A Systematic Gap in Medical Practice

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Medical and specialty practices are influenced by various factors. These factors can be grouped into four domains namely epidemiological, resource, psycho-social, and professional domains. There are lacunae or gaps in the system and subsystem of providing services or ongoing care amongst internal and external customers of the system. Sustained action on the modifiable factors and controlling non-modifiable factors can minimize these systematic gaps.

Keywords: Domains, Duty, Factors, Medical practice, Systematic gap

Introduction:

Medical practice is both structured, guided by protocol and guidelines as well as unstructured delivered by judgment as it comes. Disease prevention, disease treatment, and health promotion are the three primary domains of medical care. Obstetric practice mostly deals with the physiological condition; that is, pregnancy and childbirth which are not diseases. A small fraction of clients has abnormal pregnancy and delivery. Some can be predicted while others are unpredictable. The observational window for the laboring patient is short whose journey started nine months ago in 90% of cases. Around 10% will have unpredictably shorter gestation. The efficiency of an observational window is also contextual. It varies by epidemiological domains like place, time, and person; resource domains like infrastructure, technology, science, and expertise; psycho-social domains like attitude, credibility, and protection; and professional domains like ethics, regulation, guidelines, and inter-specialty communication. There are differences in each component creating a gap in all medical practices globally but more in ob-gyn practice.

Epidemiological domains

Duty bearers from easy access areas comment on the duty discharged by the duty bearers at geographically inaccessible areas for the things done at their capacity. The second delay in reaching one health facility to another brings also a blame game against professional ethics. Personal attributes of every individual in provider-consumer relations and communication bring at times a negative message to the community and media despite of job done in good faith. The diurnal and seasonal variation in the availability of resources would also affect the clinical outcome in health facilities. Poor understanding of the gravity of the problem by non-technical managers puts further burden and limitations on the technical duty bearers.[1]

Resource domains

There has been ongoing advancement in medical service, technology, concepts, principles, processes, and art over time. However, there is differential distribution around the globe but the commercial advertisement is sensitizing everyone. Neither the timely acquisition nor its adoption is in effect. Teaching-learning is based on regular practice and recent advances, and the references are from the ideal situation or the source of new knowledge is compatible with the origin only. Thus, the disparity between theory and practice is apparent in most of the places and time. It means our training institutions are not equipped to match with the recent knowledge and skill. The commercialization of education and essential health services contributes to the compromised quality of education and service. Then, the result will be the production of inefficient and mechanical human resources. Customized service delivery based on the context and use of basic and common sense will be lacking. The absence of a sense of cost-benefit analysis, technology-driven intervention without human touch, and ignoring wider acceptance and affordability are pushing us away from the real world.[2]

The affluent-resource constraint gap is much greater in low- and low-middle-income areas. That hinders the easy translation of advancement into practice. Even technology in charity cannot be accommodated due to constraints of infrastructure and the required expertise. This yields dissatisfaction and a negative attitude. Search for comfort, livelihood, and career opportunities appear as the determinant of the out-migration of intellectual assets that widens the existing gap.

Psycho-social domains

The attitude of care seekers towards the health delivery system and service provider and vice versa determines the health environment of the care delivery process. There are differential expectations of either side. Care seekers expect maximum care despite of existing facility as they are usually unaware of the context, and duty bearers expect the clients to know their limitations and be convinced of the care. This is the systematic communication gap that is prevalent in low-resource setups to affect satisfaction levels. Service outcome depends on the efficiency of resource domains. If there is a gap in it, there will be the question of the credibility of the service delivered. Bridging the gap in the breach of credibility becomes a real challenge to the professionals as well as the institution.[3]

Protection is required for both duty-bearers and the care-seekers. Duty bearers' protection should be in terms of livelihood or remuneration, stability in the practice area, legal support, and institutional support to discharge the expected responsibility. Care seekers require support for the expenditure or insurance, a healthy environment for care-seeking, and a user-friendly service delivery system.[4]

Professional domains

Providing treatment to the patient is a provider-consumer agreement. The degree of its compliance depends on modifiable factors like education, comprehension, self-decision, credibility, vulnerability, strength of care, and limitations. Routine care can be dealt with over time but urgent care is compromised. The informed consent process sometimes doesn't work and requires forceful life-saving intervention that contradicts the prevailing ethical principle. The provision of legally authorized representatives (LAR) will not be in the system in most of the places in the globe.[5,6] These are contextual dilemmas. Unilateral regulatory intervention on care providers without regulated consumer action puts further moral and legal pressure on care providers. Consumers could be individuals, organized groups, or mobs. To boost up morale of either side, there should be a balanced and justified reward and punishment system which is usually lacking in the workplace. Most of the practice guidelines are based on the maximum services available in terms of diagnostic and therapeutic advancement which is hardly translated in other setups. Consumers expect to have the maximum care as per guidelines despite contextual limitations. Thus, minimum service guidelines would make all comfortable in discharging their respective responsibility.

Body function remains in equilibrium in a healthy state but there will be disequilibrium in a diseased state. Any intervention for the pathologic process has some effect on any bodily system. Practice guidelines are based on clinical research with the exclusion of so-called vulnerable groups which would also be the target group to apply research-proven intervention.[7] The bulk of the people are either pediatric populations or pregnant women labeled as vulnerable groups, but the intervention appropriate for others is directly applied to those groups of the population. This is unjust and brings differing opinions between specialties. At times there is a negative outcome from the treatment provided by non-ob-gyn specialties like administering diuretics in severe pre-eclampsia leading to further vascular compromise and iatrogenic shock. Handling reproductive pathophysiology is unique to the usual treatment of non-reproductive conditions but these conditions especially pregnancy-related conditions exclude the specific research. Steroid hormonal treatment for reproductive dysfunction is poorly understood and practiced by most of the ob-gyn practitioners. The tapering dosing pattern of corticosteroid treatment is wrongly translated for the sex steroids as well. This ignores the threshold bleeding leading to iatrogenic dysfunctional uterine bleeding.

There are programmatic gaps, research gaps, and resource gaps distributed into different domains in the quality of healthcare delivery. Social, political, technological, professional, and scientific modulations are required to minimize the identified gaps.

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