

# Revamping the Health Sector is the Crying Need

by Md Asadullah Khan

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pathological tests sometimes complicate the problem of the patient and there are cases when these have led to fatality. Overcrowding in hospitals is a notorious problem. Patients sharing a bed in the filthy corridor of the hospital is a common sight. DMCH which can accommodate about 1000 patients at best is now being occupied by about 2000 patients. And shortage of staff and doctors makes it even worse. DMCH which has about 185 doctors can ill-afford to take care of 2000 in-door patients. The recent report of a baby who was still alive but sent to morgue as dead in one such hospital has made headlines. Routine enquiries are conducted and the search for scapegoats goes on. Government apathy and incompetence of the doctors have exacerbated the problem no doubt. But there is plenty of blame for all parties and overcrowding is just one part of what typifies the chaos in health care in the country. Because of extreme neglect in replacing the dirty linens at least once in a week and total carelessness shown in serving meals to the patients and carrying garbage to the trashbin, many patients are contracting infections while still in hospital bed. All told, a system that is so much chaotic will be hard to fix unless a crash programme and a concerted effort by all concerned can be mounted.

The emergency outdoor of the DMCH presents a ghastly look. Only four exhausted doctors continue to face a dilemma in handling an ever increasing number of casualty cases. Paradoxically, the country has made a great leap forward in at least two sectors: Clinico-pathological labs and coaching centres. In a word, there has been a mushroom growth of pathological labs, clinics and coaching centres in the nook and cranny of country, with very little attention towards quality, and accuracy. Doctors attached to these clinics are doing brisk business with little attention to the financial capability of the patients. Reports have been rife that doctors, through greed and poor judgement are advising a long list of pathological tests, many of them totally needless, worth thousands of taka. There is a growing sense that the money is ill spent. Patients are willing accomplices ever ready to put their faith in what appears to be scientific evidence, despite estimates that almost 50 per cent of all tests performed are unnecessary. Worse, owing to sloppy laboratory work or doctor's mistakes the results are too often wrong or misinterpreted.

The consequence of such wrong diagnostic tests are horrific. This may actually harm patients by failing to detect serious diseases or by indicating illness when none exists. It is worth recalling that the days when doctor's decisions were guided solely by what they heard, saw, felt and thought have gone the way of the house call. The consequence of such hurriedly done tests with technicians of poor knowledge and lack of responsibility being so horrendous, it

is high time for state-level investigations about the way these tests are performed. Government must introduce and enforce uniform proficiency standards for laboratories. This must be done with the sole objective in mind that faulty lab procedures and tests can have devastating consequences. As it appears from the seminar and conference paper of the doctors, because of technical error, cholesterol readings can vary enough to cause confusion about whether treatment is needed.

No wonder tests beget more tests. In our country, various blood analysis that were previously advised one at a time are now packaged in blocks of 20 or more. These type of pathological tests are not free from vices especially in our country prone to fallibilities, weaknesses and mistakes by the glibble technicians. It is pertinent to recall the stern warning issued by an eminent physician of the New York City's Einstein College of Medicine "when you run a lot of tests, the possibilities are higher that one or more will come out wrong".

More disturbing, some doctors with a motive to make profit may advise needless tests when they have their own equipment or they are attached in some way or other with the pathological laboratories. But patients or their relatives face the biggest quandary and dilemma in either avoiding the physician's advice or going by it. But the truth still holds that the more experience a physician has, the fewer the tests that should be necessary.

Hospitals, medical centres, educational institutes in this country are somehow retaining their existence in the face of serious dearth of funds, facilities and equipment. In the backdrop wealthy people of our country should come up and place their fortune for the cause of the have nots. This would definitely be a blessing especially at a time when these institutions are hungering for money and the government support is drying up. Even in a rich country like the USA, these sort of donations are welcome. The trustees of Glass Boron State College, late in 1992 have made some exceptional gestures. Overwhelmed by a magnificent 100 million dollar pledge by a local businessman, Rowan, the trustees not only voted to take the money but in an expression of gratitude also decided to rename the school Rowan College of New Jersey. Coincidentally another institution like Harvard Law School accepted a somewhat less spectacular but still welcome 3 million dollar from its alumnus Reginald F. Lewis boss of the biggest black-owned business in the US — the food conglomerate TLC Regional International INC.

More in the line, Stanford University alums David Packard and his wife Lucille, who gave their school 70 million dollar in the late 1986 for children's medical centre is an exceptional gesture that must be followed in our country. In the neighbouring country, Industrial barons and business magnates have advanced the cause of health and education by making splendid contribution in setting up hospitals, medical centres and medical research centres.

