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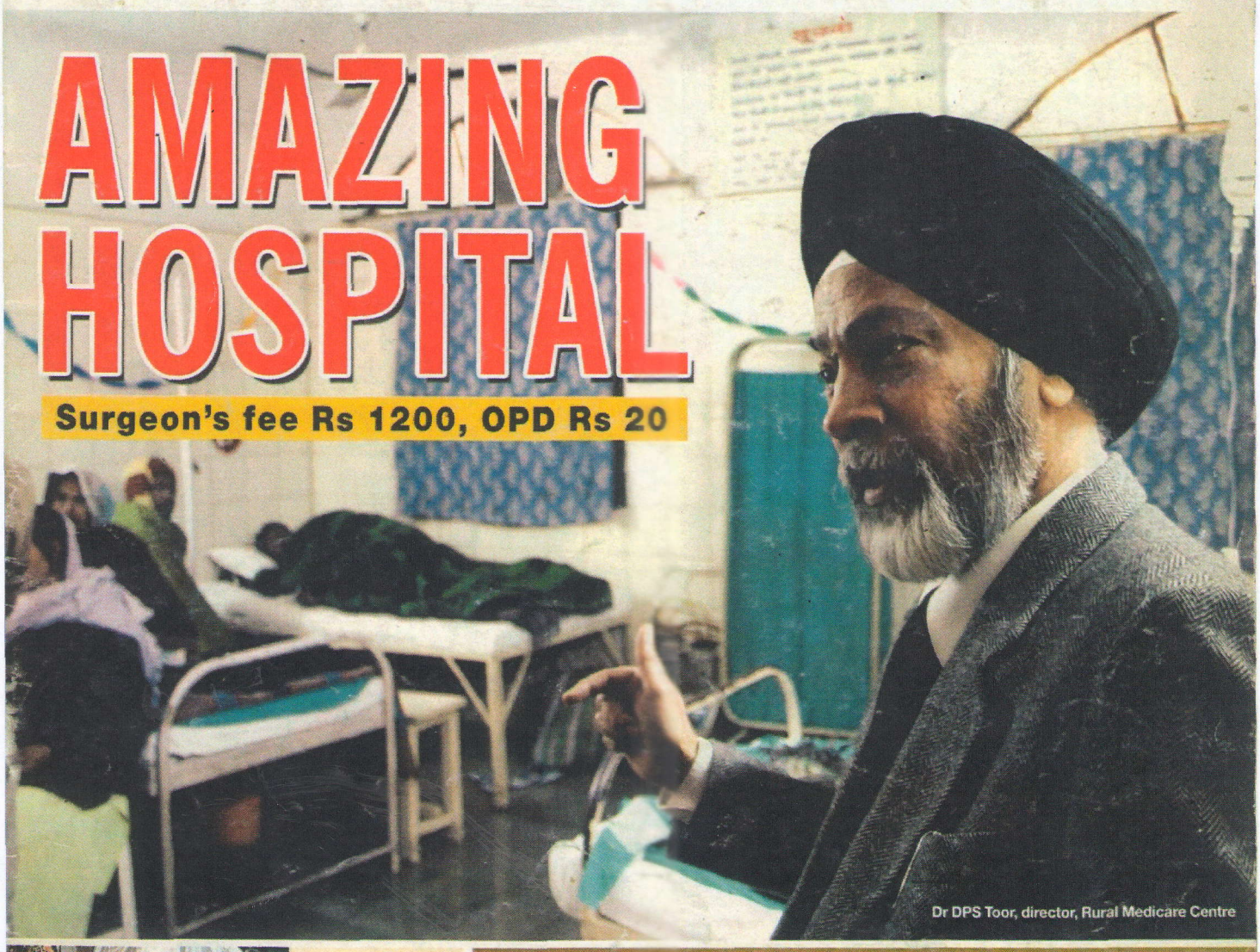
AMAZING HOSPITAL

