Letter from Chennai

BOTTOMS UP

The Government of Madras and its successor, the Government of Tamil Nadu, have always had an ambiguous attitude towards prohibition. It is introduced when finance ministers realize there is money in alcohol and within a few years time, it is withdrawn. However, it is a far cry from permitting the sale of liquor in the private sector to nationalizing it, which is what the government did by promulgating an ordinance amending the Tamil Nadu Prohibition Act, 1937 (Tamil Nadu Act X of 1937). Tamil Nadu State Marketing Corporation (TASMAC) and cooperatives associated with it will hereafter run the retail trade in the state. In a press release, the government said that liquor dealers had formed cartels by means of which they could corner the market. They violated the maximum retail price fixed by the government, and sold spurious and contraband liquor, to the detriment of the consumer. It was in the interest of the consumer that the government decided to take over the trade and run 'bars in an orderly and hygienic manner'.

Doubts were raised about how the government would find the manpower to run its liquor shops. However, conveniently, for this plan, the workload of ration shops in the state was reduced by the denial of supplies to everyone earning more than Rs 5000 a month. The staff thus made redundant could be diverted to the liquor shops and bars. Meanwhile, there is agitation among those registered with employment exchanges, all of whom think they are best suited for this convivial service.

In the 1960s, I worked in the Government Stanley Hospital that serves an industrial area. I was familiar with many of the families living in a nearby slum. There was a dramatic improvement in the standard of living of the slum dwellers when prohibition was introduced, and the even steeper decline when it was lifted. Children were better fed, better clothed, and generally more healthy and happy when their father could not waste his money on alcohol. I am all for prohibition, and I am dismayed that we have swung from one extreme to the other.

Does not every Indian have a fundamental right to drink or smoke as he/she desires? Let me tell you the views of one of the greatest protagonists of prohibition. On the last occasion when Rajaji was the Premier of Madras, my father was a senior civil servant. When Rajaji introduced prohibition, he left a loophole for well connected people to obtain a permit to purchase and consume alcohol on the flimsiest grounds. My father was a social drinker and had the permit. When some foreign visitors came to Madras for discussions on some project with the government, Rajaji asked my father to entertain them. On one such occasion, my father asked him how he could reconcile his views on prohibition with the fact that he had actively incited him to drink along with the foreign guests. I heard Rajaji's reply: 'I am not bothered about people like you. You are affluent and sufficiently well informed to look after yourself. If you choose to ruin your health by drinking that stuff, it is of no concern to the state. My responsibility is towards the poor, who do not know better, and who will seek refuge in drinking for their problems, making those problems worse. It will benefit them if the government enforces prohibition.' These may not be his exact words, but that was the meaning. When the prohibition was lifted, I was still in Stanley and the nutritional standards of my patients from the neighbouring slum dropped dramatically, and they became prey to ever more illnesses.

Perhaps prohibition has proved to be unworkable. By the same token, the government's handling of matters which should be left to the private sector has also proved to be inefficient and corrupt. I do not think the drinking public of Chennai will be protected from substandard and adulterated alcohol if the government takes over the trade; a different set of people will profit.

WATER

Our government has enthusiastically arranged to provide us with liquor to drown our sorrows, but it has done nothing to provide us with a more essential liquid, water. Time was when we had a water meter in our houses, and paid the municipal corporation according to our consumption. Many years ago, the corporation took the wise step of disconnecting the meters, and charged us a flat water rate. We have not had a drop of water from the Metrowater pipe for months now, but we still have to pay the rate, since it is not linked to our use of water.

The Veeranam lake in Cuddalore district, some 230 km south of Chennai, is considered as a means of augmenting the city's water supply. The Veeranam project was inaugurated in 1968. Unfortunately, it has been a political plaything. One government works to implement it, and then yields place to another party, which shelves it merely because it was promoted by its rival. We have yet to see any water from it, or from the more recent Telugu Ganga project to bring us water from the Krishna river, 350 km north of Chennai.

