

Letter from Chennai

'Clothes make the man. Naked people have little or no influence on society.'

—Mark Twain

CLOTHES MAKE THE MAN. NOT ANY MORE

When I entered medical college in 1953, the nearest thing we had to a uniform was a grubby, greasy plastic apron that we wore in the dissection hall. We happily took it off as soon as dissection was over, and for the rest of the day we were free to dress in what clubs would call 'smart casuals'. Our greatest ambition was to reach the third year when we could wear a white coat and have a stethoscope snaking round our necks, and when we attained that we felt we had achieved all we had set out to do in life. This was the acme of our desires, and from that day I have been in a long white coat and a tie every working day.

Our infectious disease specialists shattered the comfortable routine a few days ago. They insisted that we were carrying deadly bacteria from one patient to another on the sleeves of our well laundered, dazzling white coats, and on our carefully selected ties. Henceforth, they decreed, you can go to the wards only in half sleeves, and ties may not be worn. We were informed on a Thursday that the new dress code would come into effect from the next Monday. I must confess that I did not give in easily. A doctor without a coat is next to naked, and in Mark Twain's words, would have little or no influence on the world around. In any case, we are not like the surgeons of old, who displayed their experience in the form of caked blood and pus on coats that were never washed. I put aside all my other work, sat down in front of my computer and called on PubMed to raise the evidence that they were talking through their hats.

Alas, they were not. PubMed gave me a number of references. I went through the first ten, and gave up when I found they unanimously gave scientific evidence that doctors, paramedical workers, medical students, all had their coat sleeves, especially the cuffs, loaded with *Staphylococcus aureus*, often the dreaded methicillin-resistant *Staphylococcus aureus* (MRSA). Pockets were another bad area, but since patients are unlikely to come in contact with the doctor's pocket (unlike doctors, who pick their patients' pockets clean), this might be less important. Indeed, the UK Department of Health has introduced a new dress code that requires doctors to be bare below the elbow: short sleeves, no wrist watch, no jewellery, and no necktie when carrying out clinical activity. I went shopping immediately, and added a number of half-sleeved shirts to my wardrobe, hitherto rather deficient in them.

Interesting possibilities were raised in discussion with the administration, but it soon transpired that T-shirts and Bermuda shorts clearly met with official disapproval.

I am not convinced that I have been killing my patients all these years by infecting them with MRSA, but once one gets used to it, I must confess that half sleeves and an open neck are rather more sensible in Chennai's weather than a long coat and tie, and I am quite happy with the change. Not so some of my junior colleagues. You seniors have all made (or marred) your reputations, and do not need to look smart, they complained, but we have yet to impress our patients and have them come back to us. We need to look like doctors. There are sceptics in the UK too, who wonder

whether the new dress code will last, but for the present both the UK and the Apollo Hospital of Chennai are sticking with it.

My search for white coats in PubMed led me up a different path. There were ten times as many references on white coat hypertension as on infection. I believe the medical profession is secretly rather proud of its ability to intimidate some people enough to raise their blood pressure, though it would never do to admit it in public. Will we still be able to awe our patients? As it is, the literature suggests¹ that nurses tend to record lower blood pressures than their white-coated partners on the same patients. And even if we can still stir the blood pressure up, 'half-sleeved hypertension' sounds so much less imposing.

LAUDABLE ASPECTS OF ORGAN DONATION

From the time the Transplantation of Human Organs Act came into force in 1994, and was adopted by Tamil Nadu in 1995, Chennai has led the country in deceased donor organ donation. Sadly, it has been an illustration of the old adage: 'In the kingdom of the blind, the man with one eye rules.' We at Apollo have done more such transplants than any other unit in the state, but that hardly exceeded 20 in any year. For years I have been preaching that the real push for deceased donor organ donation must come from the medical profession. All doctors should donate the organs of all their loved ones who predecease them, and should make sure that their own organs are used when their time comes. This example will surely snowball into an ample supply of donor organs. I must confess that the response till recently was hardly encouraging, and the government showed not the slightest enthusiasm.

The year 2008 marked a change and I hope this will set off a trend. Some months ago, sadly, the teenaged son of a doctor couple took a ride on a two-wheeler. He was hit by a lorry, and succumbed to his injuries. As he lay brain dead in a hospital, his parents, noble souls in the true tradition of the medical profession, overcame their intense grief and donated all his organs. He gave life to four people and sight to two others in the very moment of his death.

The newspapers gave the incident full publicity, and this did indeed have an effect. In the next few days, a number of other families donated the organs of the relations they had lost. In November 2008, a function was organized to thank 13 families of deceased donors. The Governor, Shri Surjit Singh Barnala, and Dr Anbumani Ramadoss complimented the families for this public-spirited gesture in their hour of grief.

