Correspondence

Caste prejudices in medical colleges

Dr Mani1 probably reflects his personal views as in Tamil Nadu more than 70% seats are reserved and bright children of the forward castes have been facing reverse discrimination in selection for over 40 years. They suffer in silence because they are a minority and are second class citizens in their own state.

I wish to suggest that Dr Murmu2 should cease to be classified as socially and educationally backward as he is now a doctor.

In the long run, the caste system and prejudice will be eliminated only by universal education. Job reservation was promised by our Constitution for only ten years after Independence in 1947 but our present politicians have extended it mainly to win votes.

Dr Murmu should visit some of the medical colleges in Tamil Nadu and see for himself whether reservations have increased or decreased caste prejudices.

In the scientific community, there should be only one caste, i.e. the caste of specialized workers who are devoted to science. I do not understand the purpose of reservation in medical institutions. In sport, we judge people only by their ability and do not reserve places for the scheduled castes and tribes. Why should this not be so in the work place?

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Editing a medical book

While working as a young independent surgeon, I felt the need for a book by eminent and experienced Indian doctors, which might benefit others like myself.

When I suggested this to these 'eminent' Indian surgeons, their responses were very discouraging, perhaps, because I belonged to the private sector and not to a venerable academic institution. I then decided that book writing should not be the prerogative of so-called academicians and I had just as much right to produce a book as they had. I decided to edit a multi-author book on surgery which would be useful to young surgeons working single-handedly in small hospitals in the third world.

Few of the potential Indian authors responded to my initial letters. I imagined they must have thought who is he? Will he be able to complete the book? Will our efforts be wasted? Will he take away the credit due to us? Some said: 'I promise to write but contact me once 80% of the manuscripts are in.' They wanted to jump onto the bandwagon at the end of its journey. I admired those, who refused immediately, because I then could look for other authors.

Eventually since I was left with too few authors from India, I looked for others in western countries. Every one I wrote to replied, many gladly accepted my invitation and some referred me to others. 'It may be worthwhile collaborating with Indian friends' wrote one. Some even offered to write 2 or 3 chapters. A few regretted their inability to write because of other commitments. They all encouraged me greatly and this was in marked contrast to my experience with Indian authors.

Chapter writing started trickling in. Eventually nearly all arrived and those authors who did not respond to my telephone calls or letters or whose chapters did not reach a certain standard were excluded. The schedule suffered, and unfortunately, a number of important topics had to be left out.

I collected the chapters—subjected them to peer review—and made sure they fitted into my format which emphasized what was practical and possible in India and contrasted this with western countries. A well known publisher agreed to take the book after assessing a few sample chapters.

I submitted the complete manuscript. However, despite repeated reminders and entreaties that the current pace of medical science would make the subject matter outdated, production stretched over years. For instance, laparoscopic cholecystectomy which had just started when the manuscript was submitted and has gained rapid popularity was not included.

When the book finally did come out, it appeared to be attractive and, most important, affordable. The publishers agreed to do their utmost to promote it strongly. I thought I had arrived, and was ready to be judged for several years of work and waiting.

It is now over a year and my book has still not reached many libraries and I still do not know whether or not it has fulfilled my aims.

There have been encouraging reviews in the Indian Journal of Surgery, The National Medical Journal of India and British Journal of Surgery. The British Journal of Surgery calls it a surprising book because it runs into 494 pages, costs only US $24.95 and originates from India.

When I look back, I realize I was unaware of the amount of work involved in writing a book and I was perhaps a little over optimistic after it was published. I learned not to be easily frustrated when promises made by authors and assurances from publishers are not honoured. However, I was glad I completed my project and I hope other budding authors will learn as much from my experience as I did.

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Sex education in Indian schools

Recently, I read an interesting news item published in the British Medical Journal on the unsatisfactory AIDS control programme in India.1 It mentioned that the Indian Government was considering the introduction of sex education in schools. I feel that this action is based on ignorance of the sexual behaviour of Indians and will have major social repercussions. In the USA and other industrialized countries, by the age of 13, 8.1% of school students have had sexual intercourse and by the age of 16, 50.1% have had sex with 2 or more partners and 30% with 4 or more.2,3 Thus, since the late 1980s, all American schools have introduced sex education in their curricula. In spite of this, the US teenagers' knowledge about AIDS prevention has shown little change.2

In India, the human immunodeficiency virus (HIV) is transmitted through adults in their twenties and thirties and not through school-going teenagers. Our traditional family values and close parental supervision are the best ways of protecting our population from this threat. If lessons on safe sex are introduced into Indian school curricula, their first effects will be to encourage sex at an early age and the importance of using condoms will be forgotten.

Even in the United Kingdom, many workers feel uneasy when talking about sexual practices.4 In India, this problem will be even more pronounced and therefore we should stick to our traditional moral values. We should censor the film industry and control the western mass media which are promoting sexual licence as well as smoking and drinking.1,4

The reasons why our AIDS control programme has not been effective lie elsewhere. We need to focus our efforts on rehabilitating the high-risk and HIV-positive groups who are socially discriminated against. Blood unscreened for HIV is being transfused in hundreds of small towns, because we have not stressed the importance of voluntary blood donation and have also not provided adequate testing facilities and personnel. Long distance truck-drivers also need special attention. They hail in small wayside inns on the periphery of metropolitan cities and indulge in unsafe sex with local women. They become infected with sexually transmitted diseases and, in turn, transmit these diseases to their spouses and others in the community.

