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NewsLetter

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EDITORIAL

DEFENSIVE MEDICINE

Defensive medicine is defined as the needless ordering of tests, procedures, and visits and/or referrals, or avoidance of high-risk patients or procedures, primarily to reduce malpractice liability. Defensive medicine is the situation in which a doctor practices medicine, either through diagnosis or treatment, not to help the patient, but rather to prevent legal action (a malpractice suit) if a problem occurs. The doctor goes beyond what is usually necessary for diagnosing and treating the patient so they can ensure they are not missing any unlikely but possible condition. They may perform procedures that the patient wants or expects even if they aren't clinically necessary, to keep the patient satisfied. For these reasons, defensive medicine is said to lead to overtesting and overtreatment. They want to prevent bad outcomes (however unlikely) and to prevent having an angry patient. But this overtesting and overtreatment may contribute to as much as 34% of the additional annual healthcare cost. It is observed that amongst obstetricians, C-sections are often thought to be defensively motivated, the doctors with higher C-section rates are also sued less often.

Another aspect of defensive medicine is when a physician avoids treating high-risk patients. They cherry-pick patients who are more likely to have good outcomes, or they choose a medical specialty that has less risk of malpractice suits. This can result in the most talented doctors not treating the patients who need their skills the most. Overtreatment with antibiotics is an example of defensive medicine that endangers everyone. A parent may expect a prescription for antibiotics when she takes her child to the doctor for a cold. The doctor knows it isn't needed, but the mother insists on getting a prescription. The doctor gives in. Now the child's normal bacteria are killed by the antibiotic, leaving only antibiotic-resistant bacteria. As this occurs, again and again, strains such as MRSA develop that are resistant to most antibiotics and can sicken and kill many patients.

Another common situation is when a middle age man enters the emergency room with chest pain. The attending physician diagnoses him with indigestion. The physician wants the man to change his diet, take medication and go home. But due to a worried look on the faces of the patient and his wife, the doctor has second thoughts. Despite his conviction that the diagnosis is correct, the physician orders a battery of tests to rule out a heart attack, and everything is normal. This is called defensive medicine. These tests cost tens of thousands of rupees and though not medically necessary, were obtained to protect the doctor from a potential lawsuit in the event that he missed something.

Defensive medicine has been practiced for decades and spread to countries the world over to become an epidemic, causing unnecessary hospitalizations, tests, invasive procedures, drug prescriptions, consultations with other physicians, avoidance of high risk patients, and congested waiting lists. This can cause serious consequences. Clinical medicine has always been based on patient physician trust, Unfortunately, this fundamental trust has been progressively eroded by lack of patient face-time, increasing lack of clinical autonomy, and liability concerns. Survey of America's Physicians (17236 physicians)gave a dismaying picture of the medical profession: just 14% of physicians surveyed have the necessary time to provide the highest levels of care, 60% have been detracted from patient interaction by electronic health records, 54% have a negative morale, 49% suffer from profession to their children, 48% intend to reduce hours, retire, get a non-clinical job, or limit patient access to their practices, and only 37% have positive feelings about the future of the medical profession. This is not a picture limited to one country. On the contrary, these feelings are increasingly shared by doctors in many other countries. Physicians spend more time inserting data into a computer than at directly caring for their patients, for each hour doctors give direct clinical face time to patients, approximately two further hours are spent on electronic health records. Caring is not only about examining patients, ordering tests and prescribing drugs. It is about spending time with patients, being at their side, talking to them without hurrying, showing a sincere interest in their condition and in its social implications, answering their questions, and addressing their concerns. If this relationship is lost or diminished to unacceptable levels, then defensive medicine is the logical consequence.

Another issue is the fact that patients, who are well informed and educate themselves via the internet, are ultimately in search of experienced physicians who they can trust and who will look after them. Are patients looking for doctors who rigidly follow algorithms and guidelines? They aren't. As much as a recipe book does not guarantee success in cooking, so clinical guidelines cannot guarantee success in diagnosis or treatment. Medicine cannot be, and is not as black and white as protocols and checklists seem to imply. Physicians and surgeons must decide on the basis of imperfect data, and face unpredictable patient responses to treatment and outcomes that are not black and white. It is time to stop disproportionate ordering of tests in an attempt to achieve an unobtainable diagnostic certainty. Hence the public and the physicians need to be educated that medicine is not a perfect science but rather an imperfect art, as it always has been. It is a huge mistake to expect perfection and totally predictable results that no one can guarantee even in the most technologically advanced environment. Coupled with the modern society's lack of tolerance for inevitable morbidity and mortality, poor outcome is then presumed to indicate a wrong process. When doctors are involved in an unexpected adverse event and/or patient related harm, they are sued by the patient or relatives.

