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### Public health in India: unethical neglect

The vital importance of public healthcare in our country has long been neglected.

In most developed nations, public health systems play a crucial role in maintaining the health status of the populace. While the private sector focuses on curative medicine and is oriented to the individual, the government is responsible for public health services, which are concerned with preventive medicine and disease control and treatment for the population as a whole. However, public healthcare can be effectively implemented only when the government is sincerely committed to providing such healthcare facilities to its people.

When it comes to providing world class quality medical treatment, we are at par with most developed nations and can provide high quality treatment at a far lower cost than most of them. But we lag far behind when it comes to providing public health services, many of which are particularly important for the common man, for 80% of India's population. While we boast about our booming economy marching at a fast pace, we still have numerous segments of our population suffering from disease and hunger.

Time and again, experts have voiced the need for trained public health personnel. After much deliberation and delay, the Public Health Foundation of India came into being on March 28, 2006 (1). Yet, till date, it is not fully functional as an independent body and its presence is hardly registered in Indian medical circles. There is only one institute in India whose master's degrees in public health and applied epidemiology (National Institute of Epidemiology, Thiruvananthapuram, Kerala) are recognised by the Medical Council of India (2). A few other universities and deemed universities offer degrees or diplomas in public health. But it is not clear if all of them follow a common course relevant in the Indian context because there is, as yet, no governing body for public health training regulations in India. So, if we have admitted to the importance of public health in India, why does the state fail to provide for its development? The lack of experts and funding has forced us to modify the results of studies and measures undertaken in other places to fit our needs, and this has often had disastrous results (3,4).

There are not many public health specialists in India excluding those doctors employed in international health agencies like the WHO, UNICEF, and NGOs providing healthcare to the community. Meanwhile, all the evidence indicates that India desperately requires such experts to boost its community and primary healthcare. Admittedly, we have made much progress in the control of malaria, tuberculosis, HIV/AIDS, blindness, leprosy etc. But much more can be achieved. For this, we require qualified and trained public health experts, trained by competent institutes, to replace the 'experts' who do more

harm than good to the offices of public health they head. Then only would we be practising true medical ethics in the care of the community as a whole.

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### Analysis of physicians' strikes and their impact

Resident doctors often resort to strikes for reasons concerning safety at the workplace, better working conditions, better remuneration, and policy issues such as caste-based reservations and appointments to institute positions (1). Although many articles have discussed whether or not physicians should resort to strikes, few have analysed the prevalence of strikes, their direct impact on healthcare delivery, and beneficial outcomes, if any, for physicians (2-5). We conducted a single centre retrospective study for analysing the same.

In March 2011, an application was filed, on behalf of Rahul Yadav, one of the authors, at the Office of Public Information of Guru Teg Bahadur Hospital, New Delhi, under the Right to Information (RTI) Act, 2005, asking for information on all strikes called by the Resident Doctors' Association (RDA) of the hospital over the previous five years. Information was obtained on the frequency and duration of strikes and their consequences; demands of the residents and remedial measures taken by the authorities; any punitive measures imposed by the authorities; and the number of times the provisions of the Emergency Services Maintenance Act (ESMA) had been invoked. The impact of strikes on healthcare services in the hospital was assessed by analysing the number of patients seen during working days, averaged over a month, preceding the strike period, and the number of patients seen during strike days.

The reply to the application under the RTI Act revealed that during the preceding five years from April 1, 2006 to March 31, 2011, work was struck on five different occasions, amounting to a total 22 days (eight days in August 2007, two days in April 2008, six days in September 2008, three days in October 2008 and three days in February 2011) in five years, an average of 4.4 days per year. The common factor mentioned for all the strikes was "misbehaviour by attendants with residents". The April 2008 strike concerned misbehaviour of attendants with nurses.

The RDA's demands were related to improvements in security. There were no incidents of violence. ESMA was invoked twice in October 2008, and in February 2011.

There was a significant decrease in the number of patients attended to in the outpatient department (OPD) during strike periods, compared to the number of patients seen preceding each strike. The number seen in OPDs each day, averaged over a month, preceding the five strike periods, were 4,866, 4,719, 4,920, 4,878 and 4,550 respectively, and the average number seen in OPDs during the corresponding strike periods were 1,680, 2,377, 3,668, 1,389 and 3,093 respectively. The cumulative average of the number of patients seen during the strike period is 2,441.4 which is only 51% of the cumulative average of 4,786.6 patients seen during the month preceding the strike period.

Information on remedial measures by the management revealed that during the August 2007 strike, the management promised that "the present security will be scrapped and a better agency will be employed" and "regular surveillance will be done in the security services and patient care facilities". A written assurance was given in reply to our RTI application, for time-bound implementation of these measures and also that no action would be taken against striking doctors. During the April 2008 strike, the management issued directions for regular rounds by security officers. A file was moved for 95 extra security guards. During the September 2008 strike, the management deployed additional security, installed close circuit televisions at intensive care units. Also a "one patient-one attendant" norm and the display of a gate pass by one attendant at a time were made mandatory.

No record was available of whether any RDA member's services were terminated or suspended, or whether there was a cut in the salary of any RDA member due to the strike.

Our analysis of the strikes revealed that there is a significant decrease in the average number of patients seen in OPDs during strikes. Though striking residents often start parallel OPDs during strikes, it is clear that the health services are seriously compromised during strikes (5). Some studies have shown that strikes have led to decreased mortality though the reasons suggested for this were scarcity of emergency services and lack of emergency surgeries (4).

Repeated strikes for the same demands suggest that despite announcing appropriate measures every time, the management has failed to address the grievances of the residents adequately.

Tight regulation of security personnel and a serious assessment of the quality of security services are needed. Inclusion of RDA members in the decision making team may help formulate effective policies for ensuring the safety of residents at the workplace.

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#### Human embryonic stem cells: cells without end?

Recently, human embryonic stem cells (HESC) have been in the public discourse for a number of reasons. Prominent critiques have been about the ethical issues related to killing human embryos, adverse reactions, immune-rejections, malignancy, phenotypic/genetic anomalies in transplanted cells and futuristic notions of eternal life. Key stake holders in our social and health system need to provide sustainable solutions for an under-mentioned issue that concerns not only medicine and science; but also humanity as a whole.

HESC policy models vary between countries, from being restrictive to permissive and flexible. Countries like India, China and the United Kingdom have a flexible policy. In India, HESC treatment is allowed for incurable conditions. All countries except the USA have legally banned reproductive cloning. In the present scenario of varied legal frameworks, resource-limited nations like India still need an open platform for evidence-based HESC application and a responsible discussion on the HESC concept.

Should stem cell research be encouraged in India just because it is easier to produce embryonic cell lines owing to greater legal flexibility and lower costs? A significant chunk of the Indian population still exists below the poverty line and donors are willing to 'sell' eggs for meagre incentives without ever questioning their own rights or the medico-legal aspect. This certainly raises concerns about inducement or coercion of vulnerable groups. The issue is not just 'whether to pay' but also 'when and how much to pay'. Who must set these boundaries, and how does society conduct an informed debate on this subject? The promise of stem cells is too alluring to be undermined just because these concerns are not posed and addressed adequately.

The common Indian is perplexed by extreme claims and confusing terminology. There is a clash between religion and science in this spiritual nation. But we don't need a biology or philosophy degree to understand what the real issue is. The fundamental ethics is easy enough to understand when it involves large scale production and instrumental killing of viable embryos. Destruction of human life cannot be justified, even in the name of saving another life.