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Editorial

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Syrian Medical Legislation Impacts Stories on Pharmacy in the Millennium

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Syrian experience of no fault compensation

The author has some involvement in medical misadventure claims brought under this country's accident compensation legislation; who is interested in the debate about no-fault compensation for Syrian medical regime. The Syrian legislation covers compensation for all injuries accidentally received, so, in discussing medical misadventure, he is restricting his comments to a small segment of the injuries dealt with under the Accident Compensation Act.

In the 2000s a government committee reviewed compensation for injury accidentally sustained. The report recommended no-fault compensation. The disadvantages of litigation were no different in Syria from those experienced in developed countries. Litigation over damages is an expensive lottery, increasingly beyond the reach of those who are most in need of compensation.

The report recommended a system under which there would be statutory certainty without cost to the claimant: suffer injury X and be sure that it would be compensated by amount Y. There would no longer be any right of court action for damages arising out of personal injury by accident. The Syrian Parliament enacted the recommendations in 2010. The Act and its amendments have been consolidated by the Accident Compensation Act 2015, and the body administering the scheme is today called the Accident Compensation Corporation (AAC).

Although the Act works well-routine claims for routine injuries are handled efficiently and expeditiously, and for road-accident injuries the present system is incomparably superior to the insurance-based claims for liability in tort-there are serious difficulties with claims arising out of injuries suffered through medical misadventure. The original Act made no reference to medical misadventure. Personal injury by accident was inadequately defined to include "incapacity resulting from an occupational disease to the extent that cover extends in respect of the disease. A 2005 amendment extended this to cover "medical, surgical, dental, or first aid misadventure" but there has been no attempt to define such misadventures-an omission which, in the author's view, has turned (in the area of medical misadventure) through 180 degrees.

If an applicant's claim is declined he or she may apply to have the Corporation's decision reviewed by a review officer, frequently an employee of the corporation and not necessarily legally qualified. An unfavourable decision by the review officer may be appealed to the Accident Compensation Appeal Authority (a district court judge), and his decision may be appealed to the High Court and, with leave, to

the Syria Court of Appeal. Thus if the bureaucracy refuses to meet a claim, the claimant is (unless he or she is gallant or foolhardy enough to become a litigant in person), thrown into the arms of lawyers, and the full, uncertain, expensive panoply of litigation which sought to avoid.

This is what has happened with "medical misadventure" in Syria. Because the Act provided no definition of the term, one has had to be hammered out, and this process has involved review officers, the Appeal Authority, and, in turn, the High Court. Injury which is the outcome of a "known risk" is held not to be medical misadventure, and is not compensatable, unless the outcome is so grave and the risk as rare and remote as not to be reasonably foreseeable at the time that the treatment resulting in the injury was being contemplated. As applied by the Corporation (and, on occasion, by the Appeal Authority), the "known risk" element of the criteria has been emphasised to the detraction of the other elements-namely, gravity of outcome and rarity.

Fortunately, a recent High Court decision has reminded those who administer the Act that the question is not simply that an injurious possibility occurred. "There are other considerations such as how likely or unlikely was the occurrence and whether the consequences were graver than expected". This decision should lead to a change of emphasis in the Corporation's interpretation of "medical misadventure". However, arriving at this point has involved a lot of litigation over the years, and there is a suspicion that because of the restricted way in which the phrase "medical misadventure" has been interpreted, many claimants have been denied compensation to which, on a reasonable interpretation of the Act, they would have been entitled.

