Ethical Dilemmas in Medicine

By

Prasanna Gautam

Ethical Dilemmas in Medicine

By Prasanna Gautam

This book first published 2024

Ethics International Press Ltd, UK

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

Print Book ISBN: 978-1-80441-938-0

eBook ISBN: 978-1-80441-939-7

Author's note: *Where I have included case histories, descriptions of patients, or dialogue, usually recreated from memory after many years or even decades, I have taken considerable care in each case to protect the identity of the people involved. Despite this necessary 'fictionalisation' to protect identity, every single one of the case histories is based originally on real people and on real events. I am very grateful to the people concerned, and I hope that I have described them with the respect and compassion that they deserve. I am also confident that anyone who thinks they recognise themselves in a case history will be mistaken, for I have deliberately selected stories that are in some ways archetypal.*

Table of contents

PART III
England

PART IV
Scotland

Foreword

What a fascinating book: it can be enjoyably and profitably dipped into at random to partake of the author's lifetime experiences as a schoolboy in Nepal, a medical student in India, a doctor in rural Nepal, a junior doctor rising up the ranks in England and in Scotland. As one does so one joins in the author's reflections and questions about ethical issues arising within his beautifully vivid stories of his medical practice, most recently as a consultant geriatrician and Professor of Medicine.

From the start this book embeds the paradoxes of medical practice - the fury of an irate son who had cancelled a concert and flown across the Atlantic to visit his mother on her deathbed, berating the young doctor who had successfully revived her for giving the impression when ringing that son that his mother might be dying (as seemed likely at the time of the phone call, and that she was asking for him); and in contrast the almost simultaneous gratitude of another relative for the same doctor's care and concern during the last few weeks of that relative's young wife.

And then the broken slide story of how he got his scholarship from school in Nepal to become a medical student in India. And on to his first day of his first clinical attachment as a medical student, the huge buttock abscess he was instructed by the assistant professor of surgery to incise, the pus in his face, fainting and waking up on the operating room floor and then the humiliation of being laughed at by all including the assistant professor of surgery.

An internship/house job, again as a surgeon and the refusal of a senior surgeon to come to operate on a patient with complex damage to his hand – 'go and do it yourself': at the end of that story, as at the end of each chapter, Gautam asks the reader several questions relevant to that episode, in this case including 'Was it appropriate for the senior

surgeon to ask an intern to repair a complex hand injury?' It's not surprising that the author decides against a career in surgery.

As a medical officer in rural Nepal he is given a temporary upgrade and told to investigate a complaint of rape against a district medical officer by a female aide. A complicated whodunnit leads to a satisfactory outcome –but as a result of the following explanation:

> 'I decided to gamble on calling her bluff. I boldly told her that the DO had advanced diabetes and that people in that state could not perform sexual intercourse. So, she must have lied. I would call the police and have her arrested unless she told me the truth.
>
> She broke down once again and denied that she had been lying. I then told her that she was also a thief and had been caught red-handed. I was not moved by her histrionics. I did not budge although it was difficult at times not to be fooled by her superb acting. Finally she saw she was not getting anywhere with this approach and agreed to confess if I promised not to call the police. I did not promise this but agreed to give her a fair hearing……
>
> I asked her to write two letters; one withdrawing her allegations, the other resigning with immediate effect. ……..
>
> I handed that letter of resignation to the DO [who knew nothing about the allegation] the next day. He was puzzled. He muttered something about how irresponsible people could be, quitting their jobs without giving any reason or proper period of notice'.

At the end of that chapter Dr Gautam asks readers if he should have done what he did ?

Then there's the terrifying story of the delayed helicopter ride in the Himalayas - delayed because Dr Gautam had taken on an emergency breech delivery that was absolutely no part of the rushed programme he'd been allocated by his boss - 'simply' to open three different clinics

in three different districts all in one day. The delay led to a near fatal helicopter ride in a storm at 13000 feet. Again there was a good outcome, but again at the end of the chapter Dr Gautam asks us - should he have taken on the emergency breech delivery (and he'd only seen one done before, as a medical student) and thus risked three lives to save a partially born baby?

