LETTERS

Globalising the rot within?

Dr Pandya in his hard-hitting commentary, "Medical Council of India: the rot within" (1), characterises the problems plaguing the council. The Medical Council of India (MCI) is entrusted with supervising the quality of medical education in the country and promoting medical ethics; but such has been the disrepute of the MCI, due to allegations of favouritism and corruption, that the central government has now finalised a draft bill to replace the MCI and other councils (such as the Dental Council of India, the Indian Nursing Council and the Pharmacy Council) with a National Council for Human Resource in Health (2). The draft bill is available on the Ministry of Health and Family Welfare website (3). The current system of working through the various councils which have been characterised as "dens of corruption" (4) definitely needs an overhaul. It still remains to be seen if the establishment of the national council, an autonomous body, will bring in much needed reform in the regulation of professional health education in the country.

Dr Pandya has listed in detail allegations of impropriety against the various officials associated with the MCI. Dr Ketan Desai, the current president of the MCI, has had several concerns raised about his conduct and the receipt of large amounts of funds in the past. In its recent general assembly, held at New Delhi from October 14 to 17, 2009, the World Medical Association elected Dr Ketan Desai, unopposed, as president of the WMA for the term 2010-11 (5). The WMA on its website states: "As an organization promoting the highest possible standards of medical ethics, the WMA provides ethical guidance to physicians through its Declarations, Resolutions and Statements." (6) It is surprising that in spite of the past questionable history of Dr Desai, the WMA, as the torch-bearer of ethical conduct by physicians, still chose to elect him. This makes one wonder if we are now globalising the rot within.

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Safety and ethical issues of bare hand cadaver dissection by medical students

Dissection is not only a skill, but also an art that is identified as the signature of a surgeon. Besides the surgeon, all medical practitioners exhibit their proficiency, or the lack of it, while performing procedures such as the draining of an abscess, removal of a cyst, venesection, and so on. The initial learning seat for this marvellous art is the anatomy dissecting room.

Beginning from the basics of sanitation like simple hand washing, we follow strict aseptic precautions while performing surgery or invasive procedures in patients. This also applies to cadavers, which may harbour a multitude of organisms like Mycobacterium tuberculosis, prions causing Creutzfeldt Jacob disease and Gertsmann Straussler Scheinker syndrome, even after embalming (1). There is no definitive evidence to show that HIV is inactivated after embalming (2,3). Moreover, there is no system in practice to check the presence of these infections, either before or after the cadavers are embalmed. Against such a scenario, it is imperative that all persons handling cadavers follow universal precautions. However, in reality most students and teachers of anatomy in medical schools in India do not take even simple precautions, like wearing gloves while dissecting cadavers. Students who want to wear gloves are sometimes prevented from doing so by senior faculty members who believe that students will be able to appreciate the feel of the various tissues and organs better with bare hands. There is no rationale to their point of view because, as surgeons, these students will feel the same structures in live individuals in the operating theatre, only with gloved hands. So they're actually supposed to know how structures feel to gloved hands, not to bare hands.

The principles of universal precautions will be hammered into young brains only if they are made to follow them in every invasive endeavour. Not only do gloves help in warding off infections, they also protect the skin from the irritant effects of formalin used to preserve cadavers.

It's even more disheartening to know that the instruments used by these students are never sterilised. They are simply washed with water at the end of each session. As students are handling sharp instruments for the first time, they are more prone to cuts and bruises. There is also a high probability of these medical students being infected by highly pathogenic organisms. Adding to the problem, there is not even a steam steriliser or an autoclave in most of the departments of anatomy in medical colleges in India, to sterilise the instruments used during dissection. Even the regulatory body which approves the establishment of medical colleges in India does not make it mandatory to have these simple instruments in departments of anatomy (4).

In western countries, these precautionary measures are mandatory for everyone performing a cadaver dissection. So a

basic tenet of ethics, justice, is violated by us. Moreover, as bare hand dissection of cadavers is hazardous, the second basic principle of ethics, beneficence and non maleficence, is clearly violated. Even if some students bring their own pair of gloves, preventing them from wearing them violates the third basic principle, autonomy. So it is very unsafe and unethical to allow – and sometimes force – students to dissect cadavers with bare hands. It is time that we realise this and start practising universal precautions during cadaver dissection. The regulatory bodies should also modify their regulations to include sterilisation equipment as a basic necessity in the departments of anatomy of medical colleges in India.

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Quacks in anorectal practice in India

Most human beings will do almost anything to prolong their lives or relieve themselves from the suffering of a disease. Others will do anything to exploit these desires by selling what they claim to be magical remedies even for incurable diseases. "Quack" is one of the several names used for those who pretend to practise medicine but without training, qualification and registration from the appropriate council or authority (1). Although some may be harmless, many are very dangerous.

Quacks in surgery are mainly in the treatment of anal canal diseases where they are often more popular than trained and registered practitioners. One can find their advertisements in every city and town.

