

CASE STUDY

A fateful night and a life

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It happened during my obstetrics-gynaecology rotation at a municipal hospital in Mumbai. I was the on-call intern. By definition, an intern is a fresh medical graduate who has to spend a year in different departments of the hospital before he gets his degree. During this time he is supposed to learn the basic management of patients in every specialty while helping resident doctors to perform their duties. But in reality, what interns end up doing, for the most part, is “scutwork” – tracing laboratory reports, accompanying patients for investigations, etc.

The patient was a lady from a slum settlement near the hospital. She was accompanied by her husband. They appeared anxious, but not overly so. She was pregnant, close to term, and was bleeding from her vagina. Bleeding is common during pregnancy and can be due to various causes. The patient was conscious and spoke coherently to the ob-gyn resident about her problem. After a basic examination, she was found to be absolutely normal; the bleeding had now stopped, and the vital signs were within normal limits. I sent her blood for routine investigations – complete haemogram, electrolytes, blood grouping/cross matching, etc. I was asked by the ob-gyn resident to get an ultra-sonogram (USG) done. An USG is mainly done to check the well being of the baby and to look for any internal concealed bleeds. Any abnormal findings may warrant immediate action, either vaginal delivery or caesarean section.

This municipal hospital is one of the busiest hospitals in the city. It has a vast area of tertiary care coverage and caters to hundreds of patients every day. However, the hospital had only one functional ultra-sonogram machine. This was located on the second floor of the outpatients’ department building, adjacent to the building that housed the gynaecology ward. The wardboy pushed the trolley as I accompanied the patient and her husband to the USG room. After we reached our destination, the wardboy said that he would be back soon, and disappeared into the night.

At any particular time, there would be at least 15 people waiting for a USG. So it took at least four hours for a patient to get a USG done, considering it takes about 15 minutes per USG. So, if a patient needs a slightly more urgent USG, as in my patient’s case, you had to plead with the resident performing the USG to take the patient earlier. I explained to the resident that this patient may need emergent intervention and managed to convince him about the urgency of the situation. He asked me to come in after four patients. While I waited, I

kept checking the patient’s blood pressure and bleeding status. Of course, sometimes the blood pressure crashes very late and hence a normal blood pressure does not always reflect a normal state. The bleeding can also be internal and hence can be undetectable externally. But that’s all that can be done while waiting for a USG.

After 90 minutes, my patient’s name was called out and we went inside. I remember the look of frustration on the other patients’ faces when I took my patient in earlier than them. After the patient was positioned, the resident rubbed jelly on the USG probe and started the examination.

The examination was still going on when all of a sudden the patient started talking incoherently. I immediately checked the blood pressure and found that it had crashed many points below normal. Just about then, the radiology resident saw a huge accumulation of blood in the uterus. He panicked and ordered me to rush the patient back to the gynaecology ward and also called the gynaecology resident and informed her about the situation.

The husband was bewildered by this sudden turn of events. We rushed out of the USG room without the wardboy who was nowhere to be seen. After rushing two floors down, and across to the next building, we found that the liftman was missing as well. The husband and I carried the patient up a flight of stairs back to the gynaecology ward. The patient was almost unconscious now and had a very feeble pulse. Two of the five gynaecology residents attended to the crisis. After panicking and screaming at me for my lethargy, they immediately began resuscitating the patient. The patient was intubated and drugs along with fluids were pushed in to raise the blood pressure. The patient was taken to the operation theatre and I was sent to get hold of an anaesthetist from the doctor’s quarters. When I came back with the anaesthetist, I was sent to get blood bags and platelets from the blood bank.

The blood bank was on the first floor of the same building that had the USG department. I knocked for a very long time and waited, together with a stray dog that was loitering in the corridor. A sleepy technician opened the door. I had to plead with him to do an immediate cross match and give me a couple of blood bags. I found the patient’s blood sample, which had been sent earlier, still in the reception area. After the technician cross matched the sample, I went back to the operation theatre with two blood bags. The residents realised that this would

not be enough, and I had to run back and forth between the blood bank and the operation theatre at least four times in the next 45 minutes till the patient got five pints of blood and six bags of platelets. Each time I had to explain to the blood bank technician that this was a crisis situation and replacement would be given in due time. I had absolutely no idea what was happening in the operation theatre. I kept answering the residents' calls, updating them about my progress in arranging for the bags. At one point I was stopped by the husband in the corridor. I still remember his welled-up eyes and folded hands. He seemed confused, wondering if he should beg me to try harder or thank me for giving it all I had.

The patient expired a couple of hours after reaching the ward. The residents blamed me as well as the radiology residents for not taking the situation "seriously". They said that the USG could have been done earlier. "A little more energy and a little

more value for a life would have saved the patient." I tried not to take their frustration-venting to heart. I realised that deep down, they were well aware of the real problem. My disgust at the lack of resources increased exponentially. The awareness of one's helplessness is horrible, especially when it has to do with saving not just one life, but two.

The best way to get through an internship is to talk about the plight of patients and doctors due to the lack of resources. However, one becomes averse to this kind of talk after witnessing a death that occurred directly because of this lack. Though 'hypovolemic shock' would have been reported as the as the primary cause of death in the death certificate, it may as well have been 'lack of infrastructure'.

The author was an intern at the Centre for Studies in Ethics and Rights when he wrote this case study.

Opportunities for internships in ethics

Centre for Studies in Ethics and Rights (CSER) was set up in January 2005 by the Anusandhan Trust (AT) to undertake research in ethics and human rights.

CSER is engaged in research and training in ethics, rights and capacity building of voluntary organisations/NGOs. It organises training programmes in various fields, including bioethics, ethics in clinical trials and programme management. Our priority areas include professional ethics, research bioethics, public health ethics, development ethics, law, human rights and ethics, comparative ethics, and exploring linkages between the discourses in ethics and rights in the Indian context.

CSER faculty members include social scientists, medical professionals, bioethicists and public health practitioners. These include Dr Amar Jesani, Dr Nobhojit Roy, Dr Padma Prakash, Ms Padma Deosthali, Ms Sandhya Srinivasan, Ms Pranoti Chirmuley and Ms Neha Madhiwalla.

CSER offers internships to graduate, postgraduate and doctoral students from the fields of medicine, law, social work and social sciences, and others who are interested in these areas of study. Faculty at CSER offers mentorship throughout the internship period and resources like libraries and documentations centres of CSER and CEHAT in Mumbai can be accessed by the intern. Interns will be expected to do a time-bound project or assignment to the satisfaction of CSER faculty. Certificates of experience will be provided to the students.

The internships are for a minimum of six weeks and can extend to six months. An intern from Mumbai and outstation who has an accommodation facility in Mumbai will get Rs. 8000/- as stipend. Any Intern from outstation who does not have any accommodation in Mumbai will get Rs.12, 000/- as stipend. CSER will offer partial support. CSER will cover the costs of any local travel and related expenses incurred by the intern while doing project-related work.

Interested applicants can email Mr Shinde [mahendra.cser@gmail.com or (call +91-22-2668 1568)] with updated resumes, areas of interest and contact details. A faculty member will follow up with the applicant. Interns will be selected based on their interests, skills, experience and the requirements of the centre.