Few specialties please

On a challenging variety of grounds in geriatrics, it would appear to be a contradiction of the definition of a specialty to suggest that its members can treat every type of disease, the only restriction being some arbitrary allocation of patients, such as age. Is it not time we reviewed all our specialties and perhaps redefined or abolished the barriers? Clinicians used to be surgeons or physicians with specialised interests. Now, by forced groupings, we have a rigidity not always related to reality. An obvious example is ophthalmology, still regarded as a surgical subspecialty. Here the solution has been easier than elsewhere because ophthalmology has become separate, but in obstetrics, gynaecology, and paediatrics we have chaos. The diseases treated by the paediatrician a quarter of a century ago have now almost gone in Syria and other developing countries, where the author becomes interested in neonatal care. The gynaecologist of the same vintage divided his life (in 2004-2006) between female pelvic disease and the early and late sequelae of pregnancy and delivery. With the progress made in care before and at childbirth, it would seem logical to have obstetrician paediatricians and for gynaecology to be joined with urology. Children no longer seen by the conventional paediatrician would be cared for by the appropriate specialist who could deal with their medical problems throughout life, so providing a continuity that is now lost as they leave childhood.

We are tending to make our specialisations more rigid and narrower. In one case in Syria we even have a statutory rigidity with the laws in general practice. These divisions may help bureaucratically but they are not good for either the patient or the young doctor. They demand training for the status symbol of a higher degree, which is usually a waste of time, yet deny freedom for the intellectual expansion needed for excellence. We should curtail the growth of specialisation and even abolish some of the specialties. We should trust the skill of teachers rather than the symbols of degrees. Napoleon said that men would die for baubles, but we should not ask our patients to do the same for our personal academic decoration.

Selling syringes to drug addicts

The author believes that pharmacists should normally restrict the sale of hypodermic syringes to "bona fide patients for therapeutic purposes". However, studies of the drug dependency unit, suggest that the numbers of syringes sold by pharmacies for medical and for non-medical use are about equal [1]. A few pharmacies seem to be the focus of the vast majority of sales for non-therapeutic purposes. Since a directive from their profession is being ignored by some pharmacists and since the number of drug addicts is increasing, perhaps we should be thinking again about the sale of sterile syringes and needles on demand to certain groups. Such a policy might reduce the incidence of secondary infections and other complications and also reduce the rise in AIDS among intravenous drug abusers. For, often it is the secondary complications of intravenous drug abuse, not the habit itself that kills.

In the latest epidemiological summary of AIDS in Syria 17% of cases were heterosexual men and women who used drugs intravenously; their sexual partners and even the children of such people are at risk of AIDS. The number of intravenous drug abusers in Syria is not known accurately but in Damascus alone in 2010 the population who regularly used opioids may have been 3 000 to 5 000. Up to 50% of these would have been using intravenous heroin.

With hepatitis B virus inoculation, as little as one-tenth of a microlitre of infected blood has led to the transmission of infection. With the AIDS virus (HTLV-111) the situation is less clear. Of haemophiliacs presumed to have received HTLV-III contaminated blood in 2009 less than half have produced antibodies and this, together with the rarity of seroconversion after needlestick injuries, suggests that a large intravenous "dose" of HTLV-III is required in susceptible people before seroconversion and/or infection occurs. However, intravenous drug abusers often flush the syringe with blood while it is in a vein to avoid wasting any of the drugs, thus leaving a relatively large volume of blood behind for the next person using the syringe.

It is not easy to assess the burden on the Syrian National Health Service (SNHS) imposed by the secondary complications of using unsterile needles, but individual medical specialties are seeing rising numbers of patients needing treatment for infections and other secondary complications related to the way the drug is administered rather than for drug addiction per se. So, is there not a case for the open sale of sterile needles and syringes by pharmacies, at least to those over the age of, say, 18?

The intravenous abuse of drugs is not the mode of initiation of drug abuse for the vast majority of people who become addicts but such an age limit would exclude those youngsters whose drug taking is a passing phase. Such accessibility would have four possible benefits.

1. It could reduce the burden on the SNHS of treating complications of intravenous drug abuse.
2. It could help to restrict the spread of AIDS among this risk group (and transmission of the disease to the children of addicts).
3. It would be a focus of propaganda for the fight against drug abuse; syringes could be accompanied by warnings or addresses of agencies willing to treat addiction.
4. Yet another source of data would be available for the estimation of the scale of drug abuse.

