

Letter from Mumbai

UNsung HEROES

During discussions on the lamentable state of medical practice in India, there is a common refrain: 'We do not have role models that our youngsters can follow.'

I beg to differ. We have adequate role models despite the widespread greed, corruption and lack of ethics. Let me provide some examples from my own experience.

Dr W. D. Sulakhe

My batch of students, entering the wards of the Sir J.J. Group of Hospitals in Bombay (now Mumbai) in 1959 for the first time, had Dr W. D. Sulakhe as our teacher. He was one of the Professors of Medicine and an Honorary Consultant in medicine.

In contrast to the impeccable suits that adorned other consultants of his seniority, Dr Sulakhe was dressed in simple cotton shirt and pants. He did not even use a tie around his neck. While the other consultants arrived in flashy cars—one consultant had a driver dressed in spotless white who rushed out of the car as soon as he had parked it to open the door for the consultant to emerge—Dr Sulakhe came to the hospital in a BEST bus, walking into the compound from the nearby bus stand. He carried a simple handbag containing papers, some journals and a book. He often had a bemused look as he surveyed his colleagues in the Honoraries' Room.

And yet, none of my colleagues forgot the lessons he taught on the importance of obtaining a good history from the patient and the value of clinical examination. His patients received his undivided attention. He was never in a hurry to rush to another hospital or consultation. After he had concluded his work, he walked back to the bus stop and returned to his clinic the way he had come.

I met him for the last time, many years after he had retired from the hospital and medical college, when he attended a memorial meeting in honour of Sir Jamsetjee Jejeebhoy. As always, he strolled into the compound from the bus stop. When I greeted him, he was somewhat surprised. 'You remember me? I thought I would have been completely forgotten in this compound by now.'

In 2007, our batch decided to celebrate the 50th anniversary of the day we joined Grant Medical College as students. Our colleague, Dr Madhukar Bandisode, who had travelled all the way from the USA for this celebration, echoed the feelings of many of us when he said, 'I have always striven to follow the example set by our teacher, the late Dr Waman Dattatray Sulakhe.'

Dr Vijay Dave

Dr Dave joined the department of neurosurgery at Sir J.J. Hospital as an Assistant Honorary Neurosurgeon to Dr Gajendra Sinh in the early 1960s. He had just completed his postgraduate studies under Drs Wilder Penfield, William Cone and others at the Montreal Neurological Institute—one of the world's leading centres in the neurosciences then, as now.

While Dr Gajendra Sinh was—and is—an extrovert, full of humour and wit, Dr Dave was silent, spoke seldom and concentrated more on his work. Dr Gajendra Sinh, hailing from a princely family, arrived at the hospital in a large British car (I cannot recall the make but it may have been a Bentley). Dr Dave, then residing in Santa Cruz, came by bus or train.

Both were excellent teachers and complemented one another.

What struck me then about Dr Dave was his sincerity in seeking the opinions of those much junior to him. I was just a registrar in the unit and yet, from time to time, Dr Dave would ask, 'Pandya, what do you think we should do in this puzzling situation?' The query was made not just to test my knowledge on the subject but in an attempt at a serious joint consultation. If the suggestion made by me appeared logical and worthy of implementation, he would promptly agree and proceed to act on it.

I distinctly recall the patient with haemophilia and subdural haemorrhage treated in our ward in 1963. We drilled burr holes to evacuate the subdural clot but had no means of attending to the haemophilia. Factors VIII, IX and other such exotica were only to be found in the journals, not in our hospital. Predictably, the clot reformed. I sought the guidance of our professor of haematology, Dr Jaggubhai Parikh. (He had worked with Dr Maxwell Wintrobe and was much respected in our hospital.) Dr Parikh gave me a tip. 'I have sometimes found that in localized haemorrhage—as into the knee joint—injection of blood freshly drawn from a healthy person stops the bleeding as it contains the necessary factors. I have not read of this being done in the cranial cavity but you can consider it.' Dr Dave came for his ward round soon after and I passed on this information to him. He was excited. He found the suggestion full of merit and in keeping with scientific principles. 'Why don't we try it out on our patient?' He got the patient transported to the operation theatre and aspirated the clot from the subdural space. He then injected 20 ml blood freshly drawn from a volunteer in the operation theatre. It worked. There was no more subdural bleeding and the patient went home, asymptomatic. Needless to add, Dr Dave sought out Dr Parikh and conveyed this experience to him, while thanking him for the excellent advice.

