and a young man, Dr K S Sanjivi was physician to me and all the family, and he became a dear friend to all of us. I have never met anyone I regarded as a more ethical person, and he was and still is my role model. Perhaps the idea of a doctor as a friend is old fashioned. In that respect, I would rather not be modern, if that means being cold and professional.

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Reference

1. Kurpad SS, Machado T, Galgali RB. Is there an elephant in the room? Boundary violations in the doctor-patient relationship in India. *Indian J Med Ethics* 2010 Apr-Jun;7(2):76-81.

White coated corruption

Vijay Mahajan has succinctly put into words the decrepit and deplorable state of medical education and practice in India (1). One need not even scrutinise the references for most of the facts that he states: they are common perceptions to all concerned.

He also gives a list of remedies to all the ills affecting medicine in India today. His remedies are not new; they have been acknowledged by change makers over centuries. Yet, we do need to remind ourselves of the need to "refuse bribes", "follow medical ethics" and "treat poor patients same as the rich".

The crucial point, however, is, do we -- as a medical community and indeed, as a nation -- have the capacitance in spirit to execute these "good" changes? Do we have the integrity, honesty and purity to acknowledge and then resist endemic corruption? I sometimes feel that as a people, we Indians have a genetic trait of being corrupt, lazy, sloppy, dirty and generally inefficient, at least in our own country.

I remember a conversation that took place many years ago over lunch in a resident doctor's mess in a public teaching hospital in Mumbai. The talk was on alcohol, or, rather enjoying alcohol. One female resident doctor remarked on how everyone in her family enjoyed alcohol and that on their recent visit to Gujarat they had carried bottles of premium scotch in their car. Gujarat being a dry state, their smuggling was discovered at the border patrol. She gleefully added that they bribed the patrol police with a bottle of the same stuff and were allowed to carry the remainder of the cache ahead.

On this, another doctor remarked on how she and her family (all educated, well to do, city dwellers) could indulge in such illegality, bribery and corruption.

I can still remember her answer, even after 20 years. She said, "What is wrong in being dishonest and corrupt?"

She, in essence, represents the corrupt blood that seems to flow within every "second" Indian. It does not matter whether he or she is a doctor, a policeman, a judge, a banker or a bureaucrat, nor whether he is rich or poor, a rural peasant or an urban sophisticate. The streak of pettiness, one-upmanship, dishonesty and selfishness seems to run in all.

Given this state of affairs, who is going to "refuse favours from pharmaceutical companies" or "make a commitment to rational drug use"?'

Vijay Mahajan also lists steps to be taken by the government to improve the scenario. Steps such as "transparency in the allocation of funds" or "enquiries by people of integrity into medical corruption" are good on paper.

The problem, once again, is that our government is by our own corrupt people, for our own dishonest people and of our own valueless people shorn of grit or integrity.

There is a vernacular saying which translates as: "When the fence itself swallows the farm, where should the farm complain?"

How can such a government effect all the laudable, grand reforms which our profession needs desperately?

To give only a few examples of corruption in government offices: several private medical colleges are founded and run by politicians, where the emphasis is on money making using education as an instrument; the government gives subsidies to distilleries to produce alcohol while common people die of thirst, hunger and debts; the former director general of police of Haryana is convicted of molesting a minor; a murder convict is chief minister of Jharkhand, etc.

There are millions of untold slips between the cup and the lip in India and reforms will likely remain on paper.

The only durable way out is strengthening the spirit through the values of honesty, truth, integrity and love. It will take a revolution of the heart to change the scenario. No amount of recommendations or paper reforms will salvage the situation.

While stringent laws are made to, and do deter, many a defaulter, many wannabe culprits are unabashedly immune to the intimidating powers of the law. They know that they can pay their way out of their punishments.

The roots of this disease are deep, and therefore the solution will have to be deeper. I would think that time-tested, age-old golden practices in spirituality like yoga, vipassana and religion without the rituals would go a long way in building the character of our society.

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Reference

1. Mahajan V. White coated corruption. *Indian J Med Ethics*. 2010 Jan-Mar; 7(1): 18-20.

Surgical training in India

The letter on surgical training in India (1) ought to open the eyes of surgical teachers in myriad departments in the country. In the absence of a structured theory and practical curriculum, it is left to the devices of teachers and their goodwill, the enthusiasm of students and their willingness to learn, and

certain other factors. All this together is not enough to produce a surgeon with standard skills and knowledge.