But there is a glimmer of good news in the face of the most bleak scenario engulfing the nation. An ordinance aimed at standardising fees of doctors, the charges of different medical services, and private practice by doctors and fixing the minimum salary of doctors working in private medical hospitals and clinics will allay the deep-rooted frustration lurking in the minds of the doctors. However it would be most sound to fix the minimum salary of doctors working in private clinics at Tk four thousand with just one year experience and at least Tk seven thousand with 3 years of service, taking into consideration the fact that a doctor in getting his degree and coming out of the college premisses had to spend at least seven years of schooling including interne. The country must try to honour and pay due status to its sons who are on the threshold of an enlightened career and who are going to heal the mortal wounds of the nation.

# Of EPISTAXIS — Bleeding from the Nose

by Dr Md Alamgir Chowdhury

**EPISTAXIS** or bleeding from the nose is a common condition. It itself is not a disease but it may well be a manifestation of a number of other diseases. It is most frequently seen in children and the elderly but may occur at any age. Most cases are minor, with no more than a few millilitres of blood loss. But occasionally life endangering serious bleeding calls for expert and immediate blood transfusions.

### Anatomy

Epistaxis usually originates from the nasal septum supplied by the following blood vessels — Septal branch of sphenopalatine artery, Septal branch of greater palatine artery, Septal branch of superior labial artery. The terminal branches of these vessels form a plexus on the anterior part of the septum known as Little's area — frequently the site of epistaxis. Little's area is shown in the figure one.

Infection. Post operative. Tumours of nose and sinuses. Congenital hereditary telangiectasia. Environmental — high altitude, air conditioning.

General Causes of Epistaxis  
Hypertension. Abnormal conditions of blood or blood vessels — Leukaemia, Purpura, Haemophilia, Scurvy, Vitamin K deficiency, Hodgkin's disease. Drugs like Aspirin, Non-steroidal anti-inflammatory agents, Anticoagulants.

### Clinical Features

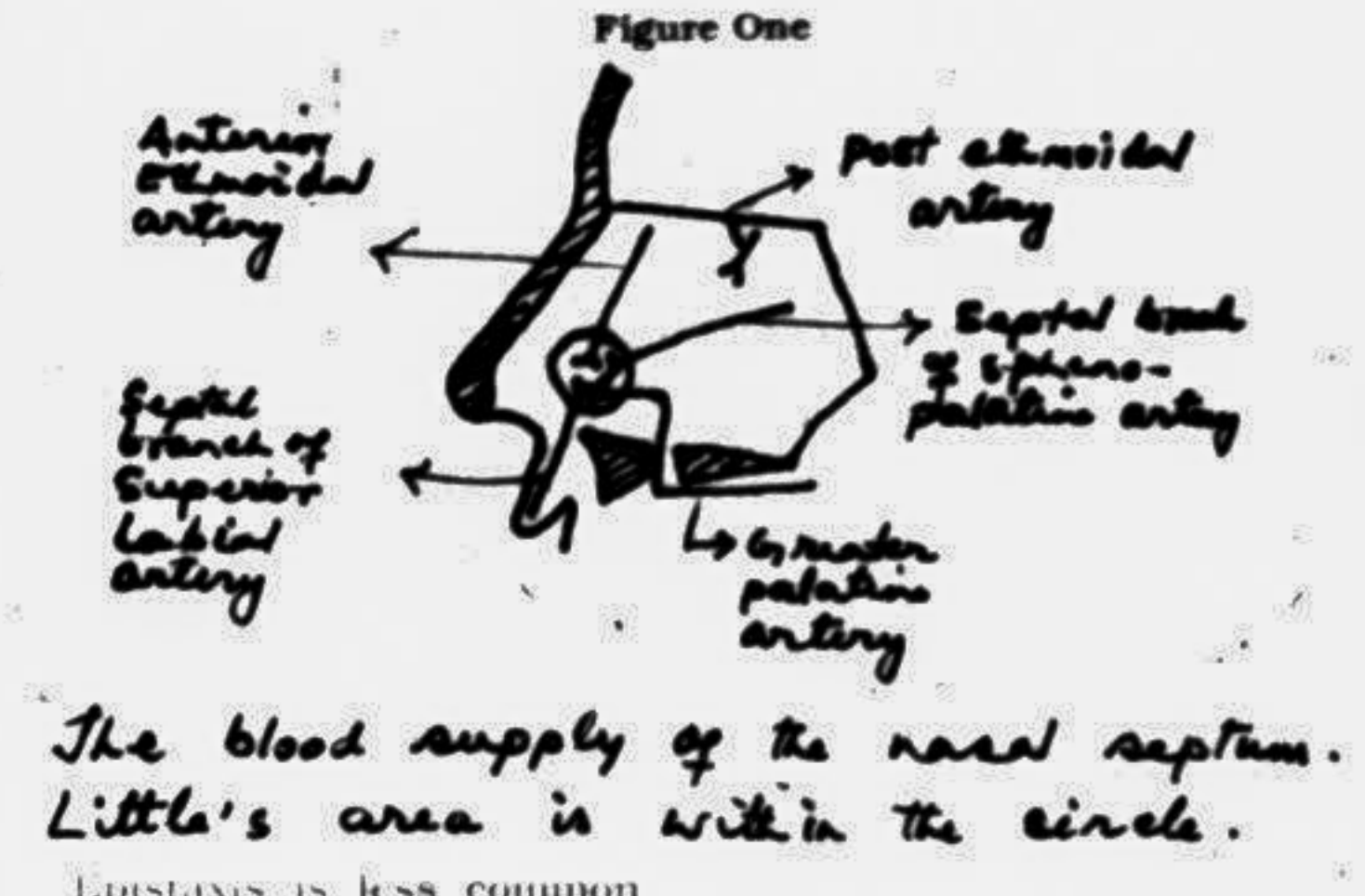
Nose can start bleeding suddenly, but may be preceded by a headache or discomfort in the nose. The bleeding point is usually single and unilateral despite the presence of blood in both nasal cavities. In 80 per cent of cases this is in little's area although in older patient's the point is more likely to be situated high up posteriorly. Blood may then trickle into the throat, be swallowed and subsequently vomited immediately as fresh blood or later on as blood clots. Very minute amounts of

