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DELHI MEDICAL ASSOCIATION

OFFICIAL ORGAN OF DELHI STATE BRANCH INDIAN MEDICAL ASSOCIATION

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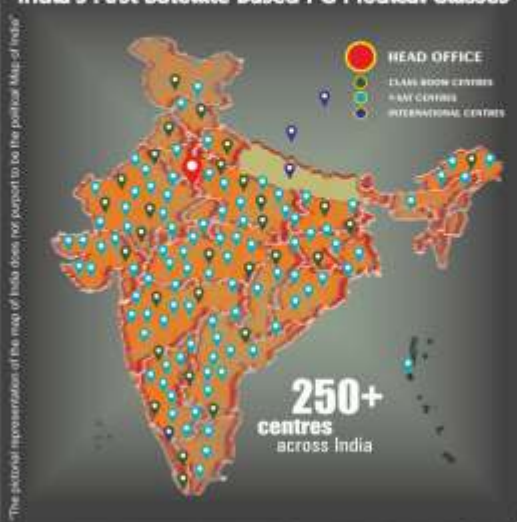
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PRESIDENT'S PEN...

Breaking bad news to patient is one of the most difficult responsibilities in practice of medicine. Although virtually all physicians in clinical practice encounter situations entailing bad news, medical colleges offer little formal training in how to discuss bad news with patients and their families.

Without proper training, the discomfort and uncertainty associated with breaking bad news may lead physicians to emotionally disengage from patients. Patients generally desire frank and empathetic disclosure of a terminal diagnosis or other bad news.

Breaking Bad News

How should Bad News Be Delivered ::

A- Advance preparation

Familiarise yourself with the relevant clinical information. Arrange for adequate time in private, comfortable location. There should not be interruptions because of your staff or colleague or phone.

B - Build a therapeutic environment/ relationship

C- Communicate well

Ask what the patient or family already knows and understands. Speak firmly but compassionately. Avoid euphemisms and medical jargon. Proceed at the patient's pace. **Encourage questions.**

D - Deal with patient and family reactions

Assess and respond to emotional reactions. Be aware of cognitive coping strategies (denial, blame, intellectualization, disbelief, acceptance). Be attuned to body language. Be empathetic. Do not argue with or criticise colleagues.

E - Encourage and validate emotions

Offer realistic hope. Discuss treatment options at the outset and arrange follow-up meetings for decision making.

Good communication has a therapeutic effect on patient and bad communication leads to a detrimental outcome.

Breaking bad news is part of the art of medicine. A bad news is always a bad news, however well it is said. But the manner in which it is conveyed can have a profound effect on both the recipient (the patient) and the giver (the physician). If done badly, it will hamper the well being of patient, impair the quality of life and future contact with health care professional will be thwarted. It is a skill that has to be learnt by the physicians.

Despite the challenges involved in delivering bad news, we can find tremendous gratification in providing a therapeutic presence during a patient's time of greatest need. Physician's attitude and communication skills play a crucial role in how well patients cope with bad news and that patients and physicians will benefit if physicians are better trained for this difficult task. The limits of medicine assure that patients cannot always be cured.

Last week a news item published in a national daily heading Pharma companies offer even women to bribe doctors. Taking a strong opposition to this news DMA challenge the authenticity of this report as 50 people is a very very small sample size. This Report is based on interviews with MR's, area sales managers, allopathic and Ayush doctors and pharma executives. The intention of such kind of sensational news is to malign the image of medical profession and to increase the TRP which will mislead the masses and make them hostile towards medical fraternity. DMA never advocates this system of incentives to Doctors by the pharma companies for prescribing their products. DMA is taking up this issues with concerned authorities.

Dr. Girish Tyagi
President



HONY. ASSOCIATE EDITOR'S PEN...

Dear all,

According to various theories of jurisprudence the law is like science which keeps on developing each passing day, after their inception based on

historical traditions and social needs.

The law once found to be a good balance between competing interests of society, are codified by a set procedure and becomes the statute to be followed in letter and spirit by the courts, lawyers and law enforcing agencies.

However the judgements of supreme courts themselves become law and enforced till they are either enacted by legislature to become statute or over ruled by law makers. Such laws are called as common law or case laws.

One such case law enforced by Hon'ble supreme court in August 1989 in the famous Parmanand Katara versus Union of India case in which a humane and moral duty of medical professionals for rendering emergency care to all, specially the accident victims, have been made a legal obligation, without any financial considerations.

The judgement given almost four decades back was so much overwhelmed by the emotional overlays of the facts of that case, that neither the extent of emergency care was defined elaborately, nor the financial implications of the same were even thought of.

It was the duty of the legislature to enact a comprehensive statute

after due deliberations where, on one hand the need of society be addressed and on the other hand the financial implications of any such service rendered by private hospitals are duly compensated.

The legislature miserably failed to do its duty in last 40 yrs. and the unjust decision of then judges continues to be a law till date.

The government of NCT of Delhi has come out with the welcome scheme to offer financial reimbursement for any cost incurred in this, but it is still unacceptable by and large, since the rates offered are dismally low, in utter disregard to the cost analysis, for providing emergency care of undefined dimensions, marred with varieties of legal obligations.

