAL

MEDICAL ETHICS: RELATIONSHIP BETWEEN DOCTORS

"There are three subjects on which the medical profession in general, is becoming weak. They are manners, morals and medicine." The set of moral principles that guide members of the medical profession in their dealings with each other, is termed etiquette of professional relationships. The basis of a good relationship between doctors lies in mutual respect and understanding.

A physician should consider it a privilege to render service to his colleagues and their immediate dependants. The Indian code of ethics urges a physician to "cheerfully render professional services to his physician-colleagues and their immediate family members without seeking monetary compensation". In this context, the terms 'immediate family' and 'dependants' require definition. The immediate family consists of parents, spouse and children. Dependants include non-earning members of the family dependent upon the doctor. Unfortunately majority of medical professional are uncomfortable extending any concessions to their colleagues.

Many of the doctors enjoy listening to patients complaining about how they have been treated or mishandled by other doctors. A patient who dislikes or develops a grouse against a doctor based on some real or imagined mistake can be extremely disparaging and indiscreet in his manner of speech. The mature doctor would do well to refrain from listening to this tirade against a colleague. If, however, he cannot restrain the agitated patient, he must studiously refrain from making any comment that could possibly be construed as acceptance of the patient's criticism.

The Medical Council of India states that a practitioner in whatsoever form of practice, should take positive steps to satisfy himself that a patient is not already under the active care of another practitioner before he accepts him. Implementing this directive is not an easy task in a country like ours where patients often switch doctors at will. Patients literally go shopping from clinic to clinic, or from hospital to hospital for doctor's opinions. Unscrupulous doctors readily accept any and every patient, often with full knowledge that the patient is under the care of a colleague. Such a commercial approach to patient care reduces the profession to a business venture.

Ethics in consultations

Consultations are a time-honoured custom and they should be encouraged in cases of serious illnesses, especially in doubtful or difficult conditions. The rights of the patient to ask for a second opinion should be respected. No medical practitioner can claim to be a specialist in every branch of medicine.

Important circumstances under which a practitioner should ask for a consultation are 'in serious illness or in doubtful conditions'. In the event of irreconcilable difference of opinion between the two doctors, the circumstances should be impartially and frankly explained to the patient concerned. It is now up to the patient to decide which of these he will follow or, indeed, whether he will seek further advice from a new consultant.

Regarding ethics of consultation, the International Code of Ethics has summarized as follows:

- The attendance of the practitioner should cease when the consultation is concluded, unless the patient has dispensed with the services of his first doctor and engaged those of another.
- In no case should the consultant treat the patient alone or hand him over to his assistant or admit him to a nursing home or hospital without the knowledge of the referring physician. (Emergencies form an exception to this rule).
- When a consultant sees a patient in his rooms at the request of a medical practitioner, it is his duty to write to the latter, stating his opinion on the case and the line of treatment he thinks should be adopted.
- A doctor called upon in an emergency must treat the patient, but after the crisis, the consultant must retire in favour of the original attendant of the patient.
- Unnecessary consultations should be avoided
- Utmost punctuality should be observed by a physician in making themselves available for consultations.

It is advised that the fee be on par with those charged by his colleagues. The practice of splitting fees must be condemned as infamous conduct. A medical man is a professional. He is not doing business. Splitting of fees stinks of commercialism. Dichotomy or splitting of fees is illegal.

Let us pledge today

- We will uphold the dignity and honor of our profession. We will treat our colleagues with all respect and dignity
- It will be our privilege and pleasure to render gratuitous services to all physicians and their family members.
- We will abide by the code of medical ethics as enunciated in Indian Medical Council (Professional conduct, etiquettes, ethics)

Dr. A. K. Dewan
Medical Director

WORLD NO TOBACCO DAY (31ST MAY 2016)

Theme: Get ready for plain packaging

For this year campaign, WHO and the Secretariat of the WHO (FCTC) Framework Convention on Tobacco Control are calling countries to get ready for plain standardized packaging of tobacco products.

Plain packaging is an important demand reduction measure that reduces the attractiveness of tobacco products, restricts use of tobacco packaging as a form of tobacco advertising and promotion, limits misleading packaging and labeling and increases the effectiveness of health warnings.

Every year on 31st May WHO and partners mark World No Tobacco Day (WNTD) highlighting the health risk associated with tobacco use and advocating the effective policies to reduce tobacco consumption.

2. Facilitate policy development by member states and the globalization of plain packaging by providing informative compelling and persuable information.
3. Encourage member states to strengthen packaging and labeling measures and restriction on advertising, promotion and sponsorship as they work towards plain packaging is a step wise approach.
4. Support members states and civil society against tobacco industry interference in political process leading to adoption of plain packaging laws.

