Soundings

Valedictory lecture

The second world war flattened most of Nijmegen, but spared some of St Steven's Kerk, a fifteenth century gothic building in the town centre overlooking a branch of the Rhine. When I was in the restored church last month people were uncertain about whether it is Catholic or Protestant and seemed to wonder why I was asking. Not for the first time I thought we can learn from the Dutch.

It was a Friday afternoon and the bells were ringing to announce a public lecture. A local professor was retiring and several foreigners had been invited to join the procession. I am not sure if this was the first overseas trip for my MD gown. It was given to me by the widow of an eminent Scottish doctor after I wrote an article about the annual trauma of the graduation ceremony. Having his name on the label is strangely comforting.

As we robed in the chapter house my stand up collar and white bow tie were outshone by united colours of Europe. A Spaniard in yellow and purple, with a fringed hat, looked like a mediaeval pontiff. Two Swedes in dark shirts and top hats might have stepped from an Ingmar Bergman film. Doctors from the low countries were in Calvinist black with discreet ostentation—emerald edging, touches of embroidery, and luxurious velvet collars—and some, in bavettes and round hats, looked like judges from the European court.

My own cap, a kind of floppy mortar board, has never impressed me but it was, I realised, in the local style. Of course: Edinburgh medical school was founded by doctors who had studied in the Netherlands. I remarked artlessly to a woman beside me that I had only just realised that Scottish academics wear Dutch caps. Suddenly blushing, I eyed her warily, but her smile gave no clue as to whether our lingua franca extended to double entendres.

The lecture itself was delivered from the pulpit while we followed an elegantly printed translation. It was about the role of homocysteine in preventing birth defects. The high, whitewashed nave had chandeliers but no projection facilities so the talk was illustrated by a molecular model, held up by the lecturer's little granddaughter and then propped in a side aisle. I looked at it regretfully. One carbon atom too many for jokes about the cysteine chapel.

This was a grand occasion for a particularly distinguished man, but public valedictory lectures are normal in the Netherlands, like inaugural lectures here. I like the idea. It could be criticised for encouraging excessive respect for seniority—an affliction among doctors in mainland Europe. Nevertheless, there is something fitting about requiring a chairholder to stand up in front of the people and give an account of his or her stewardship.

We should try it. It might counterbalance that current British fad, excessive respect for middle age. People should retire with a bang, not a whimper, and ought to dress up for it. All professors are peacocks at heart.

James Owen Drife, *professor of obstetrics and gynaecology, Leeds*

Personal view

Plunged in at the deep end

Editorial Banatvala and Doyal

On the first morning of my elective, I turned up at the outpatient clinic expecting an introduction on how the hospital was run and what would be expected of me. Instead, I was simply told to "see patients." I was at the Lady Willingdon hospital, a Christian charitable institution serving the people of Manali, a small town at the base of the Himalayas, and surrounding regions in northern India. It is run by a married couple, Laji and Sheila Varghese, who first came to the mission in 1979.

The workload is huge. Although it is a 35 bed hospital, extra space is often made for another 10 patients. About 150 patients are seen in outpatient clinics every day. The medical staff consists of three doctors, nine nurses (only one with official nursing qualifications), and 10 assistant nurses.

For the outpatient clinic I shared a small room with another doctor. The patients would have one or two relatives accompanying them. All but the most private examinations were carried out on a couch in the corner of the room. Rectal and vaginal examinations were performed behind a flimsy curtain.

One day each week was put aside for elective surgery. Emergency operations were carried out whenever necessary. Almost all the surgery I saw performed was under spinal anaesthesia. Without hi tech monitoring equipment, intubation and ventilation have a high complication rate and were therefore used only when absolutely necessary.

My first impression of theatre was that it was barbaric. A patient with a bowel obstruction had a laparotomy to investigate the cause of the obstruction. His wrists were tied down in the crucifix position: he was awake and apparently in some pain, although he was later given intravenous ketamine to make him more comfortable. Since no correctable cause was found for the obstruction, the bowel contents were brought outside his abdomen and evacuated by squeezing them towards the stomach and using nasogastric suction. However, most operations were not as dramatic as this one, and many patients appeared to be pain free.

A common theme that ran through my elective was a feeling of being useful, of helping rather than hindering, and that was certainly the case during surgery. Often, I doubled as both assistant and theatre nurse. To meet the many surgical demands, the surgical team had to work fast. As one patient was being stretchered out, the next was walking into the operating area. I saw Dr Laji complete a cholecystectomy in seven minutes, excluding closure time.

After being given a couple of days to settle in, I started doing on calls. I was expected to be on call once every two days, which was tiring, but ensured I became fully involved in the workings of the hospital. I lived in the hospital and, when I was needed, the night watchman or night nurse would bang on my door saying, "Doctor Kevin—patient, patient." I soon gave up trying to explain to the staff that I was only a medical student.

