Letter from Mumbai

EXPERIENCE AT THE CONSUMER COURT

When the medical profession was brought within the ambit of the consumer courts, I supported this move. We are accountable to our patients. If we err, we should be questioned. When the patient comes to harm as a consequence of our actions—especially if there is loss of life—we should be held responsible.

I have been examining and treating patients since 1962. I have served as a consultant since 1967.

In all these years only one patient has taken me to court. This is the story of that patient's action and its consequences.

The plaintiff is a radiologist by profession. In 2000, he developed progressive weakness of his lower limbs and difficulty in passing urine and stools. He consulted a physician in his home town and then saw a professor of neurology at the All India Institute of Neurological Sciences, New Delhi. He was told he had peripheral nerve disease and was treated for it.

As his neurological condition worsened, he consulted Dr Noshir Wadia, founder and head of the department of neurology at Jaslok Hospital and Research Centre, in 2001. Dr Wadia suspected disease in the dorsal cord and carried out a series of tests. A dural arteriovenous malformation was detected. Dr Wadia suggested its obliteration by interventional radiology. The patient agreed to this. Accordingly, this procedure was carried out. There was no improvement in his neurological findings. A check spinal angiogram showed that the malformation continued to show abnormal arterialized veins.

Dr Wadia then asked me to treat him surgically.

The patient had great difficulty standing and walking and had to be mobilized in a wheelchair. Insertion of an indwelling urinary catheter and enemas were needed.

After neurological examination and a study of the films, I advised the patient on the need for surgery. I cautioned him that the long-standing lesion had produced permanent damage in the spinal cord and surgery may produce no improvement. The chief goal of the operation was to prevent further damage to the spinal cord.

The large arterialized vein from the malformation was seen at D8. Accordingly, the D8 spinous process was marked out in the radiology department the day before surgery.

On 6 June 2001, with the patient on the operation table, we confirmed the level by using the image intensifier. We removed the spinous process and lamina and examined the dura and spinal cord. We failed to find the expected vein. However, we did find another arterialized vein with a configuration different from the large vein. This vein was not seen on the angiogram. We requested our interventional radiologist to come into the theatre. He kindly did so and confirmed our findings. He also confirmed that this vein was not seen on the angiogram. He agreed that we should obliterate it and we did so.

We had not encountered the large vein that was seen on the angiogram. Unwilling to blindly extend the laminectomy up or down, we decided to close up. Another reason for doing so was the need to assess the changes following the obliteration of the unexpected arterialized vein.

As the patient recovered from the operation, it was obvious that no harm had followed. That evening, we noted mild recovery of power in the toes and feet and improvement in sensations. Obviously, the vein had played a role in the creation of the patient's syndrome.

We explained our findings at surgery to the patient and relatives and advised a fresh spinal angiogram 2 days later, to be followed by another operation to obliterate the larger vessel.

Over these 2 days, further improvement was documented in the patient's muscle power and sensations in the lower limbs by us and by Dr Wadia's unit.

The fresh digital subtraction angiogram (DSA) showed us the location of the intact arterialized vein in relation to our laminectomy. At the second operation, reaching this vein and obliterating it was not at all difficult.

He made good recovery from both operations. Additional improvement in his lower limbs after the second operation made it possible for him to stand and walk along the corridor in the ward. The Foley's catheter could be removed. He was walking when he went home. Not only had he not worsened from surgery but had improved to the state where he could stand, walk and void urine without difficulty.

The patient's history, findings, results of tests before and after the two operations and the operation notes were documented in detail—as is done with all patients.

As a matter of professional courtesy, neither Dr Wadia nor I charged him any fees.

He made no complaints either during his indoor stay or during follow-up examinations with Dr Wadia and, later, with other consultants.

