People often do not bring their child to the booth even if the booth is located near the building. Discussions show that that they do not perceive their children to be susceptible to polio because doses have previously been administered; they also rely more on the advice of their family physician or paediatrician.

During our monitoring visits, we found that a few children remained unvaccinated despite a team visiting their home to administer the vaccine. One family told us that none of their children was under five years of age. We knew this was untrue. When we finally persuaded the parents to allow us to see their under-five child, we found that the child had not been vaccinated because he was sleeping when the team visited and the parents did not want to disturb him. We came across another almost identical instance when the male child was sleeping during the paramedical worker's visit.

This is a serious concern. People are becoming insensitive to an important public health programme, that too at a crucial juncture. It is important to explore strategies to overcome this hurdle.

A Verma, *department of community medicine, Surat Municipal Institute of Medical Education and Research, Surat 395 010 Gujarat, INDIA. e-mail: anupamver@gmail.com*

What is ethics really all about?

The word "ethics" has been used in various contexts – from legal mine fields to coffee table discussions. Given this versatility, what really is ethics all about? In a general context, ethics is about giving priority to an individual's needs and moral values in an attempt to curb and control potential societal abuses. In a health care situation, ethics would involve concern about the patient and protection of the patient from exploitation or abuse. The relevance of ethics lies in its ability to make cultures more tolerant of diverse views. Its utility is contained in its capacity to change the decision-making process and influence social policy.

While this describes ethics as it should be, ethics as it exists seems to be much more utilitarian. Personhood does not seem to be a central tenet. There are arbitrary conventions that do not take into account the uniqueness of a given situation. Recourse to universal guidelines leads to the real danger of an institutionalisation of ethics. This leads to a loss of flexibility in individual situations. And because every situation is unique, this loss of flexibility makes ethics lose its relevance.

A case in point is KV, who was terminally ill with Duchenne's muscular dystrophy. He wanted to donate multiple organs while he was alive. It was an informed, independent choice. His mother petitioned the high court on his behalf. The court ruled that it was not permissible according to the existing guidelines of medical ethics and the laws of the land. KV died without being able to donate his organs. His mother decided to petition the Supreme Court in an attempt to help other individuals in a similar situation. This case leads to the interpretation that in uncomfortable decisions, the main aim seems to be to avoid litigation—the courts and health care workers tend to safeguard themselves, not the patient's choices.

This raises pertinent questions. Does ethics uphold the rights of one individual at the cost of another individual's choices/rights? After all, the needs of health care workers also come under the purview of ethics. Harvesting organs from a live young boy may be morally repugnant to the workers. Who, then, has the capability to decide whose needs, choices and values are more important? Does any human being have the capacity to judge the validity of another's choices?

The much-publicised Terri Schiavo case in the US brought up other complexities. Terri was in a vegetative state for 15 years. After much public legal wrangling about the ethics of the presence or absence of any medical intervention, she was taken off life support. Any attempt to understand Terri's wishes was largely drowned out by a loud, self-interested public debate under the ubiquitous banner of ethics. She became a symbol instead of a unique human being. Was she a victim of the institutionalisation of ethics?

In both cases, the question that needs to be answered is whether ethics is innately biased towards the more "fit" individual/s in a given situation. Is ethics just an extrapolation of "the survival of the fittest"? Are we deluding ourselves about the fundamental aims of ethics?

Bioethics has a more difficult mandate. It deals with life sciences and has to handle time-bound, rapidly changing individual needs on either side of the fence. While flexibility is required to make ethics relevant, the question still remains as to who has the greater right to ethical considerations. Is it feasible to respect every individual's free will or choice? If the choice has to be one over the other, will any decision ever be ethical? In which case, does ethics really exist?

Prabha Desikan*, department of microbiology, Bhopal Memorial Hospital and Research Centre, Raisen Bypass Road, Karond, Bhopal 462 038 Madhya Pradesh INDIA e-mail: prabhadesikan@yahoo.com*

Reservations are a stress factor

I read with interest the articles by George Thomas (1) and by Neha Madhiwalla and Nobhojit Roy (2). The authors suggest that factors like poor working conditions, communication failure and inadequate facilities are evidently responsible for the increased friction between patients and doctors. In addition, I believe the undercurrent of resentment about reservation of seats in medical colleges contributes to the stress and violence. The recent strikes are over but the issue is unlikely to die down because urban, middle-class India remains severely polarised about caste-based quotas.

Reservations were introduced in the Indian medical education system for the benefit of castes that had suffered injustice for generations and who are, as a consequence, at a severe disadvantage. However the main reason that reservations still exist in India after 60 years of independence is the "vote bank" that politicians are afraid to lose. The politicians who are advocating reservations are not concerned about the quality of the doctors that our country will produce and so we see extension after extension of the reservation period. India may not be the only

country in the world with a quota system in medical education, but it is the only country with a caste-based quota system and such a high percentage of reservations. Reservations in medical education should be on the basis of economic criteria so that the really deserving poor students benefit.

A reservation system based on caste, repeated strikes and incidents of assaults on physicians act as "push" factors for Indian physicians to go abroad. This migration further compromises the poor physician-patient ratio in India. It was recently reported that one Indian doctor is available in the US for every 1325 Americans in contrast with one Indian doctor in India for more than 2400 Indians (3). The Indian government should come up with better solutions to provide better patient care and avoid this loss of medical personnel.

***Sagar Nigwekar**, Rochester General Hospital, Affiliate of University of Rochester School of Medicine and Dentistry, 1425 Portland Avenue, Rochester, NY 14621 USA e-mail: Sagar.Nigwekar@viahealth.org*

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Increasing awareness about bioethics

As new dilemmas emerge in the field of bioethics, it becomes imperative to look at how to increase awareness about bioethics in the medical profession. As a first step, bioethics can be made a part of the MBBS curriculum. This will provide a framework that can be built upon later. An obstacle in the spread of bioethics education is the lack of a chair in medical colleges. If such a post is instituted, it will help in establishing a foundational curriculum as well as create teachers who are well versed in the issues.

Programmes such as the recent First National Bioethics Conference in Mumbai contribute to making professionals aware about the field, helps them discuss the dilemmas faced by other physicians and the strategies used to solve the issues. Brainstorming sessions in such seminars as well as the use of online message boards for dissemination of information about bioethics information are important avenues.

Bioethics should be extended to become a truly inter-sectoral issue. Physicians must evolve clear-cut bioethics guidelines, which are in consonance with the cultural context of India. In the absence of a self-evolved code, legislation may step in and this might affect the sanctity of the doctor-patient relationship. The code of bioethics must be prominently displayed in every clinic, hospital and laboratory. This will help to remind physicians of their duties and it will also inform patients.

***Santosh Kumar Awasthi**, B 160 Shivam Duplex, Opposite Ambe School, Makarpura, Vadodara 390 101 INDIA e-mail: santoshawasthi@yahoo.com*

Apology: duplicate publication

We regret to state that we have been informed that the article by Priti Elhence on ethical issues in transfusion medicine, published in the July 2006 issue of the journal (3: 87-89) had already been published in the April 2006 issue of ISBT's *Transfusion Bulletin* (14: 5-8).

Our instructions to authors clearly indicate that duplicate submission is unacceptable, but we were not informed by the author that her article was simultaneously being considered by another publication.

We regret any inconvenience caused to *Transfusion Bulletin* as a result of the author's error.

Editors