Surgeon's fee Rs 1200, OPD Rs 20



Dr DPS Toor, director, Rural Medicare Centre

SASAKAWA'S SECOND ROUND AGAINST LEPROSY

GENTLE JAPANESE SETS UP INDIA FOUNDATION

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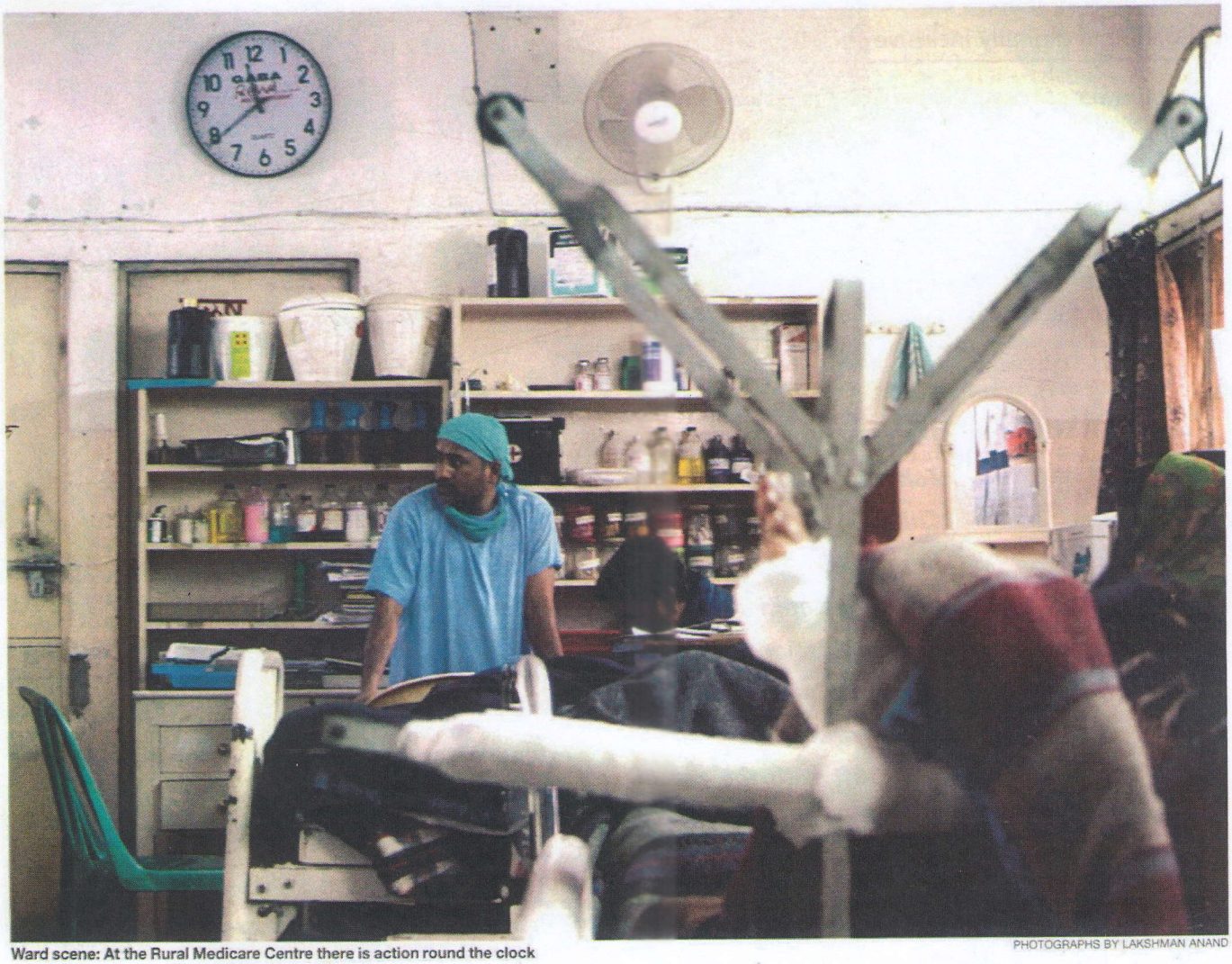


Ward scene: At the Rural Medicare Centre there is action round the clock

PHOTOGRAPHS BY LAKSHMAN ANAND

AMAZING HOSPITAL

Surgeons save lives and redefine the cost of reliable healthcare

Rita and Umesh Anand
New Delhi

THE life of Sunita, 25, was saved by a series of coincidences the other day. She was very ill with a foetus festering in one of her fallopian tubes and blood collecting by the litre in her abdomen. Left like that, she would have died, like so many women do in remote parts of Uttar Pradesh because they can't find affordable medical help. Sunita's family had all but given up hope of saving her when chance encounters delivered her to the Rural Medicare Centre at Village Saidulajaib, on the outskirts of Saket in South Delhi.

Once an ultrasound confirmed her complicated condition, the physicians at the centre were quick to act. The gynaecologist, Dr Seema Malhotra, said that she would operate. Blood was needed, for which Sunita's husband and some well-wishers went to the White Cross blood bank in East of Kailash. By the time they returned, braving Delhi's deadly evening traffic, Dr Malhotra was in her surgeon's gear and waiting to begin the operation. A statement in Hindi was ready for Sunita's husband to sign. It said that her condition was very delicate and she could die on the table.

The operation went on for more than two hours. Internal bleeding had resulted in the intestines and adjacent organs in the abdomen getting affected. Bleeding makes tissues friable and difficult to handle and suture. Halfway through, Dr DPS Toor, director of the centre, arrived on a routine visit and decided to help Dr Malhotra in the operation theatre. Together they worked dexterously to clean up Sunita and completed a surgery that might just never have been performed.

