LETTERS

Staggering apathy to injustice

I enjoyed reading the editorial by Nagral (1) on the Ketan Desai/Medical Council of India issue, but regard it as yet another expose of the general and overall apathy to injustice and procedural irregularity among our Indian population, be it medical or general, and this is both staggering and depressing.

India faces Ketan Desais at every corner, not just in the medical sector, but in every walk of life; the only way forward seems to me to be for the government to wake up and lay down the rules very strictly. Should it do so, I expect the largely law-abiding population (at least 75%, although the figure will ever remain debatable) will fall in line. There is then the scope for governmental agencies to use their resources to target those who don't play the game by the rules. They can use deterrents to enforce discipline and a civil code. This is how western societies have survived and flourished and we need to borrow the good in their systems, rather than adopt some cultural disorders.

India can best be summed up by the observance of road rules - no courtesy, no rules, no give! However, strict fines and deterrents work. Look what happened to the laws banning the use of mobile phones and requiring the use of a seat belt, both of which are being largely adhered to after a stringent system of fines.

Given the scenario of an unruly free-for-all system, private medical colleges are a major problem. It is perhaps incorrect to blame the private medical system alone, as the problem lies in the failure to set norms and enforce them. If training processes were standardised and supervised, some standard could be achieved, of that I am certain. Certainly the majority of students entering these institutions must do so on merit. I have heard of a son of a famous industrialist winning a place in Harvard Business School on the basis of his pedigree, rather than his academic performance, but that cannot be said of the majority. If the entry system is good, then the system is bound to improve.

Private systems can have checks and balances, and be sensitive to the needs of the population, provided there is law and order. Currently, those who follow the law do so because of their own conscience, not because civil law requires them to.

I cannot but recall the appalling standards in public hospitals during my student days, where untrained students and trainees ran riot, unsupervised by accomplished professionals. There were notable exceptions then, and things have changed somewhat for the better in terms of infrastructure, but we are still far away from providing standard medical care to the public. Opinion leaders in medicine often remark that private hospitals running accredited training courses do not provide enough operating opportunities for surgical trainees, whereas public hospitals provide these opportunities. Does that mean that patients in public hospitals can receive substandard care because they may be operated on by unskilled personnel? I think revision of the training programme for both undergraduate and postgraduate education is required, and this can be achieved only if medical students are allowed to apprentice during their student years in the wards and the procedure rooms, where they watch and learn, and, when it is their turn to perform, are better able do so in a manner that will ensure the patient's wellbeing, rather than harm it.

The last paragraph makes two interesting observations. It suggests that India is too far gone on the road to perdition, and revolutionary change is required to bring things on track. And the reference to perdition brings to me a sense of despair. Is God the only solution for this country?

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Ethics and law

In the April- June issue of the Journal, you have started a new column entitled as ethics and law. This is a good development. Our readers need to know the different laws that govern health care in our country. The article has achieved that objective. The article does not mention anything about Ethics.

I have been speaking about medical ethics for the last 10- 15 years in various medical fora in the country. Whenever an ethical issue is raised, the practitioner asks for the law that supports the ethical position. If I deliver a talk on consent for HIV testing, invariably somebody will enquire about a law that requires consent before testing.

I feel that the column should be described only as "law" and not as "law and ethics". Moreover it is presumed that a journal of ethics will take care of ethical issues and a special column on law will suffice. After all, as the law minister has noted, law is the minimum of morality. Hence, I request you to remove the word "ethics" from the column and call it "Law".

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Deceptive perpetrators under cover: are they on the rise

The pursuit of academic advancement in the field of medicine entails trudging through the rough terrain of medical journals. The current standard set by the Medical Council of India regarding departmental promotion in medical institutions has made publication mandatory. The need to "publish or perish" has driven academicians into a rat race where fraudulent behaviour for personal gain has reached its nadir (1). It must be accepted that many clinicians and researchers, however competent and distinguished they are in their profession, lack literary or journalistic skills. However, the current academic standards make publication mandatory for academic elevation. As a result, more and more medical professionals in academics are lured into abusive co-authorship and publication parasitism in the race to optimise "industrial standards" (2). This grey area is ventured into by the so-called "white bull" who is busy reaping the fruits of such scientific dishonesty (3). [3]

The "white bull", adopted from Greek mythology, refers to authors who wilfully, but stealthily, enter into fraud and scientific dishonesty (3). They are mainly unscrupulous senior collaborators holding departmental positions, and have a distinct behavioural pattern. Their objective is to attain fame and monetary gain while providing minimal or no logistic support towards an article.

