An Interview in the Emergency Room: A Cure in Three Stages

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Stage I: The Interview

The old man adjusts the bandage on his head, looks about and beams widely at all present. To his left, a middle-aged man uses a large cotton swab to staunch the blood that gushes from a large hole in his throat, while simultaneously trying to calm his hysterical wife. To his right, male nurses strip a plump 80-year-old down to his underwear, rub his arms, feet and chest with conductive gel and stick him full of electrodes. Somewhere down the hall, an elderly lady suddenly keels over and goes into a faint. “This, Doctor, this! This is what we were talking about…” her swarm of relatives babbles incoherently, unsettled by her sudden loss of consciousness, yet relieved that the old lady has communicated her symptoms in so unmistakable a fashion at so appropriate a time.

“Move back! Give her air. The nurse will handle this”. The middle-aged doctor nervously scratches the bald patch on his head. Scribbling down a rash of prescriptions, he moves to the next bed, to the 80-year-old now sprouting electrodes.

“Symptoms?”

“Sharp pain in the chest, sweating, breathlessness. Possible cardiac arrest”.

The doctor scans the readings, stares closely at the man’s face. He reaches out and checks his pulse, examines his pupils and asks the patient to say a few words. A few nervous scratches, and he is ready with his diagnosis. “Acute indigestion! Stomach pump, and overnight observation”. A few hurried assurances later, the doctor is ready to move on.

“A round of dressing for patient on Bed Two – recurrent post-operative bleeding…

“Bed four, oxygen. Bed twelve, saline drip. Bed Seven, refer to X-ray room”.

Onward ploughs the doctor, wading through a sea of broken bones, bleeding noses, and sunstrokes, until he finally arrives at the old man with the bandage on his head.

“Yes?”
“Doctor, for the past few days, I have been troubled by incessant itching all over my body. I cannot sleep, my mind is in turmoil. I must be admitted at once!”

“Don’t worry, Uncle-ji, skin rashes don’t require admission. I will, however, prescribe an appropriate skin tonic and a sedative to help you sleep better”.

“No, Doctor, it is a matter of life and death. I must be admitted at once”.

The doctor draws a deep breath and reaches down to that last reserve of patience saved up for a rainy day. “Do you have any other trouble?”

The old man thinks for a moment, his beaming visage now replaced by one of extreme pain. “I have no sensation in my legs,” he proclaims. “I feel dizzy, I need to be admitted at once”.

“Sir, I understand you are unwell, but we have an admission policy…”

“No, Doctor, you don’t understand. I refuse to go home”.

In the emergency room on the fourth floor of Bara Hindu Rao Hospital in Malkaganj, a harried doctor and a now-nervous old man stare fixedly at each other, each contemplating the twist of fate that has brought them face-to-face. Bara Hindu Rao is no ordinary hospital. It is a survivor of a fast-dying breed – the sarkari (government) hospital.

“Most of the charitable hospitals are no more charitable”, notes the Justice A.S. Quereshi report forlornly. “For some years their free medical services to the suffering humanity continued and did truly commendable service… But now very few of them are genuinely charitable social service institutions, such as Sir Ganga Ram Hospital, Batra Hospital etc. The successors to those noble souls have become selfish, greedy and exploitative”.

The Quereshi Committee was set up in December 2005 to examine the provision of free beds for the ‘poor’ and ‘needy’ in privately owned charitable hospitals. A long-standing policy of the Delhi Government had provided subsidised land to private hospitals on the condition they provide 25% of their beds for free. Unsurprisingly, very few ever did. Apollo Hospital, the first of the super-specialty hospitals to set up operations in Delhi, proved to be a cause for particular consternation to Justice Quereshi. Noting that Apollo hospital had been allotted 15 acres of prime land in south Delhi by the Delhi government in 1988 for a token rent of Re 1, the Committee observed that only about 20 out of a possible 140 free beds were ever occupied. The reason was that while Apollo provided the beds for free, the hospital insisted that patients pay for medicines and medical consumables that often ran into thousands of rupees. “The position of the Delhi government”, lamented the report, “is that of a person who has invested large amounts in cash and kind to buy an expensive cow, of which it is holding the horns while others are milking it and the government is watching it helplessly”.