Anorectal diseases are considered a divine curse and a matter of shame, so victims of fake doctors suffer without complaining. Patients from all walks of life and sections of society seek treatment from these charlatans. Educated and affluent people visit them clandestinely, either because mainstream treatment has failed to give relief or a cure, or because they are too shy to discuss the ailment with their family physician.

Patients also visit unqualified practitioners because of their publicity gimmicks claiming a faster, cheaper and sure cure (2). In contrast, general or family practitioners are less enthusiastic in treating these ailments. A misconception also prevails that surgery for anal ailments is followed by severe pain, incontinence, bleeding and so on, and that treatment by these people is just a "treatment" involving no surgical intervention. What's more, unqualified practitioners charge much less than real doctors do.

Some patients are happy, when their ailments get cured. But many must repent the visit for life.

Many of these "specialists" claim to provide instant relief from piles using corrosive injections that cause severe inflammation and pain. They say they practise traditional herbal medicinal therapy but use toxic chemicals and then try to correct the resultant infection with antibiotics and analgesics used in veterinary practice. The reuse of needles without sterilisation also puts patients at risk of blood borne infections.

Injection sclerotherapy is generally considered to be safe. However, it needs knowledge of anatomy of the region and the skill to inject the medication in the correct dose, depth and direction. Misapplication results in complications including severe pain, injection site haemorrhage and ulceration. Phenol injections given without aseptic precautions and in the wrong dose can have severe consequences. The injection of corrosives can cause complications like necrotising fasciitis, septicaemia and renal failure.

"Ksharasutra" is an established and proven ayurvedic therapy provided that the treating doctor is well versed with the anatomy and basics of anal fistula pathology. Wrongly done, it can cause severe pain, infection, pelvic cellulitis with progression to shock and death.

According to a study, there are around 1.5 million unqualified and unregistered practitioners in India, i.e. more than the number of qualified doctors (3). Patients who suffer the complications of their treatment are shy to come forward consult the appropriate experts (4). Medical associations and law enforcing agencies are supposed to deal with these charlatans (5). But apathy on the part of enforcement agencies has allowed these fraudsters to thrive.

To distinguish themselves from quacks, doctors should display their certificates in their clinics, abiding by the new code of ethics of the Medical Council of India. The public must be educated about the dangers of being treated by unqualified practitioners. Awareness must be created about anal canal diseases and their scientific treatment.

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Surgical training in India – a long and winding road

Recent advances in the field of medicine in general and surgical specialties in particular have been mindboggling. These have greatly improved the care of patients. Problems which were initially incurable are beginning to be solved. Keyhole surgery has revolutionised both the care and the cure of patients requiring surgical treatment. Advances have taken place in such fields, all over the world. On the downside, the career of a surgical trainee is becoming increasingly difficult.

Every surgical trainee, whether in a government-run or a private institution, enters the training programme after a great deal of effort. In a government institution, he or she enters after at least a full year of "preparation" for an entrance exam. In a private institution, a lot of money has to be spent by parents, running into many lakhs of rupees, sometimes even crores. Either way, it is a lot of hard work - whether for the trainee or his parents.

No standard goals are set in any surgical programme in this country as to what the trainee is expected to know within a certain timeframe. This is in relation to skills as well as theoretical and clinical knowledge. Institutions which have attempted to set some goals have not been able to follow them through, for one reason or the other.

Teachers of surgical specialties do not take it upon themselves to "make" surgeons of the trainees who pass through their departments. Many trainees pass out of their programmes without any knowledge of basic techniques essential for them. No institution has made it compulsory that trainees should have completed doing or assisting with a set of procedures within a certain timeframe. This leads to the production of half-baked surgeons. Many times, trainees have to spend more years in other institutions trying to acquire these skills. This results in prolonging an already long training period in a surgeon's career.

Although the development of sub-specialties does have its own advantages, it takes even longer for trainees to acquire such extra skills that are available only at select centres. Entry into these centres, either as trainees or as staff, is extremely difficult at the best of times. In most cases, especially in private hospitals which advertise training posts in surgery or Diplomate of the National Board, the ulterior motive is to get cheap labour out of people who enrol for the training programme. To get a trainee to do any job is an "advantage" because he or she will do it without question, for fear of the repercussions of refusing. The amount of money paid to them is substantially less than the prescribed pay for a non-trainee recruited for the same job. The trainee is most likely to complete the stipulated period of time (usually three years), making it unnecessary to search for a regular, qualified employee. Fellowship programmes, which are floated by many so-called "institutes of excellence", also offer jobs to fellows in order to obtain cheap labour.

Medical students aspiring to become surgeons go through a lot of hardship right from the time of qualifying for the training programme to the time that they complete their training. If the above mentioned flaws are corrected, it will make surgical training more meaningful and fruitful. After all the system needs to give its young professionals a fair deal.

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