Letter from Chennai

THE MURKY VIEW FROM THE SINGLE WINDOW

There are a large number of engineering and medical colleges in Tamil Nadu, and many of which are not run by the government. A student had to apply to each of these individually, and often had to enter the college of his or her second preference while awaiting the results of the application to the first. The government brought all the institutions together under what it called a ‘single window’, so there was a common entrance test. Candidates were called in order of their rank in the test and were offered the choice of seats available in different colleges. I am sure this made it convenient for the students, and it seemed to be an excellent idea.

Nothing in Tamil Nadu can be so simple. The government wanted the single window to apply to all colleges, including the deemed universities. A group of deemed universities, including the Ramachandra Medical College, went to court, and also appealed to the Central Government. The Department of Secondary and Higher Education advised the Tamil Nadu Government not to interfere with admissions to these deemed universities. The Centre cited the University Grants Commission (UGC) guidelines of 2000: ‘Admissions shall be made on an all-India basis to identical courses in all the deemed-to-be universities through a common entrance test conducted either by the University Grants Commission or by an institution or agency identified and approved by the UGC.’ Since the modalities of this test had not been worked out, the Centre had permitted the universities to conduct their own entrance tests for the present, and therefore the State had no right to interfere.

However, the Madras High Court ruled on 6 August 2001 that the State Government was right to institute the single window. It said that the 1997 UGC regulations were statutory, having been placed before Parliament, and could not be modified by interpretations but only by modification of the regulations themselves. The single window system admitted students according to merit, and those with contrast for Rs 3500 to Rs 4500 for plain, and Rs 5000 to Rs 6000 with contrast. Many patients take advantage of this facility, which is working well now. One hopes it will endure. One criticism has been that only 15 per cent of the patients receive MRI scans. The department is working on improving the system to ensure that everyone has access to the facility.

The fact, however, is that as long as admissions are regulated by institutions, they take in people who make ‘donations’ to them. None of these institutions would be willing to sacrifice this pot of gold.

It has not all been smooth sailing for the government in the High Court. One applicant who failed to obtain a seat in the open category in the MCh course in Genitourinary Surgery challenged the admission of a service candidate in preference to him. The government had reserved that seat for a service candidate but the selected candidate had fewer marks than the petitioner. Ruling in his favour, the Court declared that the Supreme Court held that merit alone should be the criterion for admission to superspecialty courses, and no special provisions were permissible. The Court directed the government to admit the petitioner in place of the service candidate who had been admitted. It is reassuring to think that we will have people of quality to treat serious ailments.

The Managing Director of the Tamil Nadu Medical Services Corporation (TNMSC) recently sent a circular to all practitioners of the city, informing us that the TNMSC had made available MRI and CT scans at a number of centres in government hospitals. The public could utilize these facilities at rates much below those charged by private operators. Plain CT scans are done for Rs 500 and those with contrast for Rs 700; MRI charges vary from Rs 3500 to Rs 4500 for plain, and Rs 5000 to Rs 6000 with contrast. Many patients take advantage of this facility, which is working well now. One hopes it will endure. One criticism has been that fewer cuts (I use the word in its radiological and not its financial sense) are taken than in the scans done at private centres, so smaller lesions may be missed.

Water, or its absence, is now the dominant topic of conversation in the city. The Madras Metropolitan Water Supply and Sewerage Board (commonly known as Metrowater) has given up all pretence of supplying us with water. There is none in the supply pipes, or queue up on the road to get a meagre bucket or two from the corporation water lorries. This supply is supposed to be covered by the water rates we all pay to Metrowater, but one usually has to pay the driver of the lorry and the attendant Rs 0.50 per pot of water. A tanker holds 12 000 L, and the average domestic container may hold 10–12 L, so one lorry load could fetch the lucky staff Rs 500 per load. Obtaining water from the Metrowater lorries is a time-consuming business, for there are long queues, and those who can...
afford private suppliers use them. In the private sector, water claimed to be fit for drinking is sold for a rupee in 250 ml sachets, for Rs 10 in 1 L bottles and at a proportionately lower price per litre in larger containers. Many households which can afford to buy water by the lorry load at Rs 750 or so for 12,000 L, which of course is untreated. One cannot be choosy about the source or the quality, but then we never had quality water from Metrowater either.

