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## PHYSICIANS IN PRACTICE

# SCARS OF EXPERIENCE: UNLEASHING HOPE

CHOWDHURY H AHSAN

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It was a relatively quiet, routine post call night. I was with my co-intern Dr. Ashraful Hannan Shaheen in the medical ward of Prof Waliullah on the first floor of Dhaka Medical College Hospital. It was a cold winter night in 1985. A man from the end of the medical ward was walking towards our table. He appeared pale and somewhat distressed, with his hand across his chest. We directed him to his bed, where he coded just minutes after we were able to perform an ECG). It was not the standard 12 lead EKG A4 size print that we see today. It was a long, narrow EKG paper strip with tracings of myocardial depolarization and repolarization changes denoted as P Q R S T. It took only seconds for us to evaluate the strip and correctly interpret the ST changes in the ECG for our patient. He had acute ST elevation myocardial infarction. We gave him oxygen and tried our best to comfort him and the family. We prayed together but unfortunately lost him an hour later. Other patients were looking at us and we looked at them in silence, defeated. We knew we had most likely destroyed all the trust they had in us. My friend and I mourned in private. No, we were not in "House of God."[1]

Years later in 1995, I was in Royal Liverpool University Hospital in the UK. I had started my clinical career in Merthyr Tydfil, a small coal miners' town in South Wales, after which I moved to Royal Gwent Hospital, New Port, Wales, home of the famous Dr. John Davies. All MRCP Part 2 students had to read Dr. Davies' books in those days. Dr Davies was the first specialist cardiologist at the Royal Gwent Hospital in his native South Wales. Soon after, he recommended me to Dr Silas in Arrowe Park Hospital in Wirral and Dr Steven Saltissi at the Royal Liverpool University Hospital for the position of Registrar in Cardiology. Dr. Saltissi was the chief of cardiology at Royal Liverpool. He was rounding one day and diagnosed a man in mid-60's with Tietze Syndrome and asked me to give local injection with lidocaine. Shortly afterwards he went to his outpatient clinic,and I ignored his earlier instructions. In the following hour, I asked the nursing staff and my interns to do serial ECG's. The ECGs started to progress until the man showed significant ST elevations in the precordial leads at which point, I immediately gave him tPA. GUSTO trial[2] was published a couple years earlier. We were then following ISIS studies.[3] I went to see Dr Saltissi in the afternoon and briefed him about his patients. He asked me if I had given the lidocaine and I replied, "no."Instead, I had administered tPA. He went back to the patient, told him that he had made a mistake, and I had diagnosed him correctly. The patient smiled at me, and I promptly acknowledged that the chief had trained me well. On that day, Dr Steven Saltissi earned the most respect of any of my mentors. Royal Liverpool University Hospital did not have Cath Lab back then and Primary PCI[4] (Percutaneous Coronary Intervention) was not the first line therapeutic choice to benefit survival. Our patient did well, went home, and my team had full faith in me. We thought to ourselves, we were in House of God.[1]

**Address of Correspondence:** Dr. Chowdhury H Ahsan, Clinical Professor of Medicine, Chief of Cardiology, University Medical Center, Program Director, Cardiology Fellowship Program, Kirk Kerkorian School of Medine, University of Nevada, Las Vegas. 1800 W Charleston Blvd., Las Vegas, Nevada, NV 89102, USA. E-mail:chowdhury.ahsan@unlv.edu

Then it happened. I lost him. I lost my best friend. My friend who would ask me to sit in his clinic in Pabna, a district town in Bangladesh. He would routinely almost force me to see some of his patients, to listen to their stories and make me feel baffled, challenged and helpless. Many of the patients would have significant valve disease, particularly mitral valve disease, as well as congestive heart failure, atrial fibrillation, and of course, coronary artery disease. There was hardly anything I could do for them. Meanwhile my friend would order a cold coca cola drink for me to calm me down. He would be doing an ultrasound examination on a lady who might soon be facing obstructed labor ~~and~~ he would say to me in his soft voice, "one day we will be able to take care of these challenges, however today, all we can do is to face them". A few months later, he had chest pain, nausea, vomiting and collapsed. Within hours, he was gone. Dr Mostafa Kamal Selim was an outstanding physician committed to serving the community he had lived in. At that time, I was preparing for my presentation on Door to Balloon Time in ST elevation Myocardial Infarction. American College of Cardiology and American Heart Association have been promoting ACLS and advocating for triaging patients with suspected myocardial Infarction, championing the use of defibrillators to avoid unnecessary deaths. In many district towns in Bangladesh, even today, one can hardly find any cardiac defibrillators.

Access to healthcare and putting patients under a system of care is the fundamental basis for a successful healthcare delivery organization. We must have an oversight for the delivery of care, and we need to look into all of the contemporary clinical data with our experience and knowledge to strive for excellence at an affordable cost. We can adopt this mantra of:

A. Access to HealthCare and System of Care: One can get the care.

B. Accountability: there is an oversight for the quality of care and outcome matrix

C. Affordability: To contain cost and keep the quality of care.

We looked into the outcome data of the patients with acute myocardial infarction presenting in different areas of the state of Nevada and assigned them into groups with geographic advantage where Cath lab and cardiac care are readily available vs difficult disadvantageous areas. We observed a fourfold higher mortality in patients who presented to areas with no readily accessible healthcare (see figure 1).

