CORRESPONDENCE

Testing patients for HIV

Regarding Dr V Raman Kutty's article on ethics in public health practice (1), I beg to differ with the author with respect to the following statement:

"Perhaps they forget that the patient has an equal right to know the HIV status of their health practitioner, since it is a well known route of spread."

May I ask the author where he got this reference from? I believe that such reciprocal transmission is yet to be reported in case of HIV.

I have a few other points to raise. Why is there such secrecy about AIDS? Would you not like to know overall incidence and prevalence of HIV-infected patients in the region? If you don't have the statistics, how do you understand the extent of the epidemic? How are you going to fight it on a war footing if you don't even know (or want to know) statistics of infected individuals? If acute polio can be a notifiable disease, why not HIV? How ethical is it for an individual who has acquired HIV from other sources to knowingly infect his wife who is ignorant of his status? Is there any insurance policy or a job security for an individual who acquired the infection accidentally while serving humanity? There are no easy answers to these questions.

I feel there are many misperceptions and much hypocrisy when we talk about treating the HIV patient ethically. We need to change the overall attitude of society towards HIV patients. I fully agree with the concept that under no circumstance should there be discrimination against AIDS patients. However, I do not agree that HIV testing should not be made routine before any intervention. I can defend my statement for the reason that even the largest public hospitals in India will not be able to afford the expenses of medical and paramedical staff taking universal precautions for all patients routinely.

Let me quote the British Orthopaedic Association's recommendations on what should be worn by the surgical team for the prevention of HIV and Hepatitis infection in operation theatres (these are only excerpts):

Protection of face and head: 1. Full eye protection goggles or visor, not spectacles; 2. Closely fitting hood of finely woven material, or disposable paper, covering the neck; 3. Ventilated hood or gown in high risk cases.(*comment: these are currently not available in India*).

Gowns: cotton gowns are not acceptable. Wrapover type of adequate length gown made up of high quality disposable paper, preferably laminated at the front and sleeves. They should be of a fabric with proven resistance to strike through.

Gloves: Double gloving with cotton outer gloves. Frequent changes of the outer gloves are recommended.

Foot protection: Wellington boots impervious to penetration, knee high, well overlapped by the gown.

In every case these precautions are obviously not practical. The question here is, are we well equipped and ready to treat HIV cases in epidemic proportions?

Doctors are like soldiers on the battlefield. Their dedication, commitment and sincerity should not be questioned. Are we going to ask our soldiers to lay their lives without arming them adequately for the fight against the very strong enemy? Denying the obvious fact that most public hospitals do not have these amenities is like pulling a hood over one's eyes. Also, there is no quality control over the 'HIV kit' they provide the staff.

Ethical issues need to be re-examined in this perspective.

***Mohan Desai**, 22/B/3rd floor /Anamik Co-operative Housing Society, Arya Chanakya Nagar, Akurli Road, Cross Road No.1, Kandivali (E), Mumbai 400 101.*

Reference:

1. Raman Kutty V. Ethics in public health practice. *Issues in Medical Ethics* 2000: 111-112.

Risk of HIV from surgeons

It is now an established routine that all patients undergoing surgery have to be screened for Hepatitis B and sometimes Hepatitis C, in addition to HIV. Although it entails an additional financial burden on the patient and has its lacunae, it is tacitly accepted by the patient. It is ostensibly meant to prevent the surgical team from being exposed to the virus.

Has not the patient got an equal right to protect himself by asking the surgeon to have his blood test done? I know of three surgeons who test positive for the above infections. One is an old case of Hepatitis B and another is strongly positive. A third is positive for Hepatitis C and suffers from pancytopenia but continues to operate on patients with what can be called cursory precautions. In my opinion it should be mandatory for hospitals to screen surgical staff periodically. I invite the opinions of your readers on this issue.

***Dr P Madhok**, Ashwini Nursing Nome, 15th Road, Khar, Mumbai 400 052.*

Education without sponsorship

Excerpts from a letter to the president of the Poladpur Medical Association, Poladpur, Raigad, Maharashtra:

I was impressed by the 80 per cent attendance for my talk on how to start and continue CPR or initial management of cardiac arrest in a rural area. Until now, I have attended more than 50 CMEs, but not a single one was arranged without sponsorship… It was really creditable on the part of doctors practising in remote rural areas, where they are the backbone of rural health care, because in today's era, everything from tea to the toilet is sponsored. I noticed that everybody was taking a keen interest in the lecture...because their minds were not at all diverted as routinely happens in a sponsored conference due to stalls and other things.

Sir, I admire you and your members for the way they have adapted for learning and avoiding becoming slaves of sponsorship. I hope this message is conveyed to all presidents and officials who are putting their major energy into searching for sponsors for medical CMEs.

