Letter from Chennai

KEEPING A SAFE DISTANCE

For the last year and a half, Covid-19 has taken over the country, and, as a result, all other diseases have been kept at a distance. Travel has become difficult or impossible, and even where it is possible patients do not want to take the risk of going to a hospital where the virus may be lying in wait for them. Nor are doctors willing to put their patients in danger.

The prefix 'tele-' is defined by the Oxford dictionary as 'forming words denoting or connected with instruments or appliances for, or methods of, operating or communicating over long distances' and also 'services obtained or transactions effected by telephone or computer link'. Hence, 'telemedicine' which is the obvious answer to managing patients without making them come to the doctor. The Apollo group of hospitals has been the pioneer in the use of telemedicine in India, and is still the largest user of this technique.[1] We introduced telemedicine in 1997, and now run a large centre in Hyderabad, which handled 736 969 teleconsultations in 2019 and 662 120 in 2020. Apart from that teleconsultations can be had with individual doctors of the patient's choice. The telemedicine team will bring a laptop to the consulting room of the chosen doctor at a prefixed time. The patient can connect from his computer at home and see and speak to the doctor. This number rose from 3707 consultations in 2019 to 21 716 in 2020, clearly those patients who wanted an opinion but did not dare to come to the hospital. The prime mover for Apollo's telemedicine programme is Dr K. Ganapathy, neurosurgeon and Director, Apollo Telehealth Services, and I am grateful to him and his team for much information about these services.

As I see it, telemedicine is ideally suited for dermatology, where a history and inspection is usually enough to make a diagnosis, and for psychiatry, where the patient and his doctor can see and speak to each other. The lack of palpation and auscultation is the greatest drawback, and one is often more dependent on investigations. It would be an excellent way for a doctor to take an opinion from a consultant elsewhere. A great drawback, though one that can be remedied, is the absence of a written record. Oral instructions are often misremembered, or misheard, and the results can be disastrous. The remedy is to have the conversation transcribed. That would add to the complexity and the cost of the procedure, but it can be done. Telemedicine can also be used for ophthalmic fundus examinations, and computed tomography scans and histopathology sections can be examined at a distance, but this requires more complex equipment and adds to the cost.

I must confess that, despite the efforts of our telemedicine department to make the procedure convenient for the consultants, I have never used this method. I have developed my own system which is considerably easier and relatively foolproof and I will describe it for you. In the first place, I do not believe any telemedicine consultation is appropriate for a patient you have never seen before. The first consultation should be personal and include a thorough examination. One can partially make up for this if there is a reliable doctor at the patient's side, who can check for the essential physical findings and transmit them to you, but then I would prefer further teleconsultations also to be done in the presence of that doctor.

Every patient of mine is given a printed sheet with instructions for his follow-up at a distance. This goes: Instructions for further advice by email:

1. Please mention your name as entered in the hospital records, and your hospital identification number. This makes it easier to trace your case sheet.
2. Please give me the full list of medicines you are taking at the time of writing. This should include the name of the medicine, the strength of each tablet and the number of doses each day. Please verify the name and strength of the tablet from the strip every time, so that there is no error in the dose.
3. Let me know your present condition and any complaints.
4. Please give me the reports of any tests you had been asked to have done.
5. You may write to me at my email: *drmani@apollohospitals.com*, or fax to 044 2829 4429.

Most parts of the country are connected to the internet, and patients who do not have their own computer set up at home can go to an internet café and get connected from there. In the few places where the internet may not have penetrated, public call offices with fax facilities are available. On principle, I do not give advice on the telephone for fear of being misheard or misunderstood. I expect patients to print out and keep a copy of their email and my reply in their file. I keep a similar copy of the correspondence in their case file in the hospital.

Incidentally, when the patient comes to me, he has to bring all his current medicines in their original strip, show them to me and tell me how much of each he is taking. There should be no scope for error.

My system is especially useful in the management of chronic patients. While those coming from afar find it very helpful and economical as it saves the cost of travel and stay in Chennai for a couple of days, even residents of Chennai prefer to save the cost and time of a trip to my hospital. They are happy to have tests done at a laboratory near their home, and send rather than bring the reports to me.

I have found it possible to fine tune the long-term care of all my patients, provided they take the trouble to do their tests as instructed and report to me. It does take time and effort on my part, but are a few minutes of my time worth more than several years of additional life for the patient?

TOO MUCH OF A GOOD THING?

Regular readers of this column would be aware that I have repeatedly implored the health ministers and secretaries of the Tamil Nadu government to implement the prevention programme developed by the Kidney Health Trust of Chennai, which at a very low cost has been able to reduce the prevalence of chronic renal failure from 28 per thousand of the population to just 11/1000, 'heart attacks' from 9.1/1000 to 2.8, and strokes from 10/1000 to 1.8, at a cost of just ₹31.26/capita of population per year. In 2005 this was adjudged by the International Society of Nephrology to be the best preventive programme in the world,

[**To cite:** Mani MK. Letter from Chennai. *Natl Med J India* 2021;**34:**365–6.]

and the Managing Trustee received the John Dirks Award of the Society. From that time, I have approached every health secretary of the government with the request to take up this project, at least on a trial basis in one or two blocks in the state, but with no response. Having retired from the profession, I did not approach the current administration.

I was delighted to see a report in the newspapers a couple of weeks ago that the Chief Minister was launching 'Makkalai Thedi Maruthuvam', literally 'Medicine in search of the people', a domiciliary scheme to screen the entire population for diabetes and hypertension, and provide treatment for these diseases at home. That is exactly what the Kidney Health Trust advocated. There was no mention of the Trust in the statements made by the government to the press, but what I have always wanted was the action and not the acknowledgement. However, I am worried about the further reports in the press that malignancies, chronic obstructive pulmonary disease and mental diseases would also be covered, in addition to the existing coverage of tuberculosis and leprosy. What is more, peritoneal dialysis would also be covered at home.

Why am I worried? The success of the Kidney Health Trust's programme was largely due to its simplicity and low cost. Our government is planning something far more complex and expensive. I fear it will run for a few months and then be quietly abandoned. You might remember that some years ago I spoke of having been invited to speak at a meeting in Puducherry. The leading nephrologist of that state, who was my host, had the clout to bring four leading politicians to the meeting and to make them stay through my talk. What is more, the screening programme was taken up with enthusiasm. I was anxious then as I am now. I wanted the population screening to be done with a simple questionnaire, a recording of blood pressure and a urine test for protein and glucose. However, the health minister of Puducherry wanted to do it in style with a glycated haemoglobin.

As I said then, and I repeat now, of course, glycated haemoglobin is much more reliable for the diagnosis of diabetes than the urine sugar, just as a Mercedes Benz is infinitely superior to the jalopy I drive. However, I can afford my present car, and there is no possibility of my affording a Mercedes in this lifetime, so I stick to what I can sustain. The Puducherry programme went for a few months and then someone said it was too expensive and it was suspended, and I fear the Tamil Nadu programme will die the same way. *The Hindu* estimated an additional expenditure of ₹257 crore for the first year, and that figure will keep rising. This year's amount is itself more than I can comprehend. It is so much better to establish the most simple and the cheapest protocol, and then expand it once it runs successfully.

I hope I will be able to report to you a year from now that our medical quest to the people is working well.

REFERENCE

1 Ganapathy K, Ravindra A. Telemedicine in India: The Apollo story. *Telemed J E Health* 2009;**15:**576–85.

M.K. MANI