Further the DAK scheme enforces the private hospital for complete treatment which may continue for months, on totally unaffordable rates.

The legal enforcement of any such directive by the state is against the fundamental rights, the directive principles, the common law and medical ethics, all of them say that a doctor has the right to choose his patients and none can be enforced on him.

Such compulsions on fraternity deserves to be challenged in court of law by our associations with the finest legal opinions and representations.

Dr. Kamal Parwal

Hony. Associate Editor

TABLE TENNIS TOURNAMENT - Report

Annual sports TT tournament played at AIIMS GYMKHANA on 1st December accomplished successfully with a crowd of many competitive champions gathering from all over Delhi. Final result was winner Dr. Amit Johri and Runners Up Dr. Ashok Goyal Vasant Vihar. The spotlight and outstanding performance and player of the tournament was none other than 66 year veteran stalwart past winner and runners up of past DMA tournaments more than 10 times. DR.GOYAL was simply unparalleled and unplayable with his agility accurate unpickable killer shots. When asked about this agility at this age he attributed it all to his disciplined life style with 12 km run and cycling. And good wishes and blessings from his near dear ones. Dr. Amit Johri service was magical as it floored almost all the opponents. Third and fourth position taken by Dr Shailendra and Ashish Turkey. Congratulations to all the winners better luck for all the other participants next time Finally TT tournament ended with sumptuous snacks and drinks.

Dr. Girish Tyagi
President, DMA

Dr. Arvind Chopra
Hony. State Secretary, DMA

Dr. T.S. Daral
Chairman DMA Club

Dr. N.K. Gupta
Secretary DMA Club





Hony. State Secretary's Pen...

Dear Colleagues,

Recently a leading News Paper published a story with captioned "PHARMA COMPANIES OFFER EVEN WOMEN TO BRIBE DOCS: STUDY"

First of all, DMA strongly condemns this kind of malpractices adopted by the pharmaceuticals companies. DMA never

advocates this system of incentives to doctors by the pharma companies for prescribing their products.

As per the story, the said study report is based on in-depth interviews with 50 MRs, areas sales managers, A

llopathy and Ayush Doctors and pharma executive. Now the questioned is this that which company has done a survey, what is its authenticity and how many, people involved in the survey (including Allopathy doctors Ayush Doctor and any other) and on what basis the said News Paper has conducted this study?

Moreover, how can such a reputed Newspaper defaming the image of the medical profession on the viewpoints of 50 persons only?

In the past few years news captioned like "Doctor Ne Clinic mai Ladki ko Cheda", "Doctor Ghoos lete hue padka gaya", "Doctor ke laperwahi se jaan gayee" etc..published in the news papers with sole intention to malign the image of the medical profession and to increase their TRP and to instigate the mislead the masses and make them hostile towards medical fraternity. But after investigation, it was found that that in 90% cases the said DOCTOR either is QUACK OR NON-ALLOPATHIC MEDICO PERSON.

It hurts us immensely that on news items, features the objectionable articles, wherein they defamed our medical community with offensive allegations. The very title of the article puts our noble profession in a bad light. We fail to understand that why the respected newspaper published such an article that can potentially betray the trust of the common man in the work efficiency of doctors and drain the whole enthusiasm of work performance from professionals like us.

In the past also DMA Complaint against Ms. Anjana Om Kashyap, reporter of AAJ Tak, Bihar Tak news channel for violating Code of Ethics & Broadcasting Standards and ruining the image of medical profession to the Press Council of India and Ministry of Information and Broadcasting, Govt of India and we have also received a reply from the Press Council of India that they warned the reporter and the channel that in future all the measure and protocol be taken care off and see to it sentiments of the persons may not be hurt.

DMA always stands united in condemning such slandering and misleading articles who are defaming the image of medical profession.

Last but not the least I congratulate the President Dr. Prem Aggarwal and Secretary Dr. Ashwini Dalmiya of IMA Central Delhi Branch for organising such a wonder day long self sufficient conference CLINICON 2019- PERALS OF PRACTICE on 1st December 2019. Speakers like Dr. Yashpal Sharma from PGI Chandigarh, Dr. Anupam Sibal, Prof. Sanjay Tyagi, Prof. Anil Aggarwal, Prof. N.P. Singh, Dr. J.C. Passey were enlightened the delegates with their knowledge and experience.

Dr. Arvind Chopra

Hony. State Secretary



Trauma is the major public health problem worldwide. It is one of the leading causes of death and disability in both developing and developed countries. Nobody is immune to trauma. Every 5 seconds someone in the world dies as a result of an injury i.e. 5.8 million people of all ages and economic groups die each year from both unintentional and violence related injuries. This accounts for 10% of the world's deaths, 32% more than the number of fatalities that result from malaria, tuberculosis, and HIV/AIDS combined.