In her delicate condition, Sunita would probably have been shut out by most private hospitals in Delhi. On the other hand, if a good hospital took her in the fees would have been way beyond her means. In a government hospital she would have had to await her turn and then, too, it is unlikely that the doctors would have taken the risk of opening her up. Government doctors know there is hell to pay for cases that go wrong.

Sunita is back in her village some 40 km from Agra. She and her husband live on a few acres of farmland. They have two children. The family survives on what they grow and sell. Her case need never have been so complicated. But the first time she complained of her problem, a private clinic in Agra took her in for a few days, gave her blood and charged Rs 20,000. When she complained again,

the local midwife was called and performed her own procedures, causing more harm than good. Another visit to Agra followed. This time a blurry ultrasound showed she was in some serious trouble.

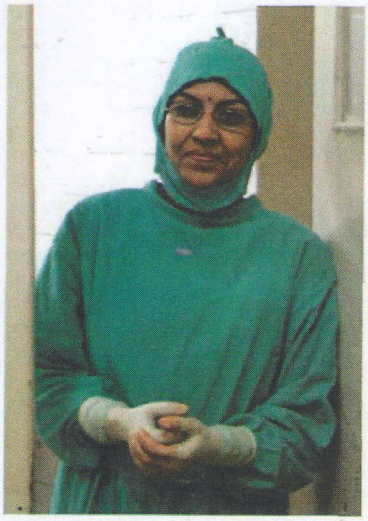
Her visit to Delhi it now seems was ordained and had more to do with sheer luck than the working of the healthcare system in the country. Her mother is a trusted maid in some houses in Gurgaon. It was further circumstance that people in one of those homes took her to the Rural Medicare Centre and put her in the missionary hands of Dr Malhotra and Dr Toor.

Most women in Sunita's situation aren't so lucky. They rarely reach the city from their villages and the city mostly does not reach them. It is even more unlikely that they will make it to a "rural" medical centre that can access the sophistications of urban healthcare.

The Rural Medicare Centre's team, of course, goes much beyond medical competence. They add soul to their professional skills and keep their centre going in order to serve the needy. Dr Malhotra's fee for the operation was an unbelievable Rs 1,200. The charge for the first examination in the OPD was Rs 20. All in all, Sunita's life was saved for just Rs 12,000, which includes the cost of blood, a reliable ultrasound at a nearby facility, taxi fare and five days spent at the centre after the surgery. If she had gone to a private hospital in Delhi, she would have spent at least Rs 60,000.

But for Dr Toor and his 20-odd colleagues, this is no act of charity. They don't flit in and out of the Rural Medicare Centre merely to cleanse their consciences. They do have their own practices where they earn more, but the Rural Medicare Centre functions as a professional establishment in its own right. For instance, Dr Malhotra is one of four gynaecologists who serve there. Three days in the week she performs surgeries and on three days she attends the OPD. The doctors take turns to be on Sunday duty, and on two days of the month each one is on standby for 24 hours.

If a surgeon sees a patient in the OPD and a surgery has to be performed at short notice, then the operation is that surgeon's responsibility. So it was with Dr Malhotra after she had seen Sunita for the first time. It wasn't her day to operate, but she had to come in. In fact, on that night the son of one of the anaesthetists was getting married. Dr Toor and Dr Malhotra should normally have been at the wedding.



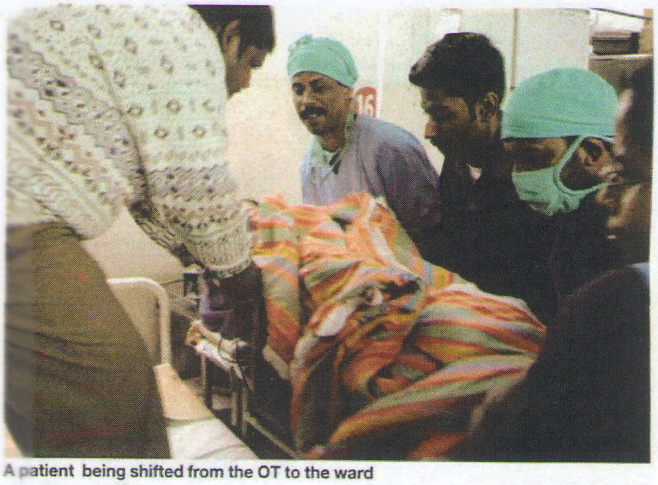
Dr Seema Malhotra, who saved Sunita's life

The Rural Medicare Centre has taken aid for some of its capital investments. But it runs on what it earns. It isn't a funded institution propped up by *remote munificence*. However, it does get the odd free gift of blankets or cloth for making OT uniforms. Grateful patients turn up with heaters and desert coolers. It also has a poor fund drawn from interest on Rs 5 lakhs given to it by some generous individual a decade ago.

