Medicos at default?

An insider's view

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OVER the last couple of months a number of writeups and letters have been published in national dailies about health care system in the country where I noticed a general resentment of people towards health service providers specifically the physicians. Only the other day, a popular national vernacular daily came up with a front page story portraying the physicians as the main villain in health care system. However, the intention of this brief communication is not to protest against this kind of attitude towards medical community or to explain their position, rather it would be an attempt to explore one perhaps very pertinent reason behind this very uncomfortable situation between two interdependent population groups. Obviously, the content would be mostly restricted to the perspectives of physicians with the hope that the medical fraternity would give a thought to it, and at the same time the rest of the community will equally reciprocate.

We all would agree that doctors do come from the same community where others live in, and they themselves and their families do also suffer from diseases and disabilities, and very often have to go to see another doctor. A general dissatisfaction towards physician community in this country is a spirally growing phenomenon and its manifestation has become very visible in recent days. More than finger count number of reasons may be sited for this state of affairs. If one were allowed to pick up an apropos reason to have a closer view, one would not probably be wrong if absence of 'appropriate communication' is instantly identified to that effect. Would it then be very irrelevant if one relates this communication need to a 'functional relationship', a basic requirement of interpersonal interaction? Therefore, in this deliberation my effort would be to look at this prevailing situation of consumer dissatisfaction toward the service providers from the standpoint of 'relationship'. Doctor-patient relationship has a multidimensional perspective. From the professional point of view of a physician, it is a science, science of understanding his client and his problems, and deciding upon its remedy. In a broader sense, it is an art also, art of establishing a seemly functional working relationship. Culmination of this functional relationship into a positive accomplishment again depends on individual competence to establish and sustain the relationship.

A doctor with all his expected adeptness and proficiency has a social recognition of a 'healer' and his client or patient is nobody but a 'sufferer'. The relationship what we are talking of is an age old phenomenon, sometimes very conventional and in certain situation very circumscribed. However, this relationship is based on certain traditional as well as ethical norms. It may sometimes appear little ambiguous and confusing because of its certain inconsistent characteristics, for it may at times appear inseparably strong and sometimes unpredictably fragile. The ethical principle that dictates this relationship prescribes mutual trust and confidence, mutual responsibility and accountability, and mutual benefit and contentment as its founding stone of application. Contentment does not necessarily mean one's happiness over treatment outcome, rather it relates to individual's gratification over the relationship. There are certain well defined objectives of this relationship between two different groups of people dealing with similar goal from different perspectives. The goal is to serve the human suffering and the objectives are to maintain health, relieve pain and suffering, restore function, and finally to save life.

In our circumstances and in also others, the treatment model is generally perceived as a 'healer' assessing a 'sufferer' to reach a diagnosis with an aim to provide treatment that may lead to remission of the suffering. In this very simple model for perception of treatment, doctors are viewed as authoritative figures, all-knowing and all powerful, with an ultimate belief that all autonomies may be relinquished upon them. Doctor, as a 'savior', is usually expected to give an answer to all the problems in question, reassure and advise, prescribe or refer to some other places or at least to 'do something'. From patient's perspective, in some situations, unfortunately though, there always lies some dilemma whether one is properly understood by the treating physician or one should demand for it, and if so, whether one would rather be persecuted!

If a physician wants to understand his patient properly, the first thing to be taken into consideration is to understand the latter's motivation, motivation for coming to a physician. Feeling of a patient who comes to a doctor may have diversified emotional tone. It may be a total submission with confidence, or perceived fear, skepticism, shyness and aloofness. There may be an immediate reaction reflecting all those feelings or it may be covert indifference. Therefore, it needs a comprehensive analysis and rational interpretation of the behaviour pattern of the patient at initial contact and subsequent interactions.

The physician in his total didactic interaction with his client should possibly first identify his own role as a healer. He does not have a 'role to perform' only, some responsibilities are also assigned to him. Ideally, he should be the first skilled contact person before the patient is sent to a bigger treatment facility, if required. The physician is supposed to do the initial assessment and give an initial solution to the problems. Assisting in and coordinating additional help, if suggested by him, is also his responsibility. In the process of doing so, he actually becomes the patient's adviser and confidant. Therefore, it becomes a continued responsibility. Down the course, the doctor becomes a part of decision making and there develops a continuous interaction with patient's family also. One important aspect is referral of cases for a better access to treatment and it is the treating physician or first contact physician who decides upon this referral, and subsequently has to share the responsibility of consequences of referral outcome.

