VIEWPOINT

Medicine in India—a view from the West

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Dr Atul Gawande has rightly earned a formidable reputation at an early age with his first opus (1), written while he was still a resident doctor in an American hospital. He now commands our attention by a forthright and comprehensive review of current medical practices in India as witnessed by him. Published in the *New England Journal of Medicine,* the essay is assured wide readership. Alas! this Journal is not read by our ministers of health in New Delhi and various states or by the bureaucrats who man the ministries of health and education.

Dr Gawande's observations in and around Nanded are also true for most other parts of Maharshtra and indeed, India. Worse conditions that those noted by him can be witnessed in states such as Uttar Pradesh and Bihar. Newspapers in metropolitan Kolkata are full of tragic tales of medical misadventure and of the visits to clinics and hospitals by stray cats, dogs and even larger quadrupeds without let or hindrance.

Man's inhumanity to man

While writing for an American medical journal, it is but natural that Dr Gawande contrasts what he obtained in Nanded with his experiences in the state of Massachussetts. The shock for him and his western readers must be great. We, in India, are hardened by our own experiences and frustrations, consequent to failures in our attempts at improving practices. Those of us who have worked in large teaching hospitals in the private sector are all-too-familiar with the crowded outpatient clinics where scores of patients must be examined and advised in conditions that border on the inhuman and when time is always at a premium.

Despite our best intentions, we are, at times, abrupt with a poor person in pain, who has travelled hundreds of kilometres to seek help. Short cuts are a way of life in such hospitals, given the abject poverty of patients and unpardonable indifference of the powers-that-be to the needs of patients and public hospitals. As Dr Gawande points out, it is the inherent strength of our rural patients that often helps doctors remedy their illness despite perennial shortages and unsatisfactory working conditions in our government 'health centres'.

His account of the elite All India Institute of Medical Sciences in Delhi also provides matter for deep thought.

Delhi is a spacious city, almost rich by Indian standards —with broadband, ATMs, malls, and Hondas and Toyotas jostling with the cows and rickshaws on the six-lane asphalt roads. AIIMS (everyone just calls it 'Aims') is among the country's best-funded, best-staffed public hospitals. Yet even it has a waiting list for surgery.

One day, I accompanied the senior resident charged with supervising the list, kept in a hardbound 2003 appointment book. He hated the job. He had recorded in his book the names of 400 patients awaiting surgery by one of the three faculty surgeons on his team. He was scheduling operations for new patients as long as six months in the future. He tried to give patients with cancer the first priority, he told me, but people were constantly accosting him with letters from ministers, lawyers, and politicians insisting that he move their cases up in the schedule. By necessity, he accommodated them— and pushed the least connected ever further back in the queue.

A needless death

Even for hardened Indian doctors, it is difficult to control emotions when we read Dr Gawande's account of the 35-year-old man who died from a perfectly treatable collection of pus in the chest that squeezed the lungs and made it impossible for the patient to breathe even as his doctor and Dr Gawande tried to help him. The cause of the tragedy? Read the original account: '*Chest tubes were out of stock. So the resident handed the man's brother a prescription for one, and he ran out into the sweltering night to find a medical store that could supply it. Unbelievably, 10 minutes later, he came back with one in hand. Yet still, it was almost an hour before the procedure was done. The casualty ward was thought to be too crowded, and the patient waited to be moved to a procedure room. There, no one could locate a minor surgical set. The resident left to find a nurse. And by this time, I was doing chest compressions. The man was without a pulse or respiration for 15 minutes before the resident could*

finally put a knife between his ribs and let the pus shoot out. It made no difference. The man was dead by then.

Such experiences are in contrast to ministerial and press accounts of how a particular Indian surgeon helped a child from Pakistan recover from complex illness in a well-equipped private hospital or of the much-touted prospects for India as a centre for 'medical tourism'. Dr Gawande's introspection after this and similar expe-riences brings him to the conclusion that most of us have also reached.

Where the fault lay is not quite apparent. Clearly, scarce resources were partly to blame. This was a hospital of 1000 beds, but it had no chest tubes, no pulse oximeters, no cardiac monitors, no ability to measure blood gases. Public hospitals are supposed to be free for patients, but because of inadequate supplies, patients are routinely asked to obtain their own drugs, tubes, tests, mesh for hernia repairs, staplers, suture material. In one rural hospital, I met a pale, 80-year-old man who'd come 20 miles by bus and on foot to see a doctor about rectal bleeding and a prolapsing anal mass, only to be sent right back out because the hospital had no gloves or lubricating gel. A prescription was written, and two hours later, the man hobbled back in, clutching both.

Corruption rules the roost

This reflects more than a lack of money, however. In the same hospital where I saw the man die—where basic equipment was lacking, the emergency ward had just two nurses, and filth was everywhere you stepped—there was a brand new spiral CT scanner and a gorgeous angiography facility that must have cost tens of thousands of dollars to build. More than one doctor told me that it was easier to get a new MRI machine for a government hospital than to maintain basic supplies and services. One reason is corruption: politicians are often happy to procure big-ticket items because they can take an under-the-table cut. More fundamental, though, is the mammoth difficulty of adapting the public system to its population's new and suddenly more complicated range of illnesses. Surgical care in particular requires rational, reliable organization almost more than it requires resources. In India, both are in short supply...The medical community in India has mostly resigned itself to current conditions. All the surgical residents I met planned to go into the private sector or abroad when they finished their training...Most attending surgeons were also plotting their escape. Many already see patients for cash on the side. Meanwhile, all doctors live with compromises in the care they give that they would never tolerate for their own families. And there lies the rub!

Dr Gawande holds a mirror up to each one of us who works in the field of health care. So much needs to be done ere we can hold our heads erect.

Reference

1. Gawande A. Dispatch from India. *N Engl J Med* 2003;**349:**2383–6.