surgically treatable disease. I have not lost my stamina. Why should I stop operating?'

'I have a waiting list of patients for surgery that extends over the next 3 months. Should I disappoint all these persons who have faith in my abilities?'

'What? I, retire? Are you crazy? With my experience and wisdom I am far better than many of my surgical colleagues half my age!'

A search through the journals shows that unless compulsorily retired or superannuated by hospital rules on reaching a particular age, most surgeons continue well past their prime, undeterred by the fact that their peak performances were in the distant past. Well-administered hospitals constantly monitor the outcome of all surgical procedures and are thus able to focus on the ageing surgeon whose morbidity and mortality statistics are worse than those of his colleagues and take action to prevent harm to his patients.

Unfortunately, few hospitals in India’s private sector fall into this category. Most such hospitals would find it very difficult to comment adversely on senior surgeons who attract large numbers of patients to the financial benefit of the hospital. In the absence of a continuous surgical audit carried out impartially and without excluding any surgeon, however eminent, how are failing ageing surgeons to be weeded out?

A commentator abroad noted that when asked, most surgeons preferred a peer review system to determine their competency, rather than an upper age limit for practising. Would a jury of peers who will decide whether the quality of surgery merits continuation or dismissal be acceptable in India? Would senior surgeons accept the verdict of such a jury, where the average age of its members is 50 years?

SUNIL K. PANDYA

Letter from Australia

Doctors face many ethical challenges in their daily work. One of these—how to behave in relation to the pharmaceutical industry—has generated widespread discussion in the Australian print and electronic media over the past year. A prominent plastic surgeon and former Australian of the Year was forced to admit that her decision to appear in an endorsement for the over-the-counter drug Nurofen, in exchange for a donation to a research foundation of which she is chairperson, was a regrettable mistake because of the negative perception it created. The Australian Medical Association’s ethics committee said that patients expect to receive unbiased, evidence-based advice from doctors, not recommendations that unthinkingly parrot marketing claims of a company, especially when money considerations may have influenced that advice. The Federal Government has now extended its pre-existing legislation that made it illegal for doctors to appear in advertisements endorsing prescription drugs to cover over-the-counter drugs as well.

Publicity was also generated when a Melbourne oncologist lodged an affidavit with the Federal Court in Sydney that alleged improper inducements made to doctors by drug companies as part of their marketing strategy. These included business class travel to attend international company-sponsored meetings (as a delegate, not a speaker), accommodation at lavish hotels and dinners at high quality restaurants. Code of Conduct Guidelines published by Medicines Australia, the pharmaceutical industry’s own watchdog, states that in relation to whether sponsorship is appropriate or not ‘the test is of being able to withstand public and professional scrutiny and the ability to conform to any relevant professional and community standards of ethics and good taste’. The Australian Competition and Consumer Commission (ACCC) considered that what the oncologist was describing breached these standards and it demanded that Medicines Australia should be made to publish data on hospitality expenditure by all drug companies on a regular basis. Not surprisingly, this was vigorously opposed.

Rational prescribing is at the heart of good medical practice and in Australia, promotion of rational prescribing depends on a strong regulatory system operating at the community level, supplemented by the activities of increasingly powerful drug utilization committees in public hospitals and underpinned by the Code of Professional Behaviour published by each of the Royal Australasian Colleges.

Australia has a Pharmaceutical Benefits Scheme to subsidize the cost of prescription drugs and its computers are able to scrutinize the prescribing habits of all prescribers. Doctors whose prescribing is found to fall outside certain percentiles are subjected to practice reviews and can be referred to an inquiry by the Professional Services Review. If evidence of serious unprofessional conduct emerges, the practitioner may be referred to the Medical Board for a hearing that can lead to disciplinary action, even withdrawal of medical registration. On a more positive note, the Federal Government funds the publication of Australian Prescriber, an excellent independent magazine about the rational use of medications. It is available online at www.australianprescriber.com.

The hospital where I work has a Drug Utilization Committee that has the power to decide which drugs can be prescribed within the hospital and to promulgate guidelines on how drugs are to be used throughout the hospital. An excellent innovation has been the production of small laminated cards carrying guidelines on antibiotics and drugs used in emergencies, which clip on behind the doctor’s identification badge for use at any time. Online clinical guidelines and an online hospital pharmacopoeia make evidence-based drug information available at the fingertips of all staff and to all doctors in the community via the internet.

The Royal Australasian College of Physicians’ Code of Professional Behaviour says that ‘the physician should not ask for nor accept any inducement, gift or hospitality which may affect or be seen to affect his/her judgement, and not offer such inducements
to colleagues; not accept more than reasonable costs of travel and accommodation when invited to speak at a meeting... (and) be cautious when giving personal endorsement of new medical techniques or therapeutic goods.' Most physicians are happy to receive these recommendations because they clarify what has, for many, been a murky area.

