

# “Ethics & Surgery in 21st Century”



## ASI consensus statement (Vapi declaration)

The first ever dedicated single theme conference on Ethical Surgical Practice

### "Ethics & Surgery in 21st Century"

2nd September, 2017- Venue: Meril Academy, Vapi (Gujarat)

Organized by



# ASI

THE ASSOCIATION OF  
SURGEONS OF INDIA

Dr. Shiva K. Misra  
(President - ASI)

Dr. J.W. Ebenesh Bensam  
(Hon. Secretary)

Dr. Ashok Mehta  
(Convener)

Dr. Sanjay Jain  
(Co-convener)

# THE ASSOCIATION OF SURGEONS OF INDIA

## EXECUTIVE COMMITTEE MEMBERS 2016-2018



Dr. Shiva K. Misra  
President

Dr. Dilip Gode  
President Elect

Dr. J W Ebenesh Bensam  
Honorary Secretary

Dr. C Raja Krishna Prasad  
Honorary Treasurer

Dr. G Laxmana Sastry  
Secretary Hqrs

Dr. Sanjay Kumar Jain  
Joint Secretary

Dr. Santhosh John Abraham  
Director Surgical Studies

Dr. Chintamani  
Chairman / Chief Editor IJS

Dr. T Narayana Rao  
Secretary – Website

Dr. T Narayana Rao, Vizag  
Dr. Vakamudi Prakash, Nellore  
Dr. Ramanamurthy P.V, Vijayawada  
Dr. Sarbeswar Bora, Nagaon  
Dr. Alok Abhijit, Patna  
Dr. Sitaram Prasad Singh, Sitamarhi  
Dr. Bindey Kumar, Patna  
Dr. Siddharth Tamaskar, Raipur  
Dr. Srivastava K.N, New Delhi  
Dr. Rana A.K Singh, New Delhi  
Dr. Bharat Panchal, Ahmedabad  
Dr. Pankaj R. Modi, Ahmedabad  
Dr. Gunwant Rathod, Ahmedabad  
Dr. Bhardwaj SS, Bhiwani  
Dr. Fazlul Qadir Parray, Srinagar  
Dr. Satish Kumar Midha, Ranchi  
Dr. Sadashivayya Soppimath, Hubli  
Dr. Ashok Godhi, Belgaum  
Dr. Aravind Patel, Bellary  
Dr. Siddesh G, Mysuru  
Dr. Y.M. Fazil Marickar, Trivandrum  
Dr. C Karthikeyan, Trivandrum  
Dr. R Padmakumar, Cochin  
Dr. Abhay Narendra Dalvi, Mumbai  
Dr. Dilip S Gode, Nagpur

Dr. Jaisingh Shinde, Pune  
Dr. Manoj Jain, Nashik  
Dr. Sanjay Kumar Jain, Bhopal  
Dr. Mukesh Shrivastava, Jabalpur  
Dr. Achal Gupta, Gwalior  
Dr. Chitta Ranjan Das, Bhubaneswar  
Dr. Sreejoy Patnaik, Cuttack  
Dr. Chanjiv Singh, Jalandhar  
Dr. U S Dhaliwal, Amritsar  
Dr. Raj Govind Sharma, Jaipur  
Dr. Shyam Bhutra, Ajmer  
Dr. Raj Kamal Jenaw, Jaipur  
Dr. J W Ebenesh Bensam, Nagercoil  
Dr. Sai Krishna Vittal, Chennai  
Dr. N T Srinivasan, Kovilpatti  
Dr. S R Subrammanian, Chennai  
Dr. G Laxmana Sastry, Hyderabad  
Dr. G Kanakaraju, Kothagudem  
Dr. C R K Prasad, Hyderabad  
Dr. Ashutosh Sayana, Haldwani  
Dr. Nikhil Singh, Lucknow  
Dr. Sharma J P, Dehradun  
Dr. Probal Neogi, Allahabad  
Dr. Diptendra Kumar Sarkar, Kolkata  
Dr. Gargi Bandyopadhyay, Kolkata  
Dr. Makhan Lal Saha, Kolkata

## **SECTIONAL REPRESENTATIVES (GC) 2017**

Dr. M Velusamy, Sathur, President – Association of Surgeons of Rural India (ASRI)

Dr. V Sitaram, Kolkata, President – Indian Association of Surgical Gastroenterology (IASG)

Dr. B K C Mohan Prasad, Madurai, President – Indian Association of Surgical Oncology (IASO)

## **CO – OPTED GC MEMBERS - 2017**

Dr. Jayant (Naraina) V Bhandare, Panaji - Chairman - Goa State Chapter of ASI

Dr. S Rajendra Singh, Imphal - Chairman - Manipur State Chapter of ASI

Dr. Pratap Sanyal, Agartala - Chairman - Tripura State Chapter of ASI

Dr. Ramesh Bharti, Tanda - Chairman – Northern Chapter of ASI

Dr. Somnath Ghosh – Chairman – West Bengal State Chapter of ASI

## **CONTRIBUTERS:**

1. Dr. Shiva K. Misra, President
2. Dr. Ashok Mehta, Past President
3. Dr. K S Shekhar, Past President
4. Dr. V N Shrikhande, Mumbai
5. Dr. B Krishna Rau, Past President
6. Dr. R P Srivastava, Past President
7. Dr. Santhosh John Abraham, Past President
8. Dr. Suresh Chandra Hari, Past President
9. Dr. M C Misra, New Delhi
10. Dr. J W Ebenesh Bensam, Honorary Secretary
11. Dr. C R K Prasad, Honorary Treasurer
12. Dr. Sanjay Jain, Joint Secretary
13. Dr. G Laxmana Sastry, Secretary – Hqrs
14. Dr. T Narayana Rao, Website Secretary
15. Dr. Dilip Gode, Nagpur
16. Dr. Chintamani, Chairman / Chief Editor – IJS
17. Dr. Fazil Marickar, Trivandrum
18. Dr. C Karthikeyan, Trivandrum
19. Dr. Rana A K Singh, New Delhi
20. Dr. K N Srivastava, New Delhi
21. Dr. Kanaka Raju, Kothagudem
22. Dr. Vinayak Senthil, Chennai
23. Dr. Vivekananda Subramania Nathan, Chennai
24. Dr. Om Tantia, Kolkata
25. Dr. M L Saha, Kolkata
26. Dr. Diptendra Sarkar, Kolkata
27. Dr. S S Bhardwaj, Bhiwani
28. Dr. Bhanwar Lal Yadav, Jaipur
29. Dr. Prabha Om, Jaipur
30. Dr. Shyam Bhutra, Ajmer
31. Dr. R K Jenaw, Jaipur
32. Dr. Raj Govind Sharma, Jaipur
33. Dr. Arvind Kumar, New Delhi
34. Dr. Sarbeswar Bora, Nagaon
35. Dr. Sreejoy Patnaik, Cuttack
36. Dr. C R Das, Bhubaneswar
37. Dr. Winston Noronha, Chennai
38. Dr. J P Sharma, Dehradun
39. Dr. Ramesh Agarwalla, Kolkata
40. Dr. S Soppimath, Hubli
41. Dr. Ashok Godhi, Belagavi
42. Dr. G Siddesh, Mysore
43. Dr. Shalabh Gupta, Ghaziabad
44. Dr. K C Dewani, Jabalpur
45. Dr. Nikhil Singh, Lucknow
46. Dr. M S Senthil Kumar, Chennai
47. Dr. Y S Raghuvanshi, Guna
48. Dr. P Raghu Ram, Hyderabad
49. Dr. B N Mohanty, Cuttack
50. Dr. Satish Midha, Ranchi
51. Dr. Shekhar Suradkar, Thane
52. Dr. Jaisingh Shinde, Pune
53. Dr. C S Rajan, Bangalore
54. Dr. U S Dhaliwal, Amritsar
55. Dr. Rajan Luthra, Kanpur
56. Dr. B Madhu Shekar, Armoor
57. Dr. Pradeep K Verma,
58. Dr. S K Jain, New Delhi
59. Dr. C K Durga, New Delhi
60. Dr. P K Kohli, Gurgaon

## Ethics & Surgery in 21<sup>st</sup> Century

Doctor Patient relationship is at its lowest ebb. Medical profession is receiving all time low respect and rating from all sections of the society. Corruption is rampant in the society and the doctors are also part of the same society. Majority of them are doing excellent work in given scenario in the country. Health has always been the area of low priority for both Central and State Governments. More than 80% of health care services are provided by the private sector, though it is getting more and more expensive getting out of reach for the poor or even middle income group individuals. Legislations like consumer protection act and similar legislations have been adding to the cost of healthcare delivery.

Being a surgeon is the toughest job on the planet. Profession has a long gestation period, is stressful, with long working hours and poor family life. Becoming a surgeon and establishing a decent clinical practice as per ever increasing statutory requirements, is adding to the cost of the treatment. Medical schools and corporate hospitals owned by non-medical persons with profit motive have done no good for the medical profession. Merit has been pushed to the back seat. Lust has been added to greed. Medical profession is no longer seen as a service to mankind but it is perceived as profit making healthcare industry. Patients want the best with 100% positive outcome, done through latest technology, in most comfortable settings, at lowest cost possible.