While all these dynamics happening, a very basic well-perceived need is often ignored. In a given situation what is needed on the part of a physician is professionalism. We often fail to look at the characteristics of professionalism from a holistic viewpoint. The professionalism from the perspective of a physician encompasses many critical issues like respectfulness towards his profession, his client and his family; understanding his own profession and his client as a person and a sufferer; to be supportive to his client and his family in their suffering and also in their achieving a good life; appreciating the given problem and factors responsible for its causation and continuation; and finally identifying the role of the patient and the physician himself in all those issues of concern.

Conceivably, in our situation, a visible gap has been created in mutual understanding and tolerance between physician community and the rest of the population. Therefore, we may have to revisit the prescribed virtues of a healthy doctor-patient alliance to repair the damage already done in this highly valued relationship.

The most essential requirement to meet all those purposes described above is an 'effective communication'. The main aims of this effective communication, from the perspective of a physician, are to understand the 'illness' and also to understand the 'ill', and the main means of communication is 'listening' and 'talking'. In order to achieve this, one has first to comprehend the purpose and objectives of this communication. Reduction and containment of initial worries and anxieties of the patient and his family is the foremost objective of an effective communication. The client should specifically be given a feeling of being 'held together'. He should be helped to muster all his psychological resources, as identified in the course of communication, to accomplish the job. It would, down the line, help the physician to assist the client in coping with his problem more effectively.

The subsequent step is to prevent 'humanistic crisis'. Management of humanistic crisis is more than a medical management. It is a combination of personal and impersonal aspects of medicine where 'empathy' surpasses the 'sympathy'. Prevention of humanistic crisis requires an intensive dialogue, dialogue between the 'healer' and the 'sufferer'. The medical dialogue or communication has three arbitrary stages. First stage is the stage of 'personal meeting' where there is initiation of dialogue and confirmation of mutual role and identity. Next is the 'examination' stage where the personal meeting shifts to an impersonal interaction where the communication centres an issues related to disease and disability. Thereafter, comes the stage of 'healing through meeting' where the previous two stages are integrated into a shared decision making. It is important for the physician and his client to understand what really happens during a dialogue or communication. If it is observed carefully, it may be seen that doctors speak more about bodily or physical component of the disease or disability, and patients utter more words on psychosocial and emotional issues during most of the personal communications. No difference is found in this matter between communicating parties of two different sexes. A successful intervention is only possible if priorities of both the parties are focused at the same direction.

We often forget that doctors and patients are products of a given society and a given culture, and both may have idiosyncratic past experiences. Past experience has an added influence on one's subsequent behaviour. Ideally, doctors must have knowledge of personality development, understanding of dynamics of human life changes, knowledge of complexities of life's experiences, and a proper understanding of contribution of abovementioned factors in establishing a 'relationship'. A very vital question needs to be answered at this stage. Should learning about the patient be enough to give him appropriate treatment and management? A doctor must learn first about himself, and then allow free expression of thoughts by his patient. In the process, one should be very non-judgmental, have empathy and must provide support.

If so much is talked about relationship, one may logically ask, "does 'relationship' replace 'treatment' itself?". Actually, this relationship helps patients feel better, develop a sense of trust and hope, explore own problems, comply medical regimen and finally achieve positive outcome of treatment. A doctor needs to remember that a functional rapport is affected by timely action, need based service delivery, treatment cost and cost minimization, among others. From a physician's perspective it is also very important to understand how to accomplish a safer working alliance. It principally depends on how he brings in his personal and social values in his professional practice. He must maintain professional ethical standard, uphold legal virtues and recognize values of the patients and his other professional colleagues at the same time. The physician must also be careful that certain factors may adversely affect this very precious and coveted relationship. Cultural prejudice ingrained in one's mind, his past experiences, personality, family and upbringing, preconceived ideas, feeling and attitude towards others, and finally modern technological advancement in diagnostic and treatment procedures, all, if not very carefully dealt with, may affect the relationship. The technological advancement in medical science made the whole dynamics of disease treatment lot more easy and efficient, but perhaps at the same time it brought in a mechanical transformation in doctor- patient relationship.