Imagine our surprise when Dr Wadia and I were summoned in 2003 to attend the consumer court to answer his charges of medical negligence. His chief complaint pertained to the first operation being at the wrong level. He disregarded the fact that it was fortunate we operated where we did as we discovered and obliterated an arterialized vein not seen on the angiogram. Had we not done so, over time, this would have enlarged and perpetuated and even aggravated his neurological deficit. He also overlooked the fact that despite our earlier cautionary note, he had made significant neurological improvement, was now ambulant and voided urine without a catheter.

The case was finally resolved in 2017, all charges made by the plaintiff being dismissed by the judges. I do not have to dwell on the effects of the unwelcome presence of the sword that hung over our heads during the trial. Dr Wadia died in April 2016 without having been cleared of the charges against him.

There are lessons to be learnt from our experience.

1. Detailed documentation helped.
2. We had obtained and submitted affidavits from two senior and respected consultants (in neurology and neurosurgery) from another reputed hospital in the city. These were referred to in the final judgment.
3. Be prepared for a long-drawn ordeal—and this word is used advisedly. Consumer courts, like other courts, have a huge backlog of cases. The facilities available to the judges are limited. In our case, the hearing was in a crowded room that was ventilated by fans. Accommodation for sitting was markedly restricted. The lawyers had to stand in a very narrow space, almost jostling with each other.
4. The respect we encountered as doctors up to the new millennium

is no more evident. Years ago, each time I was asked to give testimony as an expert witness, I would be put on the witness stand within minutes of my arrival. The judges deemed my time to be precious as I had patients awaiting me. During the hearings in the present case, on several occasions, after waiting for many hours for the hearing to commence, we would abruptly be informed that the case was adjourned to the next month or later.

5. *Adjournments*: These are the rule rather than the exception.
   a. A large number of cases are listed for hearing each day even when it is obvious that all of them cannot be taken up.
   b. A common cause for adjournment is prolonged argument in cases listed before ours. These arguments can go on and on, at times over a full day or more.
   c. In our case, after the case had dragged on for several years, the plaintiff requested an adjournment over several weeks as he had decided to discharge the lawyer who had represented him all these years and appoint a new lawyer.
   d. One adjournment, a year or so ago, continues to puzzle me. Our case was first on the list. There was no representative of the plaintiff as the case was taken up. In the interest of fair play, the judges adjourned the case to the afternoon, in case the counsel for the plaintiff had been delayed. When we gathered after lunch, there was still no one on behalf of the plaintiff. Instead of hearing the case *ex parte*, the judges adjourned the case to another date several weeks later.
   e. On one occasion, the counsel for the plaintiff had to attend to her mother who was to undergo surgery. On another occasion, she had to travel abroad.
6. Delays may occur because one or the other judge has other commitments on the day of hearing and a new judge would rather take up a new case than hear a case where some arguments have already been made.

When the consumer courts were formed, it was stated that all documentation will be in simple format, on plain paper and that any lay individual could argue his own case, the appointment of lawyers being unnecessary.

This has given way to a system similar to that in any other court. Documentation has to be in legalese, affidavits are required and lawyers—many of them senior—were *de riguer* in all the cases I witnessed over the years it took for the final decision of our case. I never saw a non-legal person fight his own case.

AN INTERESTING TED-X TALK

The Seth G.S. Medical College in Mumbai organized a series of official TED-X talks in the auditorium of the Tata Memorial Hospital. These were recorded on video-cameras and are probably in the public domain by now.

One of them will long remain in the minds of those privileged to attend.

Dr Ravi Ramakantan, a senior and respected Professor of Radiology, was asked to talk on what it takes to be a good doctor. In the course of his talk he described an episode which deserves repetition here. During his narration, he displayed the relevant images on the screen so that all of us could see what he had been shown.

As head of the department of radiology he had instituted a review each morning of all radiological procedures the previous evening and night. Towards the end of one such review, a radiology resident told the group of a little child, son of very poor parents, who was admitted the previous night. The child had persistent difficulty in breathing over the preceding 48 hours. Frequent coughs, restlessness and marked difficulty in feeding had rendered child and mother distraught. Sleepless over 48 hours, both were at the end of their tether. They had travelled a long distance to reach the hospital.