Bara Hindu Rao Hospital at Malkaganj, like Rajan Babu Tuberculosis Hospital down the road at Kingsway Camp, is not an expensive cow. In fact, it is not even a charitable hospital. It is a good old sarkari hospital built on acres of green, leafy sarkari land – a collection of large boxy buildings sectioned into small pokey rooms.

Free healthcare in India is read in the context of Article 21 of the Constitution of India – Protection of Life – and Article 47 that directs the state to improve the nutritional standards of the population and improve public health. However, a series of studies, including a 2007 WHO survey, point to a severe shortage of hospital beds.²

This shortage has forced hospitals like Bara Hindu Rao and RBTB to evolve what doctors call ‘a discretionary policy of admission’, and an interview technique to separate the really, truly, sick from the sort of, maybe, sick.

The doctor at the Casualty ward of Bara Hindu Rao peers closely at the man’s bloated stomach, and looks down at the patient registration card.

_Name: Anish Khan, s/o Azghar Khan, said the clerk’s scrawl on the pink card. Address: Phoot Path, Bara Tooti Chowk._

Motioning the patient to come closer, the doctor extends one elongated index finger, pressing and prodding the distended stomach in an exploratory fashion.

“Daaru peete ho (Do you drink often)?”

Anish shuffles his feet nervously and nods his assent.

“Tatti aati hai (Do you get the shits)?”

“Yes, yes”. Now on surer ground, Anish nods vigorously.

“Ultrasound and X-ray required, alcohol abuse culminating in liver lesions,” notes the doctor. “Admission and observation for a period of five days”.

Anish Khan, s/o of Azghar Khan, sighs in relief and looks heavenwards in praise of the Almighty, and his earthly agent – the doctor – who has granted him five days of rest.

Up the road from Bara Hindu Rao, the interviews are not going quite as well. Rajan Babu Tuberculosis Hospital (or RBTB) is Delhi’s premier tuberculosis treatment centre. Established in 1935 to commemorate the silver jubilee of the coronation of King George V, the Silver Jubilee TB Hospital was renamed ‘Rajan Babu TB Hospital’ shortly after Independence, and is a tertiary referral hospital as part of the sarkari Directly Observed Treatment (DOT) programme. In spite of being the largest hospital of its kind in Asia,³ with 1155 beds spread over 78 acres, the continued growth of tuberculosis across the country and the hospital’s designation as a referral hospital implies that admission is far from easy.

Each morning a panel of doctors sits behind a long table – some with surgical masks partially covering their faces – while an attendant calls patients in one by one and directs them to a wooden bench placed approximately six feet away from the table. The patient is asked to place a handkerchief in front of his face, and look away while coughing. Once the patient is settled, the stage is set for a prolonged negotiation of admission.
The first step is an appraisal of documents. As a tertiary health centre, RBTB only admits patients via referral from primary DOT centres. Hence, the first five minutes of every interview are consumed in a ruffling of papers as document after document is pulled out of a large plastic bag. From this makeshift archive of illness emerge blurry chest X-rays, faded medical prescriptions, brown DOT cards and dubious test results, accompanied by an animated report regarding the progress of the illness. By the time they reach RBTB, most patients are too weak to move unattended. They sit silently – occasionally coughing to prove the authenticity of their illness – while a member of their family cajoles, coaxes, pleads and harangues the doctors into consenting to admission. The doctors for their part sit mostly silent – wincing occasionally when relatives detail the distances and difficulties they have overcome in their quest to reach RBTB. Very few patients actually have referral letters from their DOT centres – most arrive when they simply became too ill to continue living in their houses.

