Correspondence

Academics not a priority in a conference

I wish to share with the readers of this Journal an incredible experience of attending a medical conference in a historic city.

I was invited to deliver a keynote address at a four-day-long international conference organized by a private university in India. I reached the city the previous evening and was put up at a place about an hour’s distance from the conference venue. The following morning, I was ready before 7 a.m. as I was instructed. The volunteers (who were all students in the local medical college of this university) themselves turned up at 7.30 a.m. and the bus left before 8 a.m. We reached the venue at 9 a.m., just in time for my talk.

When I asked for directions to Hall ‘C’ where my talk was scheduled, the volunteers there informed me that there was a change in the programme, and all delegates and speakers were expected to assemble in the auditorium for an unscheduled award ceremony. Thus not only my talk but the scientific programme in all the four parallel sessions was postponed. The award ceremony, arranged to honour some foreign dignitaries, could start only at about 10 a.m. when the chief guest (a minister) arrived. The auditorium had about 100 foreign delegates, 20 odd Indian delegates including me, and was occupied by medical, nursing and paramedical students. The master of ceremonies started calling out the names of about 25 invited foreign faculty members to be seated alongside the minister on the stage. When only 10–12 of them came up the stage, it was announced that the remaining might have gone for ‘sight-seeing’.

The vice-chancellor gave a welcome speech where he individually called out the names of every foreign delegate and asked the audience to clap after each name. He also made some organizational, administrative and academic announcements and invited the audience each time to ‘give a huge round of applause’. In his speech, the vice-chancellor complimented the vice-chancellor for bringing so many foreign scientists to the city and told them to work towards the integration of indigenous systems of medicine with mainstream healthcare.

The main function was about awarding bulky trophies, mementos, scrolls and framed certificates (for lifetime achievement, etc.) to almost all the foreign dignitaries. Again, more than half the names announced were not present (perhaps had gone sight-seeing). I was told by volunteers that a similar award function was organized the previous day as well, compressing the scientific programme by several hours.

This ceremony was over by about 12 noon. We went to the halls for our respective scientific sessions, but were asked to be ‘brief’ in order to make up for the time lost. Some cultural/social programmes were planned for the evening and therefore discussions following the presentations were dropped entirely so that we are not late for the evening events.

Since I had already booked my return flight in the evening, I started for the airport after rushing through my keynote address to an almost empty hall. On the way back, I asked the volunteers why the award ceremony was not mentioned in the printed programme. They informed me that the time of the ceremony depends on the convenience of the minister. At the airport, I saw one of the bulky trophies awarded earlier in the morning lying in the dustbin.

Waiting for my flight, I wondered about the purpose of this conference. A scientific programme in four parallel sessions was postponed to gather a crowd for an impromptu felicitation ceremony. Scientific learning appeared to be at the bottom of the priority list of the organizers, while pleasing foreign delegates and politicians appeared much higher up. I will probably think thrice before I now go, if ever, to attend a conference organized by a private university. With so many foreign invited guests present, I wonder if this was the image India needed to project to the outside world?

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Top trending #ThankYouDoctor in India

Twitter trends reflect the mood of those active on the social media, where popular topics are supported or contested through hashtags. On 1 July 2015, i.e. Doctors’ Day, the hashtag #ThankYouDoctor trended on top of the twitter list in India (Fig. 1).1

First of July is Dr Bidhan Chandra Roy’s birthday and is celebrated every year as Doctors’ Day in India.2 Dr Roy was honoured with the country’s highest civilian award, Bharat Ratna, for being one of the foremost national leaders of the 20th century. He was a legendary physician, philanthropist, educationist and social worker. In spite of his hectic political duties such as being the Chief Minister of West Bengal, Dr Roy devoted an hour everyday for the cause of poor patients and the profession.

The significance of this online sentiment assumes importance since the social media is usually flooded with news/politics, or tweets of promotional/commercial nature. On the social media, negativity is more common than positivity, and criticism is harsher than praise on products, issues or people.3 The medical profession usually faces negativity on issues concerning medical negligence or professional misconduct, with the social media serving as a conduit for personal opinion and outburst. Marked negativity about the medical profession was seen trending in 2012 when a popular television show discussed medical negligence in India.4 A study reported that doctors are perceived as people who run after money,5 Positivity about the medical profession is usually expressed when doctors provide services in disaster situations, or when they are successful in saving lives.6,7

The twitter trend #ThankyouDoctor on 1 July 2015 is a clear message about public gratitude towards their doctors and the important role they play in society. It is heartening because (i) no other profession has been thanked like this on the social media and (ii) twitter has young users, with only 6% falling in the 46+ age category.8

![Trending India](image)

**Fig 1.** #ThankYouDoctor was the top twitter trend in India on ‘Doctors’ Day**
Twitter users have expressed their feelings for doctors; this puts the obligation on doctors to perform better. In the USA, only a small percentage of emergency physicians use twitter. But doctors in India should join twitter and other social media to appreciate and encourage the good work being done by their peers.

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Medical education: Teaching, but also embodying bioethics

Anuradha Rose and K.S. Jacob† in their editorial succinctly explain the field of bioethics, its relevance to medical education, and suggest how it could be introduced in the medical curriculum in the light of the Medical Council of India (MCI) Vision 2015 document.

