LETTERS

Media portrayal of health professionals biased?

Over the last few years, the media have been repeatedly focusing on corruption in healthcare. Sometimes, speakers on television channels fling allegations at the entire medical community. This biased picture of pervasive corruption is resented by a majority of doctors.

Doctors have been charged with prescribing unnecessary and costly medicines instead of generic medicines. While there is a lot of difference between manufacturing cost and actual price of medicines, how can doctors be held responsible for deciding the price of a drug? It is the government that has to regulate the prices of essential medicines in association with pharmaceutical companies, not doctors.

In an alleged case of malpractice discussed in an episode of a popular television show, Mr R has accused doctors of a corporate hospital of mismanaging a case of cadaver transplant of the liver and pancreas of his wife (1, 2). A nephrologist at that hospital contradicted this saying that Mr. R had withheld crucial information which may have made viewers believe his version. He mentions that Mr R had withheld the fact that the state Medical Council had thoroughly investigated the case and found no evidence of negligence by doctors. The nephrologist has also mentioned that: "The patient and her family were all informed about the risks and benefits of transplantation, more than a year prior to the surgery and informed consent was taken. The patient had developed a massive bleeding condition called Disseminated Intravascular Coagulation (DIC). She received platelets and other blood products to correct the DIC. The surgeon was fully qualified to conduct pancreatic transplantation as well as kidney transplantation and had conducted numerous multi-organ transplantation surgeries. The hospital was also registered for multi-organ transplantation."(2). Television channels and other mass media should confirm the authenticity of information before telecasting it to the world.

The numbers of doctors' licences cancelled in some developed countries and in India have been compared time and again by the media; but no comparison is made of the number of physical attacks on doctors while on duty in India and elsewhere, or of the number of people convicted of such offences; or of stipends, working conditions, duty hours, or accommodation provided to medical students and doctors. Even basic infrastructure and facilities like clean drinking water, subsidised canteens, separate toilets for women, are not provided in Indian government hospitals (2). The media preaches that brilliant students who take up medicine should consider it only as service to mankind; they should go to other fields if they want to live a good life. Why impose the burden of charity and social service only on medical professionals? It takes almost thirteen years for a doctor to reach specialist status, with a compulsory year of government service after graduation. In fact, doctors are the worst paid professionals for the hard work and dedication they put in. Why are only doctors being forced to work in rural and government hospitals after completing their education? The rural sector surely needs the help of other qualified professionals as well. Why aren't they compelled to do public service after graduation, or prevented from going abroad for better facilities as doctors are? In spite of all the hardships, even today, the medical profession has a fairly large number of selfless and sensitive professionals (3).

The media should present a balanced picture of the profession and exert pressure on the authorities to act against corrupt health professionals. If the media continue to mention only the darker side of profession, it will hurt the country's healthcare system - the public will lose faith in doctors and a large number of students who aspire to be doctors will be dissuaded from doing so.

Anupama Sukhlecha, *Department of Pharmacology, M P Shah Medical College, Jamnagar, Gujarat, 361 008 INDIA. e-mail: anupama_acad@yahoo.co.in*

References

1. Sreedhara R. A letter from Dr R Sreedhara to Aamir Khan [Internet]. *Aalatimes.com;* 2012 Jun 07[cited 2013 Mar 31]. Available from: http://www.aalatimes.com/2012/06/07/a-letter-from-dr-r-sreedhara-to-aamir-khan/ [
2. Joshi SK. Doctor, heal thyself [Internet]. Aalatimes.com. 2012 Jun 01[cited 2013 Mar 31]. Available from: http://www.aalatimes.com/2012/06/01/doctor-heal-thyself/
3. Public Health Foundation of India, National Health Systems Resource Centre, State Health Systems Resource Centre. Why some doctors serve in rural areas: a qualitative assessment from Chhattisgarh state [Internet]. New Delhi: PHFI, NHSRC, SHSRC-Chattisgarh. 2010 Apr[cited 2013 Mar 31]. Available at: http://health.cg.gov.in/ehealth/studyreports/Why%20Some%20Doctors%20Serve%20in%20Rural%20Areas.pdf

Corruption in health systems: view from Peru

Corruption is defined as the misuse or betrayal of public trust, in order to achieve a personal or private goal, instead of seeking the best for the community or country (1, 2). This is a serious problem for health systems in many places (3). It could lead to a waste of resources, and, even worse, to utterly negative health outcomes (1, 3, 4).

