View Point

All In a Day's Work: "Perils of Unlicensed Health care in Surgery"

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ABSTRACT

"First do no harm" (Latin: *Primum non nocere*) is the founding principle of the practice of medicine. This principle takes a lot of discipline and learning to achieve. Medical training and specialist training in medicine are time-consuming tedious and not meant for everyone to achieve. The value of human life and suffering can never be overemphasized. We are highlighting the bare basic facts of the state of affairs in the current day Indian settings of unlicensed health care providers rampant in rural India. This paper present view point by discussing few case reports for practising surgeons and physicians to understand and critically evaluate on modern practice and patient care.

Key words: Healthcare, medical care, medicine, perils

INTRODUCTION

Current standards of health care, advancements in medicine and instrumentation and expected standards of patients and relatives have led to a steep rise in the cost of treatment over the past few years. Above mentioned fact and the socioeconomic division created by recent economic boom in third world countries, in the light of the fact that basic infrastructure for primary health care is crumbling due to vast population and misadventures at the level of health-care administrators in a country like India, has given rise to a grave situation where the health care providers are faced with situations which can only be called disasters. The choices made by poor and uneducated patients are binding on health care professionals when they choose to discontinue care or go to get alternate treatment elsewhere.

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CASE REPORTS

Case 1

A 35-year-old female presented to us as a post-operative case of lower segment cesarean section (LSCS) day 13 who had a necrotic patch in the lower abdomen, which had been previously debrided at her local hospital, where LSCS was done. She also gave a history that a mop had been left during the LSCS which was removed on 3rd post-operative day. Here, the patient was treated with IV antibiotics, blood transfusion, regular debridement for 1 week, and improved remarkably. Wound was clean and sepsis well controlled. However, the patient absconded after 1 week and again presented after 15 days with even more extensive necrosis of abdominal wall and septic shock. Again she was taken on IV antibiotics, and debridement was done, but the patient expired after 2 days [Figure 1].

Case 2

A 60-year-old male presented to us a post-operative case of left inguinal hernia which was operated by some quack who misdiagnosed it as a hydrocele and then resected and anatomized the bowel loop which he found after opening

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the scrotum. At presentation, the patient had a gangrenous segment of the anastomosed bowel which was lying open in the scrotum and was tied to the scrotal skin by a catheter loop. The patient was in obstruction and shock and was taken for exploratory laparotomy, after resuscitation. The gangrenous portion of ileum was resected and reanastomosed, and the deep ring was tightened on the left side. Scrotal wound and abdomen, both were closed. The patient had uneventful recovery [Figure 2].

Case 3

A 25-year-old male presented to us with a history of pain in the right lower abdomen from 20 days, multiple discharging anal fistulae since 15 days and bleeding per rectum 2 episodes. On colonoscopy examination, no abnormality was detected, and computed tomography (CT) abdomen revealed large right side retroperitoneal collection with multiple fistulae extending above levator ani. Exploratory laparotomy was done during which large pus collection was found in right retroperitoneal space which extended below in the prevesical space. A perforated appendix with pelvic abscess was found. Rest of bowel was normal. After irrigating the retroperitoneal space, packing was inserted for hemostasis, and a drain was left *in situ*. The pack was removed in 24 h. The patient improved and was discharged. In post-operative period history was taken again, and patient then revealed that he has hed pain abdomen off and on and was taking antibiotics from village quack for a couple of months [Figure 3].

Case 4

A 65-year-old female presented to us as a case of post-vaginal hysterectomy with features of intestinal obstruction in an emergency. She was operated at some private hospital by some technician 15 days back for uterine prolapse and was not passing feces in the post-operative period. She started having abdominal distension and bilious vomiting from the third post-operative day but was managed conservatively for 15 days. Here, the patient was kept npo, nasogastric tube was inserted, and cect abdomen was done which showed an adhesion of ileal loop to a localized collection around the vaginal vault. On admission under our care patient was re-explored and it was found that around 3 feet proximal to the ileocaecal junction, ileum was adhered to the vaginal vault due to the incorporation of its serosa in the stitches taken in the vaginal vault. Ileum was freed from the adhesion, and serosal defect was closed. The patient improved well in the post-operative period and was discharged uneventfully [Figue 4].

