

## Letter from Mumbai

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### ARE LIBRARIES IN OUR MEDICAL INSTITUTES DEAD?

At a nationally famed postgraduate institute, the visiting professor was discussing classics in medicine with residents training in neurology and neurosurgery. While extolling the value of books such as those written by Sir Charles Sherrington, Lord Russell Brain, Sir William Gowers, Dr Harvey Cushing, Dr Wilder Penfield, Dr Percival Bailey, Dr Santiago Ramon y Cajal and others, he saw blank faces. He was surprised as during his own visit to the institute library a few hours earlier, he had seen some of these works on the shelves.

He enquired of the senior professors about the reason these were unknown to the resident doctors. The answer stunned him.

'Our resident doctors hardly ever go to the library. Our institute provides them free access to online books and journals throughout our campus. It is much more convenient to access recent papers and texts on the internet from their rooms than to trudge to and from the library.'

As our visiting professor had walked between the shelves in the institute's library, he had been puzzled by the paucity of readers—young and not-so-young, absence of excitement at the unexpected discovery of a hidden masterpiece and the dust that billowed when he pulled out texts and volumes of journals published fifty years or more ago. The explanation was now evident.

Reading is apparently restricted only to recent publications consulted by postgraduates on smart phones during ward rounds to elicit urgently needed facts on diagnosis or treatment or on laptop computers in their rooms to summon texts likely to help in their examinations.

Since they are hardly ever referred to during ward rounds, seminars and department meetings, where is the need to even think of classic publications?

What about the loss of the great advantage of serendipitous discovery as one walks up to a shelf in the library searching for a particular paper in a journal or chapter in a book and discovers a completely unrelated but stimulating essay or historical account that excites both a sense of wonder and admiration for a pioneer in research centuries ago? 'Well,' says the local professor, 'this is true but how does it help performance in an examination?'

Small wonder that we see papers in our journals claiming 'discoveries' that were made decades and even centuries ago. It is not uncommon to see references to papers by individuals or groups abroad, written on the basis of a study of a score or so patients with tuberculous meningitis while the publications of such homegrown experts as Drs Darab K. Dastur, Homi M. Dastur, Noshir H. Wadia and Prakash N. Tandon, which describe cumulative experiences with several hundred such patients, lie unread and unquoted.

It is not just Indian masters who are neglected. If you analyse papers on degenerative cervical intervertebral disc disease published from India over the past several decades you will be hard put to find a single reference to the classic monograph by Russell Brain and Marcia Wilkinson (1967).<sup>1</sup> This is despite the fact that their account contains detailed evaluation of autopsy findings in patients with this disease, histological evidence of thrombosis of the anterior spinal artery and spinal cord infarction.

If you visit the library of the hallowed Grant Medical College in Mumbai, you will be flabbergasted. On an upper floor of the

library building is a hall, partly occupied by shelves. On and around them lie hundreds of books and journals. They have not been arranged with any care and no one appears to have handled them over the past few years. Those on the floor are in irregular heaps, often askew. Many lack their covers and display torn pages. During a cursory search, I saw, in this dusty heap, mangled early issues and volumes of internationally reputed journals and books for which the likes of the National Library of Medicine in Bethesda, USA or the Wellcome Library in London, England would pay considerable sums.

The final nail in the coffin of a major medical library is in the offing at the Postgraduate Institute of Medical Education and Research in Chandigarh. A senior staff member is reputed to have stated: 'All the books and journals at the PGI's Dr Tulsi Das library will be discarded...With the revamping of the library on the cards, more terminals for electronic versions of the books will be added...We are in the process of upgrading the library where more room will be for electronic journals. There are huge numbers of printed versions and since the medical knowledge required is for updated information, we will remove the printed copies and replace them with electronic books and journals. Unlike public libraries, there is no room for manuscripts or old books.'

### ON DONATING ONE'S BODY FOR DISSECTION

Medical colleges in Mumbai had, up to a few years ago, a surfeit of unclaimed bodies that were sent to them by the authorities for dissection by students.

The advent of smart phones with personal details noted in them, need to carry PAN or Aadhar cards (or their photocopies) and other evidence of identity and data needed to contact near and dear ones has resulted in a marked reduction of unidentified victims of accidents.

The situation of plethora has given way to paucity and departments of anatomy struggle to meet the requirements of students in their dissection halls. There is another difficulty also faced by these departments. Most surgical specialties now host conferences and seminars featuring demonstration of operations on cadavers. These bodies need to resemble as closely as possible a fresh cadaver. The value of such demonstrations cannot be overstated. Innumerable observers are able to witness masters in the field perform delicate operations, often through the endoscope or operation microscope and thus enhance their own understanding and operative skills.