The current government of Dr Jayalalithaa has decided to resuscitate the Veeranam project at a cost of Rs 7.2 billion, to supply 180 million litres per day to the city. Experience makes us sceptical about this. We are used to the sight of massive pipes lying by the roadside, sometimes put to use as a shelter by slum dwellers, and wonder whether the Veeranam project is the origin of the expression 'pipe dream'. There are two clear sources of water available to the city from within itself. One is ground water, and I feel the government was wise to make it compulsory for every building in the city to install rain water harvesting so that the supply could be replenished. Unfortunately, one must first have rain to harvest water, and with the rains playing truant yet again our wells are running dry. The other, and this time inexhaustible, source of water is the Bay of Bengal which laps our shores. Experts predict that global warming will lead to a rise in sea levels in the years ahead, so we will not run short of this commodity. I have long felt that desalination of sea water is the only feasible method to maintain the city water supply when the rains fail. I am glad the government has at last considered this option seriously. The chairman of the Metrowater project said recently that desalination plants with a capacity of 300 million litres a day were planned at the cost of about Rs 15 billion. These massive figures are beyond my simple mathematical abilities, but it does not seem much more expensive, litre for litre, than the Veeranam scheme, and would probably be much more feasible, especially as it can be left to the private sector, and does not involve long conduits which can be tapped all along their course. Tenders have been called for. The last date was November 14, and the contract will be finalized within 4 months.

THE TAMIL NADU STATE MEDICAL COUNCIL AGAIN

The Tamil Nadu State Medical Council (TNSMC) continues to make noise. It recently announced that it was in the process of compiling a fresh code of ethics for doctors, in keeping with the changed circumstances. I see no point in making code after code when there is no will to implement the directives, and doctors continue to flout them with impunity. Perhaps the new code will remove all the old restrictions, so that we can do what we will and still call ourselves ethical practitioners.

DYING WITH DIGNITY

Some years ago, I wrote about the abominable condition of the city's cremation grounds. They are filthy and the staff is corrupt, demanding money from helpless mourners at every stage. In 1998, the municipal corporation invited bids from the private sector to run some of these grounds, and at least one of them, the Jayadasa Trust in Tiruvanmiyur, a relatively new part of the city, has done a fine job. The three-acre site has been transformed into a tree-lined garden. Coconut, bamboo and *Casuarina* have been planted to provide wood for cremation. Iron grills have been installed for the fires, and toilets and other amenities have been provided. I was happy to see a news item that the corporation has decided to improve the cremation grounds it owns and runs. A start has been made in one of the oldest, in Mylapore. Antisocial elements have been evicted and 24-hour security staff provided, the place has been cleaned and the scrub cleared, and adequate lighting has been installed. Not a day too soon. The least we can do for our dead is to enable them to quit this earth with dignity.

EXERCISE AND LONGEVITY

I must confess to having been a couch potato for most of my life. I have always felt that an hour spent in exercise could be better spent in improving my meagre knowledge of medicine. Some of my friends have unkindly implied that the real reason is that I am incurably lazy. I have always sought scientific justification for my views, for example the paper from the USA[1] which, while lauding exercise, said 'the amount of additional life attributable to adequate exercise, as compared with sedentariness, was one to more than two years.' Given the life expectancy of the average American, an hour of vigorous exercise a day for say 50 years as an adult would add up to 760 days, so one would prolong life by just about the number of hours one exercised. I did not think it worthwhile.

Having lived happily for three score years, I fell into the hands of doctors who insisted on my walking every day, and so I joined the ranks of my fellow citizens who trudge the roads each morning, and I am now a walker of many years experience. The proliferation of diabetic centres in Chennai, and the profusion of cardiologists, has led to ever more of us turning out. I have made a few observations. There are more women walkers than men. The majority of us are overweight, and over the years the exercise does not seem to have made any of us shed even a kilogram of fat.

Some people exercise their dogs along with themselves. There is the mournful gentleman with the hangdog look, who walks with an equally mournful-looking cocker spaniel with its long face and drooping ears. There are the aggressive young lady whose companion is a fierce-looking boxer, the lanky gentleman with his great dane loping beside him, and the sprightly young lady doctor with her pony tail bouncing as she jogs, and the pomeranian prancing with pride beside her. Do human beings take on the characteristics of the animals they associate with or do they select animals akin to themselves? What a wonderful subject for a controlled trial!

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M. K. MANI

Letter from Glasgow

ULTRASOUND SCANNING IN PREGNANCY: THE HOPE AND THE SHAME

I don't want to go blowing trumpets here but I'm afraid I really must. You'll understand that I'm not blowing any brass instruments on my own behalf but that of Glasgow (renowned for its hospitable and friendly natives who are called Glaswegians) and a certain Professor Ian Donald who worked in Glasgow.

Ultrasound scanning in pregnancy was pioneered here in Glasgow in the 1950s (the decade before my parents moved to Glasgow from India) and Professor Ian Donald was the person who did the pioneering work (*www.ob-ultrasound.net*). Appointed to the Regius Chair of Midwifery at the University of Glasgow, Ian Donald spotted the potential of sonar for medical purposes. This was aided considerably by a famous industrial company in Scotland, Babcock and Wilcox, based just outside Glasgow in the town of Renfrew. Babcock and Wilcox allowed him to use an ultrasonic metal flaw detector on excised fibroids and ovarian cysts. Following those early investigations, it was towards the end of the 1950s that the knowledge Ian Donald gained was applied to the field of obstetrics. Consequently, a great tool was developed to help obstetricians and midwives provide information on the foetus and the mother to help provide safer and better care for both.