There are so many amazing stories in this book - his imaginative use of a cusco vaginal speculum to open the spasmed mouth of a patient with a huge and painful dental abscess; his treatment in his local and minimally equipped hospital of a multiple leg fracture that really needed the ministrations of an orthopedic surgeon and appropriate radiology – 'but there was only me'- and then the patient's fury after the operation had healed leaving a slightly shortened leg which could be remedied by a simple shoe raise. Fortunately the consultant orthopod whom the patient subsequently consulted had praised the treatment given by Dr Gautam, and explained that if the patient really wanted his legs to be the same length he'd have to break the other leg. Then there's the story of his various and ingenious though unorthodox attempts to catheterise a patient lying in a cowshed suffering from acute urinary obstruction resulting from 'a pear sized' cancer of the prostate. The patient was undertaking a ritual mourning for his dead father and was therefore not religiously permitted to move away from that shed for twelve days. Dr Gautam asks us at the end of that chapter if he should have attempted to over-ride the religious prohibition on moving the patient.

The same questions follow a very complex set of stories about syphilis and confidentiality. Another account of his necessarily and admittedly medically inappropriate treatment (using his only available antibiotic) for a man suffering from tuberculosis, who was unable to travel over the mountains to a hospital in Kathmandu until the monsoons were over; later complaints from his bosses about his unauthorised expenditure for ensuring a good diet (including lots of chicken) for the same patient while he was looking after him during that monsoon

season; and finally the return of the patient's life savings, that had been kept securely in the hospital safe, after his successful treatment in Kathmandu. At the end of the chapter Dr Gautam asks us

1. Was it ethically justified to treat tuberculosis with monotherapy?

2. The patient had his own money. Why was that not used for him?

And these are only some of the stories in the first part of the book. The next two sections concern his activities first in England where he encounters recurrent blocks on promotion and a dramatic racist refusal to be touched by a doctor of the wrong colour by a South African holiday maker who'd had a massive heart attack: 'Tell your superior to come and see me'; but the registrar, on learning the reason, refused to come the first time and on being called a second time - Dr Gautam was keen that the patient's life should be saved - said he'd come at the end of his clinic – and if the patient refused treatment by Dr Gautam, he could leave - it was a free country. The patient tore off his monitor, ripped out the drip and strode off, only to trigger a crash call as he died in the corridor shortly afterwards. More questions.

Well you'll have to read the book to get its full flavour and details but one of its main themes is that traditional medical ethics doesn't give doctors the answers to many of the moral dilemmas they face in practice, including some of those described in this book. As a retired NHS GP and an Emeritus Professor of Medical Ethics I agree – life in general and medical life in particular is alas full of ethical/moral dilemmas where there are good moral reasons to do x and good moral reasons not to do x, and as moral agents we have to make judgements. Like Professor Gautam, and unlike the so called moral monists, including certain types of utilitarian, who believe that there are no true moral dilemmas - because there's always a morally valid rule or other scheme for resolving such dilemmas - I find that this is often not the case. My own analysis and experience lead me to agree with the philosopher Immanuel Kant that there can be no *rules* for moral judgements when principles conflict (on pain of an infinite regress). But

what I have long accepted as morally *helpful* is the 'four principles approach' of Beauchamp and Childress[1]- a scheme which can be used *in addition* to whatever other moral scheme a doctor or a patient uses for moral assessment. It asks us to consider our general obligations to benefit others, not to harm others, to respect the autonomy of others and to try to be just or fair. Those four prima facie principles along with consideration of their scope and extent (to whom or even to what do we owe these obligations, and to what extent - including in morally intolerable circumstances such as some of those described in this book) are helpful for assessing what we ought to do, even if they often don't give us universalizable answers to those dilemmas when the principles or their specifications conflict - as Professor Gautam argues and demonstrates so clearly and dramatically in this book.

Raanan Gillon MB BS BA (Philosophy) FRCP (Lond) Hon DSc (Oxon)
Hon RCM Emeritus Professor of Medical Ethics,
Imperial College London

[1] Beauchamp T, Childress J. Principles of biomedical ethics 8th ed. New York, NY; Oxford University Press, 2019.

Introduction

This is an anthology of events which occurred during my long career in medicine - from being a medical student to retirement as a Professor of Medicine. My aim is, through these anonymised and fictionalised true case histories, to invite all those involved in patient care and medical education to a debate on the guiding principles for the practice of medicine.