The clinician in the emergency department asked for an X-ray film of the chest. As the resident radiologist viewed the film, the diagnosis was obvious to her. One lung showed little air. Something was obstructing the main bronchus. She put up the film for viewing by her colleagues and teachers.

Dr Ravi commended her. Patting her on the back he asked her to proceed to her tasks for the day. As he told us, he expected that she would contact the residents from the unit treating the child as she went to the canteen for her breakfast and learn from them the subsequent findings.

Instead of leaving, she said: 'Sir, I have something to show you.'

A photograph on the screen of her mobile telephone showed a green towel on which lay a peanut. 'I attended the bronchoscopy and this is what emerged from the bronchus,' she said. She had been concerned enough to check her diagnosis and not await the discussion in the canteen the next morning.

'Very good!' exclaimed Dr Ravi as he was about to turn away.

'Sir, you might like to see this photograph as well,' said the resident.

Frowning a little at her persistence, Dr Ravi looked at the photograph. The child lay fast asleep on its cot. Sitting on the nearby stool, with her hand cradling the child and her head on the edge of the mattress, was the mother—also asleep. After 48 hours of agony, both were at peace. The resident had followed them to the ward to see the progress after bronchoscopy.

The group was silent. Dr Ravi once again commended her.

As he tried to leave, she said: 'Sir, there is one last photograph.'

It showed the corridor outside the child's ward. Seated on the bare ground were three children in shabby, soiled clothes. A toddler and a slightly older child were being attended to by a young girl.

Dr Ravi and others in the room looked at the resident puzzled. 'These are the siblings of the child from whom the peanut was removed. The mother, perforce, had to bring all of them to the hospital as there was no one to look after them at home. While mother and patient slept, the oldest child was looking after the other two in the corridor.'

Dr Ravi did not have to tell us that this young resident was the epitome of the good doctor. The pictures and the narrative had already done this. Dr Ravi told the audience that the resident requested anonymity when he sought her permission to use her narrative and photographs. I am also honouring her request.

A MATTER OF FAT—AND LESSONS ON MANAGEMENT OF PATIENTS

E.A., an Egyptian woman, was brought to Mumbai for the treatment of her obesity. She weighed 490 kg and was bedridden for over 20 years. She had difficulty in breathing.

She had to be transported in a modified cargo plane. Transfer to a bed in a hospital in south Mumbai necessitated the use of a hoist and widening of the entry into a special room.

After losing around 100 kg on a liquid diet and physiotherapy, E.A. underwent a laparoscopic sleeve gastrectomy. She lost an additional 98 kg over the next fortnight.

This story was narrated prominently in local and national journals and E.A. was shown repeatedly in newspapers and on

almost all the news channels on television. The names of the patient, surgeon, his colleagues and the hospital were highlighted in all reports. The hospital staff members attending to the patient appeared to bask in the publicity.

Her surgeon announced her progress while receiving a Man of the Year award for his 'contribution to the medical field'.

As optimism grew, clouds were gathering on the horizon.

E.A.'s sister complained of the fact that the patient's right limbs did not move as well as did the left. The clinicians issued statements that she had suffered a stroke while in Egypt. The initial reports emerging from the hospital had not highlighted this neurological deficit.

A reporter stated: 'In an unexpected turn of events S.S., sister of E.A., world's heaviest woman, weighing around 500 kg, has shot a video showing that her sister is very sick and she is not getting good treatment in the hospital in Mumbai where she was admitted to undergo bariatric surgery. In the video, which was shot inside the hospital, S.S. accused the surgeon of "telling lies" about her sister's weight loss surgery. "She does not talk at all. She is not able to move and she looks bluish. No improvement," S.S. says in the video.'

The surgeon treating her claimed that the sister made these complaints after she was told that it was time to shift E.A. back to Egypt. S.S. wanted E.A. to walk before such a transfer. This, the surgeon said, would be possible only after she had lost some more weight and had recovered power in her right limbs.