In many developing countries, rational drug use is something to be aspired to and fought for. Reports from Indonesia describe a widespread practice, mainly in private clinics that serve the middle class, of prescribing powders that contain a cocktail of drugs for treating childhood illnesses. One mother of a child (9 months old) provided a prescription for a powder containing no less than 23 different drugs. A survey reported in the Jakarta Post on 27 January 2006 showed that 70% of Indonesian parents gave their young children more than 4 drugs at once to treat common illnesses and in 35% of cases, 5–7 drugs were given. Eighty-five per cent of powders examined contained antibiotics and many contained antituberculcurs drugs, antihistamines, bronchodilators, even corticosteroids. Attempts by concerned doctors to warn the public of risks such as the spread of antibiotic-resistant organisms in the community not only fall largely on deaf ears, but attract fierce criticism from other doctors whose income depends on being able to service a large clientele. Needless to say, research studies to document the adverse effects of irrational drug use in Indonesia are few and far between, but awareness of the problem is growing, thanks largely to the efforts of Jakarta-based paediatrician, Dr Purnamawati Pujianto. Dr Purnamawati has been supported by WHO to develop the Health Education for Parents Program (HEPP), which aims to empower consumers of healthcare. It has, so far, been very successful. It is interesting that in Indonesia, the group most at risk from irrational drug use is the middle class. The poor, who attend government-run community health centres known as puskesmas, receive evidence-based treatment according to protocols.

It was most heartening to hear that the Indonesian Paediatric Society has taken a brave stance to reduce the involvement of drug companies at scientific conferences. All promotional material displayed will, from now on, have to be evidence-based and displays will only be allowed in the exhibition hall. A selective approach to which drugs and products can be promoted will be practised and only those whose use is supported by strong evidence will be admitted. The promotion of infant formulas will be banned. Sessions debating controversial subjects will be encouraged and conference organizers will defend their independence, even if it means holding meetings in less luxurious venues than before.

GARRY WARNE

Letter from Sri Lanka

WORLD'S FIRST REPORTED OUTBREAK OF IATROGENIC FUNGAL MENINGITIS

Five women who underwent a caesarean section under spinal anaesthesia between 21 June and 17 July 2005 in two maternity hospitals of Colombo's premier teaching hospital complex developed *Aspergillus fumigatus* meningitis. Surgery and spinal anaesthesia had been performed by different teams in several operating theatre locations by personnel who were all properly qualified and adhered to internationally accepted guidelines for sterility and surgical procedure. They had used bupivacaine and fentanyl as the spinal anaesthetic agents. Three infected women died; the fourth one recovered completely, and the fifth woman left the hospital with hearing and visual impairment after 60 days of intensive care.

The average incubation period of the infection was 11 days. Remittent fever persisting in spite of empirical broad-spectrum intravenous antibiotics, excruciating headache, mучal rigidity, papilloedema, lateral rectus palsy and cerebral infarction were the main clinical features. The cerebrospinal fluid showed pleocytosis (neutrophils and lymphocytes), and the detailed microbiological, clinical and epidemiological investigations of the outbreak have now been reported.1,2

After examining over 200 operating theatre staff and environment samples, and over 1000 samples of ampoules, disposable needles, plastic syringes, cannulas, spinal needles, etc. in their supposedly sterile and visually intact packing, 43 syringes and two pairs of gloves were found to be positive for *Aspergillus fumigatus*. The authors2 found that the three well maintained warehouses of the Ministry of Health were full of tsunami donations, and regular Ministry procurements were consigned—most inadvisedly, as things turned out—to an old, dusty, musty and humid warehouse with leaky roofs. They opine that these dreadful storage conditions lasting for over 6 months was the most plausible explanation for minute cracks in the packaging and fungal contamination. Some unavoidable delay in diagnosing the fungal aetiology and in obtaining the specific antifungal drugs probably led to the death of 3 patients.

Sri Lanka suffered its worst natural disaster in recorded history on 26 December 2004 from the tsunami, which caused over 40 000 deaths, left at least 300 000 homeless or displaced, along with destruction of buildings and roads on a massive scale. Donations of uncatalogued medical supplies and devices then poured into the country over the next several months, the vast majority of them unnecessary or inappropriate, and a significant proportion, frankly unconscionable 'dumping'. Regular storage facilities were completely overwhelmed, and this outbreak of fungal meningitis in 5 previously healthy women was probably the most tragic consequence of an uncontrolled deluge of medical supplies. The well known adverse effects of permitting the unplanned entry of donated medical supplies during natural or man-made disasters were blithely disregarded in the chaotic aftermath of the tsunami.