Adolescent performs surgery in Tamil Nadu

The doctor parents of a 15-year-old boy, Dileepan Raj, proudly presented a video of their son, a student of the tenth standard, performing a caesarean section. They are the owners of a nursing home at Manapparai, a town near Tiruchirapalli in central Tamil Nadu. They intended to present the video to the Guinness Records for possible inclusion. They also stated that he had been performing surgery since the age of 10. Following criticism in the press and a government mandated inquiry, the parents withdrew the claim and stated that the operation had been performed by them. They accused people of being jealous of their son when they were told that what they did was not permissible.

However, the inquiry found that there was prima facie evidence that the youngster had indeed performed the surgery. Both parents and the son are now in custody. Besides the obvious ethical impropriety of an untrained and immature person performing a surgical operation, a worrying aspect of the episode was the fact that the parents did not see or understand the breaching of ethics.

GEORGE THOMAS, Chennai, Tamil Nadu

Medical education to cost more

Like all other commodities, medical education in Andhra Pradesh is set to cost more especially in private medical colleges and minority institutions. Following the initial attempt at rationalizing the fee structure for medical education in 2004, the revised fee structure comes into effect from 2007.

In private and minority medical colleges, the seats that are allotted by the convener according to the candidate’s rank in the engineering, agriculture, medicine, common entrance test (EAMCET), are listed as ‘A’ category seats (50%). In private medical colleges, the seats are termed ‘B’ category (20%). In minority institutions, there are no B category seats. In both private and minority medical colleges, the remaining seats constitute the management quota.

The fee for the MB,BS course in government medical colleges has been notified to be Rs 10 000 per annum. The fees for A and B categories have been raised from Rs 30 000 to Rs 55 000 per annum; and Rs 160 000 to Rs 200 000, respectively. While there has been no change in the existing fees for category C seats of Rs 400 000 in private medical colleges, it has been increased to Rs 500 000 per annum in minority medical colleges. It is frequently alleged that amounts exceeding the stipulated fee are collected for category C seats in the name of infrastructure development, hostel fees, etc.

The state is facing a severe shortage of teaching staff. There is attrition in the number of medical seats in government medical colleges due to non-compliance with Medical Council of India (MCI) norms. With the increase in the percentage of C category seats (enhanced to 30% this year compared with 15% in 2004), medical education seems to be distancing itself well beyond the reach of many deserving poor and middle class students.

ALLADI MOHAN, Tirupati, Andhra Pradesh

Bird flu strikes again

After last year’s outbreak of H5N1 avian influenza virus in central India, the virus had not been detected in poultry samples since 17 April 2006. However, on 25 July 2007, the Department of Animal Husbandry, Dairying and Fisheries announced an outbreak of avian influenza in Manipur. Dr S. C. Dubey, Joint Director of the High Security Animal Diseases Laboratory in Bhopal, confirmed that the highly pathogenic avian influenza strain (H5N1) was present in samples from chicken that died on a farm in Chenngmeirong village in Manipur. He said that the H5N1 virus was cultured in embryonated chicken eggs from poultry samples submitted to the laboratory for diagnosis. Confirmation of the presence of H5N1 avian influenza virus was done by serological and molecular tests as recommended by Office International des Epizooties. Dr Dubey also stated that the strain of the H5N1 virus isolated from poultry in this outbreak was different from the strains of the H5N1 viruses isolated during the outbreak in 2006.

The disease appears to be confined to Chenngmeirong; samples collected from a 3-mile radius of the village have tested negative for H5N1. House-to-house surveillance has been initiated in the area to identify people complaining of influenza-like symptoms. There are no reports of human infection so far. The state government has banned the movement of poultry and poultry products in the affected area.

Culling of poultry has begun. Over 150 000 poultry are slated to be culled in a radius of 5 km around the village in 6 days.

The Government of India had issued an alert earlier for the northeastern states and West Bengal, after bird flu was reported in Bangladesh and Myanmar.