I would like to point out some similarities regarding corruption in healthcare, between India and Peru, two middle-income countries in different continents. According to Transparency International, India and Peru have a Corruption Perception Index of 3.1 and 3.4, respectively (http://www.transparency.org/country). This same entity provides the Global Corruption Barometer, in which statistics show that 85% of surveyed Peruvians assess as "ineffective" the current government´s actions in the fight against corruption; whereas in India, this opinion is held by 44% of surveyed Indians. In both countries, many cases of corruption are due to overcharging for supplies, infrastructure and new equipment, and to favours that benefit only a few.

Statistics from the Global Corruption Barometer (http://gcb.transparency.org/gcb201011/) indicate that in India, 21% of people have come into contact with medical services, and 26% of them have paid a bribe in this kind of institution in the last twelve months; on the other hand, for Peru it is reported that 72% of people have come into contact with medical services, and of them only 4% have paid a bribe, These differences are perhaps a clear indication that, where there is more corruption, less people may have the willingness to go to a health facility. However, this hypothesis should be further explored in different contexts, in order to arrive to a solid conclusion.

Corruption is a global problem, and definitely affects a population's ´s health (3), no matter where. Therefore, it should be included as a research topic worldwide, and among global health researchers, in order to fully understand the relationship between corruption and health, and its determinants (4).

The key is to develop strong programmes and strategies created to address the characteristics of corruption in a country, and that will prevent problems within the health care system, in matters of access, inequity and outcomes (1, 2). These anti-corruption strategies should be based on theory, developed according to the evidence and adapted to suit the specific contexts where they are to be applied (1).

***Rodrigo M Carrillo-Larco**, Alberto Hurtado School of Medicine, Universidad Peruana Cayetano Heredia, Lima, PERU*. E-mail: rodrigo.carrillo@upch.pe

References

1. Vian T. Review of corruption in the health sector: theory, methods and interventions. *Health Policy Plan*. 2008 Mar;23(2):83–94.
2. Huss R, Green A, Sudarshan H, Karpagam S, Ramani K, Tomson G, Gerein N. Good governance and corruption in the health sector: lessons from the Karnataka experience. *Health Policy Plan*. 2011 Nov;26(6):471–84.
3. Nishtar S. Corruption in health systems. *Lancet*. 2010 Sep;376(9744):874.
4. Hanf M, Van-Melle A, Fraisse F, Roger A, Carme B, Nacher M. Corruption kills: estimating the global impact of corruption on children deaths. *PLoS ONE*. 2011;6(11):e26990.

Void in the sphere of wisdom: a distorted picture of homosexuality in medical textbooks

Homosexuality is not a new issue in western medical literature; but an empathetic approach to it in the medical literature in India is a recent phenomenon (1, 2, 3). Equality in providing healthcare is not being practised, as evidenced by homophobia among doctors (4,5), more so in the Indian sub-continent where religious and social biases contribute to denying proper healthcare to the homosexual - as well as the lesbian, bisexual and transgender - community. The attitudes of young medical students are more amenable to change, and can be better oriented towards providing equitable healthcare, irrespective of the sexual orientation of patients (6). Here the question arises: "What does our curriculum teach about sexuality issues?"

We highlight the misleading information given in the textbooks widely followed by the students of the West Bengal University of Health Sciences. The most affected subjects are physiology, psychiatry and forensic medicine. According to the physiology textbook, in puberty "there develops attraction to opposite sex." (8). This clearly promotes heterosexuality as the only norm. Some forensic science textbooks state that homosexuality is an "offence", homosexuals "may be psychologically imbalanced", and they are "egoists", who "disregard society" and pose a "social, moral and psychological problem". (9) The term "crime of homosexuality" has been used (9) and "treatment of homosexuality" has been suggested (9). Some books say "AIDS infection is commonly transmitted by unnatural sex acts with the homosexuals" (9) and call sodomy "a sexual offence" which is most popular and widely practised among homosexuals (10). This portrays same sex behaviour as an inferior form of sexuality. In spite of a long debate on the controversial term 'gay bowel syndrome' as it indicates a link between homosexual activity and gastro-intestinal disease, it is still referred to in a standard microbiology textbook (11). A widely followed textbook of psychiatry uses terms like "cross-gender homosexuality" and "ego-dystonic homosexuality" (12).