My most satisfying case when on call was that of a man who had been involved in a car accident. His *x* ray film showed a dislocated and fractured elbow. I rang Dr Laji, who gave me some instructions on how to perform the reduction. After administering a sedative and painkillers, I enlisted the help of a passer by to apply opposing traction, and we attempted the reduction. The elbow seemed to crunch a lot, but appeared to be back in place, so we applied a posterior slab and plastered the arm, flexed at the elbow. During the procedure, we were plunged into darkness by the failure of the electricity supply (a regular occurrence), and I had to get someone to hold a torch. I then found the radial pulse, which returned to full strength after a worrying minute or two. A repeat *x* ray in the morning showed that the reduction had been successful.

Everything I had seen and experienced in my previous six weeks in Manali paled into insignificance after I had to attend a coach crash. The day had been much the same as any other in the clinic, when suddenly some cars came racing into the courtyard carrying injured people. About 20 of them had life threatening injuries—too many for us to cope with immediately. The man driving the first car said there had been a coach crash and somebody was needed at the scene where there were more injured people. I was told to go, so I picked up a stethoscope and was driven to the scene in the hospital jeep.

> *"Most people accepted disease and death as part of life"*

When I arrived, I saw perhaps three or four hundred people standing on the top of the cliff staring down at a bus that was overturned and half submerged underwater. It had fallen off the bridge into the river. After pushing my way through the crowds, and being shown the safest way to get down the slope, I found a group of men standing on the chassis of the overturned bus, trying to get any survivors out. A few policemen were at the scene, but their organisational efforts and first aid skills were poor. Five bodies lay on the rocks. Nobody knew whether they were dead or alive. I checked each in turn and found no pulse or breath sounds. All had fixed, dilated pupils. They were dead. I was quite relieved by this, knowing that they would have lived only a short, agonising time because of their horrific injuries. After waiting some time to see if there was any possibility of more survivors being dragged out of the coach, I returned to the hospital, taking a man with a shattered humerus and a woman with a head wound. For the next few days, the hospital was bursting at the seams.

The morale of the staff, patients, and their relatives in the hospital seemed good, especially considering the amount of suffering present. Most people accepted disease and death as part of life. Patients were grateful for the care provided by the mission hospital and, in contrast with the expectation in the Western world that doctors should be able to cure all illnesses, they considered it a bonus when something could be done. My elective was at times enjoyable and satisfying, at other times frustrating, and sometimes heartbreakingly sad. There was so much to be done that even a fourth year medical student could feel useful and be of help. The hospital staff had my greatest admiration. They were thoroughly dedicated and doing the best they could with very limited facilities.

Kevin Molloy, *final year medical student, Leicester*

This article and its accompanying editorial first appeared in *studentBMJ* in October 1997.

A memorable patient

Home glucose monitoring, who started it?

In 1975 there was compelling evidence that glycaemic control in pregnancy was critical for a successful outcome for mother and baby. However, diabetic control could be monitored only by the women testing the urine for reducing substances. The renal threshold for glucose not uncommonly falls in pregnancy with resultant glycosia when the blood glucose values are still in the normal range. The instruction to diabetic pregnant women was to keep "the urine blue" (clinitest tablets were still in use and when five drops of urine and 10 drops of water were added to the clinic test tablet the mixture would remain blue if free of reducing substances). My patient had obeyed this instruction, but unfortunately for her, and perhaps fortunately for the diabetic fraternity, she developed a drastic reduction in her renal threshold for glucose, which resulted in a prolonged hypoglycaemic episode. So at 26 weeks of pregnancy I advised her to come into hospital to be monitored. Her response to this request was, "What are you going to do in hospital that I cannot do at home?" My reply was, "Measure your blood glucose." Her response to this was, "Why can't I do this at home?"

The dextrostix together with the Eyetone reflectance metre had been on the market for 10 years but was largely discredited. However, if correctly used (20 minute warm up time, calibration with standards, adequate drop of blood applied to the dextrostix, accurate timing of the reaction, and careful washing of strip and blotting) blood glucose values could be achieved with a plus or minus 10% accuracy. The incentive for my patient to get to grips with the technology was overriding. It would mean that she would not be incarcerated in hospital. She learnt very fast. I still have her records. She made about three measurements a day and was not admitted until term. From then on every established pregnant woman in our unit has monitored her blood glucose. Two years later my patient was pregnant again. By then blood glucose measurements were made before most meals and at bedtime. I used to show her records at meetings because two days before delivery she was attending a wedding rather than in an antenatal bed, the accepted practice at the time. Home glucose monitoring is now universal for all insulin dependent diabetic patients and no pregnant diabetic woman is routinely kept in hospital for the entire third trimester of her pregnancy. But 23 years ago my colleagues considered this a dangerous practice. Patients may contribute more to advances in medicine than is recognised.

Clara Lowy, *reader in medicine, London*

We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.