The increasing number of cases of doctor–patient/patient family conflict—some of which worryingly have involved violence on healthcare providers—is causing concern among medical practitioners, and has led them to lobby policy-makers for legal protection. While such measures might be necessary, it is more important to prevent conflicts from occurring, or escalating to a level where violence might occur. Expertise in bioethics might help in such scenarios. Ethicists/clinicians trained in ethics can work with stakeholders and address the issues of trust deficit and communication gap, and offer insights to resolve differences of opinion on key medical decisions; for example, whether to withdraw or prolong (futile) treatment in a patient with terminal illness.

In many medical colleges, bioethics education is considered a domain of forensic medicine (especially in undergraduate medical education). This ends up being restrictive, as the focus is primarily on medicolegal issues and obligations, with much less importance being placed on an understanding of ethical frameworks to be applied during challenging moral problems in healthcare practice and research. The MCI Vision 2015 document calls for the ‘integration of ethics, attitudes and professionalism into all phases of learning’. This would require bioethics education to be included as a cross-cutting learning theme across all subjects. Bioethics education should also be conducted in conjunction with an exposure to medical humanities, leadership and team management skills, and an understanding of health policy linkages and reforms. Synergy with the recent plans to implement ATCOM (Attitudinal and Communication Competencies Module) in medical colleges will help in developing more holistic curricula for medical education. Where required, medical colleges should involve adjunct faculty with expertise in these areas to meaningfully implement the revised curricula.

Finally, these reforms would revolve around faculty mentors who not only teach bioethics, but also embody bioethics. These role models will serve as sounding boards for students.

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Comparison of two modes of gathering information on tobacco use

Tobacco use is the single most preventable cause of death worldwide. Hence, an accurate estimate of the use of tobacco is important for prevention, control and cessation activities. Interviewing people to obtain such information is known to result in misreporting, especially among adolescents. Interviewing could be validated by a biomarker or replicated using other techniques such as a computer-assisted survey instrument or ballot-box method. We investigated the use of two different delivery modes for a questionnaire: The self-administered questionnaire (SAQ) and the ballot-box method (BBM), to compare the prevalence and pattern of self-reported tobacco use among students of medical and dental colleges in Bengaluru, Karnataka.

All third year students from eight colleges (four medical and four dental) were included in the cross-sectional survey done during March–July 2013. The SAQ was a 3-page, 33-item, structured adaptation of the Global Health Professionals Study (GHPS) questionnaire. The BBM instrument was a brief 4-item questionnaire. Items common to both were about current smoking/chewing habit and pattern-of-use. The SAQ was administered in a classroom and all the students were instructed to answer additional questions on a slip of paper and drop it into a ‘ballot-box’ while leaving the classroom. Both questionnaires were anonymous. ‘Never-users’ were defined as persons who had never smoked/chewed even once in their lifetime and ‘current-users’ were defined as those who had smoked/chewed at least once-a-week in the past 30 days. ‘Pattern-of-use’ was categorized as daily/non-daily use. Ethical approval for the study was obtained from the institutional review board of St John’s Medical College, Bengaluru, and informed consent was obtained from all the participants.
Of 539 ‘on-roll’ students (324 medical and 215 dental), 441 (82%) were present on the day of the survey (medical 268, 83%; dental 173, 81%). The participation rate was 92% (405; medical 242, 90%; dental 163, 94%). More than half the participants (58%) were women with a median age of 21 years. Among both men and women, there was a higher prevalence of cigarette/beedi-smoking documented by the BBM as compared to the SAQ. While for women, the increase was from 2.9% (7/238) to 3.0% (7/234), among men it was from 15.5% (26/168) to 18.0% (29/160). No woman reported daily tobacco use. While 35% (9/26) of men who were current smokers indicated that they were daily-smokers by the SAQ, nearly half (14/29) the current smokers indicated they were daily-smokers by the BBM. Thus, overall ‘daily smoking’ by the SAQ (5.4%) was lower than that by BBM (8.6%) among men. However, none of the above differences were statistically significant (p>0.05). There were no differences in proportions reporting chewing tobacco.

Self-reported data may be subject to two potential biases—participation and information bias. Our survey has shown that these two different survey methods captured equivalent prevalence and pattern of tobacco use. Social desirability has been offered as an explanation for differences in findings between methods. The differences between the two methods were however within ranges documented elsewhere in biomarker validation studies. The limitations of our study included non-availability of demographic information on non-respondents, restriction to one geographical area and the linear order of the BBM following the SAQ method. Irrespective of the method used, tobacco use by a substantial proportion of health professional students is a cause for concern. Caution needs to be exercised in extending the generalizability of our study findings. However, we can conclude that a simple and practical method appears to provide a reliable estimate of the prevalence and pattern of smoking among health professional students.

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**Obituaries**

Many doctors in India practise medicine in difficult areas under trying circumstances and resist the attraction of better prospects in western countries and in the Middle East. They die without their contributions to our country being acknowledged.

*The National Medical Journal of India* wishes to recognize the efforts of these doctors. We invite short accounts of the life and work of a recently deceased colleague by a friend, student or relative. The account in about 500 to 1000 words should describe his or her education and training and highlight the achievements as well as disappointments. A photograph should accompany the obituary.

—*Editor*