helpful which reflexly constrict the bleeding vessels. Fledglets of cotton wool or 1/2 inch ribbon gauze are soaked in the solution of equal parts lignocaine 4 per cent and adrenaline 1:1000 can be inserted after wrong out. Keeping 5-10 minutes this may be sufficient to stop the bleeding.

4. If possible, the bleeding point should be sealed with cantery. Both electric 'hot wire' and chemical cantery (eg fused silver nitrate on sticks) are equally effective.

5. Anterior nasal packing — not all epistaxis can be controlled by the above method. Even a meticulous search may fail to find the bleeding point, which may be far posterior or hidden. A nasal pack way then be needed. The figure below shows the pack in the nostril.

Figure Two



Epistaxis is less common from the lateral wall of the nose.

### Aetiology

The causes of epistaxis are numerous; it may be classified into two groups — local and general.

Spontaneous bleeding from Little's area is common in children and in youths. Slight trauma and infection often precipitate it. Although it tends to recur, usually easy to stop. In elderly people hypertension is often associated with nasal bleeding although there is usually a local cause also. It is extremely difficult to arrest as it arises far back or high up in the nose and atherosclerosis may impair to constrict the bleeding vessels. It may also recur.

Local Causes of Epistaxis  
Idiopathic or spontaneous from Little's area. Trauma.

bleeding can cause a great deal of anxiety, raising the patient's pulse rate and blood pressure, so deteriorating the condition, even he or she may decompensate quickly and may go into shock rapidly.

### Treatment

**Minor — Moderate Bleeding**  
The first aim is to control the bleeding. This may be achieved by a combination of local pressure, position, packs and or cantery.

**Severe bleeding** : In case of severe bleeding the patient should be resuscitated. It is best to stop the bleeding as quickly as possible. Intravenous drip, blood transfusions, posterior nasal packing, definitive medical treatment or other skilled surgical procedures under general anaesthesia may be required.

The writer is an ENT specialist

# Why Nur Muhammad Refuses to Leave Home Again

Although on paper, Pakistan's health service looks basic but adequate, the reality experienced by millions of people seeking treatment is far different. The overall figures fail to take account of the enormous gap between towns and villages.

**N**ur Muhammad refuses to leave home again. The last time he left home to see a younger brother, he almost got his leg amputated. It was a nasty accident. The van in which he was travelling crashed into a tree on its way to Narowal, some three hours drive from Lahore. Muhammad's right leg was injured. He was transferred to another bus and dropped at the main crossing of Narang, a small town half-way between Lahore and Narowal. He lay helplessly on a cot at the main crossing, bleeding profusely as a dozen villagers looked on. He was spotted by a motorist who asked villagers for the nearest clinic. They directed him to one, but the doctor there, alarmed at the sight of a city fellow, promptly announced he was not the doctor.