He left Bombay to take up the post of Professor of Neurosurgery at King George Medical College and Hospital in Lucknow. The post permitted private practice. Let me recount an event I witnessed during this period. I was at his home in Lucknow when a very disturbed parent drove up in his car. His son had been gravely injured in a nearby town. He requested Dr Dave to accompany him to examine and treat the boy. He offered a large sum as compensation. Most doctors would have jumped at this opportunity even though they knew that treatment was not possible there. Dr Dave sat patiently with the father and explained the need to bring the child as soon as possible to the medical college hospital, explaining that this is what he would advise even after travelling to that town. In front of the father, he contacted the hospital and ensured prompt admission and an immediate CT scan of the brain on arrival. He promised to come to the hospital as soon as the child was admitted and personally supervise the required treatment. Thus reassured, the father opened his wallet only to find Dr Dave reminding him that time was of the essence and no fees were due.

I have been told of numerous such incidents by his resident doctors and colleagues. Is it any wonder that all those who have worked with him worship him?

Dr Homi M. Dastur

On completion of my training as a neurosurgeon at the J.J. Hospital, I joined Dr H. M. Dastur's department at the Seth G.S. Medical College and K.E.M. Hospital. The full-time teaching position

suit me admirably and in Dr Dastur I had a mentor *par excellence*. Let me provide a few examples of what I learnt from him.

He commanded respect by his excellence in neurosurgery and neuroradiology, as also his integrity and sterling qualities. He was especially concerned about poor patients and did his best to provide care of the highest standard for them. In order to ensure that no patient was ever inconvenienced, he set up a daily neurosurgery outpatient clinic. This was unprecedented but he overcame resistance by pointing out that it was unfair to ask patients with grave illnesses who had travelled long distances to go away untreated and return on a single, specified outpatient day.

Dr Dastur strode into the hospital promptly on time and left only after all the work had been attended to and he had put in a minimum of 8 hours of work. He built the department of neurosurgery from nothing to one that was nationally respected. He set up a system of patient records that enabled us to pull out the case paper, X-ray films, pathology report and findings on follow up evaluation within minutes of the patient presenting at the outpatient clinic, even after a lapse of decades. Lacking a neuro-radiologist, Dr Dastur developed the section of neuroradiology to a level of excellence where Dr Jamshed Sidhva, the Honorary Neuroradiologist at the J.J. Hospital, would consult him on patients posing neuroradiological dilemmas. He developed embolization of carotid artery-cavernous sinus fistulae, selective catheter angiography of each intracranial arterial trunk and even spinal angiography. He published papers that remain classics, especially in the field of tuberculous disease of the nervous system and craniovertebral anomalies.

These achievements, by themselves, would have evoked admiration but there were other qualities that set him apart.

When Cupid's arrow struck him and Dr Dastur wedded his bride, the event was marked by a day-long absence. He was back at work the next day and only those very close to him knew of the reason for that absence. He was gentle and soft-spoken but did not brook political or administrative interference. A powerful municipal councillor or a minister in the state cabinet was treated as any other patient, no preference being offered. The individual throwing his weight around was asked to seek treatment elsewhere since the conditions at this department were not to his liking. Courtesy was inextricably blended with discipline.