Yours sincerely,

***HS Bawaskar**, Mahad, Raigad, Maharashtra*

Dr Bawaskar's comment is welcome. Please read the Letter from Sewagram on page 130 for another example of an unsponsored meeting. -- Editor.

Stop press: a landmark judgment

On September 4, 2001, the Bombay High Court held that accredited members of the press shall be permitted to attend inquiry proceedings conducted by the Maharashtra Medical Council to probe misconduct of medical practitioners. " ... MMC cannot hold the view that inquiry proceedings held under Section 22 of the MMC Act of 1965 are confidential in nature and have to be held in camera." (1)

The judgement was in response to a case filed in the early 1990s, by Ms. Saroj Iyer, journalist; the Medico Friend Circle Bombay Group; The Forum for Medical Ethics Society and Lok Hith. The case was filed in relation to a complaint by Mr. PC Singhi to the MMC, against Dr. Prafull Desai, surgeon at the Bombay Hospital. The MMC judged Dr. Prafull Desai guilty of two misconducts, but was punished only with a warning. Ms Saroj Iyer, who was also active in the MFC, was not allowed to witness the proceedings. This judgement will be an important precedent for the presence of witnesses in Medical Council Inquiries. If a journalist is allowed, it should not be difficult for doctors and laypersons to claim the right to witness an inquiry. Are there any takers for such legal action?

Three precendent-setting high court judgments have emerged from MFC's (Bombay Group) campaign on medical malpractice: on registration and standards in private nursing homes (following from the case involving Ms. Yasmin Tawaria), the patient's right to a copy of medical records (Mr. Raghunath Raheja), and, now, allowing journalists to witness an MMC inquiry against doctors (Mr. PC Singhi).

Mr. Singhi's long fight in the civil and criminal courts is still on, and he has won several battles here. Some of these rulings are also precedent setting, and can be used by others. Some have been described in the book documenting MFC's work in Mumbai: *Market, medicine, malpractice*.

Amar Jesani, 310 Prabhu Darshan, S. Sainik Nagar, Amboli, Andheri West, Mumbai 400058

Reference:

1. *Indian Express*, October 22, 2001.

Consumer rights as applied to vaccine usage in India

The eight consumers' rights as defined by the **International Organization of Consumers' Union** are as follows :

The right to safety

This means the right to be protected against products, production processes and services which are hazardous to health or life. The right to safety has been broadened to include the concern for consumers' long-term interests, not only their immediate desires. Vaccines introduced in this country are cleared on the basis of foreign trials and data. Safety and efficacy trials on Indian subjects are done in a hurry just before licensing. These trials merely test antibody responses and very few trials monitor adverse reactions over a prolonged period of time

There are virtually no guidelines on what training personnel administering vaccines should undergo. Camps are organised where ignorant people administer vaccines. Most fatalities related to mass vaccination are due to ignorance by the staff. Storage of vaccines is woefully inadequate; most centres administering vaccines do not have the appropriate facilities to handle serious reactions to vaccines. Dangerous vaccines are still available and are used on vulnerable segments of our population — such as the whole brain rabies vaccine.

Vaccine adverse reaction monitoring systems are not available freely and very few physicians, consumers or pharmaceutical companies use them.

The right to be informed

This means the right to be given the facts needed to make an informed choice or decision. This goes beyond avoiding deception and protection against misleading advertising, labeling or other practices. Consumers should be provided with adequate information, enabling them to act wisely and responsibly. This is a right which has been abused with regards to immunisation. On the one hand we have a large populace of illiterate people whose children are subject to a paternalistic system where they are not given information on any vaccine given to their children. On the other hand, a barrage of half-baked truths is fed to the educated, illiterate, urban rich, inducing them to immunise their children against diseases for which we know neither the incidence nor the efficacy of the vaccine in our population.

The right to choose

This refers to access to a variety of products and services at competitive prices and, in the case of monopolies, to have an assurance of satisfactory quality and service at a fair price. The right to choose has been reformulated to read: **the right to basic goods and services**. This is because the unrestrained right of a minority to choose can mean for the majority a denial of its fair share.

Here again we have a populace who is utterly ignorant of its choices. Not only are there a number of vaccines against various diseases, there are also a number of brands within each vaccine, and with different combinations. Their costs vary, leaving the medical profession and public confused. The assurance of the availability of essential vaccines rests with the government. The government has taken excellent initiative in making essential vaccines available. It is also a credit to the government that the cost of importing vaccines is entirely borne by the state and is not dependent on foreign aid.

The right to be heard

This means the right to be represented so that consumers' interest receives full and sympathetic consideration in the formulation and execution of economic policy. This right is being broadened to include the right to be heard and represented in the development of products and services before they are produced or set up. It also implies a representation, not only in government policies, but also in those of other economic powers. This right should be invoked in the recent controversy over the inclusion of the Hepatitis B vaccine in the national immunisation programme. A thorough cost-benefit and risk benefit analysis should be undertaken before introducing this vaccine. Just because the vaccine's cost is coming down and it is being indigenously manufactured does not automatically mean that it should be introduced in the national programme.