A quack practising far from the view of health inspectors, he said the doctor had gone away, despite the villagers' insistence that he was himself the doctor. Narang has a huge government hospital spread over several acres. But when Muhammad was taken there its doors were locked. "Is this the time to come to a hospital? It's closed," the motorist who took him there was told by the paramedics playing cards on the hospital's front lawn. "It could not have been past 3pm at the time," Muhammad recalls. He had to suffer for another half-hour before he was taken to another small town. There, he obtained first aid from a paramedic at a Rural Health Centre. His leg was saved. Pakistan has invested substantial money in the health sector over the last nine years — though far from the amount needed. There is a Rural Health Unit in every second village. But doctors are seldom available at these centres. City doctors posted to rural health centres find it hard to adjust to village life. Poor in-

frasture, lack of good schools for their children and poor incentives add to their disenchantment.

**Qudssia Akhlaque writes from Islamabad**

## The health gap

Population per nurse
Cuba 160
Bangladesh 8,340
Chad 37,030
Developing country average: 3,330

frasture, lack of good schools for their children and poor incentives add to their disenchantment. "Almost every doctor who is transferred from a city centre to a rural one tries his utmost to get transferred back," concedes Suleri, a senior Health Ministry official. This state of affairs renders all health statistics meaningless. While on paper more than eight out of every 10 rural Pakistanis have access to health care, in reality most of the 87 per cent of Pakistanis living in the countryside are without proper facilities. Their only chance of receiving medical aid is from a local quack, who has probably worked somewhere as a dispenser and returned to the vil-

age as a doctor or a semi-qualified hakim (traditional healer). The UN Development Programme's 1994 Human Development Report shows that there is one doctor for every 2,940 people, and 1,720 people for every nurse. But such figures can be grossly misleading. The truth is that more than 95 per cent of facilities are concentrated in urban areas. About 80 per cent of registered doctors practise only in urban centres. In its last Census of Health Facilities, the Planning Commission said that "out of the total number of private hospitals 95.9 per cent are located in urban areas whereas only 4.1 per cent in the rural areas." It is at private hospitals where one gets medical services; state-owned hospitals are more like the one where Muhammad was taken. The study paints a picture of urban-rural imbalance, noting that while there was a doctor for every 6,215 Pakistanis in 1988, the ratio was one doctor for every 1,994 city-dwellers and one for every 46,764 villagers. The study also points out that not a single nurse, except at Maternity and Child Health Centres, was found in the whole of Balochistan, the country's third largest province. While there were teams of government officials to assess and collect land revenue and perform other functions in every district, at least six districts were without a registered medical practitioner. Recognising the dismal state of the health services, the government is tripling expenditure. Targets in the Eight Five Year Plan (1993-98) include recruitment of 33,000 village health workers; a nationwide mother-and-child immunization programme; the raising of life expectancy from 61.5 years to 63.5 years; lowering the infant mortality rate from 8.6 per cent of 6.5 per cent; a re-

duction in the incidence of babies born before the eight month of pregnancy from one-in-four to one-in-seven; and universal access to iodised salt to help prevent problems of the thyroid gland. But plans are not enough. Says development consultant Agha Imran: "The government needs to critically review the national public health system to make the ongoing efforts and future plans more meaningful. It needs to institute some mechanism for monitoring and accountability to check the inefficiency of health personnel and the overall ineffectiveness of the health services, particularly in rural Pakistan, where the government is the main provider." This view is widely shared. "Among other inadequacies in the health system the issue to be addressed most urgently is of unequal spread of services," says researcher Shazreh Husain. "And with quantitative expansion of health facilities, adequate attention must be given for qualitative improvements as well." Similarly, economist M A Mullick warns that "Figures alone cannot deliver. The government needs to do more than just pumping money to improve statistics." — GEMINI NEWS

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# HEART Basic Checkup

by Mahboob Ali, MD

**T**HERE are many forms of heart disease and the common forms are coronary artery disease, hypertension, congenital heart disease, rheumatic heart disease and disease of heart muscle called "Cardiomyopathy". Heart disease can be inherited for example cardiomyopathy (heart muscle disease), or can occur when young, for example hole-in-the-heart or congenital heart disease. In order to make a diagnosis of heart disease, the general practitioner or cardiologist would have to systematically go through the (1) history, (2) physical examination and (3) investigations to come to a provisional diagnosis. Further tests are then undertaken to confirm the diagnosis or evaluate the severity of the heart disease.