Case 5

A 20-year-old female presented to our emergency as a post-operative case of appendicectomy with fecal fistula. She was

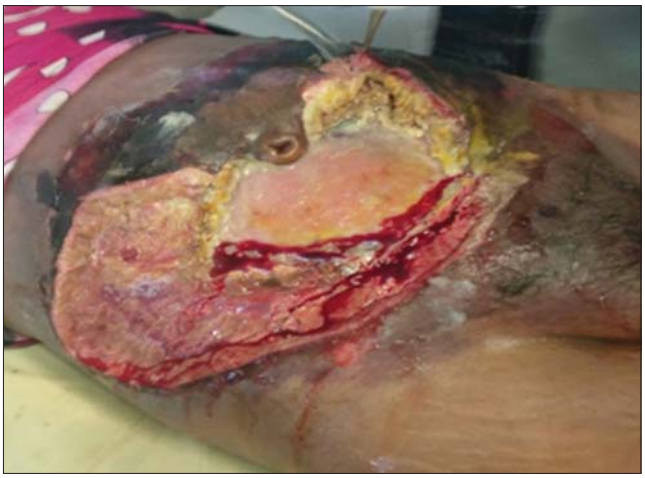

Figure 1: Patients do commit the same mistake twice

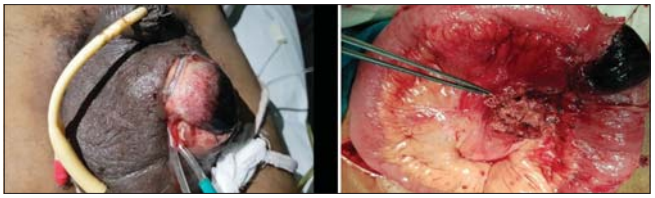

Figure 2: No procedure is small enough to be conducted by technicians

operated by some quack at a private hospital in periphery 14 days back after she complained of pain in her lower abdomen. However, in the post-operative period, she started developing abdominal distension and pain increased. On her 6th post-operative day, the quack inserted an abdominal drain which started draining fecal matter. However, no further intervention was done, and the patient was kept as such for about 1 week. When she did not improve, she was sent for a contrast-enhanced CT abdomen which revealed free air in the peritoneal cavity and then patient was referred to our emergency [Figure 5].

Here, patient came in septic shock and anuria. The patient was resuscitated by IV fluids, IV antibiotics, IV hydrocortisone, and blood transfusion. After initial resuscitation, she was taken for exploratory laparotomy. It was found that she had multiple ileal perforations with severely inflamed bowel loops and pyoperitoneum, and the ligated appendix stump was seen. The inflamed ileal segment containing multiple perforations was resected, and a double barrel ileostomy was formed. The patient improved well in post-operative period with IV antibiotics and blood and fresh frozen plasma transfusion. She was discharged after 2 weeks.

DISCUSSION

Why do policy planners feel so comfortable and self-righteous when they talk about unleashing an army of untrained health care professionals on the rural masses. Is