**Dr. Shiva Kant Misra**  
**President**  
The Association of  
Surgeons of India

### Indian healthcare in 21<sup>st</sup> century

“One doesn't need to be a doctor to start a hospital, just as one can start a hotel without knowing how to cook”.

Big businessmen and corporates who must invest their money in profitable ventures knew this very well. Up came gigantic buildings under the title 'advanced / world-class health care, where much was invested in the infrastructure and technology, but the quality of doctors was kept to bare minimum necessary to attract a junior most willing to accept the atrocious sharing conditions. These new 'Money Making Machines' picked up very well, because they gave the rich class an illusion that they can buy health with money, but also attracted the middle and lower classes under the ever-coveted term 'cashless'. The fear of illness and death was exploited with aggressive marketing. Many things started to change after 1992.

When one invests hundreds of crores of rupees, the profits must match. To maintain these hospitals in good economic health there must be continuous patient flow, admissions, tests, procedures and surgeries. Society is quite vulnerable to aggressive advertising and marketing as well as corrupt practices. To entice patients for paying procedures and surgeries and to develop a patient base, free camps are arranged in the interiors. 'Free' is a universally loved term, most people blindly fall for it.

The term 'whole body check-up' was invented to attract larger numbers. Unnecessary tests were suggested and offered under the false sense of health security. PROs and marketing teams of various hospitals started visiting private doctors for promotional inducements on admission / tests / surgery.

Patients with even simple illnesses that can be treated at primary healthcare center were taken to bigger cities now, and they proudly boasted how much land they sold to get the right treatment. The perpetual inadequacy or absence of federal / state healthcare infrastructure was never questioned. Those who had insurance cover started thinking that they now own all the hospitals and doctors. They started behaving as if they are obliging the doctor / hospital by choosing them. 'Only a good outcome is must because I am paying money' became a general expectation; thanklessness, threats and vandalism started with almost every bad outcome.

Applying the consumer protection act in India, with high illiteracy, poverty and political interference was the final straw. Doctors now could not treat patients based upon only clinical judgment, because the patient and the courts would demand proofs. So tests became necessary, to the point of finding a proof. Evidence based medicine led to the need for more and more laboratory and imaging investigations relegating clinical judgment even to treat simple routine conditions. Doctors and patients both started to suspect each other, and doctor patient relationship suffered.

Still some really patriotic doctors, clinics, smaller nursing homes and hospitals continued what was essential for the society, providing excellent healthcare at the low cost, to their patients based on decades of faith and trust. The 'Clinical Establishment Act' broke the very spine of such hospitals, because it made western standards blindly mandatory for Indian hospitals. More licensing and over 30 permissions led to demands for bribes, and so much paperwork and infrastructure investment, that it is now impossible to keep healthcare costs low. The only thing that was excluded from such westernization was costing. As the doctor is the only face of healthcare for the patient, the ultimate blame for higher costs was conveniently placed upon his/ her shoulder. All doctors turned villains now.

The hidden design to eradicate small hospitals and private practitioners are being successful now, given the hardships involved in running one's own hospital. Thousands of small hospitals / clinics have closed down. Doctors now must join corporate hospitals if they want to continue as specialists. They have no control over billing and hospital policies, and are asked to leave if they question them. Most people do not know that a doctor's payment is less than 10 percent of most hospital bills, a standard corporate protocol all over India, and if the doctor wants to help the patient, it is his own bill that he/ she will have to sacrifice.

Mediclaim (Medical Insurance) is still at a fraudulent stage in India, with many deserving patients being denied insurance, while many patients being allowed to misuse it. Mediclaim companies now have two fatal policies; to encourage the accreditation business, thereby making it difficult for smaller hospitals to survive, and to dictate lowest healthcare costs for hospitals and doctor's fees, whereby their own profit margin stays high. In such a scenario, the corporates either must inflate the bills or cut down on the quality of healthcare provided.

The big corporates required specialists who worked at the lowest salaries and accepted all their conditions. Those who had passed out without much merit from less academic medical colleges, those who had lower confidence and / or experience became easily available. Instead of increasing government medical colleges and seats, private medical education was encouraged, because the highest in the land profited from that policy. The society never objected, because the dream of 'buying a medical seat and ability of becoming a doctor even without merit' had become a reality. Only a few exceptional students benefit from private medical education.

To pay for electricity, water, land and building at commercial rates, to get no subsidies, to pay full taxes, and then to be told to "subsidize" patient bills for charity (whereas the government hospitals keep on increasing it regularly), is stressful. At every stage a hospital / doctor must pay bribe for permissions, with few exceptions. In fact, people expect doctors to pay higher bribes! Doctors belong to the same society, and reflect the same good and bad that the society has, there cannot be one-way blame game here. This does not mean there weren't greedy doctors; in fact the corporate policies helped some such doctors flourish too.

Even patients are mostly not happy with only honest and good treatment. They want multiple facilities and luxuries, trained staff, accreditations, cashless facility, no marketing/ referral/ cut practice, but still the lowest rates. How will smaller hospitals compete in such a scenario with the giant corporates?

In a few months / years, small hospitals and private medical practice will have been completely eradicated, the only healthcare options will be government or corporate. After defaming the entire medical profession and creating wide rifts between the society and doctors, the marketers of health and life corporates and insurance

companies, will keep on freely filling their coffers while providing compromised healthcare at all stages.

## **Objectives of the first ever single theme conference on ethics organized by ASI are-**

- To introduce the moral importance of the concept of autonomy to good surgical practice
- To evaluate the moral and legal boundaries of the doctrine of informed consent
- To explain and illustrate some practical difficulties in implementing the doctrine of informed consent
- To outline good surgical practice in withholding and withdrawing life-saving treatment
- To specify the importance and boundaries of confidentiality in good surgical practice
- To indicate why surgical research should be subject to independent evaluation and how to differentiate between such research and minor surgical innovation
- To assess the moral importance of rigorous surgical training and a willingness to criticize fellow surgeons in the face of bad practice.

Honest and sincere efforts have been made through the first ever single theme conference on Ethical Surgical Practice to come out with the consensus statement regarding the importance of Ethical Practice in 21st century and to publish it as a reference book for not only practicing surgeons but for vast medical fraternity of our country. The Association of Surgeons of India takes pride in coming out with guidelines on ethical practice. It will go a long way to bridge the gap between practicing medical professional and the patients.

## Ethics & Surgery in 21<sup>st</sup> Century

**Dr. Ashok Mehta,**  
**Former President,**  
The Association of  
Surgeons of India (1986)

Surgery is the first and the highest division of the healing art, pure in itself, perpetual in its applicability, a working product of health and sure of fame on earth wrote Susruta almost 2500 years back. Through all of Susruta's flowery language incantations and irrelevances, there shines the unmistakable picture of a great surgeon.

Susruta was a great Surgeon almost a millennium before Hippocrates who is considered Father of modern medicine by western Scholars; Susruta is therefore father of Surgery internationally! He described in detail the code of conduct similar to Hippocratic oath. Susruta Samhita is considered authoritative and was translated in Arabic in 8th century and later translated into latin.

Ethical principles of Ayurveda included general ethics, professional and academic responsibilities, ethics towards dying, preoperative, operative and postoperative care, principles of experimental surgery and avoidance of quackery. Trading in Medical skills for personal livelihood was considered as collecting a pile of dust leaving aside the heap of real gold! Thus treating patients on humanitarian grounds without desiring personal benefit in return or money were considered most respectable amongst the physicians.

Most of us who have taken to the Medical/Surgical profession have role models who inspired us at the start of our careers. Mahatma Gandhi who personally used to nurse wounds and daily massage the foot of a Sanskrit scholar Parchure Shastri suffering from leprosy was idol to my generation. Shastri went to Sevagram Ashram in 1939 to meet Mahatma, after his family disowned him. Overruling opposition from Ashram inmates Gandhi kept Shastri with him. In those years Leprosy was considered contagious & there was no curative treatment. The picture of Gandhiji nursing Shastri's foot is depicted on the postal stamp with the theme of 'Leprosy is curable'.

Similarly Dr. Albert Schweitzer was another role model who received Nobel prize in 1952 for his philosophy of 'Reverence to life'. A German by birth, he became a French citizen to go to a French colony of Gabon to serve as a missionary to atone for the sins of Europeans.

Hippocratic oath, a widely known Greek principles of medical ethics, taken in the name of healing gods, to uphold high standards of medical practice is relevant even today and is of symbolic value for the physicians emphasizing autonomy, benevolence, confidentiality, non-maleficence and justice. The oath emphasises "Do no harm" which forbids euthanasia explicitly and prohibits abortions.