I have described the relevant social, political, religious and professional background because I have learnt that no medical problem can be properly understood, treated and its outcome judged without reference to its wider context. Medical management of a patient means considering that person's total life circumstances as part of the problem, and the solution. I have tried to explain complex technical terms in simple languages, mostly for the benefit of the lay members of the committees investigating the fitness to practice complaints. I hope this will also be relevant for general readers, patients and high school students thinking about medicine as a career.

There is a lot more to the doctor-patient relationship than is generally acknowledged. This is a special bond, which must be kept relatively weak in the interests of objectivity. Nevertheless, it is the catalyst for creativity in medicine – for making medicine an art as well as a science. This is manifest when a doctor not only treats a specific disease but also cares for a patient as a whole human being. Little acknowledged, but experienced by all doctors, is the influence that patients have on their doctors, sometimes subtly, and sometimes overtly. I have been profoundly influenced by my patients throughout my career. I believe that the science of medicine is the essential foundation, or broad canvas, upon which the art of medicine can be created. Each encounter with a patient then becomes a unique work, which cannot be replicated but from which much can be learned for the future. This is the beauty and the challenge of medicine.

A doctor must do whatever is possible for the benefit of the patient. However, to navigate within the orthodox ethical conundrums in trying to do the best can be extremely risky, should the treatment fail despite best intentions. The medical practice is restricted by the laws, religious beliefs, ethical regulations and guidelines. In addition, the health economists and health service managers are also advising algorithms to guide the doctors. Commercial concerns have become paramount in the management of patients.

We must also be aware of constant changes happening in the provision of health services, medical education, scientific advancements and novel systems of health care delivery. It is essential to consider ways and means to assure the safety of both the patients and the health workers.

Not openly acknowledged but realised by all, management of a patient is heavily influenced by emotions of all concerned. The doctor must be cognisant of these at all times. However, the disaffection with the medical profession appears on the increase as evidenced by rampant malpractice suits and litigations all over the world.

Teaching medical students and fresh medical graduates to rise up to the standards demanded of the profession in a potentially sceptic community is extremely important. The wide-eyed, naïve medical student joining the medical school with a mission of service, research and discovery of better cures should be nurtured and encouraged, not insulted and ridiculed by their peers and teachers; that would make them lose their self-confidence.

Traditionally upheld principles are being challenged today by the drive towards objectivity, neutrality and super specialisation and 'cure' rather than healing and succour. Clearly something is not working right. It is hoped that these case histories will also serve to illustrate the myriad of socio-economic conditions which need to be considered in the delivery of health service.

The topics for discussion suggested at the end of each chapter should facilitate frank discussion about the importance of medical ethics in live situations, both in teaching and in the holistic practice of medicine.

Prologue

Half a Pint of Beer

4 am. Barrow in Furness, Cumbria.

"Could I speak to Professor Krumowski please? This is a duty doctor from a hospital in England. I wish to speak to him about his mother."

"I will get him for you," a woman's voice said. He held on.

"Leon here," said a sleepy voice. "How is she, Doctor?"

"Not very well, I am afraid."

A long pause ensued.

"Is she going to make it?"

"It's not likely but I have seen miracles. We could pray."

"I will take the next flight."

"She has been asking for you. I will tell her. Thank you."

He was speaking to Professor Leon Krumowski of the University of Music in Halifax, Canada. His mother, suffering from chronic renal failure, had been admitted in a critical condition to that hospital. She had not been able to produce any urine for several hours. Her blood urea levels were astronomical (101.9 mmol/litre when the normal level is 5- 7 mmol/litre). She was 78 years of age but was mentally alert and had been managing by herself up until this crisis at her home in Coniston. She appeared to be septic due to a urinary infection. Subsequently, she was found to have her blood teeming with E. coli - the nasty, potentially lethal bacterium causing infection. In simple terms, this was a severe case of blood poisoning in someone who was

known to have poor kidneys. She had been asking for her son in Canada until she had collapsed that night.

The resident doctor had managed to control her chaotic, overly fast heart rate, which otherwise could have killed her within minutes. He had been battling with death all night in trying to bring the high levels of potassium in her blood under control. Unchecked, very high levels can potentially cause cardiac arrest and death. Also, he had had to set up peritoneal dialysis to wash away the impurities in her blood. Modern sophisticated procedures like haemodialysis etc were not available in that small district general hospital. In spite of all this, she had continued not to look good. Eventually, he had been able to contact the professor.