Facts about plain packaging

- In December 2012 Australia became the first country to fully implement plain packaging.
- In 2015 Ireland, the United Kingdom of Great Britain and Northern Ireland and France all passed laws to implement plain packaging from May 2016.
- A number of countries are in advanced stages of considering adoption of plain packaging laws.

What about India

A study conducted by WHO and the Health Ministry had revealed that 76% of Indian movies had tobacco use and 52% of children in India, who had their first smoke were influenced by tobacco use depicted in movies.

The new Pictorial Health warnings notified by the Ministry of Health and Family Welfare vide Gazetted notification on 27/5/2011, has come to be effective from Dec. 1, 2011 which means that every person engaged directly or indirectly in the production, supply, import or distribution of cigarettes or any other tobacco products shall ensure that all tobacco products packages shall have specified healthy warnings as prescribed. Violation will be a punishable offence.

The Ministry of Health and Family Welfare notified that all tobacco products should have 85% pictorial warnings to be effective from 1/4/14. However the parliamentary panel on subordinate legislation termed the government move as too harsh and recommended 50% pictorial warning on all packets of tobacco products. However the recommendations of the committee were not binding on the health ministry.

On 4/5/2016 a bench of two judges in Supreme court, gave in its order that the manufacturers had a duty to inform people about the harmful effects of tobacco. The supreme court directed tobacco manufacturing firms to comply with a 2014 rule and display warnings across 85% of the surface of packets of cigarette and other commodities till the validity of the law is decided by the court, passed the order on a batch of petitions filed by the manufacturers challenging the rule.

Harmful Effects of Tobacco

1. Cancer of lung, oral cavity, larynx, food pipe, urinary bladder, prostate, uterus, cervix and stomach and colon.
2. Cardiovascular: coronary artery disease, hypertension, cholesterol disorder, peripheral vascular disease.
3. Pulmonary: Bronchitis, emphysema, chest infection.
4. Pregnancy: Low weight baby, premature death
5. Children due to second hand smoke chest infection
6. Nervous system: slow down nervous activity.
7. Gastro Intestinal: loss of appetite, change of taste
8. Sex leading to impotency
9. Skin: early onset of old age.

Dr. J.G. Sharma / Dr. Indu Aggarwal
Preventive Oncology Department

Let our experts help you quit tobacco
Call for free tobacco cessation advice at
+91-11-47022007 (Monday to Saturday; 10:00am to 04:00pm)

RENAL REPLACEMENT THERAPY IN SICK PATIENTS

Sepsis remains the commonest cause of mortality in ICUs across the globe despite the advancements in care. The mortality increases with associated complications like ARDS (Acute Respiratory Distress Syndrome), AKI (Acute Kidney Injury), etc. In many studies, the mortality may be as high as 70% with associated AKI. The morbidity and mortality is even higher in oncology patients.

AKI is a common pathology in the intensive care unit (ICU) and postoperative setting it is often associated with hemodynamic instability requiring fluid resuscitation with large volumes of fluid. Fluid accumulation has a significant relationship with adverse outcomes, including increased mortality and reduced renal function recovery. Oliguria has been shown to be associated with a poorer prognosis.

Indian Scenario

In India, AKI occurs in 5.7 to 24% of ICU patients. It is commonly associated with multi-organ failure, pre-existing renal disease, sepsis, and renal hypoperfusion. Renal Replacement Therapy (RRT) is reportedly used in 51-82% of patients with AKI in ICU. Mortality of patients with AKI in ICU ranges from 46.8% to 60% and use of vasopressors, mechanical ventilation, shock (septic and cardiogenic) have been used as independent predictors of mortality

The spectrum of ICU patients developing AKI and the age profile in the Indian patient population is nearly similar to ICUs in the developed world. Acute RRT is used in 8–10 % of critically ill patients, to support injured or overtly failing kidneys in the context of multiple organ dysfunction syndrome. RRT utilization is increasing steadily.The incidence of acute RRT has increased by greater than 10 % per year over the past decade. Continuous renal replacement therapy (CRRT) remains the most common form of RRT used in ICU settings.

CRRT is being used for extended indications in sepsis and acute liver failure other than below listed indications:

a) hyperkalemia
b) severe congestion
c) profound acidosis
d) pulmonary edema
e) uremic conditions

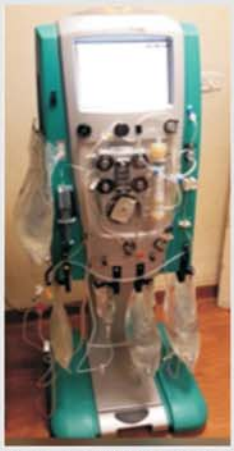

Figure 1: CRRT equipment.