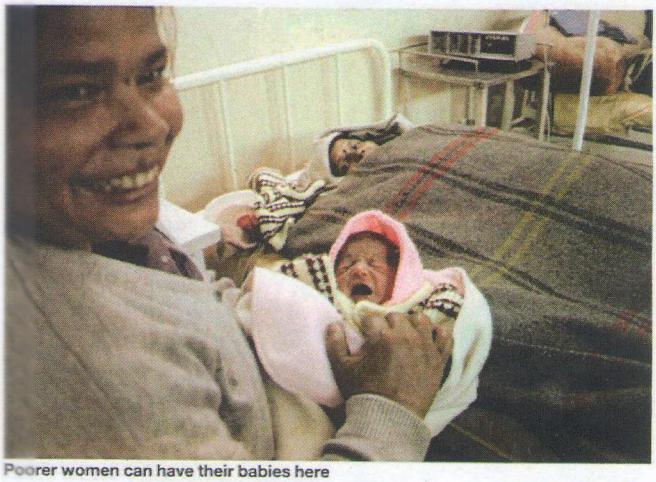
But the centre's mission is to treat people by charging reasonable fees. Its business model is aimed at demystifying the cost of reliable healthcare. What this really means is that though its fees seem paltry they are enough to provide professional services. The centre's doctors earn on an average Rs 25,000 a month. That is not much and they all supplement it with their own practices. But the decision to spend time here involves forgoing a substantially larger income. These doctors have raised an ethical question: When millions need healthcare should doctors remain wedded to a system that makes them obscenely rich or should they redefine the paradigm by which they serve and earn?

The Rural Medicare Centre

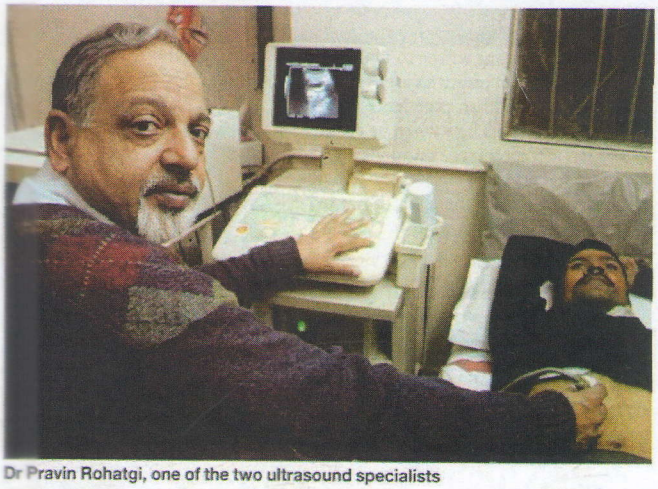
Rural surgeons don't do heart and brain surgeries. They take care of the everyday cases for which there is no reliable medical infrastructure in the country. Where can someone with limited means go to have a hernia repaired or gall stones removed?



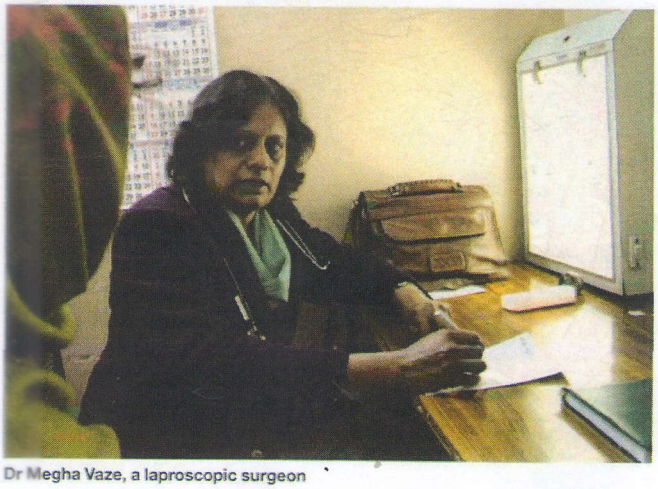
A patient being shifted from the OT to the ward



Poorer women can have their babies here



Dr Pravin Rohatgi, one of the two ultrasound specialists



Dr Megha Vaze, a laproscopic surgeon

was born out of such introspection. It was set up in the seventies by Dr JK Banerjee and his wife, Shipra, in a ramshackle godown in Mehrauli. Dr Banerjee had trained in England and returned to work in the Ramakrishna Mission hospital in Haridwar. He is a great admirer of Vivekananda. After working for the hospital for six years, he decided to make his personal contribution to taking quality healthcare to the masses at an affordable cost.

"In England I saw that what defined a developed economy was equality in access to facilities," says Dr Banerjee. "In India on the other hand there are facilities only for a few with the vast majority being forgotten and having to fend for themselves."

It is necessary in such a situation for the privileged few to reach out and share the benefits of progress. "We have eight and nine per cent GDP growth these days, but it is only for 20 per cent of the population. What does that 20 per cent of the population do to enable the others to share in its prosperity?" asks Dr Banerjee.