American College of Surgeons pledge places welfare and rights of the patients above all. It respects patient's autonomy and individuality. Patient should be dealt with, as I would want to be treated. Treat all healthcare personnel with respect, recognizing interdependency. Surgeon practices surgery with honesty, taking no part in improper financial dealings to induce referrals or withhold treatment for reasons other than patient's welfare. The pledge also expects the surgeon to advance his knowledge and skills and seek counsel of colleagues when in doubt, helping them when requested.

In words of Albert Einstein "Setting an example is not the main means of influencing other, it is the only means". Setting a personal example is the only way to influence other regarding ethics.

A moral compass guides ethical practice of surgery besides skill in art & science of surgery. Surgeon needs to display diligence & surgical competence in medical & academic activities. He needs to be an ethical model for fellow colleagues, trainees and society in which he practices. Trustworthiness is the most important quality

from ethical and moral standpoint.

It is unique characteristic of surgery that it hurts before it heals being invasive and requiring penetration of the body of a patient, often done without being involved with the care of a patient for a long time like physicians. Surgery requires instantaneous decision under uncertain circumstances, is subject to errors and carries risks, consequences, complications of the procedure / treatment.

Doctor – Patient relationship is based on trust and is fiduciary in nature. However in view of plethora of laws, it is considered Contractual from Judicial and medico legal standpoint. It is a cry away from daily Prayer of Maimonides, a physician of 13<sup>th</sup> century who asked Almighty God to grant that his patient may have confidence in him and his art and follows his directions and counsel.

John Gregory, a Scottish physician of 18th Century (1724-73) defined medicine as an art of preserving health, prolonging life, curing diseases and making death easy. He introduced concepts for transformation of medicine from business into profession and established the grounds of medical ethics, as we know it today. Making of a good surgeon is closely linked to ethics that is at the heart of professional competence and excellence. It requires introspection or analysis of one's own mistakes and responsibility toward an individual patient as well as the society as a whole. William Halstead, father of American Surgery in 20th Century considered operations in themselves were only a small part of surgical treatment but surgeons need to commit all their energy to increase knowledge of surgical science.

Ethical implications, which take on special dimension, involve unnecessary futile surgery on a terminally ill patient. As a surgical oncologist, I have often faced the delicate problems of advanced cancer that could be removed based on one's experience and philosophy such as resecting public symphysis for advanced urinary bladder cancer or inferior vena cava for a retroperitoneal sarcoma.

Implementation, development and adoption of new technologies through innovation tend to be a process more than an event. It is necessary that all surgical interventions should be controlled, considering it imperative to assess the real value of the procedure.

Challenges in the 21st Century affect many areas such as acquisition of surgical skills, quality of surgical care, education in surgery, handling of adverse events. Modern surgery has made significant progress by making surgery less traumatic and safer due to popularisation of minimal invasive surgery, better instrumentation and visualization, use of energy and cutting devices. ICUs, nutritional support, antibiotics, antithrombotics, blood component replacements have all contributed to make surgery less risky and reducing time to recovery and early return to work.

Tremendous amount of time and efforts are spent on new educational strategies such as student-centred teaching, skill based study, problem based learning, evidence based medicine, medical computing, remote medicine etc. We achieve perfection by following the Fitts and Posner multistage theory of training in robotics and minimal invasive surgery. We use simulators to master the technology.

However we spend very little time on improving and strengthening the ethical standards based on development of values of compassion, empathy, peace, positivity and co-operation, to reduce burnout & stress among surgeons.

We suffer due to giving all attention to professional work and neglecting the family and, self care resulting in unhappiness. It is essential to have a happy surgeon, to hold high ethical standards.

A surgeon needs enthusiasm, ability to express good emotions such as peace, love, compassion, and needs suppression of bad emotions of pain, frustration, anger and fear. Traditional training lacks nonverbal soft skills



training such as guidance for enhancing qualities of calmness and compassion that are lost under the weight of shortage of time, need to earn money and desire of status.

Janki Foundation, a UK based charity dedicated to positive human development initiated a programme with acronym of VIHASA (Values in healthcare- a spiritual approach) to booster up low morale and high burnout amongst healthcare professionals. Based on concept of appreciate inquiry it is a facilitated, experiential programme and consists of eight modules.

Each module would take eight hours of group learning for 15-20 healthcare professionals in ambient surroundings, away from place of work. Each group would have a facilitator and a coordinator. Participants work individually and in pairs or small groups. Exercises are based on seven spiritual tools of Reflection, meditation, visualization, deep listening, appreciation, creativity and play. Exercises appear very simple but have a deep impact at subconscious level and help incorporate positive values and medical ethics in personal and professional life.

The programme is based on three key principles. First principle is, “Physician heal thyself “ which is polar opposite of medical training keeping patient at the centre of our activity. Surgeon is the centre of the programme. He should restore purpose, vision & values, which he cherished at the start of his carrier. He must feel good, enjoy work & prevent burnout. He needs to master coping skills – not only to survive but thrive.

Second Principle is learning through direct experience. He should understand values through facilitated, experiential learning. There would be time for silence, visualization and sharing in supportive environment. It is a unique opportunity to look within for the participant, to talk to oneself and share the experience with a partner in a positive atmosphere and confidentiality.

Third key principle is it should be relevant to his work & personal life. Whatever he learns must improve his professional work and his personal life.

Professional practice depends on training, skills, attitude, and experience. Wellbeing of everyone can be enhanced through a framework of values. How, a surgeon views himself and behaves towards others brings a new vitality to surgical practice & help him rediscover personal values. Values help gain strength through motivation. Valuing self has a positive impact on others around us. Values are foundation of ethics in practice of technology- based modern surgery.



## Conclusion:

As a professional organization representing general surgeons and specialist groups, we must draw up our own code of conduct based on our traditions and challenges of rapid technological advances. Core values of peace, positivity, compassion and co-operation can be incorporated in our training though a well conceived programme of VIHASA tried out in India and elsewhere over last decade to strengthen the foundation of medical ethics, which is needed urgently.

# Communication in Medicine – Have We Got It Right?

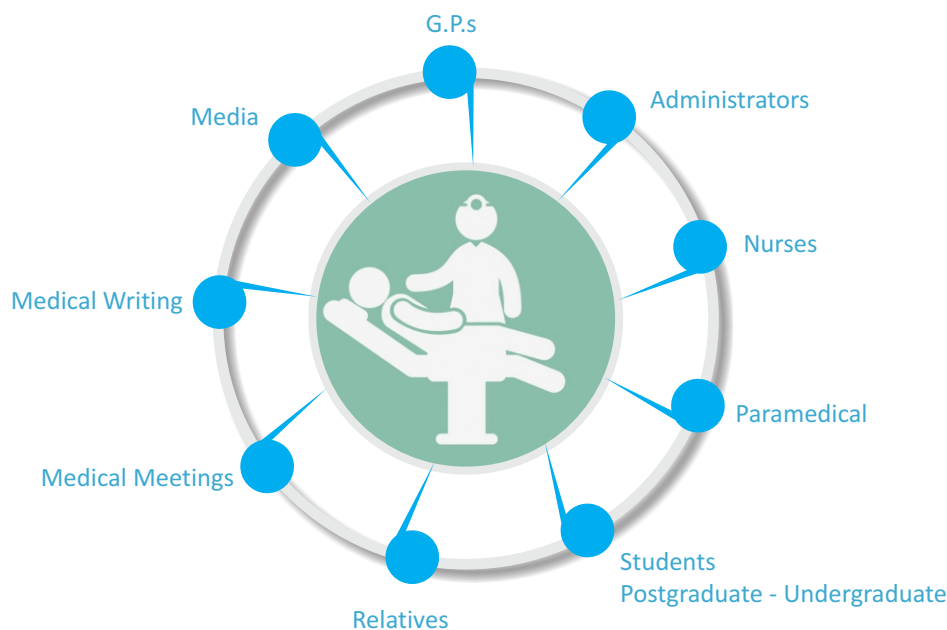
**Dr. P. Raghu Ram,**  
Overseas Coordinator,  
The Association of  
Surgeons of India

## Aims:

To highlight the importance of the art of Communication and outline ways to improve communication skills in every sphere of a Surgeon's activity.

## Facts:

Clinical competence & effective communication are essential skills for every doctor. Communication skills module is not a part of Medical Curriculum nor is it assessed. Hence, many doctors are bad at giving information.



## Doctor - patient relationship

### Ethical issue 1: **Out patient clinic**

Listening to the patient is very crucial. Listening is, in fact, more important than talking. In giving patients time and in listening to them, doctors will find some of the real rewards in practicing the art and science of surgery. In this day and age of heavy reliance on tests, one must not forget that the diagnosis of a condition, in the vast majority, can be made through good history taking and physical examination. Hence good listening is the best diagnostic weapon.

### Ethical issue 2: **Informed consent**

The Patient should be fully informed about the procedure – potential benefits and risks explained & documented clearly by the Primary treating Consultant Surgeon.

### Ethical issue 3: **Confidentiality**

Conversation between doctors & patients must remain confidential. May a time, patients discloses information, sometimes, so confidential that even his/her close relatives may not be privy to...Hence it is the duty of the doctor, never to underestimate the value of ensuring utmost confidentiality.