There are two reasons for writing about ultrasound in pregnancy—the first is that ultrasound scanning is an area that NHS Quality Improvement Scotland (NHS QIS), for whom I work, are currently looking at, and the second is the abuse of ultrasound scanning by some in India.

NHS QIS are undertaking a health technology assessment (HTA) on routine ultrasound scanning in the first 24 weeks of pregnancy. As I explained in my previous Letter, an HTA considers clinical effectiveness (including a systematic review and meta-analyses, if necessary), cost-effectiveness (including economic modelling), patients' and carers' needs and preferences, and organizational issues (including training, quality assurance and medicolegal issues) when assessing any health technology (intervention) under review.[1] The objective of this HTA is to answer the

question: 'What is the most clinically and cost-effective routine ultrasound scanning policy which can be offered to pregnant women in Scotland before 24 weeks of pregnancy: a first trimester scan only, a second trimester scan only; or a first plus a second trimester scan?' The intention is to produce recommendations for the NHS in Scotland that will ensure that all pregnant women get the same access to routine scanning in a normal pregnancy—the issues of scanning in problem pregnancies are not dealt with in this HTA.

The final report will be a 200+ page document and is scheduled for publication in February 2004. Contained within the report will be all the work undertaken, the assumptions made, and the final recommendations so that the public, clinicians, statisticians, health economists and policy-makers can scrutinize all that NHS QIS has done. For those interested in the progress of this HTA, further information is available on our website *www.nhshealthquality.org*. Currently, the last document we produced was the Consultation Report[2] of the HTA, which is also available on our website. This highlighted the use of ultrasound in the first 24 weeks of pregnancy in assessing foetal viability, measuring gestational age, diagnosing multiple pregnancies, making a qualitative assessment of amniotic fluid, and identifying foetal structural abnormalities. The draft recommendations (and I emphasize the word *draft* as these may change as comments and other evidence presented during the consultation period are considered) include the following: that all pregnant women are offered two routine ultrasound scans; a first trimester nuchal translucency scan at 11–13 weeks which also involves maternal serum screening for Down syndrome; and a second trimester anomaly scan at 18–20 weeks of gestation.

In many respects, it is not the details of the recommendations which will emerge from the HTA that are important. What is much more important is the concept that this HTA is being undertaken to assist the NHS to provide a consistent and high quality service of routine ultrasound scanning throughout Scotland. That is, it aims to improve healthcare provision to pregnant women (and hence their babies) using all the existing evidence that we have to provide the best possible care within the resources available to us. That is the hope.

The shame is what I read about the abuse of ultrasound scanning during pregnancy in India. We know from the 2001 Census in India that the female:male ratio has worsened from 10 years previously and that the overall ratio for India is now 933:1000.[3] It is also clear from my own knowledge on the issue that private obstetric clinics have been using, and continue to use, ultrasound scanning (as well as other antenatal diagnostic techniques) to selectively identify and abort female foetuses. My shame is two-fold. The first is that my professional peers are abusing medical knowledge and skills to knowingly flout the Pre-conception and Pre-natal Diagnostic Techniques (Prohibition of Sex Selection) Act in India. Furthermore, these doctors are also breaking their Hippocratic oath to do the best for their patient. The second shame is wider and asks what sort of society are we perpetuating in India that uses medical knowledge and technology not to help women and girls but seeks to subjugate them further in a medieval mind-set that aborts foetuses for the simple reason that they have XX chromosomes.

I am proud of much that India has achieved but remain to be convinced about its achievements on the rights of women. The *National Human Development Report*[3] makes it clear that there has been some slight improvement in gender equality in the past two decades in India. However, it notes that 'on average the attainments of women on human development indicators are only two-thirds of those of men'. We also know that some states in India are much further developed with regard to gender equality, with women in southern India generally faring better than those in northern India. Moving towards gender equality requires increasing female literacy and the empowerment of women. This then begins to challenge the existing gender power relationships and social/cultural norms.

But as female foeticide highlights, female literacy and education by themselves are not enough to change attitudes to female foeticide.[3] In some respects educated individuals behave in exactly the same manner as those who are illiterate, emphasizing the need for a multi-level and multi-pronged approach to gender equality.