Once a perusal of the documents is complete, the doctors occasionally ask patients their symptoms. However, such questions are few and far between, because, as one doctor remarked, “The problem is that everyone who comes to RBTB has already been told to say that they regularly cough up blood in their sputum…” For their part, doctors urge the patients to return to their DOT centres; the hospital provides admission only in the most dire situations. Regulation-bound to only accept those patients with referral letters, doctors occasionally play out a Kafkaesque script by referring the patient to a DOT centre with an informal note asking the centre to refer the patient back to RBTB. The role of the enforcer is usually subcontracted out to the attendant – and when a patient’s pleas become too much to bear, the head doctor motions wordlessly to the attendant who bundles out the patient, documents and all, and calls out the next number on the list.

The sarkari hospital thus functions as a warp in the fabric of the city; a quiet autonomous zone which every morning witnesses a pantomime of containment and cure.

Stage II: The Perimeter

According to estimates provided by the Ministry of Health and Family Welfare, tuberculosis is one of the leading causes of mortality in India, with more than 300,000 mortalities every year. WHO estimates suggest that India is also home to 30% of the total cases reported globally.

The DOT programme was launched across the country in 1997, and is hinged on setting up primary DOT centres across every city, with systematic lists of patients. The acronym comes from the method of treatment, i.e., Directly Observed Treatment, wherein each patient is assigned his/her own separate box of medication, and is required to come to the DOT centre three times a week to take his/her medication in front of the health worker, to ensure compliance with the programme.

The emphasis on course completion may be seen in the context of the rise of MDR (multi-drug resistant) tuberculosis, attributed by some to poorly designed previous programmes in which a significant number of patients failed to complete the course. The
DOT programme aims to check the rate of failure by erecting a floating frontier of surveillance around the patients.

“Each health worker maintains a list of phone numbers of the patient and their family members”, remarks a doctor at a DOT centre, speaking on condition of anonymity. “This helps the health worker keep track of patients and follow up in case of default”. DOT centres also engage community volunteers from settlements near habitual defaulters; they are paid Rs 250 per case to check on patients unable to visit the DOT centre.

Each centre also has a ‘Defaulter Tracing Programme’ wherein, once declared a defaulter, the patient is visited by a slew of representatives of the DOT programme – beginning with the TBHV (TB Health Visitor), followed by the STS (Senior TB Supervisor), the MO (Medical Officer), and finally the DTO (District TB Officer) – each urging the patient to continue with his course of medication for the benefit of his health and the health of those around him.

Perhaps it is the nature of the disease, or the devastating scale of its manifestation, or the rise in MDR-TB – but the DOT programme treats TB not just at a personal level, where it urges the sufferer to avail of treatment; it also views TB as a societal or national problem, in which it is a patient’s moral responsibility to society to get treatment as soon as possible, and not default on his treatment. “TB is spread through the air by a person suffering from TB”, notes the Ministry of Health website. “A single patient can infect 10 or more people in a year”. Thus the DOT programme seems to exist not only to protect patients from TB, but also to protect society from TB patients. An outpatient mode of treatment necessarily requires strict boundary controls and monitoring – precisely what the programme seeks to do.

But there are always those who slip through even the finest of filters.

Three times a week, on Tuesdays, Thursdays and Saturdays, a large white van donated by the Rotary Club rolls into Chandni Chowk at 7 am and parks right opposite Mashoor Jalebi Wallah. From the vehicle emerges Dr Neeraj of the Delhi TB Association. Dr Neeraj and the group he works for have been running a ‘pavement DOT’ programme for the last few years, with mixed results. Targeted primarily at rickshaw pullers and daily-wage labourers, the pavement DOT programme delivers medicines to those of ‘no fixed address’.