CRRT permits gradual fluid and solute removal. It has been associated with greater hemodynamic stability and a higher likelihood of kidney recovery as compared to standard intermittent hemodialysis (IHD). Perceived advantages of CRRT over IHD in critical illness include:

a) Adequate volume of nutrition without compromising fluid balance
b) Decreased vasopressor requirements during fluid control
c) Increased hemodynamic stability
d) Optimizes fluid balance in lung injury
e) Continuous control of fluid balance

Another critical aspect is that compared with IHD, initiation of CRRT in critically ill adults with AKI is associated with improved long-term recovery of kidney functionwith a lower likelihood of chronic dialysis. These perceived advantages have contributed to the widespread uptake of CRRT as the first-choice RRT in ICUs globally. In these regions, CRRT is usually initiated, prescribed and managed within the ICU, with RRT being integrated with other aspects of the management of critical illness. However, the definitive timing of initiation remains controversial. Some studies suggest that earlier initiation of CRRT has been associated with better survival.

Modality selection for RRT in ICU (IHD v/s CRRT) still remains a point of debate as IHD is reportedly equivalent to CRRT in terms of overall survival. Moreover, the logistic burden of administering CRRT, including the need for anticoagulation and specialized pre-manufactured solutions, and overall higher costs, as well as the need to frequently interrupt therapy to allow for off-unit testing and procedures, detract from the theoretical benefits of this modality.

The CRRT as a mode of providing RRT has been introduced at RGCIRC two years ago. Since then it has been utilized for many patients. The protocols for the treatment have been established. The ICU nursing staff and technical staff have been trained in operations of the machine. They have become familiar with various associated protocols like; effluent volume dose, anticoagulation, electrolyte imbalance correction, troubleshooting, etc.

Here we will like to share an interesting case. The patient, 51 year old female, a case of undiagnosed pelvic malignancy was admitted to RGCIRC for evaluation and treatment. The patient was a known diabetic and had pacemaker in situ. The patient suffered a 'near-cardiac arrest' situation during an endoscopic evaluation and was resuscitated and was provided ventilator and

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inotropic support. Her left ventricle ejection fraction(EF) was 15%. Following the adverse event, the patient developed sepsis with AKI. Two days after the event, RRT was suggested. Despite high doses of noradrenaline infusion her mean arterial pressure was barely above 65mmHg. She also had atrial fibrillation, ventricular ectopics, CVP more than 20 mmHg and metabolic and lactic acidosis. After a lot of deliberations, it was decided to initiate CRRT. After initiation, the patient gradually improved. The vasopressors were also slowly weaned off, RT feeding was initiated. Her EF improved to 36% and later 46%. Patient was extubated 10th day after intubation. The CRRT was continued for total 11 days. Following that her renal function had shown improvement.

To conclude, despite the advances incritical care, AKI increases mortality in ICU. Careful and timely selection of modality for RRT can be beneficial and lifesaving for many patients.

Dr. Lalit Sehgal
Head, LTACC (SICU)

CONTINUING MEDICAL EDUCATION PROGRAMME – IMA FARRUKHABAD

RGCIRC organized a CME Programme on Oncology in association with IMA, Farrukhabad, U.P. on Sunday, 1st May 2016. Dr. A. K. Dewan, Medical Director and Chief of Head & Neck Surgical Oncology delivered a talk on "Cancer Care at RGCIRC" & Dr. Sajjan Rajpurohit, Consultant – Medical Oncology spoke on "Cancer in General Practice – Family Physician Perspective". The talks were attended by more than 60 doctors from Farrukhabad.

CONTINUING MEDICAL EDUCATION PROGRAMME – IMA INDORE

RGCIRC organized a CME Programme on Oncology in association with IMA, Indore, M.P. on Saturday, 7th May 2016. Dr. A. K. Dewan, Medical Director and Chief of Head & Neck Surgical Oncology delivered a talk on "What is Latest in Oncology" & Dr. Narendra Agarwal, Consultant – Hemato Oncology spoke on "Bone Marrow Transplant at RGCIRC". The talks were attended by more than 50 doctors from Indore.

We would like to keep you abreast of the latest developments at RGCIRC. Please send us your updated address, contact number and email id at marketing@rgcirc.org


Architect's Impression of RGCIRC (post expansion)

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Editor : Dr. A. K. DEWAN