The lack of standardisation across country produces "surgeons" of varied skills and competence. Teachers have their fads and hobbies and often neglect certain areas. In many departments, teaching activities like seminars, case presentations, journal clubs, mortality morbidity conference are given the go by.

About private medical colleges offering surgical training, the less said the better.

It was my good fortune to visit the College of Physicians and Surgeons of Pakistan in Karachi some years ago. There I was surprised to see a formal surgical laboratory with mock surgical tables covered in green cloth where trainee surgeons were taught basic and advanced surgical skills in two courses covering a few days each.

The course had a formal curriculum and attending the course was mandatory for all surgical trainees in the country, regardless of their place of training. Special models were made for trainees to practise procedures like tracheostomy, venesection. Suturing and ligature were taught on models. Bowel anastomosis was taught on preserved bowel segments.

All trainees underwent a course in using computers, presentation skills and research methodology. It is my belief that such a system of training does not exist in our country. There is much to learn from our colleagues across the border.

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Reference

1. Rajappa S, Menon PG. Surgical training in India--a long and winding road. *Indian J Med Ethics.* 2010 Apr-Jun;7(2):126.

Rural doctors

Regarding your editorial on rural doctors (1), by conducting a short term course to treat our village population, the government will compromise on the quality of treatment..

Instead of conducting a course for freshers, the government should train physiotherapists who have undergone a four and a half year course and covered almost all the subjects that an MBBS student reads. There are many unemployed physiotherapists in India, and even many of those who are employed earn barely Rs 4,000-5,000 a month.

The government should take the initiative and call physiotherapists for interviews and give them six months' training in the treatment of common diseases. I think they will be far better than students who have undergone only a short course.

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Reference

1. Varghese J. The new rural doctor: qualified quack or appropriate healthcare provider?*Indian J Med Ethics*. 2010 Apr-Jun;7(2):70-2.

Rural doctors: A solution, or yet another problem in the making?

A stark difference exists in the healthcare facilities available to the rural and urban population in India (1). The country is currently facing a severe shortage of all categories of staff in the rural health system (2). While the comment made by Mahatma Gandhi that India lives in its villages holds true even today, rural India has suffered severe neglect as far as provision of adequate healthcare facilities is concerned. In recent years, planners have launched several endeavours to improve the status of healthcare in rural India. The mission document of the National Rural Health Mission enumerates many strategies to achieve better healthcare for rural India. This includes the formulation of transparent policies for deployment and career development of human resources in healthcare; the provision of 24-hour service in 50% of PHCs by addressing the shortage of doctors, especially in high focus states (Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Orissa, Uttaranchal, Jharkhand, Chhattisgarh, Assam, Sikkim, Arunachal Pradesh, Manipur, Meghalaya, Tripura, Nagaland, Mizoram Himachal Pradesh and Jammu & Kashmir), and reorienting medical education to support rural health (3). The government has toyed with many ideas to combat the lack of trained medical professionals in rural areas. A proposal to ensure a compulsory rural posting for medical graduates is yet to see the light of day. Yet another proposal to attract young graduates to practise in rural areas included the provision of extra marks in postgraduate entrance examinations (4). The status of this proposal is also unclear. However, the government has moved swiftly to propose the creation of an entire new system of medical education, tentatively labelled Bachelor of Rural Health Care (BRHC). The proposal has received a go ahead from the Medical Council of India and is intended to address the dearth of medical practitioners in the rural parts of the country (5). From this point of view, the proposal is welcome, especially considering the lack of interest of medical graduates in serving the rural population.

However, the ethical issues involved in the creation of this new course need to be examined.

It seems that entry to the purported four-year course will be restricted to students who belong to certain notified areas (6). This provision is probably based on the argument that people from urban areas are unlikely to serve in rural areas. This is a fallacious argument. Many reformers who have worked for the poor have actually been from the privileged classes. The provision is also against the constitutional promise of equality to all, irrespective of the place of birth. This provision needs to be scrapped so that every Indian is eligible to enter this course on the basis of merit.

Going by the admissions of the powers that be, the skills of such rural practitioners will be inferior to those of MBBS doctors (6). Does this course then not amount to providing inferior services to the rural population? Is not the inability of government to ensure an appropriate working atmosphere and infrastructure in rural areas partly responsible for the lack of doctors' interest in rural postings? The current initiative is likely