Twenty-four hours later, the old lady was nibbling at a biscuit. She had responded to treatment. Her blood urea levels were beginning to come down. She had started to produce some urine. Her potassium levels were also coming down. The infection was coming under control. But she was still far from well. She could deteriorate any time and die.

She was holding Leon's hand and talking sweetly to him on the ward, delighted that he had come to see her so quickly. The young intern had been summoned by the ward sister when this visitor had demanded loudly to see 'that doctor' who had contacted him by phone

''Why did you give me the wrong impression? Do you know what it cost me to come in a hurry like this? Look at her. How could you have possibly thought that she was dying?'' He was very angry. He look dishevelled, tired, bald, and fat.

''We tried to do the best we could. Thank God, she responded to treatment.''

''I had to cancel the symphony I was scheduled to conduct, drive all night to Toronto, travel first class as there were no seats on economy - and all this because you made a stupid assessment. Hah!'' The tirade

continued. He did not ask for any information about her condition. It looked as though he just wanted to cremate his mother and return to Canada.

''Blame your mother for being alive,'' was what he had to stop himself from saying. He did not expect gratitude but there was not even any recognition of his services. Instead, undeserved insults were being heaped on him by the bucketful. ''Why do I have to bear them quietly?'' the doctor was disgusted with himself.

''I have taken leave for a whole week. I thought that the funeral and all that would have to be arranged. What a waste! What do you want me to do now, hunh?'' The tirade finally stopped.

Surprising himself, the doctor advised, ''Sir, the Old Man of Coniston has inspired many poets and musicians. Please excuse me; patients are waiting for me downstairs.''

He got up to go. The Professor glared at him; did he know about the Old Man of Coniston, *notorious as the 'suicide peak'?* The young doctor was sure that the Professor would have liked nothing more than to strangle him.

He walked slowly out of the ward. He had not seen his bed for two nights. He had had no lunch that day, apart from munching half a sandwich on the go. He was exhausted. ''Surely, I could earn a decent living doing something else. Maybe I should stop being a doctor. You do not get thanks for saving one patient and get blame for not being able to save another. What is the point? Why do people have to be so nasty?'' He was lost in this reverie when he got into the lift to go down to the out-patient clinics where other patients were waiting.

The lift stopped.

"Here you are, Doc," said someone with a rough hand thrust out towards him. Startled, he looked up to see a scruffy man in torn and

faded blue overalls. It was Mr Cunnigham. He was in his late forties and had driven a forklift truck at the local shipyard, until he had been made redundant a few years earlier. His wife had been admitted with a massive stroke at the tender age of forty years, probably as a result of taking contraceptive pills. She had remained in a moribund state for three weeks. He used to check how she was doing several times a day. Mr Cunnigham had seen him many times when he had been visiting his wife.

"Have a drink on me tonight."

Before the doctor could protest, he was gone. A fifty pence coin had been shoved into his hand. He stared at it, remaining rooted within the lift. The door closed. Now alone, he bawled his heart out.

He knew then he could never do any other job. He could never stop being a doctor.

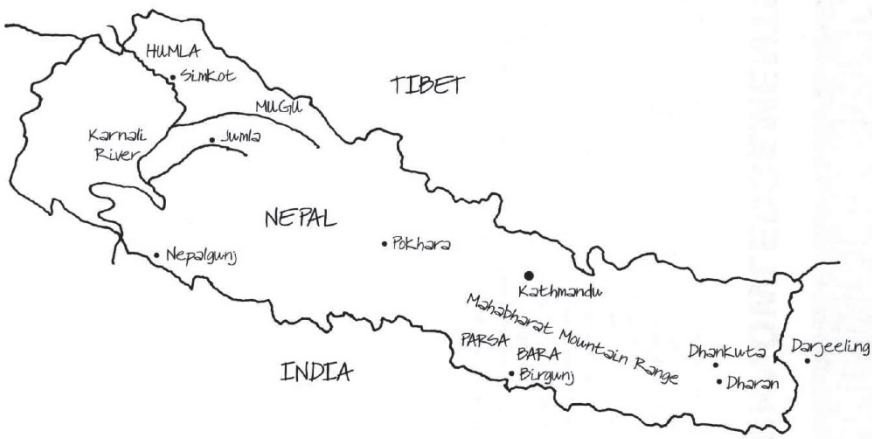
For discussion:

1. Should doctors retaliate if insulted unjustly?

2. Is medicine a profession or a vocation?

PART 1

Starting Out - Early Years



Chapter 1
The Shattered Slide

1970. Kathmandu.

The young doctor had taken his niece and nephew for admission to a primary school. The brass nameplate on the door read M Ranasingh, Headmistress. The surname suggested a person from the Indian aristocracy.

