Haffkine horses get humane treatment

The Haffkine Institute, Pune, makes about 4.5 million ampoules of anti-snake venom (ASV) annually. It houses 700 horses and periodically bleeds them to produce ASV. Concerned that the condition of horses in the Institute was appalling, Maneka Gandhi, chairperson of the Committee for the Purpose of Control and Supervision over Experiments on Animals (CPCSEA) forced the Institute to close down in March 2000, till it mended its ways. When Mrs Gandhi inspected the Institute, she found that the stables were overcrowded, the horses were poorly fed and were not properly looked after when they fell ill. Of the 700 horses, three-quarters were blind and half were too old to be recruited for producing ASV. Several mares were pregnant. Moreover, the Institute had bled 84 horses to death while preparing ASV a few months earlier. Moved by ‘the tears in the eyes of blind horses’, Mrs Gandhi felt that it was cruel, ‘inequitable’ and anti-science to let the ageing horses suffer further.

The Government of Maharashtra, which controls the Haffkine Institute, and Mrs Gandhi seem to be engaged in a battle of wits over equine rights. By asking the Institute to close down, Mrs Gandhi has shown her intense disregard for violation of animal rights. But should she have held her horses? The monsoon season accounts for nearly 75% of the 22,000 cases of snakebite reported every year. Anti-snake venom is expensive (Rs 310 per ampoule) and is poorly stocked in most primary health centres. A patient with severe systemic envenomation needs 20–30 ampoules of ASV. If ASV is not available in the market (the Haffkine Institute is the only manufacturer of ASV in Maharashtra), mortality due to snakebite might rise alarmingly during this season. With the shortage of ASV likely to continue, the medical community should be prepared to watch helplessly as more and more patients succumb to an essentially salvageable illness.

S. P. KALANTRI, Sevagram, Maharashtra

Mob burns hospital

Violence against doctors has been in the news with increasing frequency in the past few years. It once again made headlines with the shocking mob attack and destruction of the Singhania Hospital in Thane. This hospital is perhaps the largest in the private sector in the region and boasts of specialty services that are not available in the surrounding areas.

Anand Dighe, a leader of the Shiv Sena was admitted to the Singhania Hospital in Thane on 25 August 2001 with a fracture of the leg following an accident. He was operated upon for the fracture the next day and was stable after the procedure. However, within a few hours of the surgery, he suddenly collapsed and had a cardiorespiratory arrest. The probable cause was a sudden cardiac event or a massive pulmonary embolus. Following the news of his death, a mob of hundreds went on a rampage in the hospital and effectively destroyed every piece of furniture and equipment as the hospital staff fled and a small posse of policemen looked on. The damage to the hospital is estimated to be around Rs 100 million. The management is seriously considering shutting down the hospital.

The reaction of the medical community in Mumbai was fairly predictable. Statements were put out by medical organizations condemning the incident. Some were quoted as saying that doctors should be provided ‘security’ while others said that ‘we should stop treating politicians’. Coming as it does a few months after the murder of a physician by a patient’s relative, many expressed the fear that medicine has become a ‘dangerous’ profession to practice.

The reaction of the mob was obviously out of proportion, even assuming that they nursed a certain grouse against the hospital for what may seem like a sudden unexplained death. The question that needs to be examined is how the medical profession should respond to such an event. What can be done to prevent such incidents from happening in the future?

SANJAY NAGRAL, Mumbai, Maharashtra

No longer digitally challenged and electronically marginalized: Deal allows developing countries free access to journals

Six of the world’s leading medical publishers have joined forces in a unique venture in which they have put profits aside to enable more than 100 of the poorest countries in the world to access vital scientific information free of charge through the internet. India just fits into this category! For a change, it is good to be poor. The BMJ Group has been in the forefront of this initiative and many other publishers have now followed suit. To facilitate this access to information, a clever piece of software called Digital Island is used, which recognizes the users’ IP address by country. A list of titles and the scope of content available through this initiative can be seen at http://highwire.stanford.edu/lists/freeart.dil

Dr Richard Smith, the editor of BMJ, described the arrangement, which is scheduled to start in January 2002, as ‘momentous’ and one that will ‘completely transform the environment’ in which health professionals, researchers, and policy-makers in the developing world work. ‘It is perhaps the biggest step ever taken towards reducing the health information gap between rich and poor countries.’

At the moment key medical journals, which can cost more than US$ 3000 (£ 2100) for a year’s paper subscription, are simply beyond the reach of most institutions in developing countries. But when the tiered pricing scheme is introduced, the least developed countries in the world will gain access to over 1000 of the top 1240 international biomedical journals free of charge. Slightly better-off countries will be offered online access at a price that reflects national economies but still at a discount of 60%–70%.