In conclusion, defensive medicine is the consequence of a deep crisis in the relationship between doctors and society. The increasing pressure to examine more and more patients in a short period of time, and to get patients out of the hospital faster and faster needs to be stopped. Physicians must of course know the best and most current evidence in their fields. Continuing efforts must be made to educate the public that information acquired from online sources outside of an appropriate clinical context is generally inappropriate. Also, the media should realize the extremely damaging nature of reporting presumed medical errors and subjecting physicians to public trials through newspapers, radios, television or websites before they are eventually judged in court. We exhort colleagues not to succumb to pressure from the system, the patients, and their peers, and we urge healthcare administrators, policymakers, patients' organizations and journalists to cooperate and make healthcare systems better and safer.

Dr. A. K. Dewan
Director - Surgical Oncology

EMOTIONAL DISTRESS AND COPING IN CANCER, TRANSFORMS INTO A "NEW ME"

In the last newsletter, Dr. A. K. Dewan addressed what is Total Pain beautifully. Total pain includes physical, social, financial psycho-spiritual and emotional aspects given by Dame Cicely Saunders founder of the modern Hospice Care. Let us look all the symptoms one by one, but I will be focusing today on the symptom most under diagnosed, under treated, under researched and under reported i.e., emotional distress. Emotions are inherent in humans and color all the activities we do every day as happiness and sadness. Emotions are the most important engine in our lives. It facilitates the adaptation to environmental demands; influence the cognitive superior processes, for example, perception, thinking, decision-making, beliefs, motivation, learning, memory and our behavior and intentions.

Emotions are based on all physical symptoms, fears, uncertainty, or a change in sense of self. Cancer is a distress situation. Distress is experienced as a persistent phenomenon from intermittent to chronic, and from mild to severely debilitating conditions. Thus, emotional distress is common among patients and families living with a serious illness like cancer. Most of the patients report that emotional wellbeing is one of the biggest influencers on their quality of life other than pain and fatigue. Hence, it is important for the clinician and caregivers to conduct a screening and assessment for emotional distress and identify several ways to manage distress for those living with cancer.

Major causes of emotional distress are uncertainty of future, appearance of one's looks, change in sense of self, thinking who am I and gaps in early and honest communication with the patient and caregivers. **We are living with the illusion of life of being safe.** However **reality is with the cancer patients.**

How do we recognize emotional distress? Are there any signs that a person may give without directly telling us? What can providers or caregivers do to enhance our vision to recognize these signs? Numerous such pestilent feelings and emotion is normal through this process. As providers, we should make time to acknowledge, the emotions of the patients and caregivers also at transition points for example when disclosing the bad news of recurrence. Good communication skills such as open-ended questions, engaging body language, and empathy with the power of listening more and more will help in building rapport and create opportunity for a thorough assessment of distress. It is necessary not only to ask them about their emotional reactions, worries or what is the most important for them but also to observe their reactions through their open behavior. In this sense, it is important to analyze the external signs of emotional distress, an assessment that can provide clues to team members to do a global emotional appraisal. These signs are very relevant, particularly in those who do not express openly their feelings or when communication is difficult. In addition, caregivers may need to be reminded to find something that feels rejuvenating and relaxing for self-care. If experiencing significant emotional distress, it may be helpful to visit a palliative care team who can help provide techniques and resources to help.

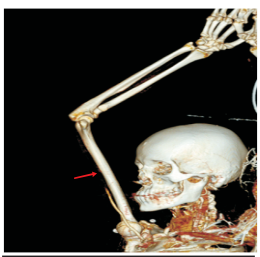
Pain and Palliative care more appropriately **the supportive care** team addresses the relationship between disease, stress, social roles and emotional manifestations to improve quality of life for not only the patients but also their families. Team always educates the patients about emotional stress coping strategies. Help the patients to remove their guilt and with good integration of mind and body encourage them to keep on working in engaging one self and remove barriers. Guide families to think about short-term plans and even facilitate these plans to help them feel more engaged in living life in the present.