As a public health physician I know that, demographically, having a favourable female:male ratio in India will have a profound impact on India's capability of progressing to the advanced industrial, technological and IT-literate society it seeks to, and can, become. Hand-in-hand with those steps need to be social and cultural advances that tackle the issues of female foeticide, and protect and promote the rights of girls and women.

From the shame of abusing ultrasound scanning in pregnancy there may be hope. I am aware of the actions that health professionals and others such as B.S. Dahiya, the Director-General of Health Services in Haryana,[4] are taking to challenge the abuse of ultrasound scanning in pregnancy in India. I applaud and support any initiative that seeks to protect female foetuses, girls and women so that they can play their role in India's future.

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Letter from Mumbai

A MATTER OF LITTLE IMPORTANCE

A hospital in Mumbai holds periodic meetings between its administrators and senior staff members. At one such meeting, suggestions for improving the care of patients were invited. One person from the audience referred to a common malpractice. 'From time to time, patients develop acute, troublesome symptoms. When the ward sister pages the relevant resident doctor, drugs—including injections—are prescribed over the telephone without the doctor coming over and examining the patient.'

He gave an example. An ageing patient had impaired mental faculties. He was due for surgery. Around 1 a.m., his wife contacted the nurse on duty. The patient was pacing up and down, wandering out of his room and even trying to descend the stairs. Unable to restrain him physically, she requested help in quietening him and persuading him to go to sleep. She could not understand his restlessness. The nurse paged the resident doctor. He did not come over. Over the telephone, he asked the nurse to give the patient a strong hypnotic tablet. Despite this drug, the patient continued to try to leave his room and go out of the hospital. His wife begged for help. When paged, the doctor sounded upset as it was around 2.30 a.m. 'Give him another tablet.' By 3.30 a.m., the wife was in tears. Not only did the patient continue to attempt moving around but now, groggy from the effects of the drug, he was very unsteady on his feet and actually fell to the ground, almost hurting his head. He had passed urine in his bed and all over his room as he could not make his way to the bathroom in his befuddled state.

In another instance, the consultant on his daily rounds came across a patient who complained of the effects of the intravenous injection given the previous night. Since he had not requested any such injection, the puzzled consultant studied the patient's case notes. Indeed, no injection whatsoever had been prescribed. The nursing sister looked up her notes. The nurse on duty at night had recorded the injection in her report with the statement: 'Given on telephonic instructions from Dr ABC.' It turned out that the doctor, when paged, ordered the injection over the telephone without coming to see the patient. He made no note on paper of this prescription ordered by him!

Concluding his plea, the doctor asked the administration to outlaw this practice on the grounds that it was unscientific, bad medicine and dangerous for the patient. He did not refer to the medicolegal consequences for the hospital and the consultant. Failure to examine a patient with acute symptoms might lead to loss of valuable time in the treatment of a potentially hazardous medical complication. The drug itself may play havoc with the patient's systems.

More interesting than this doctor's observations and plea were the responses they elicited from the other consultants in the audience and the administrators. The chief administrator felt that if the resident doctor had seen the patient a few hours earlier, the prescription of a drug over the telephone might be in order. Other consultants suggested that to ensure that no mistake was made, the resident doctor should repeat the name and dose of the drug to two separate nurses on the floor, spelling out the name of the drug and dose. There was some discussion over which tablets and injections could be ordered thus. A few agreed that having ordered the prescription, the resident doctor should, at a later stage, note this on the patient's case sheet. The administrator brought the discussion on this topic to a halt saying that the majority felt that there was nothing wrong with such a practice.

HOSPITAL MEDICAL RECORDS

At another meeting, the department of surgery attempted a retrospective audit of patient care on the basis of a study of hospital case records. A consultant spent some months reviewing all the case papers obtained from the medical records department of the hospital.

A few interesting but unexpected facts emerged from his study.

- The study could not be extended beyond 5 years as all records prior to this date had been destroyed by the hospital. The administrators base this decision to destroy records on lack of space for storage of such records. When asked whether microfilming and microfiche, available for decades or electronic storage devices freely available more recently, had been pressed into use, there was silence. Since this hospital—like all others of its size in Mumbai— also serves as a research organization, such destruction of records evoked considerable surprise and scepticism.
- Notes on hospital records were sketchy, incomplete and often illegible. Operation notes provided few details. Some consisted of just one sentence such as 'Mastectomy done under general anaesthesia'. The consultant undertaking the analysis made the following observation: 'I often learnt more about the patient's clinical state, progress and medication from the notes maintained by our nurses than from the notes made by doctors.'
- Deterioration in the patient's clinical condition was recorded using stereotyped statements. 'G.C. poor. Blood pressure unrecordable. Attempts at resuscitation failed. Patient declared dead at 3.40 a.m.' It was impossible to trace the progress of the disease, the mechanisms that had resulted in acute catastrophic failure of the patient's systems and precise cause of death from most case notes. There could be no answers to questions such as 'Did the patient die from a postoperative complication or the natural progression of the disease?' 'Was there evidence of widespread infection?' 'Was there bleeding within the body cavity and if so, which blood vessel(s) gave way?'