It is hoped that the initiative will give a clear signal to other industries, such as computer manufacturers and internet providers, to set up similar ‘ability to pay’ schemes, said Barbara Aaronson, collection development librarian at the World Health Organization (WHO). Smaller publishing groups, such as professional bodies that publish the New England Journal of Medicine and JAMA, are also expected to join the scheme.

The WHO, which has spearheaded the project together with the BMJ and the Soros Foundations Network, also aims to provide training in communications technology as part of its Health InterNetwork project to improve public health.

V. MURLIDHAR, N. ROY, Mumbai, Maharashtra
Capitation fees: The bane of merit?
The star-crossed Sri Ramachandra Medical College is in the news again. The government of Ms Jayalalitha decided that the college would have to accept students selected through the common entrance examination, but the college has obtained a stay on this decision from the Supreme Court. The college is a deemed university and conducts its own entrance examination. It is widely believed that this examination is a sham and that money changes hands for the procurement of an MB,BS seat, as well as for postgraduate seats. However, there is no proof of this, since allegedly, the money is collected without issuing a receipt.

In an unedifying spectacle, the University Grants Commission rushed to the college’s aid, issuing a statement that the college was a deemed university and therefore did not have to admit students based on the state entrance examination. It is also alleged that the MB,BS examinations conducted by the college are very lax.

The college was founded by Ramasamy Udayar, a liquor contractor, during the period when M. G. Ramachandran was the chief minister. It admitted students on the basis of capitation fee. In the past three years, there was an agitation by medical students throughout Tamil Nadu against this and two other private medical colleges, the first private medical colleges in Tamil Nadu. The Chief Minister crushed the agitation by closing all the hostels and threatening to shut down the colleges for six months. When the DMK returned to power it took over the college, and students were admitted on the basis of the state entrance examination. The founder-owner went to court, and by the time the case went to appeal in the Supreme Court, Ms Jayalalitha was in power. Her government did not fight the case and the college was handed back to Mr Udayar.

After the Unnikrishnan case, the college, along with the PSG College in Coimbatore, was forced to take some students through the state entrance examination. The third private medical college in Tamil Nadu was a part of the Annamalai University and therefore continued to admit students through its own procedures. The Ramachandra Medical College obtained deemed university status (a technique now popular with private colleges throughout India) and withdrew from the state pool. When the DMK came back to power it turned a blind eye to the situation.

It is often believed that these situations arise because of lack of vision on the part of policy-makers. Actually, the vision and policy are clear. These are means of ensuring islands of privilege. A look at the students of private medical colleges shows a large number of children of politicians, bureaucrats and the judiciary. It is therefore not surprising that they manage to exist against all canons of fair play.

THOMAS GEORGE, Chennai, Tamil Nadu

Masala

Alzheimer’s disease is the commonest cause of dementia in old age. This distressing disease is also expensive to treat and the United Kingdom spends over 6 billion pounds every year treating patients afflicted with it (BMJ 2001;323:123–4). The National Institute for Clinical Excellence (NICE) has reviewed the available drugs and formulated some guidelines regarding their use. In the past three years, three cholinesterase inhibitors—donepezil, rivastigmine and galantamine have been introduced. These drugs have been shown in several large, randomized, placebo-controlled trials to improve cognitive function and activities of daily living. They may also improve non-cognitive symptoms such as psychosis and apathy, but apparently do not modify the course of the disease.

The amount of dialysis patients receive is measured by the disease. The rapid and accurate diagnosis of tuberculosis has always been a vexing problem. Clinicians have been increasingly utilizing the supposedly sensitive polymerase chain reaction (PCR) test to diagnose the disease, especially the extra-pulmonary form. However, scientists at the Sankara Nethralaya, Chennai (Indian J Pathol Microbiol 2001;44:97–102) studied 279 clinical samples and found the sensitivity of the PCR test to be only 30%. The samples included pulmonary, extra-pulmonary and ocular specimens for the detection of acid-fast bacilli by smear, culture and PCR. The researchers used the insertion sequence of IS6110, apparently the most commonly used gene sequence; however, 40% of Mycobacterium tuberculosis from Chennai have either a single or no copy of IS6110 in their genome and this could explain why the test had a low positivity rate.

Aspirating a dose of a drug from a vial and pooling any residue for later use can hardly be regarded as something risky. However, if the operator’s hands are contaminated or if there is a nearby reservoir of potential pathogens (such as hand lotion), the contaminant grows in the medication and if this is introduced into susceptible patients, it could well be the recipe for a disaster. This sequence of events occurred at a dialysis centre in Colarado, USA where the staff pooled preservative-free erythropoietin for later use. In one month, 10 Serratia liquefaciens blood stream infections and 6 pyrogenic reactions occurred (N Engl J Med 2001;344:1491–7). An accompanying editorial points out the dangers of cutting corners.

The chef always found aphasias particularly difficult to understand. An editorial in the Lancet (2001;357:1818–19) clarifies