Letter from Mumbai

WHERE ARE OUR PUBLIC SECTOR TEACHING HOSPITALS HEADED?

Recent experience in Mumbai suggests a very pessimistic prognosis for medical education and the consequent quality of medical professionals who will be produced over the next several decades.

In the early years following India's Independence, teaching hospitals in the public sector provided medical care of the highest standards and produced doctors who could hold their heads high anywhere in the world. Teachers were appointed on an honorary basis, giving their time and energy for a pittance. They were driven by urges to excel, impart their knowledge and experience, and produce students who would eventually do better than them. They earned their butter and jam either in the early hours of the morning or in the late afternoons and evenings. The period from 8 a.m. to 1 p.m. on all weekdays was reserved for their teaching hospitals. I recall Drs Gajendra Sinh, Noshir Wadia, Noshir Antia, K. S. Masalawala, Vijay Dave, Farokh Udwadia and some other of my own teachers continuing their work in the campus of the Grant Medical College and Sir Jamsetjee Jejeebhoy Hospital till 4 p.m. on many occasions. When not teaching or treating patients, they focused on a variety of studies aimed at learning about diseases common in India which were not dealt with in any detail in western books and journals. In doing so, they produced papers that have been quoted in India and abroad over the past 40 years.

Full-time staff members who had no commitments outside their hospital and medical colleges, gradually replaced these honorary teachers. The advantage of this change was obvious. Freed from the need to travel from one institution to another and able to harness all their energies at their own hospital and medical college, teachers such as Drs P. K. Sen, Homi Dastur, R. D. Lele, S. R. Naik and others established departments that were at the forefront for decades. The subsequent careers of their students and resident doctors testified to the high standards of these teachers. I can speak from personal experience of the development of unofficial subsections in the department of neurosurgery at the Seth G.S. Medical College and King Edward Memorial Hospital in Mumbai which dealt with neuroradiology (including selective catheter angiography and later therapeutic embolization), stereotaxy, paediatric neurosurgery (including surgery for craniosynostosis), the treatment of aneurysms and arteriovenous malformations, in addition to the performance of general neurosurgery. In facilitating these developments, Dr Homi Dastur and his neurologist colleague, Dr Anil Desai, set national trends.

These full-time teachers shared a common goal: To learn, teach and treat patients to the best of their abilities and to develop.

Alas! Times have changed for the worse. The powers-that-be in the Government of Maharashtra and the Municipal Corporation of Greater Mumbai that run the public sector teaching hospitals in Mumbai have decided that these institutions are a drain on the economy and have progressively deprived them of funds and facilities.

The latest disastrous move has been the granting of permission for private practice to full-time professors. The motives driving the authorities to grant this permission make interesting reading and provide food for thought. First, many full-time professors indulge in sly private practice in any case and it is very difficult for the administration to detect and punish them. Second, the administration cannot afford to pay full-time professors the salaries they deserve. Many full-time professors leave their colleges and hospitals and enter the world of private practice to the detriment of their institutions. Ergo, permission to treat private patients will legalize an extant unlawful practice, and the extra income earned will enable them to remain in their professorial posts. While granting permission to practise, the authorities restricted it to after-office hours, insisting that work in medical college hospitals continue from 8 a.m. to 5 p.m. on weekdays and 8 a.m. to 1 p.m. on Saturdays as usual. Private practice was to be restricted to just one hospital.

Nothing was learnt from the experience at Tata Memorial Hospital—the leading cancer hospital in Mumbai—when their consultants were permitted additional practice at one private hospital. Citing huge waiting lists of patients at Tata Memorial Hospital and preying on the fears spawned by the suspicion or diagnosis of cancer, some surgeons urged patients seeing them at Tata Memorial Hospital to attend their private hospital for surgery on a priority basis. Consultants spent more time in their private hospitals than at the Tata Memorial. The care of patients, and teaching of residents and postgraduates deteriorated. It took a strong-willed Director to take the bull by the horns and outlaw this detrimental step.

We may be pardoned for drawing some unpalatable conclusions.

By confessing that professors indulging in clandestine private practice cannot be detected and punished, the authorities acknowledge their own inefficiency and incompetence.

Fears voiced well before the sanctions for private practice came through were ignored. Since the authorities could not detect or punish private practice when it was prohibited, how will they monitor private practice and ensure that it is restricted to after-office hours or at just one private hospital? What is to be done if a patient operated upon in a private hospital collapses at 10 a.m. on Wednesday, when the surgeon is to perform an operation in the teaching hospital?