Let me now focus on some other specific ethical issues related to this relationship. Factors related to sustainability of the relationship are virtually ingrained in these ethical issues. Attending the distressed and giving him comfort is the fundamental ethical need of medical service delivery. Decisions to allay one's pain and sufferings should be very carefully chosen so that benefits should always outweigh the cost, and there should always be an intention of doing good and avoiding harm. In the course of doing so, there should always be respect for the patient and his causes. Finally the patient should get appropriate fairness without discrimination and prejudice. One should well remember that the patient has rights to choose his treatment and an 'informed consent' is mandatory before starting any diagnostic or treatment procedure. Patient should be provided with an elaborate information about the procedures and their consequences. Privacy, confidentiality, privilege and protection of public safety are the other issues to be taken into consideration.

Conceivably, in our situation, a visible gap has been created in mutual understanding and tolerance between physician community and the rest of the population. Therefore, we may have to revisit the prescribed virtues of a healthy doctor-patient alliance to repair the damage already done in this highly valued relationship. In order to achieve that, both the physician community and rest of the population should honestly look for specific areas of difficulties and their pattern, learn to identify their own failures and omissions, and finally to response to those needs in a judicious and realistic manner.

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Israel: One resounding 'yes', several disdainful 'no's to UN

M.SHAFIULLAH

ISRAELI rebuff to the visit of UN fact-finding mission to the devastated Palestinian refugee camp in Jenin is the latest addition to her long list of defiance of the Security Council Resolutions. The massacre of civilian life and property partially exposed in the Jewish controlled Western media even if taken with a grain of salt, Israeli Prime Minister Ariel Sharon had every reason not to allow UN Secretary-General to send his team to Jenin refugee camp. Kofi Annan's Special Envoy after a preliminary survey of the Israeli onslaught declared the devastation as "horrific beyond belief ." After that who would like to be next to the dock of Sloboden Milosevic at The Hague Tribunal on charge of Crime against Humanity? Therefore, the Security Council Resolution 1405 passed unanimously with the rare support of the US to find out what had happened to civilian lives in Jenin by a UN fact-finding body became yet another casualty of Israeli intransigence.Jenin is the northern most city of West Bank under Palestinian National Authority that houses Palestinian homeless civilians. On 13 April Israeli troops swooped down with tanks, helicopters and bulldozers to cleanse the "den of terrorists" for nine days. And the Israeli Army left a trail of devastation of an earthquake.

From the perspective of a Jewish state Israel perceived the UN was standing in the way of expansion of its wing in the Palestinian part of the territory. To begin with, against 52 percent of the Mandated Territory the UN allotted to Israel in the Partition Plan it had occupied 77 percent of Palestinian land in the 1948 war by the time the Security Council could impose cease-fire in January 1949. Israel's hostile attitude to the UN further hardened at the adoption of Security Council Resolution 242 on 22 ovember 1967 that emphasized the principle of "inadmissibility of the acquisition of territory by war." The Security Council called upon Israel to withdraw from Sinai, the West Bank including Old City of Jerusalem and the Golan Heights occupied in Six-Day War on 5 June 1967. Israel refused to comply with that key resolution ostensibly on security reasons but in reality it annexed the conquered land on unfounded claim that Judea and Samarea, the Biblical term Likud Party uses for West Bank, was an integral part of Israel. In the same vein UNSC resolution 338 stopping Arab-Israeli war of 3 October 1973 andunderscoring the necessity of "exchange of land for peace" went against Israel's basic state policy of land grabbing. Israel invoked The Law of Return to encourage Jewish immigration without any number. Chain of settlements were built in the occupied land with twin purpose of rehabilitating the immigrants as well as to establish strong foothold in the occupied areas. Zionist entity believed that without permanent and physical presence her long term economic and political control of the occupied land would not be feasible. Therefore turning down the UN Resolutions was well entrenched in the state policy of the country. Seen from the Arab perspective Zionism was an aggressive movement against Palestinian existence and that of Jewish immigration was an invasion on their land.