When he set up a medical centre in a godown in Mehrauli in the seventies, he found that there were other doctors ready to join him. Similarly, he found some support for his ideas among members of the Association of Surgeons of India.

They tried to get the association to endorse rural surgery as a specialisation, but met with serious opposition, not just from within the association but from the teaching fraternity as well. Finally, they walked out and set up the Association of Rural Surgeons.

At the age of 69 and with a stroke behind him, Dr Banerjee now lives in Dehradun where he helps the Ramakrishna Mission. But the work he began has been carried forward. The Association of Rural Surgeons has some 400 adherents across the country.

Internationally they are not alone because there are also associations of rural surgeons in the US, Africa and Europe. The next international meeting will be in Tanzania because the African countries are very eager to learn from the Indian experience.

Dr Banerjee recalls how when he spoke in Sweden at a conference on surgical economy and efficiency in 1987 he was mobbed by the media there which wanted to know more about his approach to the delivery of healthcare.

The rural surgeons' movement is based on the belief that science and technology must be used as tools for inclusion. Doctors must seek out their social relevance. Specialised and expensive hospitals have their own roles to play. But an entire country cannot remain focussed on tertiary care. Rural surgeons are needed to cater to the periphery, which in a poor country like India is burgeoning and mostly neglected. If all doctors work at top-notch hospitals who will be around to use modern science to save the lives of people like Sunita?

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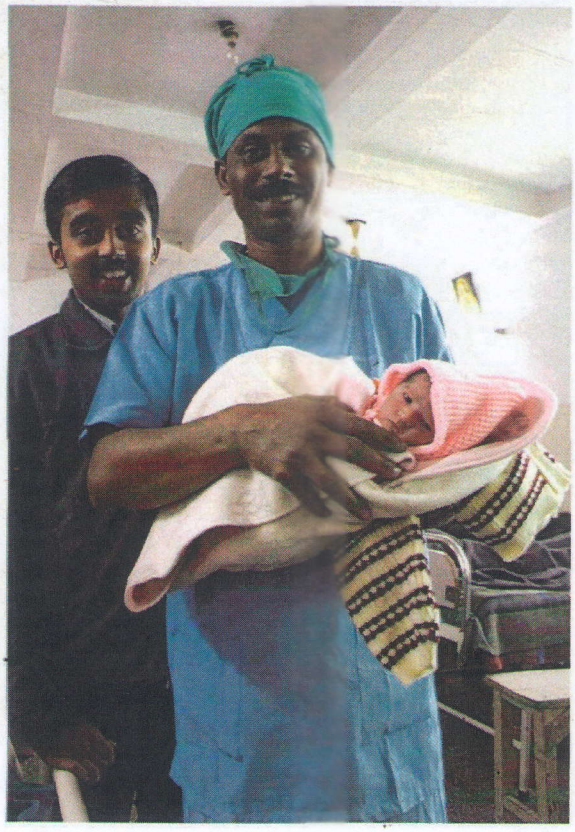


Rural surgeons don't do heart and brain surgeries. They take care of the everyday cases for which there is no reliable medical infrastructure in the country. Where, for instance, can someone with limited means go to have a hernia repaired or gall stones removed? Which doctor is on call to pluck out a poor person's infected appendix just in time?

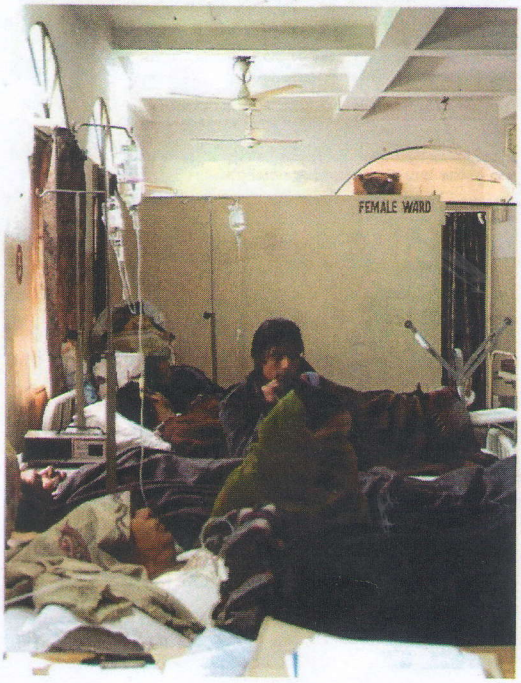
Last year, thousands of patients visited the Rural Medicare Centre. There were 171 surgeries to remove gall bladder stones. There were 86 operations to fix hernias and 15 to remove kidney stones. Five cases of enlarged prostrate were dealt with surgically. There were 138 ENT operations, 61 cataract removal cases, 189 normal deliveries, 223 caesarean sections, 135 hysterectomies.