We suggest substantial revision in the undergraduate medical syllabus and textbooks as these are the main sources of knowledge for doctors. If distorted information is provided from the start of their medical education, any seminars or discussions will be in vain. An unbiased discussion of concepts like sexual behaviour, orientation, identity, sex and gender are much needed. Specific diseases which affect homosexuals must be highlighted rather than providing the "treatment guidelines of homosexuality" (3). Policy makers, educationalists, authors and thoughtful readers must come forward to fill this void in the sphere of wisdom and forge a better patient-doctor relationship.

***Subhankar Chatterjee,** Fifth Semester Student, MBBS, R.G.Kar Medical College & Hospital, Kolkata, INDIA, e-mail: chatterjeeaspiresubhankar.92@gmail.com **Subhasish Ghosh**, Fifth Semester Student, MBBS, Medical College, Kolkata INDIA*

References

1. Rao TS, Jacob KS. Homosexuality and India. *Indian J Psychiatry*. 2012 Jan; 54(1):1-3.
2. Kalra G. Breaking the Ice: IJP on homosexuality. *Indian J Psychiatry*. 2012 Jul; 54(3):299-300.
3. Patel VV, Mayer KH, Makadon HJ. Men who have sex with men in India: A diverse population in need of medical attention. *Indian J Med Res*. 2012 Oct; 136(4): 563-70.
4. Geddes VA. Lesbian expectations and experiences with family doctors.

How much does the physician's sex matter to lesbians? *Can Fam Physician*.1994 May;40:908-20.
5. Harrison AE, Silenzio VM. Comprehensive care of lesbian and gay patients and families. *Prim Care*.1996 Mar;23(1):31-46.
6. Kalra G. Pathologising alternate sexuality: shifting psychiatric practices and a need for ethical norms and reforms. *Indian J Med Ethics*. 2012 Oct-Dec;9(4):291.
7. Dunji-Kosti B, Pantovi M, Vukovi V, Randjelovi D, Toti-Poznanovi S, Damjanovi A, Jašovi-Gaši M, Ivkovi M. Knowledge: a possible tool in shaping medical professionals' attitudes towards homosexuality. Psychiatr Danub. 2012 Jun; 24(2):143-51.
8. Mahapatra AB. Reproductive System. In: Essentials of Medical Physiology. 3rd edition. Kolkata: Current Books International; 2007. p. 363-84.
9. Mukherjee JB. Medicolegal aspects of sex and sex related offence. In: Karmakar RN, editor. Forensic Medicine & Toxicology. 4th edition. Kolkata: Academic Publishers; 2011. p. 567-695.
10. Nandy A. Sexual offences and sex perversions. In: Principles of Forensic Medicine including Toxicology.3rd edition. Kolkata: New Central Book Agency (P) Ltd; 2010. p. 687-720.
11. Ananthanarayanan R, Panicker CKJ. Enterobacteriaceae II: Shigella. In: Textbook of Microbiology. 8th edition. Hyderabad: University Press;2009.p.283-87.
12. Ahuja N. Sexual disorders. In: A short textbook of psychiatry. 6th edition. New Delhi: Jaypee Brothers Medical Publishers (P) Ltd;2006. p.132-6.
13. Ranade K. Medical response to male same-sex sexuality in Western India: An exploration of 'conversion treatments' for homosexuality[Internet]. Health and Population Innovation Fellowship Programme Working Paper, No. 8. New Delhi: Population Council; 2009[cited 2013 Apr 11]. Available from: http://www.popcouncil.org/pdfs/wp/India_HPIF/008.pdf