Within a few months of the sanction we are witness to professors operating in private hospitals in the mornings and afternoons, and at two or more private hospitals. Some consultants have been quick to follow the practices of their predecessors at the Tata Memorial. A senior consultant orthopaedic surgeon at a private hospital narrated an especially sorry experience at his own beloved alma mater. He referred a poor patient who was in great pain and needed joint replacement, to this teaching hospital. He pointed out that the costs at the teaching hospital would be a fraction of the costs in any private hospital (including his own) and would be well within the patient's reach. Since the current professor was once his resident doctor, he reassured the patient. A few days later the patient returned to him, pleading with him to proceed with the operation in his private clinic. When asked why he spurned the teaching hospital, the patient narrated his experience. He was unable to meet the professor at the teaching hospital on three separate occasions, encountering only the resident doctors. When he finally succeeded in meeting the chief, he was told that owing to the large waiting list and heavy workload, the operation could only be performed three months hence and would be carried out by one of his resident doctors. As the patient stared in shock, he added: 'If you want me to do the operation and at short notice, you must see me at X Hospital.' The patient ended his account with the

fact that the fees at that hospital were more than those at the referring consultant's own hospital. The senior consultant commented: 'When we were students, our teachers had high ideals and lived by them. Today the only motive driving full-time professors in our medical college hospitals is the urge to get rich quick at any cost.'

Current trends augur poorly for the future of medical education and care in India. While we proudly and avidly seek patients from abroad to fill the beds in our five-star private hospitals, what of the poor and middle-class patients who can never aspire to such beds and must, perforce, attend our public hospitals? Worse, who is to teach our medical students and resident doctors the art and sciences of medicine when the professors are busy at their private hospitals?

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Letter from Nepal

A DIFFERENT KIND OF MEDICINE

I knew that my recent update in internal medicine abroad was not going to bail me out here. The young woman lying in front of me had presented to our hospital in the hills of Nepal, with fever of three weeks' duration, headache, nausea and some change in mental status. Besides the history and physical examination, a complete blood count and perhaps a spinal tap would be all I would have available to make a diagnosis. A computerized tomography scan or a magnetic resonance imaging scan, although available, would be unaffordable. Elaborate laboratory tests and a neurological consultation tonight or in the coming days would not be available. The buck pretty much stopped with me. A recently donated edition of *Adams and Victor's Principles of Neurology* in the library would be my best available resource. However, the common diseases in our setting which include tubercular meningitis, typhoid encephalopathy and Japanese encephalitis are usually not the forte of these standard textbooks. It would certainly be wise to find out what the book said. But knowledge of the local diseases would in all probability be more helpful and an important basis for the formulation of my plan of therapy, which would of necessity be empirical.

This is emergency medical practice in infectious diseases for the vast majority of doctors in the Indian subcontinent. Like the tourist in Kathmandu gathering trinkets to take back home to decorate a Christmas tree, the physician has to try and find little kernels of information lurking in age-old tips such as the cobweb appearance of the cerebrospinal fluid suggesting the diagnosis of tubercular meningitis. The positive side is that the patients are usually so grateful for the little that we do for them.

So rampant is tuberculosis that when I see a young person with fever, chills and a pleural effusion which is straw-coloured, empirical treatment with antitubercular medicine is started. To cut costs, many of us do not order other tests even if available. No pleural biopsies or special pleural fluid tests. I know Peter, my infectious disease consultant in Phoenix, would have turned pale with disbelief on finding out my basis for therapy. What! All that excellent residency training gone to waste? This is certainly not the methodical manner he taught me to work up a patient with coccidiodomycosis (the counterpart of a tuberculosis patient in Nepal) in the southwest United States. But Peter, *ke garne* (what to do?)! The choices are stark—tuberculosis *v.* malignancy. Do not miss the former. If it is the latter, there may not be much to offer the patient.

It is indeed amazing how dependent we have become on the history and physical examination. If a patient has fever and chills for a week and just 'suffers silently' it is probably typhoid, but if the person is groaning with myalgias and arthralgias it is probably staphylococcal sepsis or typhus, both common causes of fever in our hospital. These unproven signs or 'hunches' come to the rescue when the initial basic blood tests are equivocal and the cultures are negative, which happens all too frequently; few modern textbooks, if any, will talk about these. In an ideal world, inflammatory markers, changes at the cellular level and treatment guidelines will be mentioned in great detail. These latter points, although certainly important, are unfortunately irrelevant for the vast majority of acutely ill patients in Nepal. In the old days, clever physicians would say they could distinguish a patient with typhoid from one with typhus from the smell. Although I would not go so far, this is an interesting observation.

I am sure that having sophisticated, accurate tests will help immensely and provide a sense of closure for both the patient and the doctor even when the disease may not be curable. However, despite the limited tests and restricted treatment options, many cannot deny a sharp sense of being truly alive at being a doctor here in remote Nepal; perhaps for us this may be a chance to realize with wonder how astute physicians practised medicine in the old days, although this can be embarrassing, as it is so far behind the times!! Western volunteer doctors in the remote Himalaya Rescue Association high altitude aid posts (Pheriche and Manang) in the heart of the Himalayas almost always find their experience of helping acutely ill patients there without any laboratory tests very rewarding. Many return to serve again and again during future trekking seasons. No question, the excitement of honing your innate Sherlock Holmes' skills that much more precisely because of a lack of investigative facilities in arriving at a diagnosis is obvious. Add to that a very grateful patient, and for many of us this is a combination worth settling for.

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