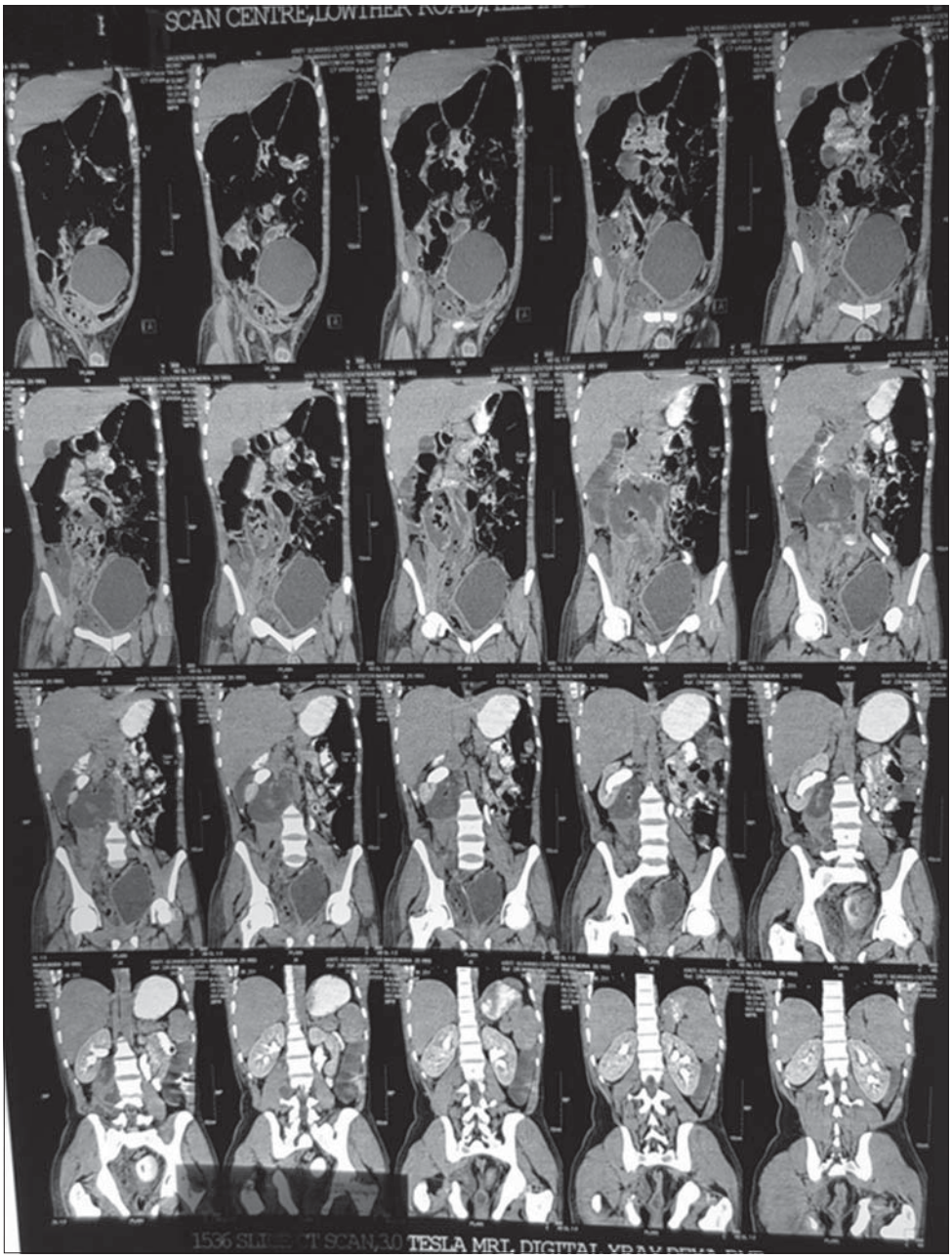

Figure 3: It takes skill to diagnose even little things. "Surgeons graveyard" no-go area for quacks

there no value of life for our rural masses? or are they totally unaware of the training process a mbbs student and a resident receives and the effort that a trainee resident puts in to earn his degree. Moreover, in any case, it seems planners wish to turn around medicine into politics … the one field where no qualification is needed.

From these cases, we can easily infer what is happening in the health care sector of India. These disasters could have been easily avoided.[1-3] The patients and their families who suffered this unnecessary physical, economic, and emotional insult are the victims of this quackery because there is still lack of awareness among our rural masses. But are they the one to be blamed? Should there be an attempt to provide short courses in medicine and legalize such inadequacy? We all know mistakes happen to every physician in the hospital. This fact alone should cause CAM therapists themselves to call for a change. Without a legal standing, professional indemnity insurance may be limited or unavailable, making the practitioner totally liable in the event of an unfortunate mistake.[4,5]

The bridge courses discussed by some planners are terrifyingly close to reality. Till date, I have yet to discover