To conclude, we must consider taking care of this important aspect of distress additionally in cancer which will help patients and caregivers to realize their inner strength to play this game in a better way. Henceforth, we will help our patients in transforming a "New me".

Dr. Bablesh Mahawar
Consultant – Department of Pain and Palliative Care

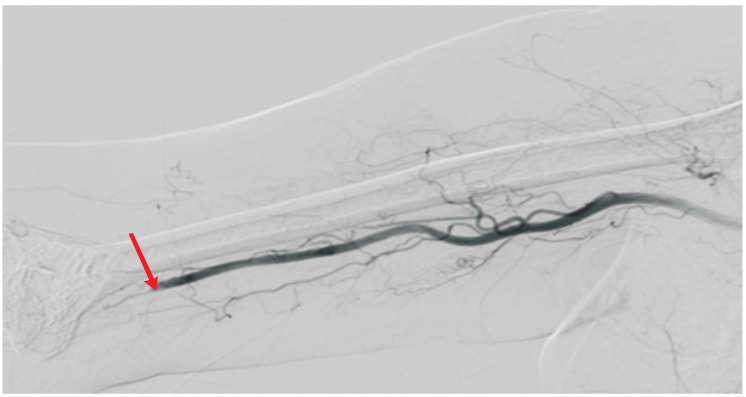
CATHETER DIRECTED INTRA-ARTERIAL THROMBOLYSIS TO SAVE A LIMB

A 62 years old lady, (follow up case of carcinoma gall bladder, on NACT, post 3 cycles) presented in the emergency department at 11 in the night on June 15, with the characteristic "6 Ps" of right hand pain, paralysis, paraesthesia, pulse-lessness, pallor and polar. An urgent CT angiography was done which showed an obstructive thrombus in right brachial artery with non-visualization of vessels distally in the forearm.



CT Angiography VR Image showing non visualization of brachial artery beyond the mid arm level.

On Doppler assessment, there was absent arterial flow in radial and ulnar arteries and their distal branches. Muscle paralysis and sensory loss was partial and venous signal on Doppler was audible. Based on these assessment parameters, this acute ischemia was salvageable if treated as an emergency i.e. threatened (Rutherford classification IIb). Hence. the patient was taken up in the Cath Lab for an urgent catheter directed intra-arterial thrombolysis.

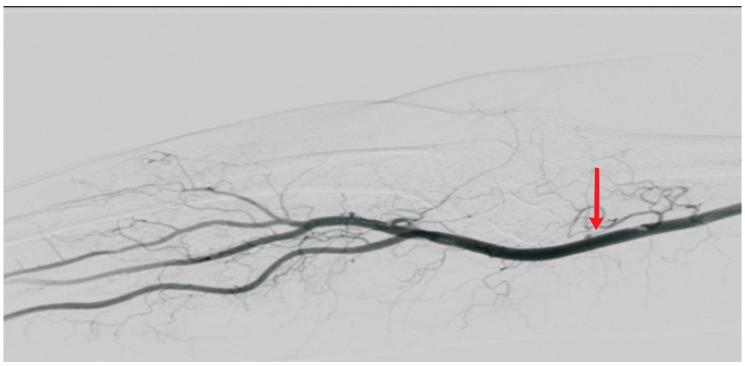


DSA showing complete cut off of right brachial artery.

After cannulating the right brachial artery, angiogram revealed complete occlusion of the artery proximal to the elbow joint with no flow into the distal vessels. After giving a bolus of Inj. Reteplase, 12 hour continuous infusion was started for catheter directed thrombolysis.

Check angiogram taken 12 hours later showed complete clearance of the embolus with good flow into the distal arteries of the forearm and hand. Thrombolysis was continued for another 24 hours.

Post completion of treatment, right hand was assessed, which showed normal perfusion with normal pulse oximetry findings and complete resolution of pain and paralysis.



DSA showing recanalization of the right brachial artery with good distal flow.