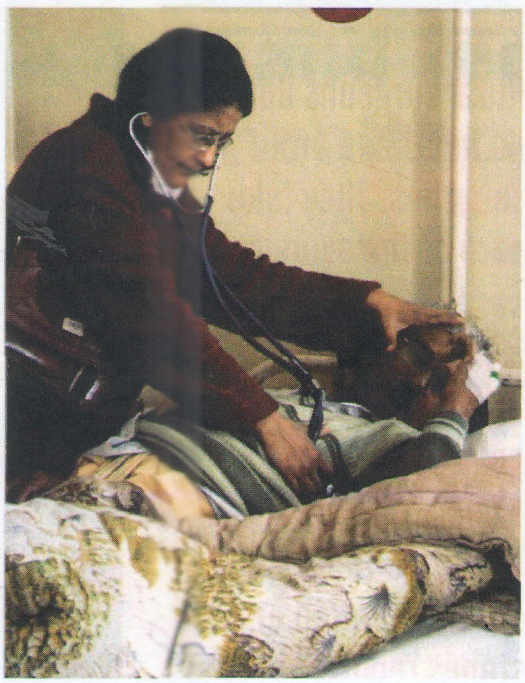
These figures are not exhaustive, but are intended to provide a quick picture of what an important role the Rural Medicare Centre plays in the lives of people.

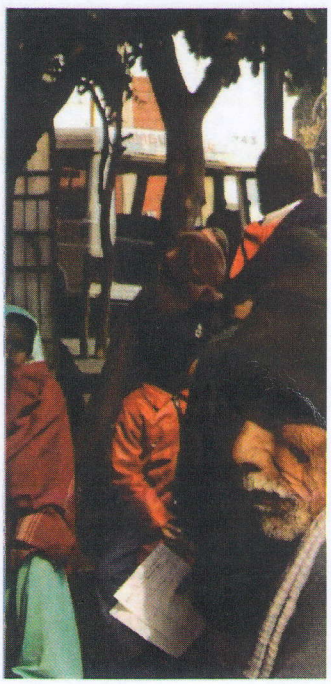
At a time when a career in medicine is equated with fat earnings and super specialisations, the rural surgeons prefer to get down to basics. It isn't easy to buck the trend and so many of the physicians who get drawn to the Rural Medicare Centre are initially enthused but then begin to fade out. However, those who stay would have it no other way.

Dr Malhotra, for instance, first turned up as a replacement for a friend gynaecologist who was going on leave. That was a year ago. She has opted to work at the centre on a regular basis. "There is mental and academic satisfaction at providing service at a minimum cost," she says. She studied at Rohtak Medical College and completed her senior residency at AIIMS. Her husband is a very senior physician and she could, given

A newborn is brought from the OT. And below: the wards, a physician checking out one of the patients and people at the gates of the hospital







Some of the team members of the Rural Medicare Centre

her qualifications and professional contacts, quite easily be anywhere else.

Dr Malhotra's story holds true for all the other doctors who bring their professional expertise to the Rural Medicare Centre. If her case finds repeated mention it is because we watched her work on Sunita's case.

Dr Toor used to be employed at Moolchand Hospital in Delhi before he made the switch in 1993 after a chance meeting with Dr Banerjee, who became his mentor.

Dr Toor has a clinic at Khan Market, but it is at the centre that he spends all his time. A short, energetic and jovial Sardar, he says: "I tell people that I spend the day in Bharat and come to India in the evening."

He is at the centre on all days till afternoon and then back again in the evening for some unfinished work. He attends his clinic for a couple of hours on Sundays as well because for many poor people it is the only day they can get off to see a doctor. Hawkers and others who live on the streets around the centre go there for treatment. A peanut vendor will have his cataract removed at the centre shortly. There are others who come with common ailments to see the general physicians in the OPD.