## Ethical issue 4 : **Ward rounds - pre operative & post operative**

It is paramount never to look down upon the patient. Whilst teaching juniors, it is important always to bear in mind to maintain the dignity of the patient.

## Ethical issue 5: **Breaking bad news**

Patients get upset when doctors fail with words. Communication is a distinct art to talk medicine in the language of the non-medical man. Compassion and empathy must be at its best whilst breaking bad news.

Key principles whilst breaking bad news and counselling cancer patients:

- Encourage participation of close family and friends
- Be honest, sympathetic and positive
- Never deny hope
- Allow airing of myths and correct them
- Anticipate interest in 'alternative' treatments
- Communicate with other members of the team – ensure a consistent approach
- Encourage a second opinion
- Be available
- LISTEN
- Never play 'god'

To keep out of law courts: to always remember the The three Cs

**Care**

**Concentration**

**Communication**

## Ethical issue 6: **Communication with colleagues**

It is always paramount to be courteous to colleagues in the operating room and never to be on 'confrontation mode' with them. One should always be kind to Nurses as they clean up after us, cover up for us and actually talk to our patients and their relatives. We must never forget to be grateful to them. Hence is essential to be kind to Nurses.

## Ethical issue 7: **Communication with media**

Whilst it is ethical to give an opinion/comment and contribute to an invited article, it is unethical to get involved in writing paid articles/advertisements in the media.

## **Conclusion:**

Communication skills need to be at its best all the way through – right from the time the patient enters the Surgeon's consulting room through seeking informed consent, Pre/Post operative ward rounds, breaking bad news... to addressing the media. It is important to master the art of Communication always remembering 'To keep the good of the patient as the highest priority'.

# Ethics & Surgery: Autonomy, Consent and Confidentially

**Dr. Sanjay Jain**  
**Hon. Joint Secretary, ASI (2017)**  
The Association of  
Surgeons of India

Respect autonomy of the patient, getting proper informed consent before any invasive surgical procedure, and maintaining the confidentiality are important, and integral part of ethical surgical practices.

## Present acts and guidelines:

Various countries, associations and boards have their guidelines. We are lacking in uniform guidelines, though there are several which are commonly referred to:

- Indian:
  - MCI - Professional Conduct, Etiquette and Ethics Regulation, 2002
  - CPA 1986 - (1993)
  - NABH - Guidebook
- International:
  - WMA - Code of Medical Ethics (1949)
  - WHO - Best Practice Protocols
  - RCS England - Good Surgical Practice

## Autonomy:

Patient's autonomy is an accepted principle. Respect the autonomy of patients & their ability to make choices over their treatments. It recognizes rights of patients to self-determination, right to make choice over their surgical care, and right to refuse any treatment. The issues of autonomy are closely linked with consent.

## Consent:

Consent refers to approval or agreement, particularly and especially after thoughtful consideration and understanding. A properly recorded consent may avoid majority of litigations and torts, but in practice, we are aware that a fully informed consent is probably never attainable in, as complexities of surgery and their many possible side effects and complications can never be explained to the nonmedical person: some of them may not even known to the medical profession. A sick person has lost some measures of autonomy. Good communication forms the soul of the concept on informed consent.

### Type of Consent:

- Implied consent
- Express consent
- Oral
- Written
- Informed consent\*
- Tacit consent
- Surrogate consent
- Blanket consent
- Informed refusal

## Consent: Principles

Before performing a procedure, it is important to receive consent from the patient. While performing any invasive and surgical procedures, it is particularly important to give a full explanation of what you are proposing, your reasons for undertaking the procedure and what you hope to find or accomplish.

Informed consent means that the patient and the patient's family understand what is to take place, including the potential risks and complications of both proceeding and not proceeding, and have given permission for a course of action. Some of important rules to follow:

- **Venue:**
  - Should be calm and quiet place
- **Principal person:**
  - The person obtaining the consent should ideally be the surgeon who will carry out the treatment. It should not be a junior member of staff. Ensure that you use language that can be understood; draw pictures and use an interpreter, if necessary. You may use images or videos available on Google.
- **Who is authorized to give consent:**
  - Self
  - Surrogate -the nearest kin.
  - None
  - If a person is too ill to give consent (for example, if unconscious) and their condition will not allow further delay, you should proceed, without formal consent, acting in the best interest of the patient.
- **Witness:**
  - Document the conversation in which consent was given and include the names of people present at the discussion.
- **Information:**
  - Should be accurate, reasonably complete, avoid technical language. Choice made free from any coercion.
  - Explanation of patient's disease
  - Recommendation of most appropriate surgery
  - Discussion of risks and benefits
  - Anticipated outcome – prognosis
  - Treatment alternatives available
  - Explanation of untreated natural history
  - Immediate and future cost.
- **Language problems:**
  - Provision of translator if necessary.
- **Clarification of doubts:**
  - Allow the patient and family members to ask questions and to think about what you have said.
- **Time:**
  - To make personal decision. It may be necessary for the patient to consult a family member or community elder who may not be present; allow time for this if the patient's condition permits.

- Consent form:
  - Template / Hand written
  - Patient's language
- Entry:
  - Is made in the medical record papers

## Practical difficulties

The difficulties in getting informed consent include:

- Refusal or waiver by patient
- Temporary unconscious patients
- Incompetence – other kind physically challenged
- Minors - Children less than 18 yrs.
- Emancipated Minors – under age 18 and married, parents of their own children, or are self-sufficiently living away from the family
- Prisoners
- Destitute
- Additional intra operative findings, change of procedure.
- Failure to identify a complication on the consent form
- Failure to properly describe a complication on the consent form
- Any other situation...

## Consent not required:

Consent may not be necessary under following circumstances:

- Examination of Medico-legal cases brought by police consent is implied under sec 53 of criminal procedure code.
- Medical examination and issue of certificates for insurance policies.
- Examination of Prisoners
- Examination under Court orders
- Request by a police officer under CR.P.C. Section 53(1)

## Confidentiality:

Physician-patient relationship is fiduciary and requires confidentiality. The principle of confidentiality is that the information a patient reveals to a surgeon is private. The surgeon is not expected to divulge information about his patient. This right to withhold information is not absolute and has limits on how and when it can be disclosed to a third party

## Breaking confidentiality:

- If the patient is threat to self or others
- Other team members – improving treatment options
- Notifiable diseases
- Public interest
- Court orders

# Maintaining Standards of Excellence & Surgical Research!!

**Prof. Chintamani**  
**Chairman/Editor in chief**  
Indian Journal of Surgery

*“Surgery is the most dangerous activity of legal society.”*  
... P.O Nystrom

The only way to survive and thrive as a surgeon in today`s world is to excel. This also applies to surgical research and that is a true challenge. The desire to excel is human and we all strive for it. While one may achieve excellence with sheer determination and hard work, would need greater effort to maintain and sustain it. This would require hard work and ethical discipline. Achieving excellence in surgery requires a range of Clinical, interpersonal & management skills.

## Lessons learnt from the Cockpit

*“If surgeons shared the fate of their patients, as pilots share that of their passengers.”*  
.....Adrian Boelen, retired pilot, Dorval, Que

Checklists form the backbone of performance in airline industry and one can learn a great deal from airlines. After introduction of checklists, the U.S. airline fatality rate dropped to 20% of what was in 1950 .No one died in a domestic airliner in 2002-2004 and that is truly remarkable. On the other hand, the estimate that up to 23,000 people died in 2004 in Canadian hospitals because of preventable adverse events is staggering. This and many such reports have forced everyone to look at the WHO checklist that is yet to be implemented in all centers especially in the developing world.

## The strengths of WHO checklist:

- Deployable in an incremental fashion
- Supported by scientific evidence and expert consensus
- Evaluated in diverse settings around the world
- Ensures adherence to established safety practices
- Minimal resources required to implement a far-reaching safety intervention

Canadian Adverse Events Study (Baker et al. 2000) showed that more than 50% of adverse events in hospitals involved surgery. The Healthcare Insurance Reciprocal of Canada reports that since inception (20 years, with most claims occurring in the last 7-8 years), surgical claims account for \$27 Million, 40% could have been prevented with the checklist or approximately \$10 Million.

The main claim types included 210 retained foreign bodies, 94 wrong body part; and, 9 wrong patients.

## Safety is **THUS** paramount and is compromised by errors.

Errors in surgery are of two types:

- **Error of execution:** failure of planned action to be completed as intended
- **Error of planning:** use of wrong plan to achieve an aim

Fixing an error would involve a person based or a system based approach [organizational accident]. It is interesting to note that most errors are due to the system related issues and therefore institution based protocols and an

organized approach would be necessary. Ensuring safety pre-operatively, during surgery and postoperatively is mandatory and would involve firm implementation of checklist. Issues like “Selecting right operation for the patient and right patient for the operation” and when /who/& where to operate would need to be addressed.