In the global estimates of 1998, injury accounted for 16% and road traffic injuries (RTIs) were the ninth leading cause of the burden of morbidity. Each year nearly 1.6 million people die as a result of a road traffic collision worldwide - more than 3000 deaths each day - and more than half of these people are the so called vulnerable road users (bicyclists and pedestrians). Twenty to fifty million more people sustain non-fatal injuries from a collision, and these injuries are an important cause of disability. Ninety per cent of road traffic deaths occur in low- and middle-income countries, which claim less than half the world's registered vehicle fleet. Road traffic injuries are among the three leading causes of death for people between 5 and 44 years of age, the most commonly affected group being men in the productive years of life. In India, more than three-fourths of all registered vehicles are motorized two - or three - wheelers in 2004 with four-wheelers in the minority. By 2020, RTIs are predicted to be the third leading cause of morbidity surpassing leading communicable diseases. As regards the disability adjusted life years (DALY's) Injury surpasses both Cancer and Cardiovascular diseases which are diseases of 5th and 6th decade of life. The United Nations Decade of Action for Road Safety (2011-2020) aims to reduce to half, the 1.3 million traffic-related deaths each year by 2020 through various measures including road safety management, safer vehicles, better informed road users and an improved post-crash response.

India is in transition from a largely agriculture based to an industry and technology focused economy. It is the largest country in the South-Asian region with a very high youth and middle-aged population, which given the changing economy, has largely adopted mechanized transport. Although in absence of hospital based data for trauma mortality, according to National Crimes Record Bureau 1,77,423 lives were lost and 4,86,567 persons were injured on Indian roads in 2015. These numbers are increasing every year. India has the highest Road crash mortality in the world. This spurt in vehicular density, however, has been so rapid that there has been little time spent by citizens and policy makers, on safety parameters associated with such high levels of mechanization. Multiplicity of road users competing for the same space on highways leads to frequent road crashes. The attitude of the public is devoid of a basic sense of safe driving, as exemplified by the high prevalence of driving without seatbelt and drunken driving. The younger generation casually violates traffic laws and frequently disregards existing speed limits, a phenomenon especially common among the users of two-wheelers. Another disconcerting phenomenon is the widespread neglect for the use of protective gear such as helmets. It is important to note that more than 50% of trauma related mortality are due to head injury. This is accompanied by a staggering increase in the socioeconomic burden, depletion of human resources, as well as emotional and psychological trauma on caregivers. As a result, the already overly taxed healthcare delivery system is put under additional strain.

Causes of increased Trauma fatalities in India

The important reasons of increased mortality in developing countries like India are non-availability of Trauma Systems in a given geographical area, which include care from the injury site till rehabilitation. In a nutshell a trauma care system works towards "**getting the right patient in the right time to the right health care facility for the right care**".

Provision of Essential Emergency Trauma Care Universally:

a. Pre-hospital Care

Twenty-two states and 2 Union Territories have adopted the Universal Emergency Number 108 for Ambulance/ Police and Fire. The current systems run on GPS/ GPRS Systems, but are not backed by proper legislative and regulatory control over

manpower training and organizational aspects. Recently, Telecom Commission, on March 28, 2016, accepted recommendation by Telecom Regulatory Authority of India (TRAI) for making 112 as single emergency number for all services like police, fire and ambulance in the country.

b. In-Hospital Trauma Care

- i. Infrastructure:** The secondary (CHC/ District Hospitals) and tertiary (University/ Teaching Hospitals) health care infrastructure presently cannot cater to the needs of multiply injured patients. There is a lack of well-equipped Emergency departments across the country. The well-equipped Emergency Departments of private hospitals do not provide holistic care to all due to economic constraints of the injured patients.
- ii. Trained Manpower:** There is lack of trained manpower that can effectively cater to the seriously injured patient at all the levels of health care (Primary, Secondary and Tertiary). The concept of a Trauma Team is non-existent and often the persons taking care of the patients are not adequately trained/ skilled in life saving protocols and procedures.
 1. Lack of trained doctors and nurses in emergency departments (CMO's and GDMO's)
 2. Absence of Trauma Surgeons/ trained surgical specialists in trauma
 3. Insufficient numbers of super specialists in various fields, taking care of an injured patient (neurosurgeons, trauma intensive care etc.)
 4. Insufficient numbers of rehabilitation professionals in hospitals

Efforts towards improving Trauma Care in India

Both the Union Ministry of Health and Family welfare (MoHFW) and the Ministry of Road Transport and highways (MoRTH), have been engaged in achieving the target of road death reduction in a big way. Although health is a state subject, the union government is planning to hand hold the states by giving them adequate infrastructure facilities for trauma care

Establishment and up-gradation of Trauma Care facilities at big University Hospitals (PMSSY Scheme)

It should be once again emphasized that establishment of innumerable Trauma Centers with heavy financial burden is not the goal of policy makers. Instead, up gradation of existing hospital infrastructure to treat severely injured patients has been undertaken. In this regard the Govt. of India plans to and is in the process of establishing about 27 Level I (presence of all specialties involved in trauma care with teaching training and research), 127 Level II Centers, 260 Level III Centre's all over the country. Many of these centers are already established and have started functioning.