This was evidenced by the issue of multiple authorship, which has risen dramatically over the years (from 4.5 in 1980, 6.9 in 2000, to over 15 in 2007), even in high impact journals, leave alone the many low profile journals (4). The incidence of multiple authorship is reported to be 80% for clinical research, 59% for life science research, and 4% for hard medicine like physics and chemistry (4).

Adding spice to the current thriving practice of "authorised deception" is the payment that some journals require for publication (5). This has given journal representatives an avenue into the trade. Substandard articles gain easy access to publication, with the white bull playing the lead role of seducing editorial staff and even reviewers. Junior researchers are at the receiving end of such nepotism. Though they may be major contributors to an article, they are forced to enter into unfair deals. Any thought of "whistle blowing" is buried under the fear of retaliation, career sanctions and thus an early end to future research ambitions (3).

Research misconduct includes deliberately providing incomplete or improperly processed data, failure to follow ethical procedures, failure to obtain informed consent, breach of patient confidentiality, improper award or denial of authorship, failure to declare competing interests, duplicate submission and plagiarism. These abuses led to the laying down of various guidelines (including those of the International Committee of Medical Journal Editors and the Council of Science Editors) (5). With such guidelines and the availability of improved anti-plagiarism software, we can presume that a substantial amount of scientific fraud has been arrested. But at the same time, the perpetrators have mutated into the form of the "white bull", which seems to be the latest invasión into the world of scientific publication. This new form of "medical deception" needs an urgent reconsideration of existing rules on a global scale, across all faculties of medicine.

All ethical researchers should have the courage to stand up and perform the role of whistle blower whenever such a situation is encountered. Regulatory bodies should ensure protection for the whistle blower, to maintain the sanctity of scientific medical research.

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Postgraduate surgical training in India

Postgraduate surgical training is supposed to be one of the toughest stages of training in medicine. While there is no doubt that surgical trainees in India get good experience in open surgery during their tenure, consultant surgeons are reluctant to train surgical postgraduate students in laparoscopic surgery.

Medical training in India commences with the MBBS of five and a half years, inclusive of a year of internship. Thereafter, candidates who clear an entrance exam can enter a three-year postgraduate training programme.

During the first year, most of the surgical trainee's time will be taken up in attending to ward patients, writing clinical notes and doing other paperwork. During the second year of training, s/he may get hands-on surgical practice, often in emergency operation theatres under supervision of a third-year trainee or senior resident doctor. In routine operations, senior and junior consultants hardly ever allow trainees to do basic laparoscopic surgeries like cholecystectomies, appendicectomies, diagnostic laparoscopies, etc., other than holding the camera port for the consultants during these procedures. None of the government medical colleges in India has a laparoscopic set-up for emergency theatres. So the surgical candidate will not do any laparoscopic surgeries even during emergencies. Third year trainees will get limited opportunities. Overall, three valuable years of training are completed without any significant, hands-on laparoscopic training.

It does not end here. After post graduation, there is a three-year posting as senior residents (SR). SRs operate independently in emergency theatres, assisting and performing all open surgeries in routine theatres. But here again, they hardly get to perform laparoscopic surgery independently, as the bulk of these surgeries are performed by consultants. For the sake of training, they will get a few laparoscopic cholecystectomies in the final days of their senior residency. So, after six years of training, surgeons are sent out into this modern era of laparoscopic surgery without proper exposure to laparoscopic techniques. There is no fixed curriculum that stipulates a minimum number of laparoscopic procedures be assigned to candidates during their postgraduate studies or senior residency.

Why are consultants so apathetic towards their students? The answer, obvious to most trainees, is that the consultants themselves learned laparoscopy after the age of 40, so they do not want trainees to master it at a young age. Indeed, younger consultants are keener to train students in laparoscopic procedures than their older counterparts are. The introduction of just a few laparoscopic procedures in the last six months of their training will not let trainees become expert in any of the procedures.

As trainees in general surgery, we wish to ask our consultants: If we do not get hands-on experience in laparoscopic technology during postgraduate studies and senior residency, who will give us guided training once we graduate?

The answer is: no one. There are few laparoscopic training centres in India giving hands-on experience to beginners. These are generally in private hospitals, and they are very costly. A few surgeons try to learn the procedures on their own in some small hospitals. Some lucky chaps get training outside the country.

The surgical curriculum must state the year-wise goal of a surgical trainee, including the number of laparoscopic and open surgical procedures which the candidate must perform and assist in before completing postgraduate studies and during senior residency. There should be a performance evaluation before the trainee can be promoted to the next year. Surgical trainees should not get a senior residency merely on the basis of interviews; they should also have references from their tutors on their performance.