## **Surgical research:**

It is often said in the field of science and especially medicine that “if you have not documented what you think you have done, you have not done it”. Research forms the back bone of evidence to progress in the field of providing health care to our patients. Surgical research also involves adhering to the ethical guidelines that are universal.

The pillars of research ethics are **autonomy and informed consent**.

## **Autonomy and confidentiality:**

- The information a patient reveals to a surgeon is private
- This has limits on how & when it can be disclosed to a third party.
- Patient (and the person treating the patient) has right to dignity.

The scenario when confidentiality can be broken include:

- If the patient is threat to self or others
- For improving treatment options
- In Public interest

## **Informed consent:**

“Informed consent is a process in which a person agrees to participate in clinical research with complete knowledge of all relevant facts, such as the risks involved or any available alternatives. It is designed to protect individuals participating.” ..... Belmont Report

## **Functions of informed consent:**

- Promotion of individual autonomy
- Patient participation in rational decision making
- Reducing civil/ legal liability of clinician/ institution

Clinical care vs clinical research:

- Clinical care:
  - Standard clinical practice in caring for patients
- Clinical research:
  - Benefit future patients and society
  - Dealing with unknown
  - Needs to be regulated

## **Regulations are designed to:**

- Ensure quality and integrity of data collected in clinical trials /study
- Ensure that the rights, safety & welfare of research participants are protected.

## **Rights of human subject to understand:**

- The nature of research,
- Risks & benefits involved
- And to agree or not agree to participate.



## Consensus reached during the ASI conference on Bioethics:

The above issues were discussed amongst the learned delegates and a consensus was reached that is as follows:

1. ASI needs regular consensus meetings regarding the guidelines for the management of common Indian surgical conditions in a safe and reproducible manner.
2. The emphasis was to find an “Indian solution to the Indian problems” rather than replicating western trials and evidence for Indian patients.
3. Safety checklist must be implemented at all centers with a vigour taking the help of state representatives.
4. ASI would need a committee that would play a major role in monitoring that the right and safe practices are implemented and would also provide a white paper to the government.
5. ASI should play a major role in the development of curriculum for the training of Indian surgeons including those at district level. This should happen on the lines of The Royal colleges of UK and American Board.
6. ASI is already conducting workshops on scientific paper as a part of the IJS workshop series but should also ensure that research methodology workshops are included as a routine scientific activity in most conferences. For the first time these workshops have been included as a mandatory part of academic activities of ASI during ASICON and also along with the regional ASI courses.

N.B: Inputs and co-operation from all esteemed ASI members are welcome to make these guidelines even more surgeon and patient friendly.

### Acknowledgement:

Would like to congratulate, thank and compliment the ASI President Dr Shiva kant Misra and the convener of the workshop Dr Sanjay Jain for organizing such a lively, timely and vital workshop on ethics. The guidelines are by no means static and would need re-enforcements from time to time.

# Ethical issues in Surgical Practice - Professional Reimbursement

**Dr. C. S. Rajan,**  
GC Member (2010-15)  
The Association of  
Surgeons of India

Medical Services in the country stand at cross roads, with regard to its practice vis a vis the monetary compensations that the doctor receives.

Doctors are only human, and need to have all the requirements to live a decent life for themselves and their families. This is true for the surgeons too, who have to use their skills that have been acquired with great difficulty and long hard hours of work and training, to earn the monetary compensations. There is a big gray zone as to what is the adequate compensation, but certain ethical guidelines are definitely needed to allow a fair surgical practice for both the surgeon and the patient.

The idealistic values learned in medical College, CHANGE when the doctor steps out from a world of 'practice of medicine' to one of 'medical practice'. 'Practical' adjustments are required to be made in clinical and therapeutic decisions, with open offers of referral of patients for a predetermined and regularized practice of fee-sharing ('cut practice').

The MCI (Medical Council of India) has revised the Ethical Guidelines for the practice of Medicine in India. These are available as

## **CODE OF ETHICS REGULATIONS, 2002**

**(AMENDED UPTO 8th OCTOBER 2016)**

**(Published in Part III, Section 4 of the Gazette of India, dated 6th April, 2002)**

## **MEDICAL COUNCIL OF INDIA – NOTIFICATION.**

These Regulations may be called the Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002.

**Chapter 6** of these Guidelines specifically relate to The Ethical Conduct & the Unethical Acts of Doctor. In this chapter, Para 6.4 relates to "Rebates and Commissions" and 6.8 is about "doctors in their relationship with pharmaceutical and allied health sector industry"

**Given below is the Table discussing these issues, as transpired at the Meeting "Ethics in the 21<sup>st</sup> Century" at Vapi on 2<sup>nd</sup> Sept 2017:**

MCI Code	Discussion / Explanation	ASI Recommendations
<b>6.4.1</b> A physician shall not give, solicit, or receive nor shall he offer to give solicit or receive, any gift, gratuity, commission or bonus in consideration of or return for the referring, recommending or procuring of any patient for medical, surgical or other treatment. A physician shall not directly or indirectly, participate in or be a party to act of division, transference, assignment, subordination,	Reading the Hippocratic Oath carefully, <b>there is no condemnation of the act of sharing one's fees with another doctor involved in the care of a particular patient.</b> It is only <b>by implication</b> that the Oath stipulates that a doctor shall charge a reasonable fee and will not increase it for sharing it in order to obtain a larger number of referrals. Every doctor determines his/her	<ol style="list-style-type: none"> <li>1. All financial transactions between doctor and patient must be above board with <b>receipts being provided</b> to the patient.</li> <li>2. Each general practitioner must charge a <b>publicly stated fee</b> from the patient for the act of medical examination, making a diagnosis and recommending appropriate treatment or referral to an appropriate consultant or hospital.</li> <li>3. Every surgeon must <b>publicly list the charges for each operation</b>, with provisions for degree of difficulty encountered and possible deviations needed.</li> </ol>

<p>rebating, splitting or refunding of any fee for medical, surgical or other treatment.</p>	<p>professional fees on the basis of experience, wisdom and self-perception of the level of skills required for a particular treatment. Fees thus vary widely from doctor to doctor. Hence a particular amount cannot be termed 'unreasonable' as long as <b>the patient is aware of the sum to be paid before the service is rendered.</b> What the treating doctor does with the fee after it is received by him is entirely and solely his concern and the patient or any other person has no say in it.</p> <p>Hence if a doctor decides to give a portion of his fees to another person (medical or nonmedical) it is entirely legal and ethical to do <b>so provided this is done openly and after obtaining a receipt.</b></p>	<p>4. <b>A fixed percentage of the specialist's fees for procedures should be openly given to the family doctor on the ground that the latter will offer follow up care to the patient at his home after the procedure.</b> This measure also transfers legal responsibility on to the family doctor for competent medical care.</p> <p>5. A body of experts in each hospital or nursing home should monitor the performance of various procedures to ensure that they are based on scientifically valid indications. <b>(AUDIT FUNCTION)</b></p> <p>6. <b>Health insurance should be made compulsory and fees for various examinations, procedures, visits, etc. should be fixed from time to time</b> by a committee of professionals consisting of representatives from the medical bodies, insurance companies, government and the legal profession.</p> <p>7. <b>Medical councils at central and state levels should be given adequate powers to punish erring doctors.</b> At present, positions on such councils are used only to enhance one's prestige and members of the councils are almost completely incompetent.</p>
<p>6.4.2 Provisions of para 6.4.1 shall apply with equal force to the referring, recommending or procuring by a physician or any person, specimen or material for diagnostic purposes or other study / work. Nothing in this section, however, shall prohibit payment of salaries by a qualified physician to other duly qualified person rendering medical care under his supervision.</p> <p>"6.8 Code of conduct for doctors in their relationship with pharmaceutical and allied health sector industry"</p> <p><b>6.8.1</b> In dealing with pharmaceutical and allied health sector industry, a medical practitioner shall follow and adhere to the stipulations given below:</p>	<p>1. If surgeons earn adequate financial compensation, there will then be no need or incentive for unethical ways of earning extra income. <b><i>The present pay structure is insultingly low in this respect!</i></b></p> <p>2. Not paying people enough is the surest way to promote dishonest behaviour. As a society, we must understand that if we expect doctors to work honestly and ethically, we have to reward them adequately in financial terms. The ban is apparently only on travel facilities for vacation or for attending conferences, seminars, workshops, CME programme etc as a delegate. <b>Giving a lecture seems to be excluded.</b></p>	<p>1. <b>INSTITUTIONAL:</b> The monthly salary and other benefits of full time doctors especially in teaching hospitals should be such that they are able to <b>maintain a decent standard of living commensurate with their position and seniority.</b></p> <p>2. <b>IN PRIVATE PRACTICE</b> Though what constitutes reasonable compensation is arbitrary, it is not impossible to agree on a fee range for consultations and procedures in different geographical areas and specialties. <b>These fee ranges should be clearly set by the regulatory authorities and doctors should not be allowed to charge more or less than that.</b> Conflicts of Interest in all forms of medical /scientific research, audit, presentations and publications, or work, should be declared in writing and due consent of ethical and legal authorities obtained.</p> <p>NOTE: Acceptance of Gifts &amp; Travel Expenses greater than Rs 1,000/- will invite sanction, punishment, from the MCI.</p>

