

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.

Vivek Gharpure, Paediatric Surgeon, Aurangabad INDIA
e-mail: vvgharpure@dataone.in

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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.

Arihant Sharma, drarihantsharma@gmail.com

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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

to save money for the government, as these rural practitioners are likely to be paid less than their MBBS counterparts. The failure of the rural healthcare system in India is not limited to the lack of trained manpower. Rampant corruption and the poor infrastructure are in no way less responsible. The mere provision of practitioners will not cure all the deficiencies of the current system of rural healthcare. Will enough trained human resources, without adequate infrastructure and provisions of diagnostic investigations and drugs, ensure a reasonable healthcare system? On the contrary, the provision of an adequate infrastructure will attract trained doctors, including MBBS graduates, to work in rural areas.

While the current debate has focused on the need for trained manpower for rural healthcare, the real concerns of rural practitioners have been neglected. The current stand of the government is that these graduates will receive a one-year licence that will be renewed for five years, on condition that they remain in the rural area of their states (6). This is again inconsistent with the provisions of the Constitution which allow all citizens to practise in any part of the country; and is hence, a form of discrimination. There is currently no provision for such graduates to pursue a postgraduate course, which is again an infringement of the right of individuals to further their skills and knowledge (7). These graduates will be forced to practise only in sub-centres and at most in PHCs, again an encroachment on the right to practise at the place of choice (8).

Such loopholes and ethical issues must be handled

appropriately. There is an urgent need to consult all stake holders before we end up creating more problems than solutions.

Vishal Sharma, Alka Sharma, Department of Medicine, University College of Medical Sciences, Delhi 110 095 INDIA e-mail: docvishalsharma@gmail.com

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Corrections

The authors of the NBC abstract "Exploring gender issues and needs of family care providers of PLHAs: case study from Pune, India" (Abstracts. *Indian J Med Ethics.* 2010; 7(4):277) are: Rewa Kohli, Latika Karve, Vridula Purohit, Vinod Bhalerao, Shilpa Kharvande, Sheela Rangan and Seema Sahay.

In the Clinical Trials Watch column in the October-December 2010 issue, the total number of trials given in the phases section of the "year missing" column was given as 10. The total number of trials in this category was 4.