Letter from Chennai

CAMP MEDICINE
Of all the branches of medicine, ophthalmology is the one most suited to the camp approach. The patient need not undress for examination, and a diagnosis can easily be made. A dark room cannot be easily provided, but a van could be appropriately modified and used for the purpose. The most common cause of blindness is cataract, and surgery has developed to the extent that it could be an outpatient procedure, or at the most require a day’s hospitalization. The benefit to the patient is enormous, and some people made a specialty of conducting such camps, striving to set new records for the number of patients operated each day. Unfortunately, the eye is vulnerable to infection, and once in a way a bad infection, or a string of infections, may lead to total loss of vision and sometimes to loss of the eye itself. I am sure I would not want to have my eyes operated in a field hospital. An analysis of cataract surgery in India revealed that the results of surgery in camps were good (postoperative acuity 6/18 or better) in 24.3%, borderline (6/24 to 6/60) in 65.2%, and poor (worse than 6/60) in 20.5%. While some of the poor results could be explained by bad selection of cases, an important factor was complications directly related to surgery.

I believe it was Aravind Eye Hospital at Madurai which initiated a revolution in camp-based cataract surgery. The camps were used only for diagnosis, and patients were brought to the hospital and underwent surgery under ideal conditions, eliminating most of the complications of cataract surgery. They could stay overnight in the hospital and go home the next day. Aravind does 150,000 cataract operations a year.

I had the privilege of seeing another example of this approach when I visited the K.G. Eye Hospital in Coimbatore recently. The hospital conducts between 15 and 20 eye camps each month. Patients are screened for cataracts, and those suitable for surgery are brought to the hospital for surgery and implantation of an intraocular lens (IOL). Only the patients are transported. Attendants are not allowed as they would add to the crowd and expense as they would need to be fed too. All necessary help is provided by the hospital staff. The patients are operated the next day and kept in the hospital for another 24 hours. After making sure there are no complications, they are returned to their homes 48 hours after they were picked up from there. The entire procedure is done free of charge. K.G. Hospital has outdone Aravind by providing free IOLs. The results have been excellent, with a very low rate of complications.

Cataract and family planning surgery are clearly numbers’ games. People establish records for the largest number of operations done in a day or in a single camp. However, it is distinctly unusual to establish a record for hernia repair. A young surgeon from Chennai recently set out to repair 50 hernias in 24 hours, and in fact achieved it with 3 hours to go: 30 of them were done free of charge. What was the doctor aiming to prove? Apparently he hopes to make it into the Guinness book of world records. The present record, we are told, is 41 in 24 hours. I would hate to be one of those statistics. I am sure hernia is not such a universal disease as to need this rapid correction.

I remember my days as an Assistant Professor of Medicine in the city medical colleges. We had so many patients that we had to see at least 20 patients an hour to complete the supposedly two-hour OPDs in 5 hours, and then go on to see the flood of admissions. No one was satisfied with this way of handling patients, but there was no alternative. The outpatient session was really an exercise in triage, separating the minor ailments and sending them away with symptomatic relief, and admitting the seriously ill ones for more detailed assessment in the wards. We did make mistakes, and I have often felt that we, and the government we worked for, were wrong in running OPDs in that manner, for we did not tell the patients we were giving them cursory care. I believe the government should provide a number of peripheral clinics in the city and employ enough doctors to make a reasonable examination of all patients, and send only the really ill ones to the hospitals. Where will we get enough doctors for this? With many vacancies unfilled in the government service, can it ever be done? I think it can. The posts should be part time, and many young doctors may be happy to supplement their income from general practice with an assured, though small, salary at the start of their careers.

THE COMMON ENTRANCE TEST: THE NEXT EXCITING EPISODE
The Common Entrance Test (CET) for admission to all streams in professional colleges will be held on 18 and 19 May, after Tamil Nadu goes to the polls. The government made this simple announcement, but the lead-up to it was as confusing as they could make it. Just a week earlier, they announced that the CET would be held on 13 and 14 May, and suddenly realized that the centres where the test would be held would be needed for counting of votes in the election scheduled for 8 May. Did you think governments plan before making statements?

On the last day of the Assembly session in February 2006, the government had a bill passed to declare that State Board students would be exempted from taking the CET, and would be judged on both the CET and the CBSE examination. However, students appearing in the Central Board of Secondary Education (CBSE) examination would have to sit for the CET and would be judged on both the CET and the CBSE examination marks. The question of how to make adjustments for the different examinations would be decided when the rules were laid down.

It did not take more than a few days for one of the students to file a public interest litigation in the Madras High Court challenging this. The court in due course struck it down, saying that it infringed the fundamental right to equality, and terming it ‘void, inoperative and unenforceable’. Further, ‘The State is hereby directed to start the process for holding the CET in accordance with the Medical Council of India (MCI) and the All India Council for Technical Education (AICTE) Regulations for all Board students for the academic year 2006–07.’ The State Government went to the Supreme Court in appeal, but the Supreme Court refused to overturn the Madras High Court decision, and hence the government is now going ahead with the CET as usual.

Regular readers of this letter will remember that in June last year, our Chief Minister announced that the CET would be abolished forthwith, since it favoured students from the cities
who had access to tutorial colleges, and put those from rural areas at a disadvantage. Then, as now, the courts struck down the order. They admitted that the present system was unfair to rural students, and called on the MCI to amend the regulations in such a way as to remove the inequality.

Surely a government which so keenly desired the welfare of its rural constituents would have worked vigorously in the succeeding few months, negotiating with the MCI and the various school boards to find a way to equitably balance the standard of marking so that admission to professional colleges could be done on the basis of the marks scored in the school board examinations. We heard nothing of such discussions in the past 9 months, but a bill was hurried through the legislature at the last possible moment. It was obvious that it would be struck down by the courts, since nothing had been done to address the inherent inequalities in the different examinations. Why go through the exercise at all? Was it just to impress the rural electorate that they have a government which cares for them, and tries ever so hard to help, yet gets frustrated time and again by the courts? Seventy per cent of the voters live in villages.

BIOMEDICAL WASTE

Just to show I have nothing against the government, let me give you an example of where the state leads the country. We have had an advisory committee on hospital waste management, working with the Tamil Nadu Pollution Control Board and the Department of Health. Eleven facilities have been set up for biomedical waste treatment in different parts of the state.

Under the system, all infected materials, including gauze, would be stored in red bags, human flesh, placenta and amputated parts in yellow bags and glass vials in blue bags. The segregated waste would be stored in Biomedical Waste Storage Rooms in hospitals. A sum of Rs 3 per bed would be provided to the Common Treatment Facilitator in Salem for collection of waste.

Human and animal waste is being incinerated or buried deep in the ground in designated areas away from human habitation, and far from groundwater sources, to avoid contamination. Unused or discarded medicines are also disposed of in the same way. Infected materials must be autoclaved or treated by microwave, or else incinerated. Sharps must be chemically disinfected and then put out of shape to prevent reuse.

While the stress so far has been on getting private hospitals to comply with these regulations, steps are now being taken to get government hospitals also to fall in line. Karnataka took the lead in that respect, pulling up some government hospitals in Bangalore even in August 2005. This is an area in which we would like all states to vie with each other.

However, rumbles of discontent are being felt. People in the vicinity of the areas designated for disposal of these materials fear that they may be exposed to infections, and that their water and air may be polluted. With a country as densely populated as ours, one cannot find a completely uninhabited area for this purpose.

REFERENCE


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