In addition, establishment of 16 more AIIMS like institutions all over the country with fully developed Emergency and Trauma Care facilities will add to the capacity for trauma care in the country.

A responsible citizen

Majority of persons (more than 50 percent) die at the scene following road traffic crash and only preventive strategies can reduce this number. As a responsible citizen, it is our duty to obey traffic rules such as no drinking driving, no use of mobile phones, use of Zebra crossing, use safety devices such as helmet, seat belt etc.

A Good Samaritan

A Good Samaritan is a person who, in good faith, without expectation of payment or reward and without any duty of care or special relationship, voluntarily comes forward to administer immediate assistance or emergency care to a person injured in an accident, or crash, or emergency medical condition, or emergency situation.

Some important points about "Good Samaritan Law" are-

1. A Good Samaritan will not be liable for any civil or criminal action for any injury or death of the victim.
2. Good Samaritan who informs police or emergency service regarding an injured person not to be compelled to reveal his personal details.
3. Disciplinary action against public officials who coerce Good Samaritan to reveal his personal details.

DMA GUIDELINES FOR ISSUING A MEDICAL CERTIFICATE

- (a) Medical certificates are legal documents. Medical practitioners who deliberately issue a false, misleading or inaccurate certificate could face disciplinary action under the Indian Medical Council (Professional Conduct, Etiquette and Ethics), Regulations, 2002. Medical practitioners may also expose themselves to civil or criminal legal action. Medical practitioners can assist their patient by displaying a notice to this effect in their waiting room.

It is, therefore, a misnomer to state that medical certificate is “not valid for legal or court purpose”, and should be avoided. Registered medical practitioners are legally responsible for their statements and signing a false certificate may result in a registered medical practitioner facing a charge of negligence or fraud.

- (b) The certificate should be legible, written on the doctor’s letterhead and should not contain abbreviation or medical jargon. The certificate should be based on facts known to the doctor. The certificate may include information provided by the patient but any medical statement must be based upon the doctor’s own observation or must indicate the factual basis of those statements. The certificate should only be issued in respect of an illness or injury observed by the doctor or reported by the patient and deemed to be true by the doctor.

The Certificate should :-

- (I) Indicate the date on which the examination took place.
- (II) Indicate the degree of incapacity of the patient as appropriate
- (III) Indicate the date on which the doctor considers the patient is likely to be able to return to work
- (IV) Be addressed to the party requiring the certificate as evidence of illness e.g. employer, insurer, magistrate
- (V) Indicate the date the certificate was written and signed.
- (VI) Name, Signature, Qualification and registered number of the consulting Registered Medical Practitioner.
- (VII) The nature and probable duration of the illness should also be specified. This certificate must be accompanied by a brief resume of the case giving the nature of the illness, its symptoms, causes and duration.

When issuing a sickness certificate, doctors should consider whether or not an injured or partially incapacitated patient could return to work with altered duties.

- (c) The medical certificate under normal circumstances, as a rule, should be prospective in nature i.e. it may specify the anticipated period of absence from duty necessitated because of the ailment of the patient. However, there may be medical conditions which enable the medical practitioners to certify that a period of illness occurred prior to the date of examination, particularly in relation to patients with a minor short illness which is not demonstrable on the day of examination and should add supplementary remark, where appropriate, to explain the circumstances which warranted the issuance of certificate retrospective in nature.
- (d) It is further observed that under no circumstances, a medical certificate should certify period of

absence from duty, for a duration of more than 15 days. In case the medical condition of patient is of such a nature that it may require further absence from duty, then in such case a fresh medical certificate may be issued.

- (e) Record of issuing medical certificate - Documentation should include :
- (I) Patient to put signature/thumb impression on the medical certificate
 - (II) Identification marks to be mentioned on medical certificate
 - (III) That a medical certificate has been issued
 - (IV) The date/time range covered by the medical certificate
 - (V) The level of incapacity (i.e. unfit for work, light duties, etc within scope of practice)
 - (VI) Signature/Thumb impression of patient

An official serially numbered certificate should be utilized. The original medical certificate is given to the patient to provide the documentary evidence for the employer.

The duplicate copy will remain in the Medical Certificate book for records. The records of medical certificate are to be retained with the doctor a period of 3 years from the date of issue.

Dr Girish Tyagi
President, DMA

Dr Arvind Chopra
Hony. Secretary, DMA

Dr Arun Gupta
President DMC

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BRANCH NEWS

IMA DNZ BRANCH

IMA-DNZ organised an **CME** on 29 November 2019 at Hotel Crowne Plaza, Rohini. Dr Aparna Jaswal, a renowned cardiologist & expert in Electrophysiologist at Fortis Escorts Hospital deliberated on Stroke Prevention in AF & some new devices.

It was highly appreciated by audience for simplicity & clear concept. Dr N N Jha, President moderated the session. More than 125 doctors including past presidents, senior physicians of the area participated.



Dear friends, On **World Diabetes Day** on 14 November 2019, IMA-DNZ in association with NDPF & Saroj Hospital, Rohini organised an audiovisual education awareness programme on various aspects of Diabetes.