Water supply is now a thriving industry in Chennai. The Indian Express recently reported that in Chennai we pay Rs 360 million a month for water. A source of concern is that most of this water comes from wells in villages around the city. That water should have been used for agriculture. Owners of wells find it more lucrative to sell their water than to use it to grow rice, with all its uncertainties and the labour involved in growing and marketing it. Will this have repercussions on our food supply in due course of time?

Meanwhile the city continues to grow, and we have more thirsty mouths every year. Neither the government nor the corporation has a workable plan to provide us with more water. Many Gulf countries use desalination plants which make sea water potable. These are said to be very expensive, and we are poor. However, the corporation recently spent huge sums of money on the construction of a large number of flyovers that merely transfer the congestion to the next traffic light. This money could have been better used in the purchase of a desalination plant. Also, if we were to get an assured supply of water from Metrowater, we would not mind spending Rs 360 million on it. The Bay of Bengal is not short of water as yet.

The City Physicians’ Association of Chennai is three years old, and celebrated its birthday recently with a gala award ceremony, joining many other associations in the city which make such awards. A large number of elder physicians and a couple of surgeons were given a scroll of paper describing them as ‘legendary professors’. The New Shorter Oxford English Dictionary defines legendary as ‘very famous or notorious’, which might be a chastening realization for some of the recipients. While one or two of those so honoured might qualify for this definition, the majority could hardly be classified with the superlative in either direction.

We must realize that we cheapen any award by giving it to too many people and too easily. Samuel Johnson said, ‘He who praises everybody, praises nobody.’ Milkha Singh refused the Arjuna award because it had been presented to so many people whose achievements in sports were nowhere near his own, that he felt it was degrading to accept it. An award is prestigious only if it is exclusive, and if the strictest criteria are used in deciding the recipients. Then makes people give these awards, and what makes people accept them? Byron perhaps had the answer: ‘The reason that adulation is not displeasing is that, though untrue, it shows one to be of consequence enough, in one way or other, to induce people to lie.’

A more meaningful part of the award meeting was a session called ‘Down Memory Lane’ in which some of the recipients were asked to speak for ten minutes each on two memorable patients. None of the speakers adhered either to the time limit or to the subject. This was fortunate, for what they said was more valuable than a thumbnail sketch of a patient would have been. Almost all of them spoke of how they practised medicine in the old days, and the importance of the clinical approach, which is now being lost. Alas, none of them spoke of the erosion of ethical values or of the downgrading of our medical colleges from the centres of excellence they once were.

In my last Letter from Chennai, I commiserated with Mr Nair, who was roughed up by the police. I hereby withdraw the sympathy I expressed. He has actually been honoured, for he received the same treatment as a former chief minister and two serving central ministers.

REFERENCE


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Book Reviews


The results of medical interventions are spread over a continuum of events that range from the most unacceptable—death—through a variety of unfavourable outcomes that we collectively classify as ‘morbidity’ and finally to those that are viewed as being an improvement from the state in which the patient was first seen. Traditionally, the judgement regarding the outcome of a medical intervention has been left to treating physicians who, by virtue of their training and bent of mind, have always preferred to make their evaluation on the basis of whether some objectively measured parameter has returned to its normal limits. For example, hypertension is detected when certain established values are exceeded; treatment is then initiated, and the decision regarding the success of treatment is made on the basis of whether the elevated figures have returned to their normal values. If they have, the outcome is ‘favourable’; if not, it is ‘unfavourable’. No attempt is made at any point in time to involve the patient in this decision, since his or her input in this regard is considered ‘subjective’ and thereby unacceptable.

In recent years, there has been increasing awareness of the fact that what the physician deems as being successful may not always coincide with what the patient expects from the process that he or she has been offered. Increasingly, issues of cost-effectiveness also need to be addressed in any assessment of medical outcomes. ‘Outcome Analysis’ and ‘Outcomes Research’ have become tools for health care delivery that are being used with increasing frequency, particularly in systems where there has been an emphasis on ‘managed care’.

This handbook attempts to introduce the newcomer to the