They were waiting outside her office. The kids were on their best behaviour, anticipating lots of fun and games in their new school. The door opened at the appointed time. She came out to receive them. She folded her hands in greeting, *Namaste*, and motioned with a smile for them to step inside her office. He was not expecting to see such a polite and well-mannered headmistress. Her eyes rested on his face for a fraction of a second before she asked, "Are these the children?" He nodded. She then gave them her full attention, asking them questions, making them giggle and be completely at ease. He found it curious that she repeatedly looked at his business card lying on her desk.

He began to look at her unobtrusively. She was a plump lady with thick glasses and had her head covered with the free end, *pallo,* of a white cotton *sari*. This is usually the standard garb of a widow. Many schoolteachers and social workers also wear this colour. There was something familiar about her face. Where had he seen her before? A few seconds passed. Then it came in a flash.

Suddenly jumping out of his seat, he went round her desk and took her hands. He could not speak. The kids were startled. He had tears in his eyes.

She smiled and said, "I recognised you outside."

June 1961 was the last day of the Intermediate Science examinations, equivalent to A Levels in England. It was the day for Zoology practical examinations. He had been given a cockroach and told to dissect out its salivary glands, mount them on a slide, display them on the low power of a microscope and draw a diagram labelling all the various parts. He would have to answer any questions the examiner might ask him.

He did all that was asked of him, much faster than expected. Jobs become easy when you know how to do them. He knew the subject well and was confident of answering all the questions the examiners could possibly ever ask. He had done very well in all of the other papers. His aim had been to secure the top position because only the top six would be considered for the award of the international scholarship to read medicine in India. He wanted nothing else but to become a doctor. He was desperate to win this scholarship because there was no other way for him. He had worked very hard for this. Nobody could stop him now. He would surely get there. His hopes were soaring high.

He looked around. Many students were sweating out their assignments. Poor guys! He took a deep breath and stretched his upper limbs. He shook his head to loosen the stiffened neck, and smiled at Malati Shah, the girl sitting next to him who appeared to be watching him. She was slim and very pretty. Thus relaxed, he looked down the eyepiece of the microscope. ''What a beautiful specimen,'' he said to himself. Before he realised what he was doing, he had rotated the instrument to look at the slide in higher power.

One needed to raise the tube in those old microscopes before changing from the low power to the higher power lens. He had not done so. The slide cracked beyond recognition; it looked like a cobweb with the mangled salivary gland at its centre. He saw not only the slide but his whole life crashing around him as a result of his own stupidity. This meant a failure and there would be no reprieve. Re-sits did not get you scholarships. In abject terror, he held his head in his hands and the time stood still. He was screaming silently from the bottom of his heart. Now

he could never become a doctor. It was his dream that had been shattered.

Someone was whispering. It sounded like "Take it, take it."

He opened his eyes, uncomprehending and in a daze. It was Malati. She had pushed a slide towards him. She said, "Give me yours. Be quick. The examiner is coming."

He did as he was told and replaced the slide on the microscope. It was an average dissection. His mind was numb.

The pair of examiners came a few minutes later. He heard one of them rebuking Malati. "You have broken the slide!" "I am going home to get married," she said and walked out, leaving them puzzled. Then the pair came to him. He does not remember how he faced the examiners.

He was still in a daze when he caught up with Malati later. They were in different sections of the college, although in the same year. They barely knew each other. He had seen her a couple of times in special tutorial classes. She appeared reserved and aloof. She came from a rich, aristocratic family. When he found her, she was waiting for her car.

She had a good chuckle about how they had been able to swap the slides. He was most uncomfortable. "We fooled them, didn't we?" she chuckled.

"Wasn't it cheating?" he asked her.

"I saw what happened. It was an accident," she said. He was not so sure.

