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Challenges in Healthcare Sector- A Medico Leadership Perspective

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ABSTRACT: *Healthcare specialists, by virtue of their extensive proficiency in the field of medical sciences play a momentous position in our every stage of life. Their service to mankind in not only saving and extending lives, but also to control epidemics is exceptionally commendable and far beyond comparison.*
Respect for autonomy of patients to choose or deny the course of treatment, beneficence -to act considering the best interest of the patient, not to cause harm at all times and to distribute the scarce health resource to the needy are the four important guiding principles of medical ethics.Yet,ethical controversies in this sector have not become uncommon in the recent years.
This research paper aims toexplorecertain consumer complaints of reportedmedical malpractice andits aftermath on overall reputation of the hospitals.
The study also extends to find out the ethical leadership choices taken by key leadership in hospitals during such crisis situations to not only defend the repute of the hospitals but also to proposeprotectiveactions to elude such destitutions in the long run.

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I. INTRODUCTION

Healthcare sector demands utmost efficiency and clarity in identification of the nature of illness through a systematic analysis of the patients medical history, illness reported , examination of signs and symptoms in deciding the best course of treatment to cure the patient.

Such a noble profession weights clinicians and specialists to create an optimum treatment plan with paramount care and justice and thusthe school of medical science suggest every qualified and certified physician to necessarily take "Hippocratic Oath", a swear upon a number of healing Gods to set standards and abide by the same for the best course of treatment with utmost fair and justice to the mankind.

The crux of Hippocratic Oath pronounces*Primum non nocere,* meaning first "do no harm" and another equivalent phrase was found in the book of Epidemics which states medical student to "either help or not harm the patient".

Despite itemized professional code of ethics, medical malpractices occur when appropriate treatment is neglected at the right moment, omission of appropriate action or wilfully administering substandard treatment that cause harm, injury or death of the patient.

II. OBJECTIVE

The main objective of this paper can be expressed as follows:

1. To list out certain medical malpractice exposed in hospitals.
2. To analyse the repercussions of such malpractice towards the reputation of both the hospital and the key medical specialist.
3. To understand the initiatives taken by top leadership as a response to this adverse situations to evade such impending casualties.

III. LITERATURE REVIEW

Thomas Percival, dating back to 1803, published the requirements of medical professionals and code of ethics for the field of medicine was adapted in the year 1847 and from then medical ethics was practiced worldwide as a more self-conscious discourse.

Jeffrey Berlant, being a critic to Percival's code for physicians' ethics as he considered them as anti-competitive, guild-like nature of the physician community.

Apothecaries Act, passed by the Parliament of United Kingdom initiated compulsory apprenticeship and formal qualifications for the apothecaries which was the beginning of the medical profession in UK.

A study of Patient Safety Incidents (PSIs) by HealthGrades found that "Failure to Rescue", meaning failure to diagnose and treat in time, was the most common cause of a patient safety incident, with a rate of 155 per 1,000 hospitalized patients. Unfortunately, the study did not further break down statistics into the types of misdiagnosis, delayed diagnosis or other factors. [1]

According to the Medical Malpractice Centre, in the United States, there are between 15,000 and 19,000 medical malpractice suits against doctors every year.

The National Patient Safety Foundation (NPSF) commissioned a phone survey in 1997 to review patient opinions about medical mistakes. Of the people reporting a medical mistake (42%), 40% reported a "misdiagnosis or treatment error", but did not separate misdiagnosis from treatment errors. Respondents also reported that their doctor failed to make an adequate diagnosis in 9% of cases, and 8% of people cited misdiagnosis as a primary causal factor in the medical mistake. Loosely interpreting these facts gives a range of 8% to 42% rate for misdiagnoses.

Misdiagnosis rates in the ICU or Emergency Department have been studied, with rates ranging from 20% to 40%. These misdiagnosis rates are likely to be higher than the overall health care misdiagnosis rate because of the time-critical and serious nature of the diagnosis under these crisis conditions.

Davenport (2000) lists the top five malpractice-risk conditions in order of prevalence as myocardial infarction, breast cancer, appendicitis, lung cancer and colon cancer, and notes that almost all suits are cases of misdiagnosis or mismanaged diagnostic tests leading to delayed treatment. Myocardial infarction and appendicitis are likely to be related to emergency department visits, whereas the three litigation-prone types of cancers are more common in general physician work.

The rates of **misdiagnosis in the emergency department** or ICU have been studied. A study found a rate of 20% of misdiagnosis in the ICU. For example, non-typical presentations such as a young person or a woman having a heart attack are less likely to be correctly diagnosed. Furthermore, an ECG test does not rule out a heart attack even if it is normal, and some physicians rely too heavily on this test.

Appendicitis is another common and serious misdiagnosis in the ED. Initial misdiagnosis rates of appendicitis in children are high, ranging from 28% to 57% under 12s to almost 100% misdiagnosis for appendicitis in infants (Roth rock et al, 2000).

Johns Hopkins Hospital in Baltimore found a 1.4% error rate in pathology tests in patients referred for cancer treatment. Of the 86 total misdiagnoses, 20 had benign tumours misdiagnosed as malignant and presumably received unnecessary cancer treatment. An earlier Johns Hopkins study of prostate cancer biopsies found an error that ruled out cancer in six out of 535 cases.

Few Medical mishaps

Delay in treatment:

Medical practioneers of a renowned north based hospital were convicted following their delay to administer proper treatment to a 51 year old woman who was suffering from a cardiac arrest. Following this the chief cardiologist was arrested and questioned but later the court released him on bail.

Wrong diagnosis and Faulty Treatment:

An FIR was registered against another doctor who was indicted of overbilling and negligence in treatment for a seven year old child who was later diagnosed to dengue. The child was not administered anti-platelets. After an extensive investigation, the court declared it as a bailable offence and hence the doctor involved was rescued without any major damage.

Over Billing:

In another bicycle accident, the poor guy though fortunate enough to survive from minimum injuries was taken to hospital by ambulance and was advised an unwanted CT scan and was kept in emergency room for one hour and later discharged with a hefty bill of $31,613.

The above is not exhaustive list and includes few others like billing for services not rendered, extended stay in hospital as the patient insurance, unnecessary prolonged treatment etc.

Recommendations and Suggestions

Doctors being in noble profession are accountable to public for any misguidance rendered during the course of treatment. The top leadership in the hospital plays a vital role during such crisis situations as they need to safeguard not only the repute of the hospital but also to ensure a cordial relationship. The below listed are few such initiatives taken by the key leadership:

- Lack of proper communication and co-ordination was found to be a missing factor and hence a team of trained professionals with more determined effort to be set to communicate and ease the patient with utmost transparency in both the treatment process and cost aspects.

- Setting up public grievance redressal cell consisting of medical experts and specialist to handle complaint
- Preferable a person with sound medical knowledge to be designated in the top position in order to clearly understand the intricacy of the issue else the management becomes completely dependent upon the treating doctor to respond to patient queries.
- To set the right tone for the expectation of the patient as seldom patient misunderstands the outcome of the treatment due to improper doctor-patient relationship.
- Adequate support staff nurses and house keeping with suitable expertise to optimise hospitality and patient comfortness.

IV. CONCLUSION

Healthcare is the only field where we do not have the option but to accept what our healthcare specialist dictates on treatment plans.Irrespective of our affordability, we surrender to the clinician. Hence it is very important for each and every doctor to be patient, transparent and communicate all the possible outcome of the treatment along with the tariff. This will definitely pave way to eradicate misunderstanding of communication between the provider and the receiver.

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