

PERSPECTIVE

Mandatory Basic Life Support Training: Why not In India; Mandatory End-of-Life Care Policy: Why not In India; Mandatory Medical Research Requirements: Why so In India!

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Abstract

In the world of things and doings, mandatory is a human invention for the times when optional and free-will do NOT get things done. When quality of life gains momentum to catch on with the age-old run for quantity of life, the medical education, medical decision-making and medical policy-making do NOT leave an option for medical practitioners but to follow the mandate as required and warranted by society they cater for. Herein I want to review and discuss some of those potential mandates for practitioners of medicine from the perspective of (a) a person who can be in the hot seat of a patient himself, (b) a physician who can be caught in the dubious scenarios of treating patients similar to himself, and (c) a medical teacher-researcher who till recently as an inquisitive medical student was himself delving with similar questions for the system. In a nutshell, this is my perspective from my limited understanding that basic life support (BLS) training and end-of-life care (EOLC) policy are in need for mandate to being made mandatory whereas medical research requirements (MRR) are in need to be made optional without covert-overt penalties.

Keywords

Cardiopulmonary Resuscitation; Terminal Care; Biomedical Research; India

My Perspective

In the world of things and doings, mandatory is a human invention for the times when optional and free-will do NOT get things done. When quality of life gains momentum to catch on with the age-old run for quantity of life, the medical education, medical decision-making and medical policy-making do NOT leave an option for medical practitioners but to follow the mandate as required and warranted by

society they cater for. Herein I want to review and discuss some of those potential mandates for practitioners of medicine from the perspective of (a) a person who can be in the hot seat of a patient himself, (b) a physician who can be caught in the dubious scenarios of treating patients similar to himself, and (c) a medical teacher-researcher who till recently as an inquisitive medical student was himself delving with similar questions for the system.

Basic Life Support (BLS) Training: Times have not changed much since the time I completed my medical school and anesthesiology residency in India over a decade ago when we were quite unaware of the mandatory need for BLS training (1) because we only used to do BLS training out of our own volition. The costs in Indian Rupees for completing the training used to seem prohibitive because its incompletely-explained utility/efficacy to us (the voluntary trainees) combined with the natural decay in our knowledge/skills of BLS required repeat training every two years as per the recommendations. Since those times, there has been explosive abundance of exposure to American media programs (documentary-reality-fiction) wherein BLS performance has been shown as a normal routine (knee-jerk-reaction) not only for the practitioners of medicine but also for nurses, mothers, nannies, pregnant women and parents to name a few, besides the personnel involved in human rescue operations/activities. Even the BLS performed on domesticated animals have not been left far behind during the projection of American way of life with its corresponding focus on safety and surety of life (animal or human). Therefore, even if we forget about the need for BLS re-training every two years, we should question ourselves why we are NOT training our young and old, medical and non-medical, even for once in their lifetimes about BLS, because one never knows when one's BLS training can save one's loved ones, unless we as a community want to continue as an ignorant community of bewildered bystanders during the times of need for resuscitating our loved ones. The good start for the conscientious among ourselves can be to overcome our reluctance by at least educating ourselves with the BLS knowledge (at least education if NOT training (2)) that is being offered free online (with optional fee-for-issuance to BLS certification) as per some websites (3,4).

End-of-Life Care (EOLC) Policy: My exposure to EOLC is recent since the last decade. The irony is the contradiction of my writeup and my concerns as a person/physician/teacher which has now swung from the time of resuscitation to the time to palliation; however, our imperfection being human, while asking us to garner our resources for our pursuit to saving lives, complementarily requests us to reflect and prepare for the times when this pursuit is bound to fail. It is those times which are more

difficult when a person is critically/catastrophically ill/near-dead and the providers/caregivers do NOT know whether to resuscitate or NOT resuscitate, and if resuscitated, whether to withdraw the case-specific futile artificial life support interventions or NOT, wherein the self-supported healthcare economics of patients' kin can eventually run dry in vain. The gravity of our communities' situation is exposed when practitioners analyze their local institutional data, wherein more than one-third candidates in need of resuscitation may NOT be deemed "eligible" for resuscitation (5) secondary to ethical dilemma faced by the providers/caregivers at the institutions, because EOLC policies are either absent or ambiguous at best due to the missing resolve among judiciary or legislature to formulate legally binding EOLC policies for those critical clinical scenarios. Even though there may be many other issues for people-in-command of healthcare to deal with, they must still have to wake up with the resolve to create a system, wherein not only their living but also their dying and death is peaceful, unless we as a community still want to die and allow the death around us in the continued state of ambiguities that we as healthcare providers are used to, in the absence of clear-cut formulated EOLC policies (6-7).

Medical Research Requirements (MRR): As a kid, I always used to resent my friend, Amit, who used to top the class and out-score my rank only because of my poor show in the "drawing" as a mandatory academic subject being scored for final tally of our scores. I was NEVER able to outgun my artist genius friend until I moved out to another school wherein "drawing" was NOT scored at all for the final tally. Just like "drawing", the medical research is an art born out of inquisitive minds who have a gift to ask, explore and execute their visions. Although I am a little bit better in regards to pursuing medical research as compared to being a "drawing" artist, I empathize with my fellow colleagues who suffer from the same worries just like my childhood ordeal, and henceforth arises my question (8) why MRR are mandatory to all in the academics when the academicians may ONLY be gifted clinicians-teachers and NOT gifted researchers irrespective of the eligibility characteristics at the time of recruitments and/or renewals per their contractual academic jobs. Although medical research means investing in the future that holds the key of our survival as a practitioner and as a person, MRR cannot be shoved

down academicians' throats who may choke on them in the absence of natural teeth (gifted aptitude) to sink into medical research.

In summary, this is my perspective (as an Indian residing in America) based on my limited understanding (while having had the golden opportunity to closely observe both worlds as an anesthesiologist) that BLS training and EOLC policy are in need for mandate to being made mandatory whereas MRR are in need to be made optional without covert-overt penalties.

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