In turn, the hospital in Mumbai filed a police complaint that despite being warned not to give E.A. fluids by mouth, S.S. had done so, making aspiration pneumonia likely. S.S. said, 'I fed my sister a few drops of water as she was thirsty,' claiming she had not been told about not giving water to her.

As these conflicting statements hit the headlines in the daily newspapers and the video film was shown on television, concern grew in the corridors of power.

The Maharashtra Health Minister visited the hospital to take stock of the progress in her treatment. 'Doctors at the hospital have done a commendable job in treating E.A. It will be ungrateful to make allegations against the bariatric surgeon and the team at the hospital that is working on her case,' said the Minister.

Enquiries on E.A.'s progress were made from the office of the Minister for External Affairs in New Delhi.

Why did the government choose to get involved? One newspaper offered this explanation: 'The government showed its concern in the case for the first time since E.A. came from Egypt to Mumbai as the number of patients who visit India from the Middle East is quite high.' Perhaps there was fear of the loss of wealthy patients from the countries around the Persian Gulf.

E.A.'s sister S.S. said she did not trust Egyptian or Indian doctors and had called specialists from VPS Healthcare (VPS) to check E.A. Sensing an opportunity, experts from this centre in Abu Dhabi flew in to examine E.A. They offered to fly her to their hospital so that she could be given appropriate treatment.

Initial reports after this offer quoted the local team in Mumbai warning against such a move. 'E.A. has a high risk of liver failure and severe weakness owing to her rapid weight loss. Transporting her will only exacerbate her health problems.' They did not see the contradiction with the earlier report of their wanting the patient to return to Egypt.

A headline in a local newspaper probably provided a more rational reason for the objection. 'Shifting E.A. will hit medical tourism in India.' An expert from the hospital in Mumbai was quoted as saying, 'If she goes back, it won't leave a good impression.'

VPS provided a list of experts (including specialists in intensive care) from Abu Dhabi who would accompany her from Mumbai.

The local surgeon and hospital in Mumbai eventually accepted the decision by E.A.'s sister for such a transfer. The surgeon treating her in Mumbai is said to have provided 10 000 medical documents to the Minister for External Affairs and these visiting experts.

The team from abroad imported a special stretcher from Italy and made arrangements for a special ambulance to transport her to the airport and a chartered aircraft to take her to Abu Dhabi. Eighty-three days after she landed in Mumbai and amid flashing camera lights, Egyptian E.A. left for Abu Dhabi. Hours before E.A. left for Abu Dhabi, her sister S.S. issued a letter to the press alleging that E.A.'s health had worsened in the past 3 months and clarifying her stance on shifting her out for further treatment. At a press conference held at the hospital, the medical team said it had 'forgiven' E.A.'s sister S.S. for making bitter allegations against them.

Lessons that can be drawn from these events

- The primary concern of the hospital and its staff members has to be the welfare of the patient.
- Public announcements on a patient with an unusual medical problem and providing journalists and television crews access to the patient are unethical, in poor taste and can create unanticipated problems.
- All codes of ethics insist that patients must remain anonymous in medical discussions on their unusual or 'interesting' ailments. This principle was flouted right from the start.
- Washing dirty linen in public discredited clinicians, the hospital and the patient's family.
- The urge to cash in on 'medical tourism' has spawned several morally incorrect practices.

(I have deliberately removed the name of the hospital and its consultants and replaced the names of the patient and her sister by their initials.)

ÇARAKA SAMHITA NEEDS CORRECTION

The Times of India (Mumbai) reported an announcement by the Maharashtra University of Health Sciences (MUHS). MUHS decided to form a committee to review some references about gender and caste system in the ancient ayurveda reference book. This decision came after some activists raised objections over the contents of a textbook of MUHS's Bachelor of Ayurveda, Medicine and Surgery, referring to some techniques to conceive a male child provided in *Çaraka Samhita*.

The rationale was clear in their minds. 'The *Çaraka Samhita* is at least 3000 years old. The references in the ancient text might not go with today's law and lifestyle.'

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