We had occasion to treat an ageing Parsi gentleman for spinal disease. He was relieved of his symptoms. After he was discharged from hospital, this gentleman visited Dr Dastur's residence during his absence and left a box of sweets. On his return, Dr Dastur found the box heavier than expected and on opening it found bars of silver beneath the layer of sweets. The next morning he attended the outpatient service and then applied for leave for a few hours. He looked up the gentleman's address in our case records and went to his home. Politely but firmly, he explained that he could not accept this generous gift as hospital rules did not permit it. The patient graciously accepted the explanation and silver bars. If he was surprised at this unusual event, he did not display it.

None of these three aspired to any position of power. They have never been elected president or chairperson of any association or served in any capacity on national or international commissions or committees. And yet, in their own ways, they have influenced those who entered their spheres of activity and made them the better for these experiences.

I can provide more such examples but these will suffice to support the statements I made at the start of this letter. Lack of role models is not the problem. The ability to search for them, find

them in unlikely surroundings and see them for what they are instead of what they appear to be at first sight is what is now atrophying.

WASTE IN HOSPITALS

We cannot afford the luxury of waste.

The careless misuse of expensive items is an extravagance that is especially condemnable when the cost has to be borne by someone else—in our case, the patient. Just in case such wastage has escaped your attention, let me draw your attention to some of the instances that worry me during my daily routine.

Drugs

I often witness long prescriptions in the files of patients coming to me. Antibiotics—often in combinations—are prescribed without a rational indication for them. A multitude of vitamins, tonics and nutritional supplements are given to persons obviously well fed and at times even to the obese. If the haemoglobin and protein concentrations, vitamin levels in the bloodstream were checked in these patients before the supplements are prescribed, they would be well above the normal range.

I am puzzled by the prescription of drugs said to restore brain function in patients with irreparable damage by infarction or injury. While there may be some justification for these in the acute phase when an attempt is made to preserve tissue around the lesion, I cannot see the rationale for such drugs being prescribed months and even years after the insult. In any event, rigorous assessment of the claims made by the manufacturers of most of these prescriptions have failed to uphold them.

It is not uncommon to see antibiotics being rotated in rapid succession in patients in the hospital. The process of thinking appears to be: 'Fever, let us give antibiotic A.' When the fever fails to respond within a day, 'OK, prescribe antibiotics B and C and withdraw A,' and so on. The impatience on the part of the patient, his family and doctor alike ensures a series of antibiotics being prescribed till the jackpot is struck and the fever disappears. Why is this wrong? First, we are encouraging the development of resistance of organisms to the antibiotics prescribed for a short period. Second, there is so much wastage. While a strip of 10 capsules has been purchased each time, only 2–4 of the capsules or tablets are used ere the strip is discarded for the next antibiotic.

Gloves

The panic induced by knowledge of the human immunodeficiency virus (HIV) and hepatitis virus endures and flourishes. How else can I explain the use of gloves by doctors, nurses, ward attendants and cleaners almost all the time? I see gloves being donned before cleaning the skin for an injection and while giving an injection. Gloves appear to be *de rigueur* when mopping table tops in the patient's room and even when changing the patient's clothes, irrespective of the HIV status of the patient.

The claims for the rationality of such behaviour become even more indefensible when the unsterile gloves provided in cartons are discarded in favour of those in sterile packs. Of late I note a preference among many staff members of all categories for sterile 'hypoallergenic' gloves for the above purposes despite the difference in cost between them and the unsterile gloves!

Add to this wastage in the form of disposable sterile gowns, special masks incorporating impervious plastic caps and footwear in the operation theatre whenever the laboratory report shows even a doubtful or weakly positive result for antigens against hepatitis B virus in a patient and you will see that we are adding

considerably to the costs to be paid by the patient merely to ensure safety to ourselves.

Lights and fans

In multi-storeyed hospitals there are a multitude of fans and lights in the corridors and waiting areas meant for the relatives of patients. It is not uncommon to see lights blazing everywhere during broad daylight and fans running at full speed when there is not a single soul in the region.