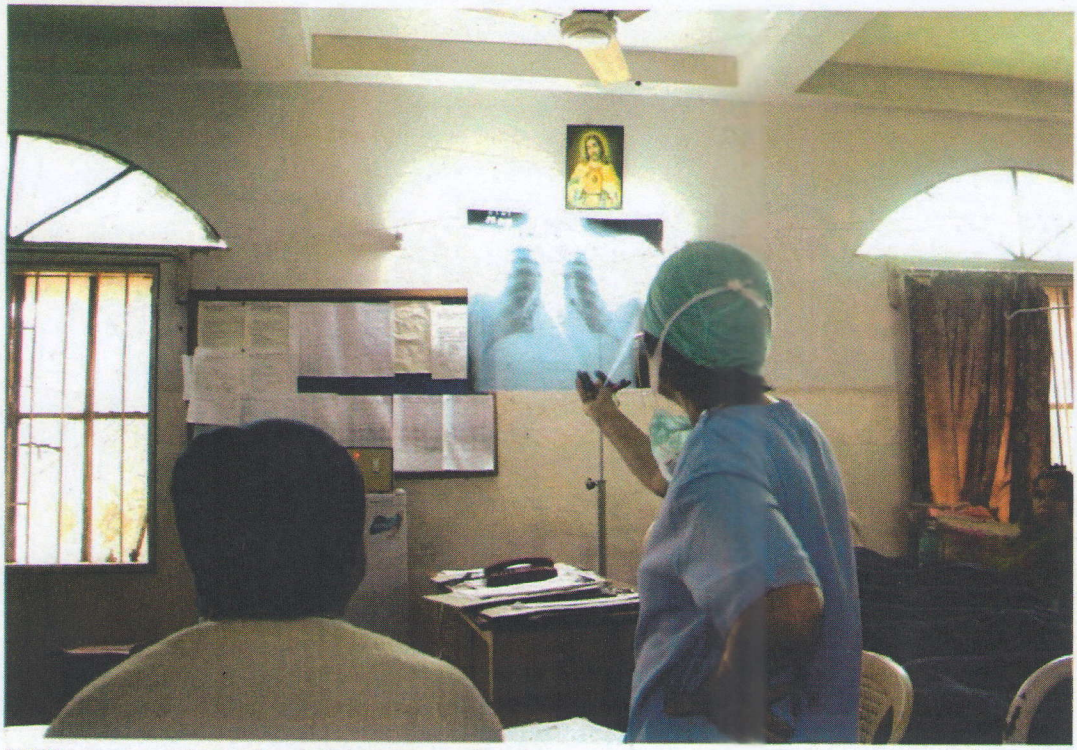
The faith in Dr Toor is enormous. It is not uncommon to see families pleading that he conduct an operation himself, though this in not necessary and often not possible. Dr Toor may be in full flow as the director of the centre, nimbly moving from room to room and ward to ward, but at his core he is a team player. He will introduce you to Dr Megha Vaze, also a general surgeon, emphasising that she is a laproscopic surgeon and is better qualified than him. "I depend on her when I am in trouble. She is the one who bails me out," he says.

"A centre like this depends on teamwork," says Dr Toor. "You need everyone feeling involved and working together. Above all, this applies to the centre's employees who are not doctors. After all, we doctors perform the surgery and go away. It is the others who look after the patient – checking the temperature, blood pressure, administering blood, saline, and drugs. A medical centre has to run round the clock and for that it needs dedicated and happy people."

Dr Toor's own involvement in the early nineties began by sheer chance when he came across Dr Banerjee and his anaesthetist wife and began helping them. The Rural Medicare Centre was then still its smaller avatar in Mehrauli. But it was a busy place because people from the surrounding areas knew they could go there and find treatment.

Dr Banerjee's own reputation was huge. People who went there would only ask for him. In those years, Dr Toor seemed inexperienced because of his slight build and youngish looks. At 54 now he remains youthful, but he has greyed and his eyes tell you that he has seen a lot. But at the Mehrauli clinic no one wanted to go to him. They only knew of Dr Banerjee.

Then one day a man turned up with the tip of his finger cut off. He burst into Dr Toor's cabin and said: "My finger is cut, will you stitch it for me?" Dr Toor took a look and found that the finger was severed and there was nothing to stitch back. The man then fished in his pocket and took out the severed portion



All faiths are respected and so there is Christ's picture on the wall

of the finger and asked Dr Toor to stitch it back. Dr Toor demurred saying it wouldn't heal. The man insisted: "How do you know unless you try," he said.

Dr Toor stitched back the finger and told the man to come back the next day convinced that the surgery would not work. The man returned and to Dr Toor's surprise the finger hadn't turned black, but was instead red and showing signs of life. In coming weeks the finger healed completely.

The man told his story to others and began sending patients to the Rural Medicare Centre who now asked for Dr Toor and his reputation as a lucky surgeon grew. He finally took over as director when Dr Banerjee and his wife moved back to Uttaranchal. "He is a team player," says Dr Banerjee, explaining the choice. "A director must be someone who does not dominate and carries others along."

People flock to the Rural Medicare Centre because, like the man who almost lost his finger, the doctors there are their only hope.