<p>A medical practitioner should not accept any gifts, travel facilities, hospitality, cash or monetary grant, etc for himself or his family.</p> <p>He / She must obtain full ethical and legal clearances for medical research sponsored by industry, while Maintaining Professional Autonomy. Affiliations and Endorsements to be declared</p>	<p><b>Why there is a problem with pharma companies sponsoring medical conferences in India...?</b></p> <p>Ethics codes forbid individual doctors from accepting gifts from a drug manufacturing company. <b>Surely it is not acceptable for them to do so collectively</b></p>	<p>A grey area, needing more discussion and clarity from the MCI.</p>
---	--	---

- In the absence of a clear, logical, bold and community oriented health care policy on the part of the government and a lobby of strong, honest, clear thinkers representing the medical profession in the corridors of power, the present situation of 'Cut Practice' is unlikely to change in the near future.
- Cut practice has to stop, and believe it or not, hospitals, laboratories and even doctors want the practice to come to an end. But nobody can do it in isolation for fear of losing out.
- All the MCI needs to do is to conduct a few robust covert investigations and deal with the culprits decisively - by that, give out a punishment that will deter others from indulging in similar malpractices. Punishing a few is all that is required to see lasting changes....!!
- There is No substitute for one's own competence and conscience acting as an internal judge and counsel, in matters of financial and career success of the surgeon.

## References:

1. Professional Conduct, Etiquette and Ethics- Medical Council Of India  
<https://www.mciindia.org/documents/.../Ethics%20Regulations-2002.pdf>
2. An objective look at 'cut practice' in the medical profession - P. A. Kale  
 Indian Journal of Medical Ethics Vol 4, No 1 (1996) > ORIGINAL ARTICLE
3. The Ethical Doctor by Kamal Kumar Mahawar - Goodreads  
<https://www.goodreads.com/book/show/31839086-the-ethical-doctor>

# Ethical & Legal Dilemmas in Surgical Practice

**Dr. P. K. Kohli,**  
**Medico-legal Consultant &**  
**Advisor Medical Education**  
Gurgaon

## I. End of life care

- Dilemma 1:** When a critically ill patient, on life supports, becomes moribund and there is no hope left, the surgeon should medically & ethically withdraw the life supports and allow the patient to die with dignity. But is that legally correct? Usually, the family supports such a decision but sometimes the family (or one member of the family) may not agree to consent even when convinced that by continued life supports we are merely prolonging the process of death. There is no codified law on withholding & withdrawal of life supports in such terminally ill patients. The law on brain death for cadaver human organ transplantation is different and for a specific purpose. Here the dilemma may arise even when the patient is not brain dead but otherwise moribund.
- Dilemma 2:** There are two reports of the Law Commission of India on terminally ill patients (Report no 196 and 241) and a judgment of the Supreme Court of India (Aruna Shanbaugh case) with elaborate guidelines. However, these deal with situations of Persistent Vegetative State (PVS). PVS is a chronic situation, where intervention of the High court may be acceptable in each case for a decision, as recommended in these law commission reports and in this Supreme Court judgment. However, in acute cases, during the course of treatment, if a situation arises when there is no hope left and the process of death has begun, approaching the courts for a decision appears impractical. So, if we cannot adopt the protocol suggested in the above reports & the abovementioned judgment, we need to have some guidelines for such acute patients who are already in the dying process.
- Dilemma 3:** The dilemma is equally serious for the patient's family members. Even if they are convinced that further attempts are only prolongation of the process of death, they are not willing to say so because of the possible social reactions to interruption of the treatment in the last phase of life. Moreover, Advance Directives (Living Will) are also not legally valid (nor are they commonly made) in India.
- Dilemma 4:** The limited resources of the hospital are being consumed by a futile exercise on a patient where the process of death has already begun. Equity demands that the same resources could better be used on another salvageable patient.
- Dilemma 5:** The Parliament has prepared a bill on Terminally ill patients and released it for public debate. The bill has been rejected by the medical fraternity, because it does not address the acute condition when the process of death has begun. It has more or less adopted the protocol, which the Law Commission & the Supreme Court has recommended for Persistent Vegetative State. That may be acceptable in chronic PVS state but in the acute situations during the course of treatment, it is not practical to seek decisions from the High Court.
- Solution 1:** There should be credible guidelines on the issue so that the interests of the dying patient as well as the professional interests of the doctor are protected and at the same time enabling the family members to feel satisfied with this decision. When the process of death has already begun, the person should be allowed to die with dignity and as less pain & discomfort as possible.
- Solution 2:** Individual doctors taking such decisions on their own may be questionable. Different motives & interests may be alleged, with or without connivance with some family members of the patient. Appropriate guidelines with safeguards, evolved by the ASI, however, can be a credible solution. If a protocol is

recommended by the ASI and the surgeon takes a decision following the recommended protocol & guidelines of the ASI, he will be correct legally as well as medically & ethically.

8. **Solution 3:** The ASI guidelines must be based on the principles of Patient autonomy, Beneficence, Non-Maleficence and Equitable distribution of resources, which have also guided the Law Commission reports & the Supreme Court in framing the guidelines in cases of Persistent Vegetative State. The ASI guidelines should also eliminate the arbitrariness of the treating physician in taking such a decision.
9. **Solution 4:** Examine this issue through the doctrine of Informed Consent rather than the prism of Euthanasia (active or passive). In Euthanasia, one is talking of killing the person with active or passive support of the doctor. Here, we are talking of allowing the patient to die naturally with dignity when further efforts are not only futile but painful.
10. **Solution 5:** ASI should create credible guidelines for the help of the members and at the same time interact with the legislature in a formal manner to get the ASI protocols incorporated in the Bill on Terminally ill patients, before it becomes an Act.

### **ASI protocol suggested**

1. All hospitals to constitute "Allow Natural Death (AND) committee" consisting of 3 senior & experienced professionals. It may be two senior doctors & one senior nurse, depending upon their speciality and areas of interest. The composition of the committee may be left to the discretion of the head of the institution, based on the available resource. Whereas this can easily be done in bigger hospitals it may be difficult for smaller hospitals. For smaller hospitals they may be allowed to form such a committee collectively among the surgeons of the city, or with the help of IMA branch.
2. Whenever there is a situation where the treating physician, after having made all the efforts, feels that the 'game is up' for his patient and there is no point continuing with the efforts because the process of death has already started, he should bring in this aspect in his periodic discussions with the family members. As a matter of fact, this proposal should not be brought up suddenly. Frequent communication of the criticality of the patient, plan of care and the chances of survival, would allow the family to mentally prepare themselves for the eventuality. Similarly, if one or more family members feel that further efforts are futile, the treating physician should make an objective assessment from this angle and express his honest opinion before the family.
3. If the treating physician as well as all the family members present are in agreement that further efforts are futile and the patient should be allowed natural death with dignity and without the agony of chest compressions & other life support measures, the process of AND should be initiated. The first step requires the family to fill the AND request application form.
4. The AND request application form has 3 situations, one or more of which need to be ticked. These are :
  - a. The above mentioned patient had made an advance directive / living will stating that in the terminal stages of his life, he would like to die with dignity and without the agony of chest compressions and the life support measures (copy enclosed), reflecting his desire.
  - b. The above mentioned patient had verbally told the family members that in the terminal stages of his life, he would like to die with dignity and without the agony of chest compressions and the life support measures (statement enclosed)
  - c. The abovementioned patient is already in the process of dying and further resuscitative efforts are futile. We believe that he would have desired and it is in his interest, that he be allowed to die with dignity without the agony of chest compressions and the life support measures. After ticking one or more of the

above (a to c), all the available family members sign and request the AND committee to issue AND order. The treating physician either rejects it or accepts it, depending upon his professional opinion. If accepted, he signs it and sends it to the AND committee.

5. One of the AND committee members independently examines the patient, talks to the family members, talks to the treating physician and examines the medical records. If not convinced, the matter finishes there and the AND protocol is abandoned. If convinced, he talks to the other two AND committee members, who would be free to make their own independent assessments.
6. If all AND committee members are in agreement, they all will sign the "AND order" which will be signed by the treating physician as well. This order states that the AND committee, after following the due process are fully convinced about the genuineness of the AND request by the family members of the abovementioned patient and in view of this, we release the AND order. The AND label be put on the patient's right shoulder & right wrist and arrangements be made for the respectful transfer of the patient to his home as per due process.
7. With this AND order, a pre-defined AND label is put on the patient's right shoulder & right wrist. So, all care givers would know from this label that no resuscitation is to be undertaken and that he is waiting to be discharged.
8. Arrangements are made for the patient's transfer to his home, at the convenience of the family members. On the date and time on which they want him transferred, the patient is transferred in the hospital ambulance with the existing life supports in situ and with a doctor as escort. The doctor carries the discharge summary & the AND order with him.
9. At the patient's home, he is put on the bed and after that the life supports are removed, with all the respect that he deserves. If the family wants, the NGT, FJ, Foley's catheter etc are retained in place for the terminal care at home. Discharge summary is given to the family against receipt, on the second copy.
10. The doctor returns and submits the AND patient transfer note.