The right to redressal

This means the right to a fair settlement of just claims. This right has been generally accepted since the early 1970s. It involves the right to receive compensation for misrepresentation or shoddy goods or services. Where needed, free legal aid or an accepted form of redress for small claims should be available. This right unfortunately is not available to most of our population. There is no vaccine injury compensation programme. The legal rights are also not very clear. With the passage of the CPA, this may change.

The right to consumer education

This means the right to acquire the knowledge and skills to be an informed consumer throughout one's life. The right to consumer education incorporates the right to the knowledge and skills needed for taking action to influence factors which affect consumer decisions.

Very little is done to educate the populace on vaccines and their effects or adverse reactions. With a large population, differing literacy levels and a multiplicity of languages, mass communication is a challenging task

The right to a healthy environment

This means the right to a physical environment that will enhance the quality of life. This right involves protection against environmental problems over which the individual consumer has control. It acknowledges the need to protect and improve the environment for present and future generations. Provision of clean drinking water is probably more important than immunising the entire population against typhoid or hepatitis A.

The right to basic needs

The right to basic needs means that availability of articles which are the basic need of every consumer must be ensured. Vaccines should be classified as a basic need and exempt from taxes. The government must pass laws to compel essential vaccines and provide for compensation for defined adverse reactions.

There should also be a political will to manufacture essential vaccines indigenously.

***Jagdish Chinnappa**, Manipal Hospital, Airport Road, Bangalore 560 017.*

MFC annual meet 2002: Nutrition and food security

The recent developments in Orissa have again brought into focus the fact that food security in India is, at the best of times, precarious. All too often, the familiar picture of overflowing grain stores and starving people is invoked. India by all accounts appears to have attained self-sufficiency in food production with overflowing food stocks and the ability to avert large-scale famines. Yet, apart from crises during which there are severe food shortages and deaths, there is evidence that a large proportion of children are malnourished and that there has been little improvement in the nutritional status of vast sections of people. Policy changes over the last decade — liberalisation and WTO requirements including measures such as removal of quota restrictions, changes in cropping patterns — are likely to significantly affect food security. There are fears that such policies will aggravate the situation of poverty and unemployment, diminishing people's capacity to feed themselves adequately. This raises many issues that impinge on many disciplines, necessitating debate that cuts across a range of sectors and activities.

In order to bring together the evidence and enable discussion, the Medico Friend Circle (MFC) has organised a meeting on this theme. The Annual Meet-2002 of the MFC to be held at Sewagram, Wardha on **January 24-26, 2002**, will focus on **nutrition and food security.**

MFC is an all-India group of socially conscious individuals from diverse backgrounds, who come together because of a common concern about the health problems in the country. MFC includes medical, public health and social science professionals as well as researchers and students, community health and gender activists. It is a loosely knit and informal national organisation. Annual meetings usually on a theme have been a regular feature of its activities. MFC does not receive any funding and is funded and managed entirely by its members on a voluntary basis.

The Annual Meet 2002 will focus on the following issues:

1. Status of nutrition/malnutrition in India: evidence from recent data; **2.** Health impact of under-nutrition and inadequate nutrition; **3.**Review of nutrition interventions and related public policy issues: Public distribution system, Integrated Child Development Scheme, Mid-Day meal schemes, etc.; **4.**Review of nutrition education in India; **5.**Wages and employment and issues in nutrition; **6.** Issues in investigating and documenting under-nutrition, starvation and suspected starvation-related deaths; **7.** Politics of food and food security including impact of WTO, new technology, etc., on people, and **8.**Food security as a rights issue and related Public Interest Litigation in courts.

We invite papers based on the above themes. All relevant papers will be published in the* Medico Friend Circle Bulletin *and tabled at the meet. For details about submission of papers and participation in the meet, please contact:

S.Srinivasan, Convener, Organising Committee, 1 Tejas Apartments, 53 Haribhakti Colony , Old Padra Road, Vadodara, Gujarat 390007, Phone: (0265) 340223. E-mail: chinus@email.com, chinu@wilnetonline.net

The emphasis will be on field level studies and empirical evidence from different parts of the country as much as on issues emerging from more formal research studies. The object of this meet as in other MFC meets will be to facilitate understanding which participants can 'take back' from the meet and apply in their immediate work.

However, written papers/paper presentation is not a prerequisite for participation at MFC meets. We would like to invite all interested activists, scholars, professionals and students to attend the meet.

***Neha Madhiwalla**, B/3 Fariyas, 143 August Kranti Marg, Mumbai 400 036.*

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