The adoption of a resolution in the UN General Assembly on 10 November 1975 condemning "Zionism as a form of racism and racial discrimination" was viewed by Israel as prejudicial to her psyche. The Jewish State moved heaven and earth to undo the UN resolution until it was rescind in mid-ninety. The UN resolution 242 and 338 were vital for war and peace in the Middle East. Those resolutions recognized Israel's right to exist and renounced violence and were also endorsed by PLO Chairman Yasser Arafat in his historic address to the Special UN General Assembly Session in Geneva in 1988. In addition he accepted a two-state solution of the Israeli-Palestinian conflict transforming PLO from confrontation to co-existence alongside the Jewish State. However, the recognition to PLO as the sole and legitimate representative of the Palestinians and granting the Organisation an Observer status at the UN was interpreted as a hostile act against Israel. The Jewish State rejected the gesture of reconciliation made by PLO Chief.Israel doubted the ability of the Palestinian State to accommodate 3.5 million Palestinians living in the Diaspora. Hawkish Israeli leaders like Benjamin Netanyahu and Ariel Sharon were sounding alarm bell to the West that the refugees ultimately would be pouring into Israeli territory thus dilute the Jewish character of the State. They had been selling the idea that the new state besides destabilizing Israel, would eventually turn into a spring board of terrorism against the interest of Israel and the USA. Relentless Israeli campaign designed to deny the statehood to Palestine has become obvious to all. After the 11 September attack, Americans have become tuned to swallow any kind of stuff in the name of fighting terrorism. The flouting of the successive UN resolutions with impunity suggest that the hard liners in Tel Aviv and the powerful Jewish lobby in the USA appeared to have succeeded to a great extent in bringing around the White House, the Capitol Hill and the US media to appreciate the Israeli point of view. Israel's latest violation of the Security Council resolution on Jenin fact finding mission with benign indulgence of the sole superpower points out to this direction.

However, it would be unfair to the 54 years' history of the State of Israel to say that it mulled all UN resolutions. The Zionist Movement embraced the UN General Assembly resolution No 181 of 1947 with jubilation on an unparalleled scale. That was the Anglo-American sponsored resolution adopted at the UNGA for Partition of the Palestinian territory providing for the creation of the Israeli State and the Arab Palestinian State. Palestine comprises some 10,000 square miles. Of this, the Arabs who constituted two-third of the population, were to retain 4,300square miles while the Jews who represented one-third of the population and owned 6 percent of the land , were allotted 5,700 square miles. The Jews also awarded the fertile coastal belt while the Arabs were to fend for the hills. The partition plan legitimized what had been illegitimately acquired. It was a charter of legitimacy for the State of Israel and fulfilled thousand years of quest for a homeland for the Jews who were unable to live with other people.To date the Zionist accepted and implemented only one significant UN resolution that voted to create the State of Israel without boundary in 1947. In the words of Moshe Dayan one-eyed hero of 1948 and 1956 wars "people abroad should realise that, quite apart from their strategic importance to Israel, Sinai, the Golan Heights, the Tiran Straits and the hills west of Jordan lie at the heart of the Jewish history. We have not yet reached the end of the road. It is the people of Israel who will determine the frontiers of their own state."

It is educative to read the fundamental Zionist principles enshrined in Israel's Declaration of Independence of 1948 which includes the following: "The State of Israel will be open for Jewish immigration and for the Ingathering of the Exiles. It will foster the development of the country for the benefit of all its inhabitants. It will be based on freedom, justice and peace according to the vision of the prophets of Israel. It will ensure complete equality of social and political rights for all its citizens, irrespective of religion, conscience, language, education and culture. It will safeguard the Holy Places of all religions and it will be faithful to the principles of the Charter of the United Nations."

How many principles of the Charter of the United Nations have been laid to rest under the Palestinian bodies in the Sabra, Chatila and the Jenin refugee camps? Perhaps Ariel Sharon only knows.

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CORRIGENDUM

The designation of the author at the bottom of the article "A city of rickshaws ..." published on Focus page of Friday, May 10, should be read as ".... Additional IG ..." instead of ".... AIG....".

Alzheimer's disease now has treatment

PROF ST HOQUE

MR Rahman, aged 80, is unaware of the most recent events in his life, and sometimes even forgets the name of his daughter, Marium, who cares for him, and whose home he now lives in. He has only a hazy idea of where he is or what day or year it is. He sleeps in the day, wakes in the night and would wander off if not supervised. He is aggressive and sometimes violent towards Marium and her family, and imagines that there are burglars in the house. Marium has had to give up her job to look after him. Twenty years ago, aged 60, Mr Rahman was a primary school head teacher in charge of 200 children and 10 staff, and looking forward to an active and fulfilling retirement.

These symptoms are not only related to advancing age but may be considered as disease. This disease is known as Alzheimer's Disease (AD). Let's start by becoming familiar with the disease.