Promiscuous and unnatural sexual behaviour should be regarded as a sin. Sex education
in India should be targeted at adults through the mass media. Indian school children are, by and large, innocent and safe.

16 June 1994
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Medical colleges—Capitation fees

In India, of the total seats in medical colleges, the share of the private sector increased from 3.6% in 1950 to 17% in 1986. The doctor-patient ratio has also increased from 1:5750 in 1952 to 1:2239 in 1986–87. (If we include doctors practising all systems of medicine the ratio now is 1:935.) However, the majority of these are concentrated in urban areas with nearly half of all the doctors registered with the Maharashtra Medical Council (MMC) working in Bombay. Yet the infant mortality rate in this city is 150 per 1000—one of the highest in the world! Do we actually need to produce any more doctors especially those who will work in cities? Yet the medical education industry continues to thrive.

The capitation fee is the amount given as 'black' money (usually amounting to almost Rs 10 lakhs and separate from the high tuition fees) required to procure a seat in a private medical college.

Three private colleges were started at Pravara, Karad and Amravati in Maharashtra in 1985. After a prolonged agitation by the Maharashtra Association of Resident Doctors, and following high court litigation, the opening of further colleges was postponed (or so it seemed). However, in 1990 (an election year), the Government, with recognition from Bombay University, started the D.Y. Patil Medical College and the M.G.M. Medical College in Vashi (New Bombay). Needless to say, these colleges were owned by politicians belonging to the ruling party.

More than 10 new colleges were opened within that year. Many of them do not even have a functioning hospital. One of them has started a college in the first floor of a school. It is rumoured that one night before an inspection team from the MMC arrived, they organized cadavers for dissection in the anatomy room. What kind of doctors will they produce?

Students who have paid large sums of money for medical education will demand a quick return on their investment when they start practising and the already commercialized health sector in Bombay will be further corrupted. More people will sue doctors for malpractice.

It has been very difficult to use public interest litigation against the capitation fee system because the courts only recognize 'white' money and because no person has come forward to say that he had paid 'black' money. Yet in states like Andhra Pradesh the high court has actually banned capitation fees.

However, the Supreme Court in a surprise turn-around has effectively again legalized capitation fees by allowing high tuition fees for 50% of the seats with the rest to be awarded on merit only. The managements of these colleges now charge Rs 5 to 6 lakhs for the entire course, an indirect admission that earlier they were charging the same amount in 'black' money.

There are other loopholes in the recent Supreme Court judgement.

1. The merit list farce: The merit list formed for the private seats is from among the students who have pledged to pay the high fees and does not reflect the merit of all the candidates.
2. The unfilled seats: Only a small segment of society can pay Rs 5 to 6 lakhs, in white money and this has led to a situation in which many of the payment seats remain unfilled; e.g. in Terna Medical College none of the payment seats were filled. This gives the owners unlimited powers to select their own students and negotiate the fees in black money.
3. Medical colleges in Nepal: Many owners are setting up medical colleges in Nepal where the Supreme Court judgement is not effective. The students will study in India till the college buildings there are completed!

I have also learnt that in a secret deal between the Bombay Municipal Corporation (BMC) and the D.Y. Patil Education Society, the Rajavadi Hospital with its 'patient material' has been leased to the society. In return the society would provide a sum of money for the improvement of the hospital. This means that the plans to construct a hospital in New Bombay by the society have been postponed, perhaps indefinitely. Whether the money paid by the society will ever be used to improve the hospital is yet another matter.

However, the most serious fallout of all this regards the appointment of teachers. Until now all medical teachers had been appointed by the Municipal Medical Selection Board (MMSB). Now they are being appointed by the D.Y. Patil Society, again throwing merit to the winds.

Why is the medical fraternity silent? The answer is that these private education societies provide them jobs and also offer medical seats to their children. In fact even the relatives of many senior staff members of municipal colleges are studying in private medical colleges.

Students from these private medical colleges with poor teaching facilities appear for the MB, BS examination together with those from municipal medical colleges. Will the examiners who are selected from among the senior teachers be endorsing the corrupt capitation fee system?

All is not yet lost. Speaking out against these misdemeanours is sometimes remarkably effective. When a government hospital in Bangalore—the Bowring Hospital was given to a private college, there was a sustained agitation by its resident doctors and the order was withdrawn.

In 1992, the Tamil Nadu government doctors, including many senior staff, also prevented the opening of a private medical college in Madras. We must act quickly because there is not much time before the situation becomes irretrievable.

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Entrance test for DM and MCh

The entrance tests for superspecialty courses of DM and MCh in Indian institutions are as varied as the climate of this country. While a cardiologist at the Sree Chitra Tirunal Institute, Trivunanthapuram is expected to have a good background knowledge of internal medicine, such knowledge is superfluous for one in Delhi. Similar discrepancies abound nearly in all subjects depending on the 'free will' of the institutions. These patterns of examination are based on precedence and may be changed without notice, as there are no a priori reasons for them anyway. However, they do not actually change, because change would require thought. Most people would agree that at that level, one cannot have a primary school-like syllabus, and that it is the right of institutions to decide the best way to recruit their students, but I believe that a debate on this issue seems to be warranted. Those in positions of authority should set guidelines for tests which are applicable to all institutions. I think the entrance test should seek candidates with an aptitude for the discipline rather than those who have worked in that particular discipline for many years. For this to happen, the test has to lean heavily in favour of the basic sciences related to the superspecialty, rather than on knowledge of the superspecialty itself. I think people with aptitude would make better superspecialists than those who seek a degree only to legitimize their practice.

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