Lanky, slightly awkward and seemingly devoted to his work, Dr Neeraj clearly takes his role in enforcing the perimeter rather seriously. “These people are everywhere”, he states in his matter-of-fact manner. “TB can strike anyone at anytime, but it is generally known as the poor man's disease”. A significant number of pavement DOT patrons work as waiters, cooks and helpers on a daily-wage basis with a number of wedding contractors and caterers. “You may not know it, but you could go for a wedding tomorrow where one of these people could be serving you drinks and small eats, or chopping your vegetables or cooking your food”. However, Dr Neeraj is also
aware that a number of his patients routinely default on their treatment. Which is why the pavement DOT treatment has been slightly modified. “Two particular drugs have been replaced, to prevent the spread of MDR-TB”. Dr Neeraj agrees that in ideal circumstances, most of his patients should either be in a hospital such as RBTB or at a regular DOT centre. However, the DOT programme’s insistence on high rates of success has meant that health workers at DOT centres often turn away patients they feel are likely to default and hence ‘spoil their figures’. Hospitals on the other hand are very reluctant to admit them, as most janta (general) wards prefer the patient to be admitted along with a ‘helper’.

**Stage III: The Refuge**

To:
The Medical Superintendent
Rajan Babu TB Hospital

Dear Sir,

This is to state that Satish Kumar, s/o of Lallan Singh, is a pavement dweller and lawaris (without kin). Due to his illness he has been unable to work for some months now, and is poor and destitute. Hence, it is requested that his meals be provided free of cost for the duration of his stay at RBTB Hospital.

Sincerely
Signed
xyz

While treatment is undeniably a part of life at the general ward of the hospital, a significant number of patients admit themselves to escape the dhakka mukki (push and shove) of everyday life in this hard city of searing summers, freezing winters and uncompromising monsoons. Prolonged energy-sapping illnesses are the hardest to deal with, especially for those who must work every day to eat every night. Common wisdom, at Bara Tooti Chowk, Choona Mandi Chowk, Khoya Mandi and other countless crossings where lawaris and phoot path residents spend their nights, suggests that even a couple of weeks at the hospital, with regular meals and prolonged rest, will cure the body faster than most medicines. However, a few days in the general ward prove so powerful a tonic that most leave as soon as the pain recedes, the fever subsides, or the plaster cast hardens.

For those unfortunate enough to not have a relative staying on to fill water from the cooler on the fourth floor,
to escort them from X-ray room on the second floor to the ultrasound room on the ground
floor to the ward doctor on the third floor, the hours at RBTB pass painfully. The monotony
is broken only once a day by the arrival of Bhagwan Das.

“Bolo bhai, mein hoon Bhagwan Das Naayi; aaj kis kis ne nahin banayi (Speak up, I am
Bhagwan Das the barber; which of you has not shaved today)?” The unmistakable opening
couplet is repeated day after day, week after week, in ward after ward. In shuffles Bhagwan
Das Naayi, dispeller of gloom, arch-nemesis of boredom and, most importantly, barber
extraordinaire. Undeterred by the precautionary signs hanging in every ward, unworried by
the very real dangers of TB contagion, Bhagwan Das sweeps through the room, trimming,
lathering and shaving his customers. Gently he coaxes their reluctant heads into the right
position, simultaneously keeping up an incessant chatter of the latest news and gossip from
the outside world.

The son of a well-known barber, and inheritor of Punjab Hair Dressers in the east Delhi
locality of Shahdara, Bhagwan Das turned his back on his progenitor’s craft at an early age
and began to drive an autorickshaw for a living. Unfortunately, his promising career as an
autorickshaw driver was cruelly cut short when he was run over by a mini-van in late 1999.
For a year Bhagwan Das lay in the general ward of GTB hospital, nursing a disfigured foot
and a ruptured urinary bladder, eating a strictly regulated diet and pissing through a plastic
tube. It was during this time, he says, that he found his thoughts turning to the spiritual side
of life. He also discovered his morbid fear of open vehicles.