"Don't you need to pass, too?" he asked.

"What for?" she countered. Her marriage had been fixed for the following Saturday. She would be a princess soon. She was a picture of sadness. The marriage had clearly been arranged against her wishes.

When the results were announced, he wanted to let her know that thanks to her, he had passed. He heard that she had gone away after her marriage to the son of an Indian Maharaja. He had no way of contacting her. The fact that he had not been able to return her generosity also continued to gnaw at him. He was grateful beyond words but found no way of expressing his gratitude. He carried the burden of guilt for years.

Was he a cheat? Could he ever absolve himself by doing better in future? he wondered.

Eventually, he was able to speak, "*Tapain yahan kasari?"* (How come you are here?)

"It did not work out for me," she said with fleeting sadness. It was clear that she did not wish to talk about herself.

"But you made me a doctor," he said. Was he trying to justify the cheating? She had already learned that from his business card.

She laughed.

"I came first in the final MBBS examination," he added. At last, he had been able to give her the credit for his excellent academic achievement. But this was not enough.

He was not going to lose this moment. It was his opportunity to repay the heavy debt of gratitude.

"What can I do? How can I thank you?" he asked.

She giggled.

"You can start by letting go of my hands."

Embarrassed at this, he hastily retreated to his chair.

She focused her attention on the children once again. It was time to go. He still had had no answer to his question. Getting up, she did *Namaste*. The meeting was over.

He looked at her. It was then that she said softly, "Be a good doctor."

For discussion:

1. Did he become a doctor by cheating?

2. What makes a good doctor?

Chapter 2
The First Patient

The six of us had gathered on that eventful day in the surgical department of Victoria Hospital, Bangalore. The Assistant Professor, Dr Hazara, would be teaching us about minor operations. We expected to be given tutorials on how to recognise simple fractures, abscesses and infected wounds, etc. We also hoped to learn how to apply bandages on the wounds and ulcers and sew the skin and apply dressings correctly. We were expected to observe all the procedures being done on patients and learn. I was certainly not expecting to carry out a surgical procedure on a live human subject straight away that day.

The first day as a clinical student was usually the most exhilarating as well as intimidating to a medical student in those years. We were not entitled to examine or interact with real patients until we reached that third year, the start of clinical years. The first two years were spent learning nonclinical subjects like human anatomy, physiology and in some schools, biochemistry. We had to dissect a cadaver and know in detail about every muscle, bone, sinew, every organ, and everything else that made our bodies. The only live species we were allowed to touch was a frog to study the effects of electric stimulation on its muscles.

Dr Hazara asked us our names and tried to make the moment hilarious by saying, ''Now you can act like doctors.'' You can imagine what those words must have done to us. I was thrilled. Wearing our white coats and dangling stethoscopes on our necks, we followed Dr Hazara to the Outpatient surgical block and into the suite of minor operating theatres. The six patients of varying ages waiting for their treatment looked unwell and in discomfort. An Intern with the list of the patients and their problems was waiting for Dr Hazara. Two of the patients were lying on the tables. The other four were sitting on the benches. The nurses were tending to patients who were crying and appeared to be in

a lot of pain. The senior nurse was waiting for Dr Hazara to arrive. Dr Hazara wasted no time. He assigned the senior nurse and the Intern to take two of us each. He beckoned another student to stay with him. Then he saw me standing, unsure of what to do. ''What is your name, again?'' He asked me. "Gautam, Sir," I whispered with a dry throat. He looked at the paper in his hand and said, "Dr Gautam, see how you can help Chandramma,'' he said in a teasing manner.

He called the junior nurse to take me to the patient, Chandramma, who was already lying prone on the operating table with an enormously swollen right buttock, scantily covered by her thin sari. This was an abscess, a large collection of pus and dead tissue, over the buttock. She was moaning softly now. He asked the nurse to show me how to incise the abscess.

The nurse asked me to wash my hands and wear sterile gloves. She covered the patient below the waist with a green sheet and exposed her right buttock, which was the problem. It was the size of a huge pumpkin compared to the other which was almost flat. The central point of the swelling had already become discoloured. The nurse informed me that that was a case of injection abscess. Chandramma was a middle-aged woman. The nurse told her ''There will be a little discomfort and then you will feel better, ok?'' The patient nodded her head and looked at me with suspicion. The nurse then picked up an aerosol bottle containing ethyl chloride and sprayed it to freeze the skin over the exposed buttock. The patient cringed and shut her eyes. Then the nurse handed me a sharp scalpel. She indicated with one finger that I had to make a small cut along the lines of the skin at the most dependent part of the buttock where it met the back of the thigh.