Dr N N Jha, President DNZ & Sr Physician along with Dr R M Chhabra & Dr S K Mundra Sr Physicians elaborated different aspects of DM. Dr RV Singh Sr Eye surgeon & Past President DNZ educated about eye complications. It was well attended by more than 100 persons.

The event was followed by refreshment for doctors.



IMA KAROL BAGH BRANCH

IMA KBB organised lecture on **Good Touch and Bad Touch** by Dr Latika Bhalla at the MCD Primary School, New Rajinder Nagar on 29th November 2019. Sukriti Gupta from Modern School helped as young peer educator promoting the use of Biodegradable Sanitary Pads.





दिल्ली मेडिकल एसोशिएशन

एवं

हिन्दी अकादमी

द्वारा आयोजित

हास्य कवि सम्मेलन

रविवार 29 दिसम्बर, 2019

स्थान :

**दिल्ली मेडिकल एसोशिएशन
डी.एम.ए. हाऊस, दरियागंज, नई दिल्ली-110002**

समय: 7.00 बजे सायं से

आमंत्रित कविगण :

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डॉ. टी.एस. दराल

आप सब सादर आमंत्रित हैं।

डॉ. गिरीश त्यागी
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डॉ. एन.के. गुप्ता
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Neurology Services

The Department of Neurology is among the largest and oldest in North India, providing comprehensive care to all kinds of neurological ailments besides imparting education to postgraduates and participating in clinical research activities. We provide 24x7x365 emergency services by a dedicated team of neurologists backed by equipped ICU with critical care medicine department, among the best in the country. A day long outpatient consultancy operates from 8 am to 8 pm on all working days which includes free general OPD services for 2 hours, four times a week. Robust and dynamic leading performances with 9 postgraduates, aims for an exceptional patient care and safety. Together with dedicated faculty and epidemiologist, there is a stimulus for research. There is a well respected Ethics Committee in place.

The phrase of 'Time is Brain' in Acute Ischemic Stroke is pursued with utmost care, which meets international standards and adheres to Stroke Unit concept. Epilepsy program, approach to neuromuscular disorder and EMG guided Botulinum Toxin. A injection is supported by an excellent clinical neuro-physiological lab, headed by personnel specially trained in the field. Pioneering work in chronic degenerative neurology backed up by an excellent genetic and nuclear medicine department. Neuro-immunology, an upcoming and exciting sub-specialty is of special interest due to an excellent outcome with timely care.

Psychiatry Services

Institute of Psychiatry and Behavioral Sciences is well equipped to deal with increasing load of persons with psychological issues and psychiatric morbidity and contributes to the mental health and psychological well being of the society by its multifarious activities. Mental illnesses cause immense misery and distress affecting multiple areas of a person's life including socio-occupational functioning. Mental disorders (9.7%) rank almost as high as cardiovascular diseases (10.5%) in the total global burden of diseases. The WHO has projected depression as 2nd in the urgent health problems worldwide by 2020.

The Team

The SGRH team of committed mental health professionals is well trained from some of the best academic institutes of India. We have :

- 8 Psychiatrists including 2 Child Psychiatrists
- 5 Clinical Psychologists
- 2 Occupational Therapists
- 2 Special Educators

Facilities:

- General and private inpatient and outpatient services on all working days
- Emergency services on all days

We cater to whole spectrum of psychological and behavioral problems and psychiatric disorders viz :

- General Psychiatry: Anxiety Disorders, Mood Disorders, Psychotic Disorders, Psychosexual Disorders, Stress, Interpersonal Issues and Lifestyle Issues
- De-addiction: Alcohol and Drug Dependence, Behavioral and Technology Dependence
- Child Psychiatry: ADHD, Autism Spectrum Disorder, Behavioral Issues, Parental Guidance
- Liaison Consultation Services: Medical Patients with Psychiatric Issues, support for patients of Kidney and Liver Transplant, support for Gender Dysphoria in Plastic Surgery, Assistance in Reproduction
- Emergency Psychiatry: For severely sick Psychiatric patients
- Counseling and Psychotherapy: Interpersonal Therapy, Marital Therapy, CBT etc.
- Psychological Assessment: To support Psychiatric, Psychotherapeutic and Certification work

Academic activities :

- We constantly strive to update ourselves to strengthen our mental health services and professional skills :
- DNB Program for post graduate teaching and training for over a decade
- Psychology Internship and observership Program of over two decades is sought by students from all over India and overseas
- The Institute and its team members have a robust presence in professional societies and conferences



Neurology Team

Sitting L to R: Dr. Rajeev Ranjan, Dr. Ish Anand, Dr. PK.Sethi, Dr.C.S.Agarwal, Dr.Anshu Rohatgi, Dr.Laxmikant R.Tomar, Dr.Anuradha Batra
Standing L to R: Dr. Rajeshwari R, Dr.Nirja, Dr.Shah Dhruvil Jatinbhai, Dr.Neha Pandita, Dr.Rahul Sharma



Neuro Surgery Team

Dr. Anshul Gupta, Dr. Rajesh Acharya, Dr. Samir Kalra, Dr. Satnam Singh Chhabra, Dr. Aijt Kumar Sinha, Dr. H. N. Agarwal