## SOP for EOLC decision

Family asks for AND/DNR.  
Makes application for it.  
Treating physician can veto, if not convinced.  
However, if treating physician is convinced, he refers to AND committee.

One AND committee member discusses with the treating physician as well as with the family and examines the patient and records, independently.

- If not convinced - veto
- If convinced, refers to the other members, who may assess independently
- If committee unanimously agrees, 'AND order' is signed

AND order is also signed by the treating physician

- AND band is put on the patient's right shoulder and wrist
- Arrange for due transfer of the patient to his home, at the convenience of the family

# SOP for transfer of AND patients



- 1 • Transfer in hospital ambulance  
• Transfer with all life support systems in situ
- 2 • Doctor to accompany, with discharge summary  
• Respectful conduct and professional care all through
- 3 • Remove gadgets at home, after shifting to bed  
• May retain NGT, Foleys catheter, IV line, if desired
- 4 • Prepare a transfer note and annex it in the case file  
• Enter in the AND register for statistics

## II. Professional Jurisdiction of Surgeons (who can do what)

This is a dilemma, which is often the subject matter of litigations as well as discussions in the media. There are no clear guidelines, which can predictably stand the scrutiny on medical, legal & ethical grounds. Whether a general surgeon is allowed to perform OBG procedures (e.g. Caesarean section, hysterectomy, ovarian surgery) or cancer procedures (e.g. breast lump biopsy, lumpectomy, MRM, tissue biopsies at other sites) or Laparoscopic procedures (e.g. cholecystectomy, TLH, Bariatric surgery, GI cancer surgery) or Urological procedures (e.g. TURP, Cystoscopy, PCNL) and so on. Similarly there may be overlap between the scope of General Surgeon & Paediatric surgeon, between Orthopaedic surgeon, spine surgeon & neurosurgeon and so on. For a proper resolution of such dilemmas, there should be proper ASI guidelines.

It is important to understand that license to do medical practice is granted by way of registration with the Medical Council of India. MBBS gives the basic knowledge & exposure of all departments (including surgery). The MCI registration however, does not define the professional jurisdiction within which the doctor can practice. For safe surgery, one must have requisite knowledge, experience and competence to do that particular procedure. How this can be assessed & ensured is the dilemma.

### ASI guidelines:

1. All members should get MCI registration, not only with MBBS (which is mandatory for doing medical practice in India) but also upgrade their registration with each recognized postgraduate qualification. This is a requirement of the MCI and so should be fulfilled. The professional qualification is a reflection of the knowledge gained about the subject. Therefore, if you have the postgraduate qualification of the concerned speciality & have got yourself registered with the MCI with that qualification, your knowledge about the subject cannot be questioned medically, legally and ethically. So the first pre-requisite for safe surgery is fulfilled.
2. Adequate Experience is the second pre-requisite for safe surgery. The experience has two dimensions – length of experience & quality of experience. This is assessed by your exposure & performance during & after the postgraduate qualifications, and the level of experience (as observer, assistant, performer under supervision and independent performer) gathered in the speciality / procedure under question. The evidence of such experience is documented by way of the Logbook and / or the Operation register, Testimonials from the expert under whom you gained experience and also through publications of your work in standard medical journals. Therefore the members are advised to maintain & preserve these documents for use in case of need.



3. Competence is the third essential pre-requisite for safe surgery. This is difficult to assess. The only evidences that can help in the matter are testimonials of other expert, log books & publications elaborating on the outcomes, especially the rates of complications & mortality.
4. So, if you are a general surgeon with MS in general surgery but have a reasonable experience of having performed say Abdominal Hysterectomy, initially under the supervision of an expert and then independently, with good results, you will be medically, legally and ethically correct in performing such a procedure. In case of a litigation with this allegation, however, you will be required to provide the evidence of your knowledge (postgraduate degrees), experience (log book, testimonials, publications) and competence (log book, testimonials, publications)
5. If the hospital has a robust credentialing and privileging system in place, then the matter is relatively simplified if you have been granted privileges for that particular procedure.

### III. Electronic consults

There are a number of healthcare portals through which the patients seek and the doctors provide professional consultations. It is true that it is a very convenient, easy & cheap mode of consultation both for the patient as well as the doctor. However, it has some inherent shortcomings. There is lack of physical examination and mostly a lack of face -to- face communication between the doctor and the patient.

Besides such portals, the patients may often seek consultation through email, SMS or WhatsApp. Here again, the convenience needs to be balanced against credibility and quality of the opinion. Errors and lack of prudent precautions may result in complications – medical, legal or ethical.

#### ASI guidelines:

1. Online consultations should always be accompanied by a disclaimer “This consultation is without the facility of physical examination of the patient. Take this only as a professional guidance and not as a final opinion. You should therefore supplement this online consult with a proper conventional face to face consultation”
2. Online consultation should be brief and limited to the immediate symptomatic relief.
3. Online consultation in emergencies should be limited to the guidance regarding the appropriate hospital where the patient should be taken, precautions during transportation and first aid measures if any, to make the patient comfortable.
4. Online consultation might be more useful in your follow up patient since you already know several details about him. Still you need to be careful about how much and to what extent you should be telling online without having done a physical examination, at that time. You should also be careful especially in dis-satisfied patients, because they might be recording the conversation without your knowledge. So, as a matter of principle, speak less and listen more and try to help him with the basic advice, depending more on non - pharmacological measures than medicines.
5. If the consultation is through the local doctor who has physically examined him, your online advice can be more useful.
6. If there is provision for uploading of the documents & images etc there will be value addition to your opinion but the basic precautions and limitations will still remain.

## IV. Internet educated clients

Many of our patients today gain information from internet search before & after seeking the professional consultation from a doctor. Even during the course of treatment, they often try to 'cross check' with internet, to gain satisfaction. Whereas it is good if the patient is well informed, information from the internet may sometimes confuse the patient and may even compel him to wrongly believe that the line of treatment adopted by the doctor / surgeon was not the best. The general tendency to believe information on the internet to be more reliable than anything else, is erroneous. Much of the general information on the net is unverified and not peer reviewed. Secondly, the general information on the internet may not be applicable to the facts and circumstances of the patient in question.

### ASI guidelines:

1. Whenever the patient comes with some information from the net, with or without a hard copy, do not get irritated and do not reject it outright. You must appreciate him for his efforts to educate himself about the disease / procedure etc. If he is describing something, listen to him. If he has brought a print out, you must read it. Please don't brush it aside and don't get angry.
2. After listening to him and reading the print out, if any, inform him about the limitations of the info from the net. The information from the net is of a general nature and this may or may not fit into the overall clinical picture of the actual patient under treatment. Secondly, since you have physically examined the patient and seen the medical records & the reports, your observations & opinion would be more accurate & rational as compared to the generic info from the net.
3. Any patient who is intelligent enough to seek information from the net is likely to understand its limitations, if explained properly. However, if the patient is too prejudiced by the net information and is continuing to ignore your professional opinion, there is no need to continue the arguments. You just make a mention of this in the records and politely and tactfully advise him to take another opinion.
4. Sometimes the information brought by the patient is actually supporting what you have been trying to explain. He may not have understood the article and its technical aspects well. In that case his efforts to get the net info will facilitate your task to counsel the patient.
5. As a parting message, you should appreciate him for the internet research that he had done but caution him that all such info must be verified & cross checked with your doctor, especially to find out if that info is applicable or not to you.

## V. Handling patient pressures

Patients are our valuable clients. We try to help them clinically as well as administratively. However, in today's context, if we are not careful, we might land ourselves into trouble, by going out of the way to help him. Sometimes, the patient might try to compel you to do something you don't think is right. He might put pressure through your relative or through some VIP or through some muscleman or may be by luring you with money. The common pressures faced in the Government set up are related to early booking for room or specialized investigation or surgery, fake medical certificate, fake admission, fake reports, manipulation of post mortem findings etc. In the private sector the pressures are usually for discounts or fake medical certificates or changes in the name, age or history of the patient, largely to ensure TPA approval.

## **ASI guidelines**

1. Adopt a professional approach in your practice and do not succumb to pressure.
2. If it is a question of discount, let him follow the discount protocol of the hospital and on compassionate grounds give whatever discount is feasible.
3. For manipulations in medical records or fake certificates, you should never agree because that will amount to a criminal act in connivance with the patient. This can have serious consequences.
4. Use tactful communication to explain your limitations. If need be escalate the matter to your superior.
5. Sometimes, the patient refuses your treatment if his demand is not met. Let such a patient go and put a note in the records about the pressures you had resisted.

## **VI. Discount policy**

We are all giving lot of discounts day in and day out. But still we are described as looters in the public perception. Sometimes, when a complication or death has occurred, out of sympathy we give a big discount, on compassionate grounds. Instead of appreciating that, the patient (or his lawyer) might project it wrongly as an attempt by the doctor to cover up his negligence or deficiency of service. In view of this, it is important that we adopt a uniform policy of discounts by which proper & correct perception is created in the public and we are able to protect our interests also.