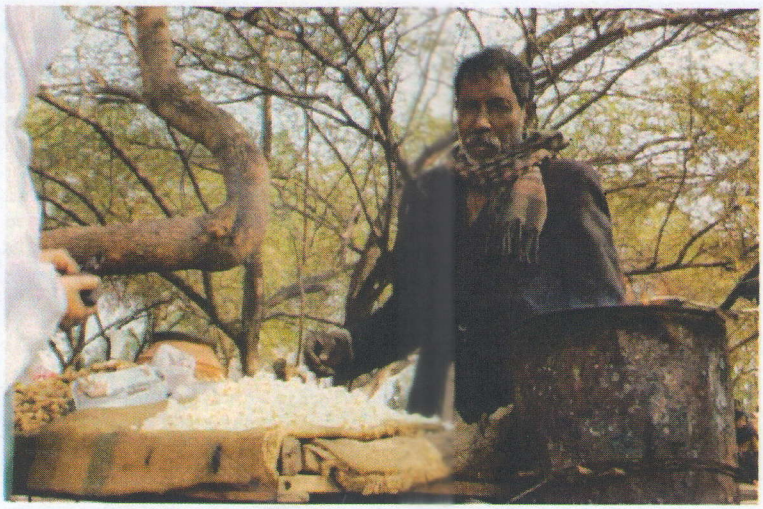
Dr Toor points out that the role of the general surgeon is often not fully understood. For many ailments and diseases a patient can go to one doctor or the other. The medication can change as indeed can the diagnosis. But when surgery is needed nothing less than a surgeon will do.

So, the finger that needs to be stitched back or the appendix that must be plucked out or that corrosive ectopic pregnancy in a festering fallopian tube, all need to be immediately attended to by a surgeon.

It is this role that the rural surgeons fulfil. Dr Toor does three operations on his surgery days and so do the other surgeons at the centre and their work is just a drop in the ocean considering the vast number of Indians who have no access to healthcare.

"When I go to conferences I always say that we are all needed. We need Max, Fortis, AIIMS, Escorts and our Rural Medicare Centre. You need a strong core but you also need to reach the periphery. If doctors serve only the rich, who will treat the poor and the needy? In fact the importance of serving the periphery keeps increasing. The government hospitals are overburdened and the doctors there struggle with inefficient and inadequate systems," says Dr Toor.

Moreover, with an increasing number of people leaving rural areas to come to the city, the majority of them in slums and on the streets, there will be an exponentially bigger need for affordable services of the kind the Rural Medicare Centre provides. "Soon 50 per cent of India will be living in its cities, and where are the facilities for them," Dr Toor points out.



This vendor will soon have his cataract removed at the hospital

One way forward, according to Dr Toor and his colleagues, is to hand over primary health centres to voluntary organisations of doctors who want to serve the needy both in cities and villages. The government clearly cannot fulfil this role.

There is also the need to recognise the role of rural surgeons. A big step has been taken with the Union Health Ministry deciding to introduce a course in rural surgery. It will give physicians a DNB or Diplomate of the National Board in rural surgery. The idea is to give physicians basic skills in surgery so that they can work at remote locations.

But finally it is the spirit and not official recognition that drives the rural surgeon. Recalls Dr SK Basu, one of the founders of the Rural Medicare Society: "Its very foundation was the dream to cater to the healthcare needs of the economically less privileged people and enable them to buy expertise with dignity across the counter."

In the Mehrauli godown where it began in 1976, the Rural Medicare Centre had just three beds. The front of the godown was converted into the OPD where barely three patients could sit. The consultation fee was Rs 5.

Leading the way at that time were Dr Banerjee, Prabhat Mukherjee, Arvind Das, Dr Jharna Sen, and Dr Shipra Banerjee. Nitish De was the chairman of the society and Prabhat Mukherjee the founder secretary. They were joined by Dr Gurjeet Singh, Dr J Trikha, Dr Shashi Ghosh.

"I still remember the thrill of performing the first caesarean section on a diabetic mother in a 6 ft x 9 ft operation theatre," says Dr Basu. "I must admit that the act was not without a sense of trepidation as infrastructure at that time was virtually non-existent. Neither did we have the requisite number of colleagues to give us the much required encouragement and moral support."

Over time, the doctors moved from the godown to a small building in Mehrauli. The shift to the current location at Saidulajaib, near Saket, came in 1993 when the then Lt Governor of Delhi, PK Dave, who gave them the land. SK Chakravarty and his wife Monica played an important role in this.

The building went up as a simple red brick structure, quite unique in its architecture. It now has 30 beds, a modern operation theatre, 22 serving doctors, 66 paramedical staff and four resident doctors. There is a pharmacy and a canteen. There are two ambulances which are frequently pressed into service.

Dr Banerjee believes that what India needs is several such small hospitals. The idea of creating the centre at Mehrauli and the one that now exists at Saidulajaib was to showcase a workable business model which others could replicate. "You need 30 and 40-bed hospitals staffed with qualified physicians and paramedical staff and sustained by local communities. You also need to train local people," says Dr Banerjee.

But to go beyond isolated examples such as the Rural Medicare Centre, a policy framework is required. Healthcare that reaches the masses will have to become a political priority. Right now there are no incentives for setting up decentralised, high-quality and affordable facilities. Instead the emphasis is on large corporate institutions, which are expensive and accessible only to a few. And so, doctors who want to serve where they are needed most have to, like the rural surgeons, cut their own paths in search of professional relevance.