Faced with these requirements, the department of anatomy at Seth G.S. Medical Colleges has taken two important steps. It is using every means at its disposal to bring to the attention of the citizens of this city the need for donating their corpses for medical education and research. Specially trained staff members reach out through the media to voice this plea. A system has been set up to provide prompt information to anyone seeking information. Courtesy and a will to help are evident to the enquirer.

Documentation for registering oneself to donate mortal remains has been kept simple. On registration a photo-identity card is issued bearing details on the donor and telephone numbers of the donor's residence and the department. A request is made on the card that should the bearer be found in a lifeless state, these numbers be called.

Staff members are on call at all times. On receiving information

of a body being brought in, the department swings into action. During working hours, the body is transferred at once to the cold room (see below). The relatives are escorted to an office and arrangements made for an affidavit to be signed by the immediate family members on the voluntary donation of the body of their loved one. After office hours, the body is stored in the cold room of the hospital morgue. It is transferred to the cold room of the anatomy department the next morning.

To meet the requirement for surgical demonstrations noted above, the donated body is carefully maintained, without the injection of formaldehyde or glutaraldehyde, between 0 and minus 7 degrees Celsius. The creation of such a storage system with unfailing regulation of temperature was crucial to the efficacy of the system.

The number of such donations is showing a slow but progressive rise. It is of interest that eminent senior citizens are registering themselves for this purpose.

Readers of this journal will welcome enlightenment on similar efforts in other parts of our country.

#### FREQUENCY OF TESTS PERFORMED IN HOSPITALS AND INTENSIVE CARE UNITS (ICUs)

At the outset, let me state that I have no difficulty understanding the needs of the clinician ordering frequent tests in a patient with a wildly fluctuating or deteriorating clinical course. My problem is the performance of such tests in the presence of stable or improving clinical states.

I often see patients bringing with them thick files. They place them on my table and expect me to go through them after I have completed my clinical examination. I find the experience daunting especially since I spend considerable time in eliciting a detailed history and performing a clinical examination.

As I struggle with the files, I find an interesting series of reports if the patient has been in the ICU of a hospital for more than a day or two. Each day is marked by the addition of several sheets of reports. These include electrocardiograms, X-ray reports on the chest and its contents and a series of laboratory reports ranging from complete blood counts, hepatic and renal functions to estimations of serum cortisol and thyroid hormones. The cumulative sheets at times number 100 or more, the tests have been repeated daily and, in most instances, showing no significant changes!

When I ask the patient about alterations in symptoms and general condition in the period during which this battery of daily tests was performed, I am usually told that there was no significant worsening and, in some cases, even a slow but steady improvement.

This phenomenon evokes a few queries.

Do clinicians in these ICUs order, as a routine, the performance of a series of tests irrespective of the clinical progress of the patient? If so, what is their motive?

Are these tests a substitute for talking to the patient and performing a meticulous assessment at each visit?

Are the experts ordering such tests aware of their costs to the patient?

Do those in charge of ICUs survey the number of tests with uniformly negative results ordered by clinicians in charge of individual patients?

Are attempts made to inject common sense and rational behaviour into this practice?

#### COMPUTERIZED LABORATORY REPORTS

In bygone times, the clinical pathologist painstakingly carried out the tests required to inform physician and patient of the values and concentrations noted during their analyses. Thus, the lymphocyte count would be provided as 45% and serum creatinine as 1 mg.

With the advent of computerization, we receive reports that boggle the mind of at least this clinician. Details are provided that appear illogical and illusory. How does one respond to a lymphocyte count of 34.56% or a serum creatinine concentration of 1.257?

How does one measure 0.56 of a lymphocyte?

As noted above, it is certainly important to monitor trends, especially in the critically ill. A rising serum creatinine concentration is ominous as is a continually rising or falling white cell count. But does a serum creatinine concentration of 1.257 really mean that renal function of the patient is worse than when it was 1.233? My difficulty is complicated by the fact that even in a healthy, asymptomatic person, if I get the serum concentration of creatinine checked four times during the day, I may get differing values around the figure of 1 mg.

Shouldn't the heads of laboratories provide their reports in such a manner that the significance of their findings is evident? Can rationality not overrule the outpouring of a computer?

While on this theme, may I invite our gentle readers to study a brief and wise note by a thought-provoking radiologist? He deals with measurements in computerized imaging.<sup>2</sup>

#### REFERENCES

- 1 Russell BW, Wilkinson M. *Cervical spondylosis*. London:Heinemann Medical; 1967.
- 2 Phillips CD. Wet read: No. Do NOT measure that. *Appl Radiol* 2018;47:32.

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