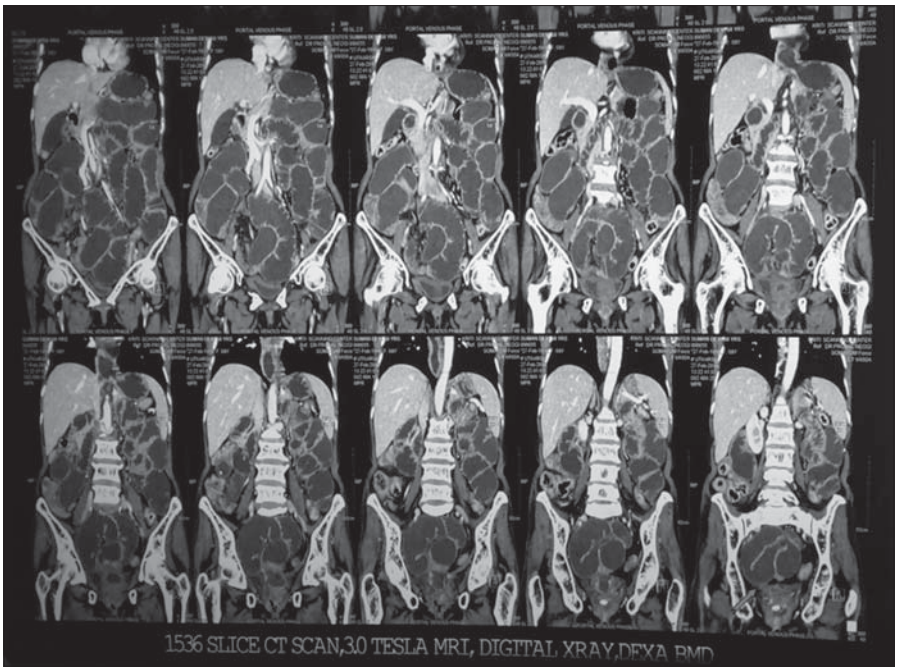

Figure 4: Proper surgical training is not without a reason

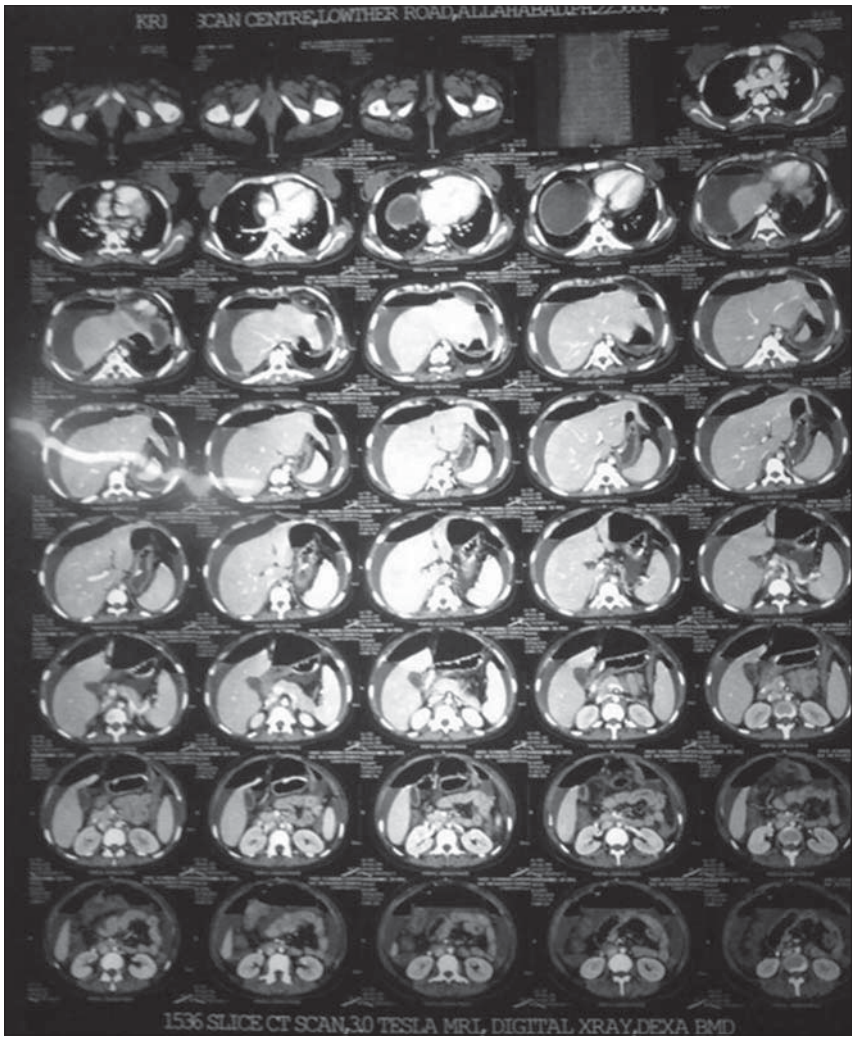

Figure 5: Post-operative care needs medical training

a single MBBS graduate who wishes to practice alternative medicine. And if there are specialties of ancient allied medicine majority whose graduate do not have confidence in their science and who find their branch so outdated that they want to upgrade or prescribe modern medicine. Should we not scrap such courses altogether. The graduates who feel the need to upgrade may be given a chance to pursue the entire curriculum and if they earn their degree then only should they be allowed to practice.

Using schemes such as bridge course and allowing improperly trained doctors to prescribe and practice modern medicine is going to increase the suffering of patients exponentially and the sort of cases highlighted above are only going to become much more common.

CONCLUSION

We tried to raise several concerning issues by discussing few case report and highlighted few points in discussion. The most significant points which were noticed in above case reports were: perceived patient compromise from a reluctance to call senior staff, the presence of workplace bullying and a paucity of teaching. A number of areas need for improvement are required and should be discussed with a aim to provide RMOs (Resident Medical Officer) with greater access to teaching, support and orientation.

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