Psychiatry Team

Sitting L to R: Dr. Arti Anand, Dr. J.M.Wadhawan, Dr. Anita Mahajan, Dr. V.Kumar, Dr. Rajiv Goyal
Standing L to R: Ms. Anandita Anand, Dr. Priyanka Halwasiya, Dr. Rajiv Mehta, Dr. Soumya Tandon, Dr. Roma Kumar, Dr. Deepak Gupta

Helpline : Neurology + 91 11 42252077, Neurosurgery 42252073, Psychiatry 9711577911

Neurosurgery Services

The Department of Neurosurgery at SGRH is one of the largest and oldest in private setup with state of the art operation theatres and ICU set-up. Since its inception the department has performed about 30,000 Neurosurgical procedures. Department is well equipped to perform surgeries for:

- Emergency Management** : Head & Spinal injuries; Brain Haemorrhage
- Brain Tumours**
- Aneurysms** : AVM Surgery and Coiling
- Hydrocephalus** : Shunting and Endoscopic Procedure
- Functional Neurosurgery** : Tremors, Parkinson's Disease
- Spinal Surgery** : Tumours, Disc Surgery, Fixation, Cranio-vertebral Anomalies
- Pediatric Neurosurgery** : Tumours, Hydrocephalus, Spinal Dysraphisms-meningocele, Craniostenosis
- Peripheral Nerve Surgery** : Brachial plexus Injuries, Carpal Tunnel Syndrome, Entrapment Neuropathies, Nerve injury etc.

Specialised Procedures :

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Message from the Chairman

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AIIMS TOPPERS NOV 2019

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GUIDELINES FOR DOCTORS ON SEXUAL BOUNDARIES

Indian Psychiatric Society (IPS) Task Force on Boundary Guidelines

The guidelines for doctors on sexual boundaries was first drafted by **The Bangalore Declaration Group**. **The Indian Psychiatric Society (IPS)** has subsequently worked on this document and publish these guidelines with a view that IPS will hold all members to its ethical standard.

- 1) It is the ethical duty of all doctors to ensure effective care for their patients. This would mean that their own conduct should in no way harm their patient. Sexual relationships between doctors and patients invariably harm both the patient and the doctor. Trust, which is central to an effective doctor patient relationship, is inevitably damaged. In view of the power gradient that invariably exists in the doctor patient relationship, the onus is on the doctor to ensure he or she does not enter into an romantic or sexual relationship with a patient.
- 2) While the laws relating to sexual abuse in India generally pertain to women, these Guidelines aim to be gender neutral and serve as a guide to a code of conduct on doctors of any gender, and to protect patients of all genders too.
- 3) Doctors should ensure that they do not exploit the doctor patient relationship for personal, social, business or sexual gain.
- 4) In view of the power gradient in the doctor patient relationship and possible transference issues, doctors are reminded that even 'consensual' sexual activity between patients and doctors irretrievably changes the therapeutic nature of the doctor patient dynamic. This would be detrimental to the patient (even from the viewpoint of interfering with good medical care). This would mean that even if it is the patient who attempts to initiate the sexual relationship, it would be against good medical practice for a doctor to enter into such a relationship. Besides, it can be said that consent in a power imbalanced relationship is not true consent. While in some situations it may not be considered as 'illegal', these Guidelines would still consider it as a Sexual Boundary Violation (SBV).
- 5) Any non consensual sexual activity would amount to sexual abuse/ molestation/ rape and doctors would be answerable to the law of the land. (Indian Penal Code laws relate to rape, child sexual abuse, sexual molestation, adultery and sexual harassment in the workplace). Sexual activity with a person less than 18 years of age in India amounts to statutory rape (consent immaterial). The Indian Penal Code states that consent for a sexual relationship with a woman of 'unsound mind', is deemed invalid and amounts to rape. The Indian Criminal Law Amendment Act (2013), lists out details of what behaviour is tantamount to sexual harassment and stalking. Section 376C (d) states the punishment for anyone in a position of authority in a hospital, if they misuse their authority by having sexual contact with someone under their care.
- 6) It is obviously important for doctors to take a relevant sexual history and perform appropriate physical examination. This should be done sensitively and documented properly in the notes. If intimate examination is done, gloves should be used, a chaperone present and indication and findings documented in the notes. All this should be communicated properly to patients, to prevent any subsequent misunderstandings. The doctor should not touch a patient inappropriately in the guise of physical examination or sexual therapy, for own sexual gratification. Doctors need to be aware that sexual boundary violations (SBVs) can occur in all gender dyads.
- 7) If treatment that requires the patient to be sedated is used (like electroconvulsive therapy, or any procedure that requires anaesthesia), a nurse should be present during the induction and recovery of anaesthesia. This is good medical practice, not just a deterrent to sexual abuse.
- 8) Doctors are reminded that even a relationship with a *former* patient is discouraged and could be construed as unethical, as the previous professional relationship can influence the current relationship. There are serious

difficulties in defining the time frame that should elapse after the doctor patient relationship is terminated, after which a doctor *may* consider having a sexual relationship with a patient (if existing laws of the Indian Penal Code are not broken). One difficulty is that the ending of 'treatment' does not signify the end of the 'doctor patient relationship' in view of multiple issues involved, including relapse rates of illnesses and individual vulnerabilities of patients.