### **ASI guidelines:**

1. All discounts should follow ASI protocol. How much discount is to be given will be the discretion of the treating surgeon and the medical superintendent of the hospital.
2. The discount process should be initiated by a 'Discount Request application' (sample given below).
3. The treating surgeon puts a figure or percentage of the total bill and signs it. Wherever relevant, the application, after the doctor's recommendation, goes to the medical superintendent / medical director for approval.
4. This goes to the billing section for execution and to the MRD for compilation.
5. All discounts given should be compiled on an Excel sheet with S.no, Date, name, age & sex, hospital ID number, total bill, discount amount, treating doctor. These should be arranged month wise & totalled.
6. If all the doctors of the hospital or ASI members of a town pool this data, it will be a huge number per month, per quarter & per year. If all the ASI members from all the chapters & branches pool it, it would be a mindboggling figure.
7. This data should be projected in all our communications to the public (e.g. newsletter, public notices, advertisements, interviews etc). This will help to remove some of the wrong impressions about the medical fraternity.

8. Secondly, the fact that the discount process was initiated by the patient himself through the request application and also the text of the application mentions about his financial constraints, he cannot give a different story in the court
9. Thirdly, the application also states that he is satisfied with the treatment and care. This will give us a good defence in case he later decides to go to the court alleging negligence or deficiency of service.
10. Some people might be discouraged in 'applying' for the discount, for whatever reason. So be it.
11. This will also convey a message that the hospital follows a process.

## Application for Discount

Dear Sir / Madam,

Our patient mentioned above has been treated in this hospital from \_\_\_\_\_ date. We are satisfied by the treatment and services. However, we have financial constraints because of which we wish to appeal to you to give us a substantial discount in the hospital bill.

Name: \_\_\_\_\_ Relation with Patient: \_\_\_\_\_

Date and Time: \_\_\_\_\_ Signature: \_\_\_\_\_

Witness 1: \_\_\_\_\_

Witness 2: \_\_\_\_\_

Recommended by the Treating consultant, discount of \_\_\_\_\_

\_\_\_\_\_  
Treating consultant  
(Signature with name & date)

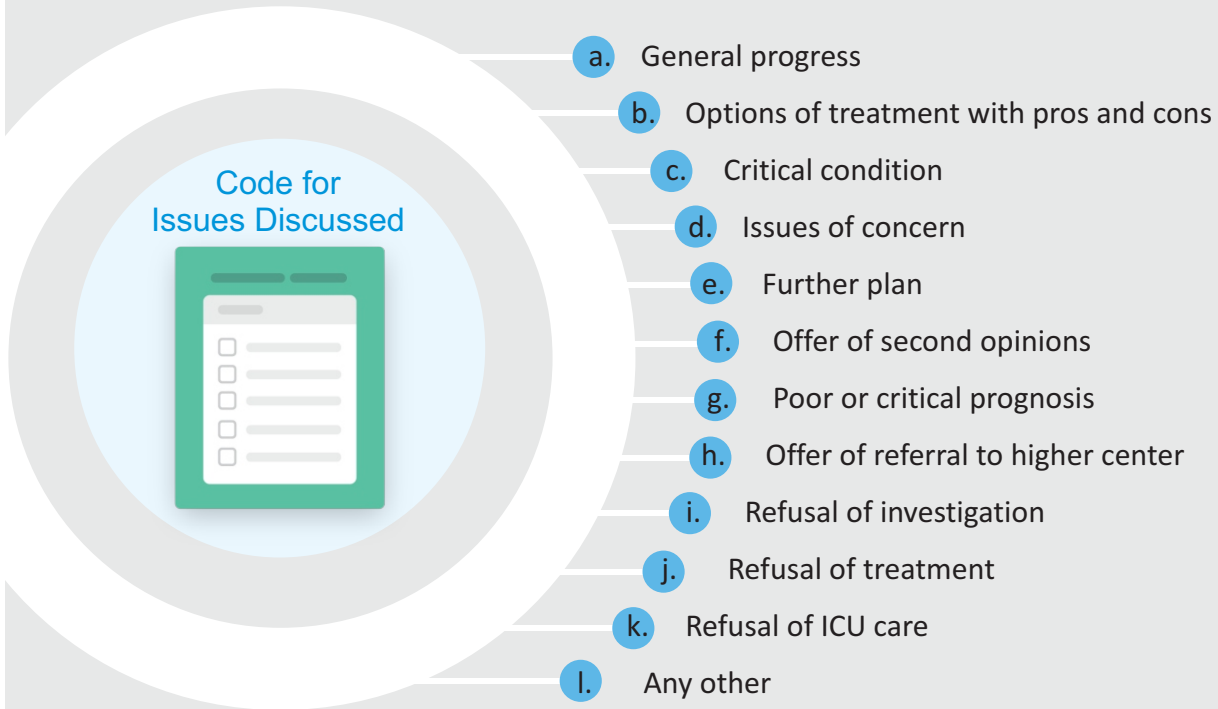
\_\_\_\_\_  
Medical Superintendent  
(Signature with name & date)

## VII. Documentation of patient communication

We communicate frequently with the in-patients & their family members but sometimes, in the court they allege that they were not informed about something under discussion. This is particularly true for critically ill patients in the ICU. Several communications take place between the caregivers (consultants, residents, nurses & technicians) and the care seekers (patients, relatives, friends & employers), several times during each day. Most of these communications don't get documented. A simple, practical and a useful method is recommended by the ASI, especially for ICU patients.

## ASI guidelines:

1. Prepare a code for various issues often discussed with the patients and relatives.  
A sample of codes is given below:



2. A patient communication sheet be prepared indicating date, time, issues discussed, who discussed, with whom discussed and signatures of both. Sample of this sheet is given below:

### Patient Communication Chart

Name: ..... Age: ..... Sex: ..... IPD No. ....

Date	Time	Issues discussed	By whom	With whom	Signature

3. All communications undertaken by the consultants, residents, nurses & technicians therefore get documented in a simplified manner.

4. The fact that the patient / relative has signed on it, it will be difficult for him to deny discussion
5. In case another relative comes & discusses something that has already been discussed, we can always show this document instead of getting into an argument.
6. This will constitute a simple method of documenting communication with patients & their relatives.

## VIII. Travelling surgeon

In today's context, many surgeons are often required to go to another hospital, sometimes in another city, to operate. Sometimes, they even have to carry their own instruments. Sometimes, senior surgeons are required to demonstrate some surgical procedures or technique, live from another operation theatre. This can have medical, legal & ethical implications. There might be issues regarding the facilities / instrumentation in the OT or the quality of assistants or the competence of the anaesthetist or the pre-operative assessment or the post operative care.

### ASI guidelines:

1. Avoid performing in operation theatres where facilities are grossly inadequate or quality is compromised.
2. Interact with the host doctor for preoperative assessment & preparation. Examine the reports & images etc through Whats App, if it is not practical to see the hard copies, before you agree to perform the surgery.
3. Try to have an interaction with the patient & family members after you have physically examined the patient. Physical examination & the interaction may be done at your centre (if feasible) or at the host centre, on the day of surgery, before the patient is shifted to the OT.
4. Always ask for the informed consent form not only to see whether it has been filled properly but also to sign it (as an evidence that you have personally given the requisite information about the surgical procedure to the patient).
5. Discuss with the anaesthetist about the PAC, type of anaesthesia, your special requirements, if any about the patient position, table tilts, length of the procedure, expected blood loss, antibiotic prophylaxis and any other thing considered relevant.
6. Must see the patient (to say hello) again before the patient is anesthetized in the OT.
7. After the operation, the surgeon must come out, talk to the waiting family members, inform the operative findings & the procedure performed, difficulties encountered, if any and the anticipated post-operative road map. Also show them the specimen removed, explaining the details, if relevant. It is also imperative for the surgeon to inform the family that, as discussed earlier, he would be leaving after sometime and that he has discussed the details about the post operative management with the host doctor and that he himself will be available on phone for any help required.
8. In case post operative complication occurs, you should try your best to visit yourself to make an assessment and plan further treatment.
9. If possible, use Computer on Wheels (COW) for audio-video interaction with the patient / family and the host doctor, if required.
10. Always take your fee by cheque or wire transfer, through the host doctor and not directly and not in cash.

# Glimpses of the Conference



Ethics & Surgery in  
21st Century





Dr. Shiva K Misra



Dr. Ashok Mehta



Dr. C S Rajan



Dr. K S Shekhar



Prof. Dr. V. N. Shrikhande



Dr. Sambit Patra



Dr. Sanjay Jain



Dr. P. Raghuram



Dr. Chintamani





ASI









**Meril Academy**

G. M. Bilakhia Cricket ground,  
Muktanand Marg,  
Chala, Vapi  
T: +91 260 3064 001  
E: profed@merilacademy.com