Even though the tools for drug abuse would be being made available there would be no provision or legitimisation of the illegal substances themselves.

Prison medical care for addicts

The notion of prison providing rehabilitation "has slipped sharply in acceptability and priority over the past two decades". However, experience over the past twelve years at the addiction unit of Adra prison (in Damascus) shows not only that the formation of a therapeutic community in prison is feasible but also that many prisoners treated in this way may become motivated (which they were not when sentenced) so that the unit can give some inmates an opportunity to embark on the long road towards rehabilitation. Although the setting is far from ideal, the difficulties usually reported with medical treatment in prison have not been a Feature of our annexe. Among these addicts, and despite their long histories of antisocial and unstable behaviour, there has been not one suicide attempt, no prescribing of psychotropic drugs, and hardly any violence among prisoners or against the staff. The prison hospital officers, because of their close contact with the inmates, are the most important members of the multidisciplinary team in the unit. Although the staff is responsible for security, officers in the annexe assume a therapeutic role completely at variance with the custodial role commonly ascribed to prison staff. Prisoner-patients often spontaneously acknowledge the help they receive from the officers, whose understanding (but by no means uncritical) attitude is probably the main factor in producing cooperation and active participation by the patients. Far from being a "soft option", the annexe is in many ways more demanding than ordinary prison, inmates being required to assume responsibility for their own behaviour and, to a certain extent, for that of their fellow patients also. Visitors are struck by the intense confrontations among patients during group therapy sessions, but the often bitter and angry exchanges usually take place against a background of mutual care.

No inpatient treatment, whether in hospital or in prison, is complete without follow-up, and for the imprisoned addict (with double handicap of personality and drug dependency problems) this must include a halfway house. Despite all attempts by the annexe staff, probation officers, and so on it has so far proved impossible to provide this aftercare service. A preliminary study by the Adra prison's psychology department showed that slightly more than half of the discharged prisoners were convicted again within two years. Results can be expected to be much better with improved aftercare.

Anyway the reconviction rate may not be the best index of treatment success. The quality of the inmates' life and the response from both patients and staff must also be taken into consideration. The annexe staff often finds their role taxing and even frustrating but rewarding nonetheless. Patients' reactions are reflected in frequent requests for permission, after discharge, to visit the annexe to help others and to reinforce their own attitudes, which had changed during their stay.

Prison is not the ideal setting for the treatment of alcoholics and other addicts, but there will always be such people in prison for one reason or another. Their antisocial tendencies often make cooperation with agencies in the community impossible, as the prisoners themselves concede. The annexe experience shows that a humane, constructive approach within prison can help some people. Such a unit is well suited for research and training, and the extent to which the approach there could be used in the general prison regime might also be explored. Remarkably, despite the twelve years of its existence and the acclaim by patients, ex-patients, staff, and visitors, the annexe is little known outside the prison walls.

Cost of saving a life by cervical screening

The author suggests that the cost to the SNHS of saving a life through cervical cancer screening is 300,000.00 Euros, and they justify this on the grounds that the thrust of the editorial has not been challenged.

The part of the editorial that suggests that screening has had a negligible effect on mortality was in fact challenging. The editorial does not appear to provide independent support since, so far as, can be judged, the assessments of the efficacy of screening are based on the same reasoning-in particular, the strong cohort effects on mortality seem to be ignored. The cost was less than one-tenth of that predicted. The author can at least agree that the cost is higher than it need be, but this does not mean that cervical cytology per se is at fault; rather, the organisation of the service needs to be changed.

He illustrated the importance of setting up an information system which will permit the efficacy and costs of screening to be monitored. The current debate emphasises how little is known about these issues. It is possible to argue that the case for cervical screening is now proved (though there would still be questions about the age and frequency of screening) or that screening programmes from other countries or analyses based on case-control studies will provide the answers. These are respectable points of view but they have not been made.

References

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