If, for whatever reason a doctor feels it imperative to have a romantic/ sexual relationship with a patient (and again, if this does not involve the breaking of any laws), then the doctor should ensure the patient's care is 'handed over' properly to another doctor. It is extremely important that the doctor discuss the issue with at least one senior colleague to ensure that the doctor himself/herself is not entering a relationship due to his/her own vulnerabilities which need to be addressed and the former patient is clearly not being exploited. Till evidence suggesting otherwise be obtained, IPS puts the *time frame as 'one year at the very least, after termination of the doctor patient relationship', with the emphasis on 'at the very least'.*

- 9) It is impractical to have a detailed list of do's and don'ts regarding Non Sexual Boundary Violations (NSBVs) as often it is the context which differentiates an acceptable boundary crossing from an unacceptable boundary violation. However, it would be useful to note that sometimes NSBVs can 'slip into' SBVs. It would be important for all doctors to be alert to warning signals in their own (or in their colleague's), as well as patients' behaviour in these situations.
- 10) Doctors are reminded to ensure that they use social media responsibly, as it can inadvertently lead to a blurring of professional boundaries.
- 11) As doctors are to ensure they do not exploit the doctor patient relationship for sexual gain, it would also imply that these Guidelines extend to protect the family members of patients too. (This would extend to family members who are also part of the therapeutic doctor patient/ family dynamic).
- 12) Any failure to follow these Guidelines, if reported to the Indian Psychiatric Society(IPS) will be referred to the Ethics Committee. It is suggested that all allegations of SBV be taken up for initial enquiry by the Ethics Committee of the IPS. If considered appropriate, they will refer the case to the local "Internal Complaints Committee" (as required by the Supreme Court mandated law on Prevention of Sexual Harassment of Women in the Workplace (Prevention, Prohibition and Redressal Act 2013.) Though this law pertains to women at the workplace, many hospitals/ nursing homes have gender neutral policies which extends to patients too.

If any criminal act is reported, then the appropriate process of enquiry by the police should be initiated. Doctors are reminded of their own ethical obligation to report unethical conduct by colleagues. (As listed in Section 1.7 of The Indian Medical Council (Professional conduct, Etiquette and Ethics) Regulations, 2002). Where children are involved, reporting is mandatory or risks imprisonment (Protection of Children from Sexual Offences Act, POCSO 2012).

- 13) Though these Guidelines pertains primarily to patients, doctors are reminded that similar care should be extended to interactions with students, colleagues and other professionals in the multidisciplinary team- indeed anyone who is in a 'power imbalanced relationship' with the doctor.
- 14) False allegations can occur. It is important for doctors to be alert to warning signals and risk situations. If the doctor finds him/ herself in the midst of an allegation (whether true or false), it would be important to reach out to colleagues for support. Members of the IPS should be available to support a colleague during any enquiry into an allegation. In the event of an allegation, support should not mean 'covering up' the issue. If the allegation proves true on enquiry, the colleague should be supported to the face the consequences of his or her behaviour. Steps should be taken to access help to try and ensure that the behaviour does not recur and patients are protected.
- 15) The Indian Psychiatric Society recognizes that SBVs are not restricted to any particular group of doctors, indeed not restricted to doctors alone, but occurs in all professional groups. In endorsing this Guidelines for Doctors on Sexual Boundaries, the Indian Psychiatric Society takes one step towards effective action against sexual abuse in our society.



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MLAG Member/Resident Doctor/PG Student	INR 2,000/-	INR 2,500/-	INR 3,000/-
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CLINICAL APPROACH TO ACUTE SKIN PROBLEMS

DR. AMIT VIJ
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CONSULTANT DERMATOLOGIST
DELHI

APPROACH TO CUTANEOUS DRUG ERUPTION

New dermatitis/rash without prior skin disease should prompt the suspicion of drug sensitivity.	CHALLENGE - many medications + few new ones, because any one of these could cause an adverse reaction	Easy to diagnose when a patient who takes few or no medications develops a rash after starting a new drug.
Knowledge of prior allergies helps to identify any cross-reactivity to current medications	Adverse reactions can occur as late as 2 weeks after a medication has been discontinued	Past drug history

Medications - allopathic, homeopathic, ayurvedic, natural or traditional products in any form, regardless of the route of administration must be considered, especially new drugs taken in the first 8 weeks before the skin reaction.	Relationship between drug intake and the onset of clinical symptoms is critical. Unless the patient has been previously sensitized to a drug, the interval between initiation of therapy and the onset of reaction is rarely less than 1 week or more than 1 month.
Drugs taken intermittently or on an as-needed basis must also be considered. Questions regarding all vitamins, pain medications, sedatives, laxatives, oral contraceptives, over-the-counter medications and natural products.	Dechallenge (improvement after a decrease in dosage or stopping of drug) and rechallenge (recurrence or exacerbation of eruption after re-exposure to a drug) are also important to document but should not be tried by a physician and is contraindicated.
Analysis of Drug Exposure	

