CORRESPONDENCE

Medical tuitions - a viewpoint

A recent article lamented the growth of private coaching classes and medical tuitions[1]. The world has changed considerably since the years of our fathers and grandfathers. Old paradigms and situations no longer necessarily work or hold true. In this context, the concept of medical tuitions needs to be examined with all its socio-economic ramifications.

Why do students go for tuitions?

There are several reasons.

a) The student wants to get a high score or a distinction.

b) The student wants to pass.

c) The student is coerced by the teacher into getting tuitions under threat that she/he will otherwise fail.

d) The parents are apprehensive about the student's future and force her/him, to take tuition.

The competition for postgraduate seats is cut-throat and in this scenario every mark counts. Students believe that special coaching will help them get those extra marks and they are willing to pay for this. To go one step back, if students are willing to pay any amount to get question papers in the XIIth standard, paying for knowledge seems to be a very innocuous act. To go one step forward, students are, in fact, now willing to pay huge sums for those tuitions which guarantee them 'hot tips', 'sure questions' or the marks they want. Parents, too, are willing to go to any length to ensure that their child does not get left behind. This reflects the general attitude of middle and upper class society where child-child rivalry and competitiveness are marked.

The other factor is that students have got used to tuition classes from the time they were in school and junior college, where tuitions are ***de rigeur*** and raise no eyebrows. There are special tuition classes for entrance examinations to medical colleges so why is there any surprise at crash courses before students appear for their MD or MS examinations?

Medical tuitions serve a purpose. The standards of teaching in our medical colleges leaves a lot to be desired. There is no uniformity in what is taught in the various institutions. Private medical colleges are abysmally poor. By distributing information - albeit theoretical - uniformly, tuition classes give the students a sense of direction. Knowledge, howsoever acquired, is beneficial.

The problem with tuition classes lies not in their-existence but in the manner in which they are conducted. Doctors who are potential examiners have no business taking tuitions as they will obviously favour their students when appointed examiners. They will subvert the examination system to achieve their means. It is here that the authorities (University of Bombay, Municipal Corporation of Greater Bombay, Government of Maharashtra) have to step in. This, however, is an unlikely event, given the manner in which they function.

Medical tuitions is a variant of the prevalent theme - private enterprise taking over the function of what should be an efficient public service because of an obvious need. Special coaching of bright students and clinics during the night, after the day's work has been completed, have been going on for ages. We now have institutionalisation of this extracurricular teaching and the addition of stiff costs.

Where do ethics come in? All we need is regulation and, perhaps, even accreditation of these classes by a regulatory agency such as the University of Bombay or the College of Physicians and Surgeons.

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Reference

1, Madhok P: Medical tuitions *Issues in Medical Ethics* 1997;5:23

Humanities in medical education

The section "From other journals" in the January-March 1997 issue (Issues ***in Medical Ethics*** Vol. 5, No. 1) contained a reference to the introduction of the humanities into medical education. Specifically, the item mentioned the use of poetry on medical rounds with residents, as described by Horowitz in The *Lancet*, 1996:347:447-449.

While Dr. Horowitz's efforts are laudable and no doubt of value to his residents, readers of your journal should be aware that what Dr. Horowitz describes is extremely modest and limited compared to the extensive and sophisticated humanities curricula that have been firmly integrated into many U.S. medical schools for thirty years.

Indeed, the first such program at any medical school was introduced at the Penn State University College of Medicine, where a full academic Department of Humanities was established in 1967. Since that time, [illegible] disciplines of the medical humanities - ethics, law, literature, cultural studies, history, philosophy, and religious studies - have been added to the faculties and required curricula at a large number of schools.

Your readers will find the required curricula at a large number of schools. Your readers will find the best current review of the state of the art in the humanities in medical education in a special issue of the journal *Academic Medicine*, Vol. 70, No. 9 (September, 1995). The principal professional society for teachers and scholars in the medical humanities, with over 800 members, is the Society for Health and Human Values, 6728 Old McLean Village Drive, McLean, Virginia 22101) U S A (email: shhv@aol.com). All interested persons would be welcome to join. I certainly hope this information will be of interest.

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Arthralgia in a villager

Arthralgia in a villager,
Who believes in private health care,
Pledges belongings
Under family pressure and own
enthusiasm.

Moves to urban environ,
And searches for specialists,
Who order tests after tests
And set off a cascade of effects.

A vicious cycle of diagnostics,
Therapy and referrals,
Galloping treatment costs
And exhausted financial resources,

Obvious exploitation
Enforces return to village,
With sheaves of radiographs
And bundles of laboratory reports.

The fat folder
And even more obese file,
Merely confirm
Simple arthralgia!

Finds comfort in aspirin
And the ministrations
Of his own primary health centre doctor,
Amidst his family and near ones.

P. THIRUMALAIKOLUNDUSUBRAMANIAN
and A. UMA

Madurai Medical College
[illegible]

Placebos

The issue of whether or no patients should be informed about placebos used in their treatment follows the moral belief of the physician that the patient must be told all about every measure used during his treatment. This, in turn, stems from the desire to be truthful and honest. In this context a classic Indian dictum is relevant.

The definition of the Sanskrit term ***satyam*** or truth is 'that which leads to good' and is not merely restricted to factual veracity. A scriptural instruction illustrates the difference. If a young woman is being chased by ruffians intending to ravish her and you provide refuge in your home, you are not bound to tell the truth when the ruffians knock on your door and seek her whereabouts. Barefaced 'truthfulness' and factual admission are clearly not the prescription in this setting, even for one sworn to abjure falsehood.

Religious works also speak of 'pious fraud' - a deception intended to benefit those deceived.

The intention behind one's utterances and deeds is crucial. I believe that all of us agree that the placebo-administering physician is unquestionably benign. Ultimately, the patient seeks cure. Whilst his or her right to information and respect as an individual are very important, the doctor's primary focus is on healing, using every available means. Given this earnestness of motive, anything apparently contrary or even incidental to this primary motive needs to be given the go by.

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Cross practice

The editorial Cross ***practice at the cross roads (Issues in Medical Ethics*** 1996;4:103- ***104)*** aptly represents the landmark judgement of the Supreme Court against non-allopathic doctors practising allopathic medicine and vice versa. It also clearly states that such practices violate, ***per se,*** the Indian Medical Council Act, constitute medical negligence and attract fines or imprisonment.

It is a disgrace for the Medical Council of India that such a judgement became necessary. Does this august body know that in Mumbai nursing homes and private hospitals are under the care of non-allopathic resident medical doctors employed by allopathic owners? These non-allopathic resident doctors not only manage general wards but also critical areas such as intensive care units and intensive cardiac care units. They not only attempt to interpret traces on cardiac monitors but also proceed to treat them and even administer DC shocks on their own judgement. The specialists who run such intensivecare units depend heavily on the findings conveyed by such doctors over the telephone and proceed to recommend changes in therapy on the basis of this information.

A recently announced Heart Brigade attached to a private nursing home sends out a non-allopathic doctor to the patient's home when it receives emergency calls.

Are those employing such non-allopathic doctors not liable for medical negligence?

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