As restoration of antegrade flow and dissolution of at least 95% of the occlusion is the consensus definition of technical success, this procedure was a complete technical success and saved the patient from an amputation.

The entire Cath Lab team worked till 5 in the morning for this case and we were so happy to see the patient get discharged with a wonderful smile on her face.

Department of Radiology

PAINCON 2019

RGCIRC garnered another feather in its cap when it successfully conducted two days national level PAINCON 2019 under the aegis of ISSP from 29th to 30th June 2019. On day one preconference event was organized on Interventional Fluoroscopic and USG Guided Pain Workshop at RGCIRC, Niti Bagh, South Delhi and Interactive Palliative Care Workshop at Hotel The Visaya, Panchsheel Park, New Delhi & on second day the Academic Conference was organized at PHD Chamber of Commerce and Industry, Hauz Khas, New Delhi.

The conference offered two days of intense academic activities spanning didactic lectures, live workshops, panel discussions. The aim of PAINCON 2019 was to highlight the role of Pain & Palliative care in management of Cancer patients. The importance of early Interventions by trained pain specialists was emphasized by various panelists during detailed discussions on current and future trends. There was an emphasis on an "interdisciplinary" approach signifying the need for the relevant specialties to communicate efficiently to ensure optimal patient benefit in terms of pain control & patient satisfaction. Pain Medicine is a rapidly evolving domain in medicine & with the cancer burden always on the rise, a robust system to tackle the dreaded symptom of PAIN is the need of the hour.

This conclave turned out to be a huge success with an enthusiastic participation from all parts of India. The event provided the platform where delegates interacted with the national esteemed faculty and refined their knowledge in all the respective fields of pain management. The conference provided the ideal forum where not only the latest happenings in the field of pain management were discussed, it also unveiled the upcoming approach, research work and the scope of future advancements in pain management.

PAINCON 2019 was organized by team consisting of Dr. Malvinder Sahi, Organizing Chairman and Dr. Sunny Malik, Organizing Secretary.

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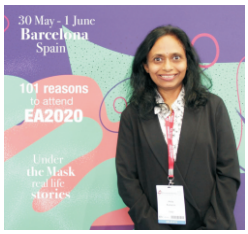

RGCIRC participated in European Society of Anaesthesiolgy Congress 2019 on 1st - 3rd June 2019 at Vienna, Austria. Dr. Anita Kulkarni , Sr. Consultant - Department of Anaesthesia presented an abstract on Transoesophageal Echocardiography measured Left Ventricular End Diastolic Area (LVEDA) as guide for goal directed fluid therapy in major abdominal oncosurgeries. LVEDA is predictable and sensitive preload parameter for fluid therapy and is also good indicator for fluid responsiveness when compared to standard central venous pressure measurement. According to our study observations and conclusion, patients receiving goal directed fluid according to LVEDA had decreased incidence of postoperative renal dysfunction, early return of bowel sounds and reduced ICU stay.

DOCTOR'S DAY CELEBRATION 2019

Doctor's Day was celebrated with much fervor on Monday, 1st July 2019 at Hotel Crowne Plaza, Rohini, Delhi. The opening remarks were delivered by Mr. D. S. Negi, CEO, Dr. Sudhir K. Rawal, Medical Director, RGCIRC, Rohini and Dr. Gauri Kapoor, Medical Director, RGCIRC, Niti Bagh. In healthcare organizations, all over the world, this day is recognized for contributions of physicians in saving human lives. In India, the date coincides with the birthday of the legendary Bharat Ratna awardee Dr. B. C. Roy. The day was marked by celebrations in the evening with mouth organ played by Dr. Sunil K. Khetarpal, Chief of Operation and Medical Superintendent and Dr. Rajan Arora, Sr. Consultant - Cosmetic, Plastic and Reconstructive Surgeon, flute played by Dr. Narendra Agarwal, Sr. Consultant – Hemato Oncology & BMT. Dance performed by Dr. Navneet Singh, Senior Physiotherapist, songs sung by Dr. Moushumi Suryavanshi, Sr. Consultant – Molecular Diagnostics and Dr. Payal Malhotra from Pediatric Hematology Oncology and Mr. Raj Kumar. The said performances were very well appreciated by the gathering.

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Editor: Dr. A. K. Dewan