about
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INTERVIEW

Dr Uday Gajiwala: 'Treat Each Patient as an Individual Case'

Dr Uday Gajiwala, Trustee and Director (Eye Program), at the helm. Dr Gajiwala, who joined SEWA Rural soon after his postgraduation in 1991 and has been serving the rural poor every since, spoke to WORLD REPORT™ on the need for a standard protocol for surgery, and why it is essential to treat every patient as an individual.

By Mridula Chettri Singh

SEWA Rural, a voluntary development organization engaged in health and development activities in rural tribal areas of Bharuch and Narmada districts of Gujarat for past 28 years, has published the Manual for Eye Operation Theatre, a first-of-its-kind handbook that details scientific data on how to prevent postop infectious outbreaks following cataract surgery. The manual is available in English and Gujarati. A video demonstrating the guidelines is also available in English, Hindi, and Gujarati. A team of six ophthalmologists working with SEWA Rural contributed to the manual.

Q Why prompted you to publish the *Manual for Eye Operation Theatre*?

The manual was born out of the unfortunate episode of cluster infection in our hospital in 2004. Thereafter, we did an intensive literature search to understand the subject, which is neglected during medical education. We realized that most of the people working in this field were ignorant about the subject, and hence we decided to prepare a comprehensive manual. Those who have received it have found it to be very helpful.

Q What does the manual contain?

It contains scientific details about how to work inside the OT and also how to monitor the work being done, targeting all the people working in the OT. A sample of the theatre layout is also given along with the guidelines, which can be modified by users based on their requirements and circumstances. The video demonstrates all the activities explained in the manual.

Q Meticulous surgeons often stress on the need to follow a standard protocol for any kind of surgery. Where does the need for checks arise and where does it end?

Laying down a standard protocol is just the beginning. We need to constantly monitor whether it is being followed. The staff needs to be trained and retrained in the science of asepsis and antisepsis for two reasons: one, we tend to forget few things over a period of time and two, the science keeps advancing every day and we have to learn new things to improve upon what we are doing.

The need for checks arises from the fact that human beings are bound to commit mistakes once in a while and even machines can end up with errors. We need to calibrate our equipment every day for accuracy and in the same way, check the work done by the staff continuously.

The need for a preop check list must have come from, for instance, operating upon wrong eye of a patient or from operating upon a patient without complete preop workup. This is more applicable to settings where different individuals do each work. Having a checklist ensures that preop workup is completed. The ward staff, theatre staff, and finally the operating surgeon upon whom the ultimate responsibility rests should sign on the checklist.

Further, standardization helps to enhance efficiency, improve monitoring, reduce complications, ensure cost-effectiveness and replicability. This improves the overall functioning of the hospital. And yes, the need to check everything starts from the moment the patient enters the clinic.

Q Intraop procedures are what are generally emphasized upon. What kind of importance would you give to preop and postop protocols?

They are equally important. Action taken during the preop and postop period can determine the surgical outcome. Our responsibility starts from the moment the patient enters the clinic and ends when we prescribe the glasses at the end of 6 weeks postop.

Recently in one of the episodes of cluster infection, the government found that the hospital did not perform sac syringing before surgery of one patient who had dacryocystitis and the infection was passed on to more patients. Now, doing sac syringing is not a part of the intraop protocol. But had this not been overlooked, probably the episode could

have been averted.

Similarly, if the patient comes for regular and timely follow up, we can pick up the earliest signs of infection and take steps to treat it. However, if we don't call the patient for follow up or if we don't examine the patient in detail, this may not become possible.

Further, proper counseling of the patient in all the postop precautions and medications in vernacular can not be over emphasized. In spite of repeated instructions being given in our hospital, occasionally patients come back for follow up on 4th day with the bandage still in position. We can't blame the poor, illiterate, rural community for this. We have to find ways to make sure that this does not happen. This is another reason why we need to be more vigilant and put checks at all possible levels to make sure that the work that we do is of the highest quality.

Q Is there any particular step in the protocol that ophthalmic staff often misses out on?

We can't pinpoint any one or two particular steps. The point is, this information is completely disregarded by ophthalmologists, paramedics, and administrators. We learn about infection control only by observing our seniors. There is an urgent need to start teaching infection control as a separate subject during undergraduate and postgraduate levels.

Still if we have to suggest one thing, the first and foremost reason leading to postop infection seems to be inadvertent touch—ophthalmic staff or part of their loose attire touching the trolley, phaco machine, or inside of the drum, or any part of the unsterile area. If we can take care of this by developing a correct mindset and observing strict discipline, chances of mishap can be reduced substantially.

Q What is the key to eliminating any risk of an outbreak?

To prevent cluster infection, we can just make one rule and follow: Treat each patient as an individual case. Don't use anything for more than one patient. Everything fresh should come in for every patient, whether is the instrument set, irrigating solution, viscoelastic, trolley preparation, or needle for administering a block.

Q Is it necessary to bring about accountability to avoid infection outbreaks?

Accountability is very much required because we tend to pass the buck on to someone else. Whenever a mishap occurs, we must introspect. Mishaps do not occur in spite of the best efforts, they occur because of a lapse in a protocol. So the first thing we need to do is to accept responsibility, introspect, come up with a standardized protocol, follow the same rigorously, only then will the number of cluster infections occurring across the country will go down.

Q Teaching standards vary vastly between various medical schools. Comment.

I fully agree. I had done only 30 cataract surgeries by the time I finished my residency. I had my certificate but I wasn't confident enough to perform a surgery independently. The scenario is worse in many parts of the country. There is an urgent need to improve training standards in medical colleges. Several papers have been published to this effect in recent times. One can refer to *Medical Education Revisited* from Medico Friends Circle to get a better insight into the problem. Our respected teacher, the late Dr R.N. Mathur, used to say, "We become good cataract surgeons but we remain far from becoming good ophthalmologists". He was so right. WR

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about SEWA Rural

Ophthalmic services is one of the many projects SEWA Rural runs in rural areas of Gujarat. The eye department, operated from its base hospital—Kasturba Hospital—provides services to over 2 million people. There are six ophthalmologists who see 50,000 OPD patients and conduct 6,000 eye surgeries annually. Approximately 125 diagnostic eye camps are conducted every year.

The organization's focus has been on community ophthalmology since its inception. "We need to strengthen primary health care, which includes eye care," says Dr Gajiwala. "This is the need of the hour as 80% of ophthalmologists practice in urban areas while 70% of the population lives in rural areas." SEWA Rural is also involved in the training of paramedic staff, including those from other organizations.