Looking away does not make things vanish

We wish to comment on the report by Al Faisal and colleagues published in *The Indian Journal of Medical Ethics* (1). In that report, the authors claim that economic sanctions imposed in 2011 were the reason behind the devaluation of the local currency, interruption of power supply, scarcity of medical supplies, and degradation of sanitation systems. Nowhere to be found in the report, however, is a description, albeit brief, of what those sanctions are and how they led to these effects. No evidence of cause and effect was presented, no suggested mechanisms, and most grave, no consideration for the interplay between sanctions and an all-out civil war situation that interrupted every sphere of economic activity in the country (2). Such biased and unscientific analysis flies moreover in the face of known facts about the Syrian economy. The political and economic isolation of the Syrian regime is not new, but has allowed Syria, in the past, to ward off most of the global economic crisis of 2008, and will certainly make it more resilient to economic sanctions *per se* (3). What is most disturbing in a report about the wellbeing of Syrians in the current conflict still is the lack of any reference to the role of the Syrian regime in inflicting death and hardship on its population. This role has been documented repeatedly by UN agencies, credible media outlets, and the international community, and was behind the mostly regime-targeting sanctions to begin with (2,4,5).

Syria marks a unique case in modern history, where a war is waged by an armed-to-the-teeth regime against its own people with 'all gloves off'. International treaties, norms, and moral constraints of conduct all cease to apply to how the Syrian regime is facing the uprising of people that is approaching its two-year mark (6). The wounded are followed to hospitals to be killed or kidnapped, the dead are mutilated and delivered to their families on the condition that they do not hold funerals, captives are tortured and summarily executed, and civilian areas are indiscriminately bombarded (2,6-8). Furthermore, a distinct hallmark of the Syrian regime's crackdown on the uprising has been the targeting of healthcare facilities and workers. Since the beginning of the uprising, doctors, health professionals and first responders were targeted and killed for nothing else but performing their professional duty towards victims of the conflict (9). The horror stories and scenes emerging from Syria are just the tip of the iceberg in a country that continues to be largely closed to the international press and relief agencies, and where communication and services are usually unavailable in areas of active military operations (2).

To be able to ignore and omit all that and single out sanctions as the cause for the suffering of Syrians requires much more than the talent of distortion.

Wasim Maziak, *Professor and Chair, Department of Epidemiology, Florida International University. Director, Syrian Center for Tobacco Studies, FL 33199 USA e-mail:* wmaziak@fiu.edu *Adam Coutts, Faculty of Human, Social and Political Sciences University of Cambridge, Cambridge UK Fouad Fouad, Syrian Center for Tobacco Studies and Faculty of Health Sciences, American University of Beirut, Beirut, LEBANON*

References

1. Al Faisal W, Sen K, Al Saleh Y. Syria: Public health achievements and the effect of sanctions. *Indian J Med Ethics*. 2012 Jul-Sep;9(3):151-3.
2. Rovera D, Amnesty International. Syria: Indiscriminate attacks terrorize and displace civilians [Internet]. London: Amnesty International;2012 Sept 14[cited 2013 Jan 14]. Available from: http://www.amnesty.org/en/news/blog-syria-indiscriminate-attacks-kill-terrorize-and-displace-civilians-2012-09-14
3. Haddad B. The political economy of Syria: realities and challenges. Middle East Policy Council [Internet]. 2010[cited 2013 Jan 14]. Available from: http://www.mepc.org/journal/middle-east-policy-archives/political-economy-syria?print
4. Friedman U. The five worst atrocities of the Syrian uprising. *Foreign Policy*[Internet]. 2012 May 29[cited 2013 Jan 11]. Available from: www.foreignpolicy.com/articles/2012/05/29/the_five_worst_atrocities_of_the_syrian_uprising
5. Delegation of the European Union to Syria [Internet]. Damascus (Syria): Europa. EU restrictive measures - Syria;2012[cited 2013 Jan 14];[about 3 screens]. Available from: http://eeas.europa.eu/delegations/syria/press_corner/eu_restrictive_measures/index_en.htm
6. Editorial. A medical crisis in Syria. *Lancet*. 2012 Aug 11; 380(9841): 537.
7. Jabbour S. Syria: tales of life, death, and dignity. *BMJ*. 2012 Mar 7;344:e1691.
8. Morris L. Syrian regime accused of 'atrocity on a new scale' in Daraya. The Independent [Internet]. 2012 Aug 27[cited 2013 Jan 11];News Asia:[about 5 screens]. Available from: www.independent.co.uk/news/world/asia/syrian-regime-accused-of-atrocity-on-anew-scale-in-daraya-8082071.html
9. Barmania S. Undercover medicine: treating Syria's wounded. *Lancet.* 2012 May 26; 379(9830): 1936-7.