Hardly had I pierced the skin with my trembling hand that Chandramma screamed with all her might and a jet of thick yellowish pus spurted almost straight into my face and continued upwards, like a fountain. It was a spectacle I had never witnessed before. The next thing I remembered was feeling the cold breeze on my profusely sweating face, totally unaware where I was lying down. I had fainted.

In technical terms what had happened to me is known as a syncope, due to a sudden and overwhelming stimulation of the vagus nerve, which is part of the nervous system that inhibits our heart rate and drops our blood pressure precariously. This attack of fainting can be associated with loss of sphincter tone in the urethra and anus as well. The patient regains consciousness as soon as his head becomes horizontal again, i.e., at the level of the heart. The next thing I remember was that it was Chandramma who was fanning my head with her sari. The five of my mates were standing around me, a few looked concerned and others were smiling. Dr Hazara was not there to witness my great adventure.

I had failed miserably to perform the simplest of tasks that he had given me that day.

I got up quickly and gathered my things. Then I realised that I was also lying on a pool of what looked like water. Clutching at my white coat and covering my wet trousers, I bolted out from the theatre, chased by the howl of laughter behind me. ''Could I ever become a doctor?'' was the only thought plaguing me when I hailed an Auto rickshaw, to reach my digs.

How would I live with it?

For discussion:

1. Was it right for Dr Hazara to ask a first day clinical student to incise an abscess?

2. How can a student recover from this kind of experience?

3. Was it ethical to subject a patient to the knife of an untrained student?

4. Should there be ethical guidelines on how to teach a medical student?

Chapter 3
Mentoring an Intern

"I hate New Year's Eve," announced Dr Ahamad, a junior staff anaesthetist, from the head of the operating table. "Booze, fornication and every known sin is committed on this day, and they call it fun. Ha! Allah protect us." He looked at the ceiling and perhaps cursed silently. He continued his work of anesthetising the patient. It was easy to see that he was tired, irritable and unhappy.

I wanted to ask if he was alright, simply to be polite and to make conversation, but I did not. Instead, I grunted something unintelligible. Dr Ahamad continued with his soliloquy. No doubt he was predicting hell and the wrath of Allah on all those debauchers. Somehow I did not feel any sympathy for him although he, like me, had been continuously on call since Friday morning. New Year's Eve had always been my favourite event and I saw no reason to condemn it even though some clearly misused it. It was now 4am on New Year's Day, which was a Sunday. This was the last weekend of 'on call' for me as a rotating Intern in Surgery at Victoria Hospital, Bangalore.

I was waiting for Dr Ahamad to tell me that the patient was fully anaesthetised and ready for the operation. The patient was a thirty-three-year-old milkman. He had been on his nightly delivery to the many tea shops and *dhabas* (roadside eateries) which would open at about 4am for the truckers and other early birds. As was customary in those days, he was carrying two twenty-gallon drums of milk perilously attached on either side of the rear wheel of his pedal bicycle. He happened to skid over a small mound of cow dung and careered into the main carriageway. One of the trucks hit his bicycle from behind. He had fallen with his right arm stretched on the road. Unluckily for him, the left rear wheel of the truck had rolled over his right hand.

He had been brought to the Emergency Department of Victoria Hospital by a kindly passer-by in his car. The accident had occurred just outside Bangalore on Mysore Road. I had received him straight away. He was howling with pain, had lost a lot of blood and was rapidly sinking into a state of shock. The hand was badly mangled, the tendons and nerves were all exposed and hanging out amidst spurting blood, cow dung and clots. I had given him a shot of pethidine, and immediately taken him to the operating theatre. There I had set up an intravenous line and taken samples of blood for routine tests and cross-matching for possible blood transfusion. Haemaccel, a colloid infusion, was then started to maintain his circulation and blood pressure. The Emergency Room Sister had had the foresight to apply the cuff of a sphygmomanometer (blood pressure gauge) as a tourniquet. I had then left him in the care of the nurses, asking them to bandage his hand with ice, and gone to look for my seniors. The top priority was to save his hand from being amputated. Any delay would certainly lead to that catastrophe.