The Government of Tamil Nadu has at last woken up to the fact that, if only the organs of the deceased could be used, there would be no need for anyone to seek an unrelated live donor. Since so few of our patients with renal failure can afford renal transplantation, and since the government supports only limited numbers, we would easily get enough organs to satisfy the demand. The government has now designated one of its surgeons to coordinate the transplant programme, and has formulated rules for equitable distribution of the organs. The rules tend to favour patients in government hospitals, but I see no objection to that as long as no organ goes waste. There will be three lists of recipients, one for government hospitals, another for private hospitals and a third that consolidates the first two. Each hospital authorized to do

transplants must upload the names of potential recipients to the Transplant Coordinator's website, and he will maintain the waiting lists in the different categories. The hospital that has a donor gets the first option for all the unpaired organs and one kidney. If there is no prospective recipient in that hospital for any organ, that and the second kidney go to the common pool. The destination of the unpaired organs and the kidneys differs. The liver and the heart will go to registered hospitals in rotation, unless there is a recipient anywhere on an urgent list. Such recipients should have been listed earlier with the Transplant Coordinator. Priority for a liver is given to patients with fulminant hepatic failure or those with a prior transplant that fails because of primary non-function or because of hepatic artery thrombosis. Priority for a heart lies with those with a left ventricular assist device or an intra-aortic balloon pump.

The destination of the second kidney varies according to whether it comes from a private or a government hospital. That from the private hospital must first be offered to the first on the combined waiting list, whereas that from the government hospital will be offered to the first on the government hospitals' list, and only if no recipient is found will it go to the private hospitals' list. It is important that the government does not want any organ to go waste. If no recipient is found in the state, it will be offered to other states, and if there are no takers there it can be offered to foreign nationals. Even hospitals that are not authorized to do transplants are encouraged to raise donors but the organs must go to the common pool. I hope the Transplant Coordinator will be provided with adequate staff to carry out all these responsibilities and to work round the clock. My experience in the days when I was in the service of the Government of Tamil Nadu was that it was easier to get the post of a senior government medical officer sanctioned than it was to get a stenographer.

While I have been committed to deceased donor organ transplantation all my life, let me reiterate that a number of those

we consider ideal donors should never be donors at all. It is a waste of life if a young person on a two-wheeler dies in an accident for want of a crash helmet. I wish our government would enforce the eminently sensible laws on its statute books, including the wearing of crash helmets on two-wheelers and seat belts in cars. While they are about it, it would be wonderful if speed limits, stopping at traffic lights, and observing lane discipline could also be strictly followed. Is that a Utopian dream?

IN AN EMERGENCY, CALL 108

The EMRI, or Emergency Management and Research Institute, is a not-for-profit organization set up by Satyam Computers. It began its activities in its home state of Andhra Pradesh, and recently the activities were extended to Chennai, though not to the entire state. I understand it also operates in Gujarat and Uttarakhand, and other states are to follow. In all the areas where EMRI functions, one has only to call 108 (toll free) in any emergency. The ambulance service has been provided without cost so far. In Andhra Pradesh, the government pays 85% of the running costs. EMRI coordinates with the police and the fire department too, so one need not hunt for different numbers to call in emergencies requiring these services.

I understand the service works efficiently in Andhra Pradesh. I have yet to personally assess the effect in Chennai, and will report on this to you later. Efficient ambulance and emergency services are certainly needed, but public-private partnership in health matters gives me a nagging feeling that the government is abdicating its responsibilities.

REFERENCE

- 1 Mancia G, Parati G, Pomidossi G, Grassi G, Casadei R, Zanchetti A. Alerting reaction and rise in blood pressure during measurement by physician and nurse. *Hypertension* 1987;9:209-15.

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Letter from North America

SCIENCE AND STIMULUS

As a part of the recent economic stimulus in the USA, the House voted to approve the American Recovery and Reinvestment Act (ARRA), which was signed into law by President Obama. The important component of the US\$ 787 billion recovery plan contains a long-awaited financial stimulus for science and research. The scientific institutions to receive direct funding from the stimulus package include the National Institute of Standards and Technology Research (US\$ 220 million), National Oceanic and Atmospheric Research (US\$ 230 million), NASA Climate Research (US\$ 400 million), NASA Aeronautics Research (US\$ 150 million), National Science Foundation Research (US\$ 2500 million), Research and development of renewable and efficient energy technology (US\$ 2500 million), Fossil energy research and development (US\$ 1000 million), Research into low-emission coal plants (US\$ 800 million), Physics research (US\$ 1600 million), high risk research into energy sources and energy

efficiency (US\$ 400 million), and funding for research comparing effectiveness of treatments funded by Medicare and Medicaid (US\$ 1100 million).

Notably, after 5 years of nearly flat funding, the National Institutes of Health (NIH) received a windfall equivalent to 30% of its entire annual budget to spend in about 20 months. Specifically, the science stimulus included US\$ 10 billion for the NIH, US\$ 1.3 billion for the National Center for Research Resources (NCRR), including US\$ 1 billion for construction and renovation of extramural research facilities, US\$ 700 million for the Agency for Healthcare Research and Quality (AHRQ), and US\$ 2.5 billion for the National Science Foundation (NSF).

The NIH wasted no time in inviting research proposals for disbursement of the US\$ 10.4 billion it will receive as part of the ARRA. Similarly, investigators have responded with enthusiasm—the NIH reports receiving over 15 000 proposals for the 200 to 300 challenge grants. It seems there is, in fact, reason for excitement.