Compared to European or US surgical trainees, Indian candidates perform negligible numbers of laparoscopic surgeries. The new world is getting trained on simulators, which we can only dream of, in a third world country like ours. Yet, with the variety of cases available, we can get adequate exposure if we are given the opportunity.

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Wearing white coats in public places: pride or parody?

It has become increasingly common to spot doctors sporting white coats and stethoscopes at shopping malls, restaurants, grocery shops, on roads, in buses and other public places. This has become a trend, especially among medical students and junior doctors, with little insight regarding its implications. Doctors may do this because they take pride in identifying themselves as medical professionals, for convenience, or because of laziness.

Medical aprons can serve as vehicles transmitting nosocomial organisms into the community and vice versa. Numerous studies done on white coats have proven this. One such study from southern India revealed that 95% of overcoats were found positive for bacterial isolates like *Pseudomonas aeruginosa, Klebsiella sp, Escherichia coli,* non-fermenting Gram-negative bacteria and *Staphylococcus aures* (1).Wearing aprons in public places can only make things worse.

The bond between white coats and the medical profession dates back to the early 1930s. It portrays the image of a doctor in the hospital. Doctors wear white coats so that they are easily recognised by their patients and colleagues; to display cleanliness; to carry equipment and to emphasise the "doctor status" (2). Many surveys have found that patients prefer doctors with aprons (3). At the same time, the general public has always been critical of the practice that some medical professionals have of wearing aprons outside the hospital premises (4).

Although wearing white coats in public is not a crime, as there are no precise rules or regulatory guidelines regarding this issue, we feel it is completely unethical (5). The onus is upon the individual doctor or student to understand the legacy and dignity of these white coats and to decide how they want to project it. This issue should also be addressed while teaching medical ethics to undergraduate students.

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The human cadaver: the silent teacher of human anatomy

At the medical school where one of us was teaching, a first year medical student came running out of the anatomy class, saying that he could not bear to see a dead body. The smell of formalin and the cadaver disturbed him. He felt that he had joined the medical field to see life, not a dead human body. It was a genuine reaction for a student to have on seeing a cadaver for the first time, in the grim environment of an anatomy department.

From the days when there were many cadavers to dissect, to a time of scarcity, anatomy dissection has traveled a long way. Real dissection is being replaced by virtual e-learning with computer-simulated models in the teaching of gross anatomy. Yet, it is very important that students learn from actual dissection. In an atmosphere where the living are ill treated, it becomes a challenge to teach a reverence for life (1) in the anatomy dissection hall - to make the medical student treat the cadaver with care and respect. St John's Medical College, Bangalore, makes this point when students start their anatomy dissection classes with a prayer thanking the Almighty for giving them a body to learn from.

During the learning of human anatomy, an invisible relationship develops between the student and the cadaver. Michelle Paff, a medical student in the US, has described the process by which she learned to respect the cadaver given for dissection. She writes: "the more I looked at her, the more I realized she used to be a real living person." As she observed the formalin-embalmed body, she created in her imagination the unique identity of a person who made a special gift so that others could learn (2).

At a university in Taiwan, students are informed of the identity of the cadavers they are going to dissect - as well as the identities of the family members of the person whose cadaver it is. The students visit the family members to thank them, as well as to pay their respects, along with the family members, to the cadaver which allowed them to learn anatomy (3).

According to Ibn Rushd, "He, who is engaged in the science of anatomy, increases his belief in God." (4) However, the anatomical study of the human body has sometimes been problematic because it requires dissection. A number of scholars - religious scholars in particular - seem to be opposed to the practice, since it implies mutilation of God's most noble creation. The utilisation of the human body and organs are supposed to be points of constant debate in Islam (5). Other religions, including Christianity, have their own sociocultural obligations and limitations with the main aim of upholding human dignity and the sanctity of human life. But whatever may be the geo-political-socio-cultural differences, there is a definite bond between the medical student and the cadaver. The sensitivity of Michelle Paff makes us understand what a wonderful gesture a human makes by donating a body for dissection and learning. It informs us also that a compassionate heart, a creative mind and skilled hands are as important as academic and clinical skills for a physician to handle life with care and dignity.

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Correction

In the Clinical Trials Watch factsheet published in the Apr-Jun 2010 issue of *IJME*, two rows of one part of the table were omitted in the final printed page. The part of the table affected is as follows:

Sponsor Ownership					
Public		15	17	24	25
Private	4	29	57	143	259
Non-profit		2	6	16	8
Public, private		2		2	10
Non-profit, public				1	
Non-profit, private			3	1	2
Individual investigator		3	4	9	6
Individual investigator, public		1	2		1
Individual investigator, non-profit		1	1	1	
Sponsor ownership not known		1	10	14	9