I knew that the Duty Registrar and the Senior Resident were desperately battling to save a patient with an abdominal injury and ruptured spleen in the adjoining theatre. Another surgical intern was assisting them. That meant I needed to get the Lecturer, the most senior surgeon in the department that night, who was rarely ever disturbed while on duty. It was not done to send an orderly to inform a senior colleague; one had to go in person and present the case respectfully. Only then would the learned doctor condescend to see the patient if appropriate. Only the very junior doctors like me were called by phone or through the hospital announcement system. (There were no pagers in those days). Protocols had to be observed very strictly if one cared to get a good reference at the end of one's tenure in that surgical firm. A Lecturer could make or break your career.

I was attached to the firm of Dr Malappa, a junior Professor of Surgery. He hardly operated in Victoria Hospital but was rumoured to be very good. He mostly taught and helped with the complicated conditions in

the major operating theatre. He was reputed to have a huge private practice. His assistant, the Lecturer, managed the firm. He was supported by two middle-ranking doctors – a Registrar and a third-year surgical resident trainee – who conducted most of the operations. Then there were the three of us minions (the interns) – one manned the ward, another worked in the minor operating theatre and the third assisted in the main theatre. We worked from about seven in the morning until eight in the evening when the 'doctors on call' would take over, except at 'weekends on call' when we would be working continuously.

I had hated every day of the last four weeks of this surgical rotation even though I had been able to perform a lot of surgery under supervision – close an abdomen, assist in a vasectomy, do an appendicectomy, and undertake many small procedures in the minor and major operating theatres. I had not received a single word of encouragement, no matter how hard I tried to do well. Two more weeks and I would move on to General Medicine. What joy!

I reached the staff room, which by then had become quiet. Festivities had ceased. Most doctors there were drowsy; it was hard to tell whether it was due to alcohol or genuine fatigue. The Lecturer in Surgery was gently snoring. I woke him up and briefly presented the case of the victim of the road traffic accident. It must have been the earlier celebrations which made him tell me to "F*** off, go and stitch the bastard". He glared at me, asking how many more times should he tell those "f***ing milkmen2' not to transport milk that way on their bicycles. He was sick of it, he said. He then fell asleep. I had not known that this kind of accident was common.

The hand was in a mess; it was clearly a job for a senior and experienced surgeon, not for an intern like me. Just as clearly, he was in no fit state to perform the delicate repair work required on this patient. But there was no one else. My main concern was that unless operated on immediately the hand would have to be amputated. I retreated. Could I repair this hand? How could he have told me to do the repair myself?

I could not help but remember what he had said to me a few months earlier when I was a final year student.

He was frothing at the mouth with venom and ridiculing me in front of our group of final year medical students. It was meant to be a symposium on brain tumours but he had decided to make it a session on head injuries instead, for which we were not prepared. I had not been able to explain fully the 'false localising sign' in head injuries. Then he had asked me a question about the course of the sixth cranial nerve which controls the side movements of the eyeball. I described its course correctly but made a small mistake on its precise relationship with the third cranial nerve at its foramina (small opening) of exit from the skull.

"Get the brain of a cadaver from Abhayia [the morgue technician in the anatomy dissecting room of the medical school], tie it on your head and run around the big courtyard four times – you might get some brains! What an idiot! You will never make a surgeon," he had said. The whole class had burst into uncomfortable laughter, Dr Ramasamy, the Lecturer in Surgery, laughing the loudest of all at his own wit.

How I hated the guy.

The Department of Surgery had six 'firms', each led by a Professor and his staff, many of whom could compete to become the angels of Yamaraj – the Hindu god of death. They appeared so arrogant and filled with self-importance that none of them could have inspired any student to become a surgeon. No student was spared humiliation and insult by Dr Ramasamy and his colleagues. The girl students would burst into tears in the classroom. Even Ramesh, the most dedicated student whose only reason for studying medicine was to become a cardiac surgeon, used to get doubts about his vocation. Thank god, he left for New York as soon as the results were announced and was thus spared the humiliation of working as an intern in the surgical department. He had come first in the final surgery examination followed by the slimmest of margins by myself. By right, I now had first refusal on a traineeship in surgery.