Dementia is a decline from the individual's previous level of function in memory and also a decline in intellectual functions such as abstract thinking, judgement, language constractional ability. We can say its a change in personality. Dementia is more than just failing memory. And AD is a common type of dementia. AD is a progressive dementia of gradual onset not explained by other causes. In day to day practice, AD is a diagnosis based on an assessment of clinical features and exclusion of other causes. Ten warning signs of Alzheimer's Disease (AD) are:

- Recent memory loss that affects job skills
- Difficulty in performing familiar tasks.
- problem with language
- disorientation of time and place
- Poor or decreased judgement
- Problems with abstract thinking
- Misplacing things
- Changes in personality
- Changes in mood or behaviour
- Loss of initiative

The diagnosis of AD becomes 100 per cent certain only after autopsy.

The other common type of dementia is vascular Dementia, a multi-infarct Dementia which is usually caused by multiple strokes at different times. Sign and symptoms are: abnormal reflexes; abnormal gait; muscle weakness. About 70 per cent of dementia is AD and 30 per cent vascular.

AD is distinct from normal aging, but memory impairment may progress with AD. But AD is a well-defined disease and treatment is now available.

Community surveys suggest that AD is under-presented and/under-diagnosed.

Prevalence: The incidence of AD increases exponentially with age, between ages 65 and 85. The prevalence of AD doubles every five years.

Increases in life expectancy will lead to disproportionate increases in AD. Main known AD risk factors are:

Sex: Greater prevalence of AD in women than in men

Family history: Having a first degree relative with AD increases the risk of Dementia by a factor of about four.

Head injury: Single head injury at least doubles the risk of AD

Lack of education: Lack of education roughly doubles the risk of having AD at age 75.

Causes:

1. The hypothesis is that a deficit in cholinergic neurotransmission is an important causative factor. The key characteristic of the AD brain is extensive and progressive loss of neurons

2. The cholinergic theory of AD is founded on two observations in mid 70's: a) In AD brains, cholinergic nerves in the cortex are significantly and selectively depleted. b) Blockage of cholinergic receptors in normal humans causes memory loss.

3. Acetylcholin as well as other neurotransmitters operate in the brain. Due to deficit in cholinergic neurotransmission the other neurotransmitters do not maintain the physiological function of cortex.

4. Calcium transport: AD patients show elevated levels of calcium. This can damage neuron directly by increasing the toxicity of glutamate. Glutamate is an amino acid present in high concentrations in the cortex which has neurotransmitter function.

5. Inflammation: AD lesions show inflammatory changes which may be a cause of neuronal destruction.

6. Aluminium is known to be neurotoxic. In AD brain high level of aluminium is detected. The evidence suggests that aluminium may have a contributory role in the disease process.

7. Genetic factors: The presence of the apoE4gene is an indicator of the risk of developing AD.

Conclusion: Cholinergic neurons beneath the cortex project a rich network of fibres through the cortex and are thought to be involved in sleep and arousal, mood and emotions, attention and memory.

The loss of cholinergic neurotransmission in the cortex is one of the most consistent findings in AD. In some areas of the brain more than 75 per cent of cholinergic nerve fibres are lost in AD.

In AD there is a reduction of cholinergic receptors, particularly of nicotinic receptors, in the cortex. Cholineric deficit correlates with the extent and type of dementia seen in AD. Cholinergic depletion occurs in normal aging but later and to a lesser degree than in AD.

Some doctors offer some patients some treatments, but many patients receive no specific AD treatment. Specialists and GPs everywhere are well aware of the lack of safe and effective treatment. Perhaps because there is so little in the way of effective treatment, and perhaps because many people confuse AD with the very mild cognitive decline that is part of normal ageing, many AD patients and the people who care for them do not seek medical help and they remain undiagnosed and unknown to the health care system. And from the physician's point of view, often it is: why diagnose AD when you cannot treat it? AD wrecks the lives of caregivers as well as patients. The caregivers are more badly affected than the patient. The fact is that AD caregivers have a high incidence of clinical depression and anxiety.

AD represents a huge burden to patient, caregiver, family and society as a whole. As the disease is somewhat shameful, we do not talk about it or get it diagnosed. Much of the passive approach has to do with the fact that no effective treatment is available.

For the first time, new treatments are being approved by regulatory authorities (FDA). Recent drug is also available in Bangladesh. These treatments benefit patients and caregivers and are easy to use. Our task is to convince people that patients and caregivers deserve the opportunity to receive active assistance. This includes diagnosis (as prognosis of what lies ahead), drug therapy and psychological care.

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