When he was discharged in 2000, Bhagwan Das stepped out a transformed man, one
who felt he had been given a new lease of life – a life he decided to dedicate to ‘seva’, the
selfless devotion to one’s fellow beings through work. The path he chose was that of his
forefathers. On 17 November 2001, Bhagwan Das picked up his old shaving kit and
scissors and stepped into RBTB hospital with a prayer on his lips and a handkerchief tied
tightly about his face.

The hospital had been pointed out to him by a fellow inmate at the GTB hospital. The aim
was noble – to shave, trim and spruce up those who even family members refused to touch.
The money held promise as well: 10 wards, at least 30 people per ward, a minimum of 80
shaves a day at Rs 10 per shave...

“The first few days were hard, but then I devised a system...” Each morning Bhagwan
Das wakes by six and follows the three-fold path that has all the rigidity of a ritual:

> Never visit the wards on an empty stomach. Bhagwan Das’ breakfast consists of two
rotis to give him energy, vegetables, a quarter chakki of butter, and a bowl of curd every
morning; and a quart of whisky and three cigarettes every Tuesday.

> Keep a separate set of clothes for the hospital. In the absence of a uniform – he is
not an employee of the hospital – Bhagwan Das has three sets of plain white shirts and
trousers that he only wears to the hospital. These are washed everyday in a solution of
Dettol, water and detergent.
Wash carefully at the end of every shift. One round of 10 male wards takes Bhagwan Das almost six hours. At the end of his shift, he washes his hands with separate soaps – one antiseptic and one Neem – kept especially for this purpose.

A chance conversation with a doctor at the hospital suggests that Bhagwan Das’ routine might actually be the most pragmatic approach to dealing with the disease. “Masks are useless”, he points out. “The physical dimensions of the bacillus are far smaller than the pores of our filters, and the risk of infection from non-pulmonary contact is marginal”.

Of course, there are special masks that are designed to screen out bacilli like the ones that cause TB, but these are expensive and hard to source. The best defence is to keep one’s immunity up, and a meal rich in carbohydrates and protein provides the fill-up that the human body needs when entering a ‘contaminated area’.

But do the doctors wear masks?

“Well, the new recruits do”, he laughs. “But that’s more psychological than anything else. Most discard them by the end of their first year here”.

In the last six years, Bhagwan Das claims that a combination of safety and seva has protected him from a disease that is highly infectious, and painful to cure. Swathed in his cocoon of confidence, there is just one further layer of protection that he ardently desires: an identity card.

“In the strange times we live in, it shall soon be essential for every man to carry verification papers. In such times, it is important for a man to have control over his identity – preferably in the form of card that one can show at to a chowkidar (watchman), or the policeman at a checkpoint. A card confirming that I am a private, self-employed man who comes to this hospital to make his living. A card that lets me walks through these gates with the ease of a man in uniform...”

The last time I visited RBTB Hospital was to look in on a friend of mine. Satish Kumar had been assigned Bed No. 53 in Ward M-III three months ago when he was diagnosed with severe bronchial tuberculosis. The doctors said he was responding well to treatment; the nurses said that the yellow pigment under his nails and his progressive deafness were no cause for concern. The ward boy assured me that the hospital would keep him for at least another two months.

But when I visited RBTB, Satish was gone.

The nurses said he recovered and left for his village; the ward boy told me he was summarily discharged to free up the bed for another patient. The social worker from a nearby ashram told me he died on the way to the ashram. The funeral was conducted at the electric crematorium at Rajghat. He was 24 years old.

I sat staring at the empty bed, scrutinising the yellowed sheets. They had probably been changed, but I thought I detected the outline of a human form, a man-sized sweat-stain...
darkening the length of the bedsheet – the trailing after-image of a thousand coughing, sweating, retching bodies, each exiled to a bed in a ward in large sprawling hospital in the heart of north Delhi.

Notes
2. WHO World Health Statistics, 2007. In fact, the survey points out that India has a grand total of 7 beds per 10,000 population. Full text online at http://www.who.int/whosis/en/
3. www.mcdonline.gov.in