



# ‘Conveyor Belt Medicine: Where are the Breaks?’

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## Commentary

Recently I read the above commentary on the heart.org on Medscape by Dr. Jaya Mallidi (3<sup>rd</sup> June, 2019). She was referring to the ST Elevation Myocardial Infarction (STEMI) conveyor belt system, where the Door to Balloon (D2B) time quality matrix demands that the patient be placed on the conveyor belt, the moment the diagnosis is made in the emergency, and rushed straight to the Cardiac Catheterisation Laboratory. The D2B time of <60-90 minutes - a quality matrix, hardly leaves any time for carrying out detailed laboratory tests and echocardiographic screening. Quite often, especially after-hours, resident doctors attend to the patients and, based on the machine reading of the ECG, raise the alarm bell of a STEMI and the cardiologist is rudely woken-up from his slumber. The retort from the sleepy head on the other side invariably is, ‘Shift the patient to the cath lab’. By the time, the cardiologist reaches the cath lab; the patient is already under the drapes, without any chance of the two interacting or having some degree of familiarization, indeed an antithesis to the very concept of ‘Heart Team’.

Darting askew, how often such angiograms turn out negative, unfortunately, is not matter of concern for the institution, or the medical professional carrying it out. Literature clearly shows that upto 65% (10% to 65%) of these patients do not have a clinical condition warranting coronary angiography [1,2]. Thus though early primary PCI has umpteen benefits, which have been adequately documented, but there is a flip side, of those who undergo a negative procedure. The consequent potential harm is neither documented, nor reported, leave alone communicated to the patient.

The conveyor belt system is not just for STEMI. In fact it's being applied now to every aspect of medicine, driven mainly by the corporate sector and their ethos of ‘Performance linked Payment’. A diligent attempt is thus made for every patient to be steered towards a particular stream of investigations, which are packaged as a bundle - a fait accompli for the patient. It is not uncommon to see a simple myalgic chest pain in an emergency ward having been exposed to, besides Troponin, the lipid profile, complete hematology, the liver and kidney function tests and a multitude of imaging procedures. The artificial intelligence based medicine, used unbridled, does further propitiate this mentality of herd-like conveyor belt based Medicine. Each individual is a distinct entity and should be treated as one -but also, is not! This conveyor belt system needs to have checks, is what Dr. Mallidi pleads for. However, she talks of only science, but misses out on the ethical aspects totally. Primary PCI has become a ‘cash cow’ of most institutions, especially in the private sector. In fact in a scientific debate, sometime back, a question was asked as to the best form of treatment for myocardial infarction - Thrombolysis or Primary PCI. A senior physician-cardiologist, with years of wisdom and wits about him commented, “Its thrombolysis in the government sector and primary PCI in the private sector”, obliquely referring to the ulterior financial and economic aspects.

Brakes thus will come, not just from disseminating the science of ‘when and how’ to investigate, or by the regulatory bodies, but by setting standards of morality by the seniors and leading by example. Secondly, and more importantly, it will come from right education starting from schools and going on to the medical colleges. Morality without science may still prosper, but vice-versa is a sure recipe for disaster.

## References

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