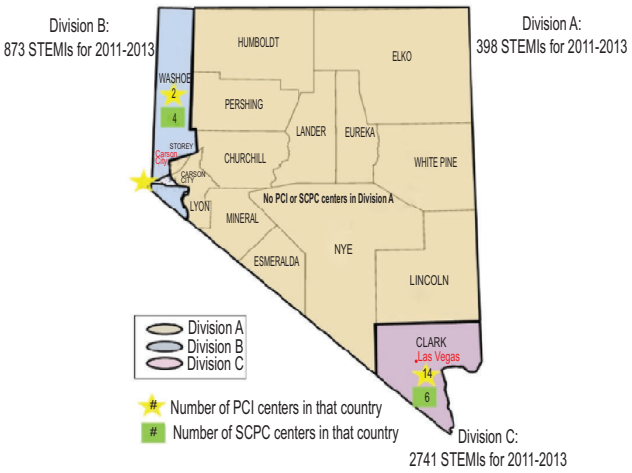


**Fig.-1:** *We divided the areas of the state of Nevada into 3 groups with immediate access to cardiac catheterization laboratories to get Primary PCI, access to thrombolytics and remote areas where access to health care is limited* (Fig.-1).

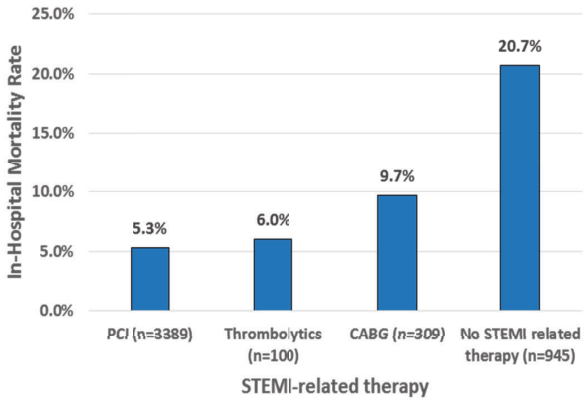


**Fig.-2:** *Those who did get Primary PCI or Pharmaco-invasive therapy with initial lytics at the* ***point of careservice centers*** *followed by transfer (Drip and Ship) to invasive strategy for areas with no immediate access to Cath lab had very similar outcomes. Pharmacotherapy is now a recognized strategy with comparable outcomes [5]. However, when we compare the group who did not receive any therapy with those who received Primary PCI or Pharmaco-invasive Therapy, the no therapy group had a fourfold increase in mortality.*

Hundreds and thousands of studies have been done in different disciplines all around the world to establish disease specific standards of care. Society guidelines and clinical pathways have been drafted to outline the care plan and provide guidance to healthcare providers for delivery of care.

**We therefore definitely can:**

**Triage—**the patients at the **Point of Care Service Centers** and upload all the info to sort out the

emergency, urgency and time sensitivity in terms of delivery of care at any corner of the country by utilizing current technology at hand with the help of an army of physicians and

**Treat:** we can start treating the patient without delay: Our pharmaceutical industries have developed and have made over 90% of the medications prescribed available in Bangladesh. We have a task to educate our healthcare providers who are in urban and rural areas and make them fully aware and confident to seek help from experts for the initiation of treatments and make a Care Plan

**Transfer:** Forward to secondary or tertiary higher care centers as needed or back to General Practitioner for the follow up care. The whole process can be organized in the electronic health record system with the help of our IT sector.

More and investments in healthcare systems keeping in mind the above fundamental principles of delivery of care will see a significant impact in the GDP and build confidence and trust among the people.

Bangladesh has made significant progress in economic fronts. The country's infrastructure has been strengthened more than ever, and the mighty projects have allowed our country to turn the page towards the next best thing for the explosive growth of opportunities and avenues for changing the fate of our people. The IT sector has significant advancement to match other developed countries of the world, whereas the health sector has been unable to utilize these resources to meet the challenges and expectations achievable in healthcare field in today's world. We already have preventive strategies for non-communicable and communicable diseases. Now we need a comprehensive plan on delivery of care for all the people of our country by involving the Government and Non-Government agencies, financial institutions, healthcare providers in all disciplines, healthcare delivery institutions and agencies so that we can build a solid healthcare delivery system. A system that gives access to the patient when needed, opens up a system of care to receive the standard of care, and provides accountability for the care provided so the care is affordable at least to the majority of its recipients.

"We shall forget by day, except
The moments when we choose to play
The imagined pine, the imagined jay."
—Wallace Stevens, "*The Man with the Blue Guitar*"

"Now is no time to think of what you do not have.
Think of what you can do with what there is."
—Ernest Hemingway, *"The Old Man and the Sea".*

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