CORRESPONDENCE

It's time to rewrite our medical textbooks

The medical curriculum in India is designed to give comprehensive knowledge of health care delivery with an emphasis on public health. Textbooks form the backbone of its courses and exams at the end of the course are the mode of testing the knowledge acquired.

Until a few years ago, only a few Indian authors wrote and published medical textbooks. Now, numerous books on any subject by Indian authors are available. While this in itself is a welcome change, the quality of the textbooks is questionable. The commercial interests of the publisher and author seem to have overtaken academic rigor. The content is diluted to churn out "preparatory manuals", "notes" and "… made easy", all aimed at the survival of the student in exams. Solved university exam papers have also entered the market in medical subjects. Such dubious textbooks could hit at the very roots of medical education in India.

Only clearing exams—which have been reduced to a mere recalling of information-- with the help of such textbooks will equip the student with a degree but not with a scientific temper or the ability to conduct research. Adding to the problem is the vastness of medical subjects and the difficulty many students experience in comprehending the language used in western medical literature.

To address this issue, medical colleges in India could regulate the publication of textbooks and encourage publication from professional bodies like the Association of Physicians of India, and others. Chapters written by specialists would be much more instructive than single-author books. The prescriptive nature of the syllabus, which recommends certain textbooks, must also change. This would lead to better and more uniform standards being applied to medical education in India, and would enable the dissemination of medical knowledge appropriate to the Indian context.

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Creating panic during disasters

From August 7 to 10, 2006, Surat faced an unprecedented flood. Armed with previous experience, the state authorities rushed rescue teams to the city on August 7 itself, though many of them could enter the city only after the flood waters receded. When compared with disasters in the past, the response was rapid. Over a thousand health personnel were deployed in these teams, which had a mix of medical college faculty and senior state and district health care personnel. The teams reported on various aspects of active and passive disease surveillance, solid waste disposal, slush removal, water logging, vector breeding, chlorination and safe water supply, animal carcasses removal, safe housing, etc. in addition to providing health care.

Meanwhile, numerous media reports predicted impending epidemics and newspapers carried incorrect reports of the causes and number of deaths. For example, on September 2, there were reports of the death of an 18-year-old due to unknown causes (1,2), when in reality this youth was suffering from active tuberculosis and had defaulted on his treatment of AKT category II (DOTS) therapy. Other incorrect reports spoke of plague and hantavirus cases and incorrectly reported deaths from leptospirosis. In some reports, people who were still alive were declared dead.

Such alarmist coverage creates undue panic and distorts the community's perception of the risk of diseases. This kind of reportage negates planned behaviour theories such as the health belief model, communication/ persuasion model, theory of reasoned action, trantheoretical models or the precede/ proceed model, and makes it difficult for safer behaviours to be adopted by the community (3). Medical professionals must encourage the media to be more ethical in their reporting of such events.

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The limits of choice

Human beings seem to value choice -- a house of one's own choice, chosen friends, clothes of one's choice, and so on. Many people, fed on choices, believe they should also be allowed to choose the sex of their child. In the past, this was done by killing the newborn baby girl. While this practice continues, technology now helps people to choose the sex of their child with prenatal diagnostic techniques. And many people choose to abort the foetus if it is female. Despite laws against such practices, they are on the increase. Other than the acute psychological trauma caused to the mother when a decision to abort is forced upon her, the worsening the sex ratio in India (927:1000 in 2001) will have disastrous consequences.

It is important to create greater awareness about the dangers of prenatal sex determination and sex selective abortion. The media, women's organisations, medical professionals, all of us must come together to stop this genocide. All registered medical practitioners must strictly follow the code of ethics

that on no account will they do a sex determination test with the intent to terminate the life of a female foetus. The law must be strictly applied in cases of sex selective abortions and doctors who participate in the crime should be de-registered.

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Creating comprehensive ethics

Efforts to improve research ethics may not succeed in the absence of ethics in clinical care. This is especially true in developing countries, where it is difficult to access routine health care. The gap between ethics in research and in clinical care may result in the poor implementation of ethical guidelines in clinical research. This could upset the efforts of international and national agencies to regulate clinical research in developing counties, and it is reflected in the difficulties often encountered by ethics committees to review research proposals in developing countries (1,2).

Research has become an attractive proposition in developing countries, both for local investigators and global funding agencies. This has brought about some efforts to improve the review of research ethics using international guidelines. One reason for these growing efforts is that the data generated by multinationals has to be submitted to the Food and Drugs Administration in the United States or other regulatory agencies responsible for granting permission to market drugs. These regulatory agencies in the developed world must adhere to the International Conference on Harmonisation Good Clinical Practice standards, which involves an initial approval by an ethics committee. But such committees in developing countries have to function in difficult circumstances and multiple forces often make their independence questionable (3).

Researchers also find it difficult to resolve the conflicts arising out of ethical requirements in clinical research and the demands of routine health care. The same clinical investigators provide clinical care and recruit patients in clinical trials. They often find it difficult to balance the two roles. Research can be strengthened by creating greater awareness amongst researchers about the ethical principles applicable to clinical as well as research settings. It is necessary to develop clinical ethics simultaneously with research ethics if we want to put in place appropriate ethics reviews of research proposals.

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The World Social Forum statement on the Global Polio Eradication Initiative

The Second World Social Forum on Health, January 20-25, 2007, condemns the World Health Organisation's lack of transparency in acknowledging the failure of the Global Polio Eradication Initiative strategy and instead

- identifying a few low-income countries as scapegoats;
- subjecting the children of these countries to an unprecedentedly high number of Oral Polio Vaccine (OPV) through the pulse polio rounds with no concern for its negative impact, and
- using monovalent OPV, an untested vaccine, without informed consent.

While the WSF on Health acknowledges the place of OPV in the overall immunisation programme as part of integrated public health services, the strategy of intensive pulse polio rounds has had a detrimental fragmenting effect on the already weak public health systems in low-income countries.

We demand an independent review of the Global Polio Eradication strategy with due consideration to the relevant epidemiology and different countries' health care priorities.

Medico Friend Circle (India)
Jan Swasthya Abhiyan (India)
People's Health Movement and
World Social Forum on Health

January 24, 2007
Nairobi, Kenya