MORBILLIFORM / MACULOPAPULAR ERUPTIONS

- Frequent drug rash
- Can occur after almost any drug at any time.
- Features variable- morbilliform, scarlatiniform, rubelliform.
- Usually associated with severe pruritis
- Distribution variable- no specific fixed sites
- Fades off with desquamation or post inflammatory hyperpigmentation.
- D/D- Viral exanthem

MORBILLIFORM / MACULOPAPULAR ERUPTIONS



TYPES OF CUTANEOUS DRUG ERUPTION

- MORBILLIFORM / MACULOPAPULAR ERUPTIONS
- DRUG INDUCED URTICARIA
- SERUM SICKNESS
- DRESS
- ERYTHEMA MULTIFORME
- SJS & TEN

DRUG INDUCED URTICARIA

- Second most common drug reaction.
- Can occur 24-72 hours after intake of the medicine.
- Manifests as severely pruritic, circumscribed, raised, oedematous and erythematous wheals widely scattered on the body.
- Single lesions last less than 24 h, although new lesions may continue to arise.
- Seen in association with anaphylaxis, angio-oedema and serum sickness.

DRUG INDUCED URTICARIA



SERUM SICKNESS

- Type III immune complex-mediated reaction
- Occur between 5 days and 3 weeks after initial exposure.
- In its complete form, combines fever, urticaria, angio-oedema, joint pain and swelling, lymphadenopathy, and occasionally nephritis or endocarditis, with eosinophilia.
- In minor forms, fever, urticaria and transitory joint tenderness may be the only manifestations.

SERUM SICKNESS



DRESS

- Drug rash with eosinophilia and systemic symptoms (DRESS) syndrome
- It is a severe idiosyncratic reaction, syndrome comprises of
- Fever
- Facial oedema with infiltrated papules, generalized papulopustular or exanthematous rash which may extend to exfoliative dermatitis.
- Lymphadenopathy
- Haematological abnormalities - hypereosinophilia in 90% of cases
atypical lymphocytes/mononucleosis in 40% of cases
- Organ involvement - hepatitis, nephritis, pneumonitis, myocarditis, hypothyroidism, encephalitis.
- It usually develops 2-6 weeks after the drug is first administered.

DRESS



ERYTHEMA MULTIFORME

- An acute self-limiting illness
- Duration of episode less than four weeks
- Symmetrically and acrally distributed lesions, typical or raised atypical **TARGET** lesions.
- Absent or limited mucosal involvement.
- Recurrent episodes.

ERYTHEMA MULTIFORME



Stevens Johnson Syndrome (SJS)

- Serious mucocutaneous illness with systemic symptoms and signs with significant mortality.
- Characterized by the presence of flat atypical target lesions or purpuric macules with blisters that are distributed mainly on the trunk or widespread
- Epidermal detachment <10% of body surface area (BSA).
- Two or more mucosal sites can be involved.

Toxic Epidermal Necrolysis (TEN)

- Definition
- Toxic = due to or the nature of a poison or toxin, manifesting the symptoms of severe infection
Epidermal = pertaining to or resembling the epidermis
Necrosis = separation or exfoliation of tissue due to necrosis
- Life threatening
- Morbilliform type: symmetrical, erythematous rash, macules & papules, lasts few days.
- Progresses to flaccid blisters and bullae → join to form large bullae → large areas of epidermis are "sloughed off"
- Mucous membranes often involved → usually 1-3 days earlier than skin lesions → eyes; oropharynx; respiratory tract; GI tract; genital tract; anus.
- Rapid progression over days. 10 – 100% of body's surface area involved.
- Discomfort, pain, fever, sore throat, cough, malaise.

Toxic Epidermal Necrolysis (TEN)



TREATMENT APPROACH FOR CUTANEOUS DRUG ERUPTION

- The ultimate goal is always to discontinue the offending medication if possible.
- The therapy for exanthematous drug eruptions is supportive.
- Antihistamines is used around the clock.
- Mild topical steroids (hydrocortisone or desonide) and moisturizing lotions are also used, especially during the late desquamative phase.
- Severe reactions, such as SJS, TEN, and hypersensitivity reactions, warrant hospital admission.



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- Dr. Ashok Seth - Sr. Cardiologist and Chairman of Fortis-Escorts Heart Institute
- Dr. K. Narasimhan - Director, Sri Sathya Sai Mobile Medical Hospital, Puttaparthi
- Prof. Dr. P. Venugopal - Ex. Cardiac Surgeon, AIIMS
- Dr. Shekhar Rao - Director, Sri Sathya Sai Hospital, Whitefield, Bangalore
- Prof. Dr. P.S. Saharia - HOD ENT Deptt., Max Hospitals, Medical Coordinator SSSSO, Delhi-NCR
- Dr. Ganesh Mani - Padma Shree Awardee, HOD CTVS Dept., Max Healthcare, Saket
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