PRABHA DESIKAN, Bhopal, Madhya Pradesh

Freedom, finally, for the Benghazi Six

The Bulgarian nurses and the Palestinian doctor, the Benghazi Six, who were under detention for having allegedly deliberately infected 400 Libyan children with HIV, were freed in July 2007, after negotiations between the European Union and the Libyan government (Nut Med J India 2006;19:353).

Of the 19 medical workers arrested in February 1999, in Benghazi after an outbreak of HIV/AIDS among children, 13 were later freed. Six Bulgarians—nurses Kristiana Valcheva, Nasya Nenova, Valentina Siropulo, Valya Chervenyashka and Snezhana Dimitrova, and doctor Zdravo Georgiev—were investigated along with a Palestinian doctor Ashraf al-Hazouz. Dr Georgiev was later released, but the Bulgarian nurses and the Palestinian doctor were sentenced to death in May 2004.

Although international experts testified that the infections were most likely spread due to poor hygiene in the hospital, reuse of syringes and that the infections began before the medical workers arrived at the hospital, Libyan authorities insisted that vials of HIV-tainted blood were found in a videotaped search of one nurse’s apartment. Later, the Libyan Supreme Court overturned the convictions and ordered a retrial. Libyan Foreign Minister Abdal-Rahman Shalgam suggested the death sentences could be ‘re-examined’ if the victims were compensated.
The Bulgarian government at first rejected the idea of paying what it called ‘blood money’ for the release of the nurses. However, the idea of monetary compensation for murder specifically allows the relatives of the victim to waive the punishment of the guilty in exchange for financial compensation.

The case was appealed to the Libyan Supreme Court, which revoked the death sentences and ordered a new trial. But the retrial, in December 2006, produced the same guilty verdict and the same sentence. The case was again referred to the Supreme Court, and the court upheld the verdict and the sentence.

On 10 July 2007, a financial settlement was reached between the accused and the affected Libyan families. The sentence was commuted to life imprisonment.

ASHISH GOEL, New Delhi

International health regulations come into effect

WHO’s revised International Health Regulations (IHR), which were approved by member states in 2005, took effect from 15 June 2007. These legally binding regulations aim to help the international body contain international public health emergencies. Countries would be required to disclose potential threats from disease, chemical agents, radioactive materials and contaminated food to the international body. The IHR (2005) build and replace earlier existing regulations from 1969, which addressed only 4 diseases: cholera, plague, yellow fever and smallpox, and were focused on control at borders and on passive notification and control measures.

The regulations require that countries nominate an IHR Focal Point, and build in systems for liaison with WHO on a round-the-clock basis. Information materials are being prepared and training sessions undertaken for relevant officials in the countries. WHO will provide ongoing technical guidance. A system is being set up to ensure the monitoring and evaluation of progress of implementation activities related to regulations at the national, regional and international levels. The IHR (2005) framework aims to define the rights, obligations and procedures in ensuring international health security without unnecessary interference in international traffic and trade.

Dr N. Devadasan, Faculty, Institute of Public Health, Bangalore called the WHO IHR (2005) a major step forward as it opened up the earlier reportable limited set of conditions to an infinite number through the use of the term ‘public health emergency’; this was important in the context of spread of infections such as Nipah, Ebola, SARS, etc. However, he cautioned that many developing countries often were wary of the intentions of WHO and developed countries, given the possibility of economic harm resulting from loss of trade and income due to a reported outbreak in the country. He highlighted, ‘While the WHO has tried to become the focal point in outbreaks, it is still not clear how well they will be able to control the economic impact of the same. How effective will they be in preventing embargos on products even though there is no scientific evidence to support such action?’ Dr Devadasan felt there was not enough clarity on these aspects within the regulations, and hence the global response to the IHR (2005) and its impact could only be judged over time.

ANANT BHAN, Pune, Maharashtra