**History**  
The patient's presenting complaint is recorded in detail, "chest pain", for example, would have to be analysed in terms of position, severity and subjective description. From a careful history, the origin of the pain may be elicited. A detailed evaluation of the family history and history of past illnesses are also noted. The patient is also asked about the level of physical activity he is capable of.

**Physical Examination**  
The height, weight, blood pressure and pulse rate are routinely taken at the first visit, so as to provide a baseline for future comparison. The doctor makes a visual inspection of the eyes, skin and hands, and also feels the heart for the size and "thrills" which might indicate heart enlargement. In heart disease, leg swelling or abdominal distension are further "clinical signs" which may reflect its severity. The next step is to listen to the heart with the stethoscope. In this way, the doctor

can assess several problems; these include evidence of heart failure, leakage or obstruction of the heart valves, or any suggestion of hole-in-the-heart. He also feels for several pulses and listens to the two in the neck to check that they are not blocked.

**Investigations**  
(i) The 12-lead electrocardiogram (ECG) is very important in assessing heart rate, heart enlargement, and the presence of coronary artery disease. The 12-lead ECG can tell heart chamber size and whether the heart rhythm is regular. This is routinely done at the first visit.  
(ii) A urine analysis is done to exclude the presence of diabetes mellitus, and also to look for protein or "casts" which may suggest kidney involvement.  
(iii) A chest X-ray is also done to look at heart size, exclude some forms of hole-in-the-heart and to look for heart failure.  
(iv) Blood tests for cholesterol, urea (to test kidney function) and electrolytes for example potassium, sodium levels, are all important when evaluating patients for/with hypertension and prior to drug treatment.

More specialised test which can be done at the clinic include the **treadmill stress test**. The treadmill stress test requires the individual to wear the usual ECG chest leads and run the treadmill. His ECG recording is simultaneously displayed and recorded at 3-minute intervals, when the elevation and speed of the treadmill are increased. The treadmill stress test is stopped when the target heart rate is achieved or, if the individual is physically unfit and may not be able to complete the test, no definite conclusion of coronary artery disease can thus be reached. The other re-

striction is that elderly patients with orthopaedic problems like arthritis of the knees, or those with lung disease, are unable to undergo the test.

**Radioisotope tests such as Thallium 201 Perfusion scanning** is often combined with a treadmill exercise test to augment the sensitivity and specificity (or accuracy) of the test. In this method a small injection of a radioactive Th 201 (which is harmless and rapidly excreted) is applied into a vein, and the perfusion of this isotope is scanned with a gamma camera, at peak exercise after resting, to see if there are scarred areas in the heart muscle, or "hypoperfused" regional areas of the heart muscles which are not receiving sufficient blood supply because of narrowing in the coronary arteries. The structure of the heart and its function may further be studied using **real-time ultrasound echocardiogram**. This is particularly important for the evaluation of the state of heart valves (i.e. whether they are normal, obstructed or leaky). By permitting indirect visualisation of the heart, echocardiography can not only measure severity of the obstruction, but also look for intracardiac clots after a heart attack. In individuals who have had a stroke, the echocardiogram can be employed to look for the source of embolism.

These are the basic tests that one can undergo for the basic heart check. The final heart test is the "Holter Monitoring". Here, the individual is strapped to tape-recorder which records the ECG continuously over 24 hours. The rationale for doing this test is to monitor the activity of the patient's heart over his "typical" day. After this time, the recording is played back on to a computer, heart rhythm and ECG complexes are analysed for rhythm problems, or to evaluate the presence of silent or omit coronary artery disease, otherwise known as silent ischaemia.

The gold standard for diagnosing coronary artery narrowing is by cardiac catheterization or coronary angiography.

The writer is Asst Prof NICVD

# Bangladesh made chairman of SAARC TB Centre

Bangladesh has been made chairman of the SAARC TB Centre at a meeting held recently in Kathmandu. Dr A K Md Ahsan Ali, Director of TB and Leprosy Control Services, represented Bangladesh at the meeting, says a press release. Nepal's Minister for Health Padmaratna Tuladhar told the inaugural session of the meeting that TB was one of the major health issues in the region, adding that each year 30 lakh people die of the killer disease in the world. He said that the most painful aspect of the scenario is that one third of the victims of TB are from this region. In combating the killer disease, he emphasised on the coordinated efforts and information exchange among the member states. Dr Ahsan in his speech gave a picture of the scale and magnitude of the scourge of TB and suggested possible measures could be taken in the region to combat it.