Suggestions for a centralized controlling system for the lights

that would ensure that all these are switched off at daybreak and switched on at dusk appear to have fallen on deaf ears. I am not aware of practices in the homes of the visiting patients but it does appear that the concept of the last person leaving an area switching off the fan has not found favour in hospitals. Would the spread of awareness of the fact that it is the patients who eventually pay for all these costs help? Or are we so inured to careless and wasteful behaviour that we don't really give a damn?

SUNIL PANDYA

Letter from Glasgow

VIOLENCE AGAINST WOMEN

I remember the incident vividly because it is indelibly etched in my memory. It was at the door of a temporary dwelling on the drive into Delhi from the Indira Gandhi International Airport to the hotel. The man slapped the woman repeatedly on the face while three small children clung to her legs. I have no way of knowing whether the man and woman were partners or were married, but the scene conveyed was one of domestic violence. I flinched and my daughter seated next to me shrieked in horror. A crowd quickly gathered and the minibus moved on—it was not the welcome to India I would have liked.

I have to stress that domestic violence (also called intimate partner violence), indeed violence against women, is prevalent throughout the world, not just India. But as my colleague who is always one to act as the devil's advocate (or as they say in Scotland, always ready to 'ask the "daft laddie" question') said: 'Violence against women—what's that got to do with doctors?' The 'daft laddie' question is the seemingly innocent question that can be asked if someone pretends not to know the background or details about a particular issue, e.g. if you are new to a post or task. The implication of my colleague's question on violence against women was obvious—there are so many other things to do that this seems to be less important. The simple answer to my colleague is that doctors and the health service pick up the pieces of violence against women in the short term with regard to (for example) injuries and the long term with regard to (for example) psychological harm to the victims. It is an important public health issue.

The UK Government defines domestic violence as '... any threatening behaviour, violence or abuse between adults who are or have been in a relationship, or between family members. It can affect anybody, regardless of their gender or sexuality. The violence can be psychological, physical, sexual or emotional. It can include honour-based violence, female genital mutilation and forced marriage.'¹ Of course, men can, and do, suffer from domestic violence as well as women, but the evidence is clear that the victims of domestic violence are overwhelmingly female.

Domestic violence perpetrated against women is just one aspect of violence against women. WHO reported that 'Violence against women, also known as gender-based violence, is now

widely recognized as a serious human rights abuse, and increasingly also as an important public health problem that concerns all sectors of society.'² The entry in the *Encyclopedia of Health and Behaviour Change*³ noted that violence against women in the USA is a major public health problem with 4000 women and girls dying annually as a result of homicide, with 30% being murdered by spouses or ex-spouses.

Violence against women takes many forms and includes not just domestic violence, but also rape and sexual assault, child sexual abuse, commercial sexual exploitation, sexual harassment and stalking, and harmful traditional practices, such as female genital mutilation, forced marriages and 'honour' crimes. Ultimately this violence against women is about power and the desire by men to wield that corrosive power against women.

It will come as no surprise to readers that violence against women is a problem in Scotland and the UK. For example, it is estimated in the UK that between 20% and 33% of women experience domestic violence, 23% of women experience sexual assault, and 7% of women experience rape through the course of their lives. The National Health Service (NHS) in Scotland has taken some steps to tackle violence against women. (Hence the 'daft laddie' question from my colleague noted above.) In September 2008, the Scottish government issued a document to initiate action entitled 'Gender-based Violence Action Plan'.⁴ The document contained a number of steps for the NHS to take and it made clear why this is an issue for the NHS. The reasons included:

- The pervasive nature of gender-based violence.
- The physical, emotional and psychological damage caused by it.
- The costs to the NHS.
- That it is a predictor of poor health and a risk factor for poor health outcomes.
- The fact that the NHS has a pivotal role in identifying and responding to gender-based violence.

Four key areas of action were identified in the Plan for the NHS in Scotland—routine enquiry of abuse within priority settings, i.e. health professionals asking patients routinely about abuse in (for example) maternity services, guidance on abuse to be disseminated