PAUCITY OF AUTOPSIES IN PRIVATE HOSPITALS IN MUMBAI

Discussion on this topic at the above meeting yielded interesting facts. Few, if any, of the large and prestigious private hospitals in the city carry out a large number of autopsy studies. Consultants defend their refusal to request an autopsy on the following grounds:

- Autopsies are not possible in the hospital. The consultant pathologist refuted this, saying that he was willing to come at any hour to perform the autopsy. He also noted that his hospital had a fully equipped autopsy room that was seldom used.
- Relatives would never agree to an autopsy. A senior consultant neurologist showed that he had just obtained permission for an autopsy on one of his patients where he remained puzzled by the illness despite all the tests performed. He had explained his dismay to the relatives of the dead patient and requested permission for examination of the brain. They had immediately acceded on the grounds that this may benefit some future patient.

In an informal discussion outside the auditorium, the consultants voiced their real fear. In this litigious era, relatives may sue the doctor if some complication from a procedure or surgery is detected at autopsy. Stern looks were directed at the timid soul who suggested that such complications would otherwise never be detected and other patients might suffer as a consequence. The pathologist rightly shot down the suggestion that there be two autopsy reports, the first edited for 'public consumption' to be placed in the medical records and the second, complete report, for 'private circulation' to the clinicians concerned.

REMEMBERING JUSTICE LENTIN

When the possibility of doctors being sued by patients or their relations was brought up, a respected consultant physician was reminded of his discussions with the late Justice Lentin. (For a review of Justice Lentin's report on the deaths in Bombay following the use of contaminated glycerol see *Natl Med J India* 1988;**1:**144–8.)

Justice Lentin told this physician of the cardinal principle employed by him when he was judging an accusation of malpractice by a doctor. In his dealings with the patient and relations, did the doctor show 'the four Cs'? Seeing the puzzled look on his listener's face, he elaborated: competence, care, compassion and communication. If there was evidence of these, the doctor had nothing to fear. He pointed out that judges were aware that doctors were experts in their fields and knew more about medicine than did lawyers and judges. Judges also recognize that there can be differences of opinion among doctors as to how a specific illness should be treated and that disparate methods can be employed. As long as generally accepted principles and practices were followed, judges would permit considerable latitude.

Woe betide the arrogant and supercilious doctor! Judges do not take kindly to an attitude of 'I know best' or 'No one can question me'. A doctor tried to defend the fact that he did not see his seriously ill patient at night on the grounds that such a visit would cost the patient more than the fee during office hours and that the patient's relations had not asked him to see the patient in the dead of the night. Justice Lentin pointed out that the onus of deciding whether or not to see the patient rested with the doctor, who, in turn, must base his decision only on the clinical state of his patient and gravity of illness.

Justice Lentin was also critical of the quality of notes on medical case papers scrutinized by him in the course of his inquiry into the glycerol tragedy. The use of acronyms understood only by a select few, lack of meaningful and relevant detail and the insensitivity of those writing the notes dismayed him.

Our consultant physician narrating these lessons learnt from the eminent jurist told of a distressed friend who showed him a discharge summary from a hospital that described his wife as 'a fat old woman'. While the description has the merit of brevity and accuracy, it caused acute embarrassment whenever and wherever this summary had to be displayed.

THE DISCHARGE SUMMARY AND INSURANCE COMPANIES

The aforementioned physician also highlighted another problem resulting from thoughtlessly written discharge summaries. Insurance companies scrutinize these summaries with great care, looking for grounds on which the applicant's claim can be rejected.

He quoted the example of a patient in her eighties who had been admitted for the treatment of an ischaemic stroke in the vertebrobasilar artery territory. As the resident doctor was taking down her history, he enquired about earlier episodes of a similar nature. She denied any such episode. He persisted. 'Did you never, ever, suffer from giddiness?' After some thought, she told him about an event in childhood, when she had felt giddy for a few days after a fall and injury to her ear. Triumphantly, the resident doctor noted on the case paper—and later on the discharge summary—'History of giddiness from childhood'. The insurance company seized this statement and tried to deny the claim. It took much effort on the part of the physician to convince the company that the giddiness in childhood had followed injury to the labyrinthine apparatus in the ear and was in no way related to the stroke suffered 7 decades later.

SUNIL PANDYA