LETTERS

Starvation of children in Syria – sanctions and the politics of revenge

As Syria completes two years of western sanctions (2011–13), their dramatic effects on health are being highlighted with first reports of starvation deaths among children in the suburbs of Damascus (1). Although heavy fighting has taken place in this area, experts had predicted for some time the unworkability of sanctions for regime change (2,3), arguing that only civilians would pay the price in a country (Syria in this case) which was once well on the way to meeting the Millennium Development Goals 4 targets on reducing child mortality (4). In this, as in the case of other "sanctioned" countries, it is not just "civilians" but the most vulnerable among them – children, who are experiencing the tragic consequences of sanctions.

Several infants have died of hunger in the suburbs of Damascus and also in Yarmouk and other pockets of the country at the epicentre of conflict.

Several children had died by mid-October (2013) and one doctor was quoted as saying to *Der Spiegel* (5) that dozens of infants are so weak that a mild infection will kill them. While the west remains obsessed with its own security and the need for Syria to destroy its chemical weapons so that they do not fall into the hands of the *jihadists,* International humanitarian law would be better served if they (the Western governments, notably the USA, UK and France) made some real effort to protect civilians by putting pressure on the Syrian government and on western-funded militias, not to continue to use civilians as a shield or a tool for vengeance.

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Practical issues in implementation of WMA's draft Declaration of Helsinki

The working group of the World Medical Association (WMA) has published a revised draft of the Declaration of Helsinki for public consultation till June 15, 2013 (1). There are many positive changes in the document with respect to compensation, education of investigators, informed consent in the case of stored samples, etc. The changes represent a step forward for ethics. However, there may be certain points of concern regarding the implementation of the Declaration.

Point 20 of the document (1) states that medical research involving a disadvantaged or vulnerable population or community is justified only if it is responsive to the health needs and priorities of this population or community and *the research cannot be carried out among a non-vulnerable population*. Will this additional clause be harmful to vulnerable populations? Researchers may use it to conduct research among vulnerable people. This was prohibited earlier, the provision being that to begin with, many new markers had to be tried among the general population before conducting the study, depending on its merit, among a vulnerable population. With the addition of this clause, the same new markers can be tried simultaneously on the general and vulnerable populations. The same can be applied to drug trials. Point 20 also states that *consideration should be given to ensuring that the community receives a fair level of additional benefits*. How is it possible to measure this? Also, what is the meaning of "fair level"?

A component of point 22 states that the protocol must describe the arrangements for post-study access by the study subjects to interventions identified as beneficial in the study. Though this is very important ethically, there is a need to consider how far it is practicable. After a clinical trial has concluded, it takes from a few days to a few months to assess and reach conclusions about the beneficial effects, and it may take some time to obtain the Drugs Controller General's approval for marketing the drug. Is it possible for a company/ institutional ethics committee (IEC)/investigator/study participant to give consent for a drug, for which the analysis of the efficacy is being worked out? The participants thus have to revert to the drugs or measures they were taking earlier till the Drug Controller General grants approval. The word "arrangement" may refer to subsidised drugs or free drugs. Would this assurance of free drugs act as an inducement to participate in trials, especially those involving cancer and end-stage disease? A component of point 32, on the subject of informed consent, states that an IEC should decide on the impracticability of obtaining informed consent in the case of stored samples. As all IECs are independent, there will be various opinions on the matter.

Further, how can impracticability be decided upon? Is the difficulty in obtaining informed consent due to a large number of samples, the fact that they have come from different parts of the country, or the fact that they are taken anonymously? Are we going to permit telephonic or verbal consent if these participants are unable to come to the centre personally? Point 33 of the draft, which deals with placebo, permits their use "for compelling and scientifically sound methodological reasons…". This needs to be deleted altogether. Again, it is difficult for an IEC to determine what "compelling and scientifically sound methodological reasons" are. The same may be true of point 37, which pertains to unproven interventions. The proposed provision opens a Pandora's box in the area of stem cell studies and other studies on genetically engineered techniques. Though the draft is a reform measure aimed at promoting ethical research, it would be useful if an appendix were added to describe the practical aspects of its implementation.

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Disparities in pay of medical teachers all over India: need for a central governing body

While most professions have national level bodies governing the pay structure of their teachers, there is no functional body to govern the pay of medical teachers. The result is that the net pay of teachers in the central institutions (such as AIIMS, and the medical colleges of Chandigarh University etc) is higher than that of their counterparts in the medical colleges run by state governments. There is a central body, the Medical Council of India (MCI), which maintains standards of medical education all over the country. Recently, the MCI stated that medical teachers should be paid in accordance with the University Grants Commission (UGC) scales. However, no proper directions have been given. There have been agitations demanding UGC pay-scales for teachers in Rajasthan, Gujarat and other states (1–3). However, the irony is that though the state governments have agreed to these scales, apart from dearness allowance (DA) and non-practice allowance (NPA), they have left out many of the allowances paid in central medical institutes, the sum of which could well be above INR 40,000 per month.

There has been a hike in the allowances of medical teachers in central institutes (4). However, most of the states have not yet decided on a policy for the grant of these allowances. Medical teachers in some states are given a conveyance allowance of just INR 1600 per month, which is very low compared to that given at the central level, i.e. INR 5000 per month. Recently, the Kerala government has started paying a risk allowance and a patient care allowance, which is 15% of the basic pay of doctors (5). Some states give a nominal amount of INR 1200 as book allowance.

The doctors in the central institutes are as dedicated to treating and serving patients as are medical teachers in the states. The number of outdoor and indoor patients per day in state-owned hospitals such as the BJ Medical College, which is attached to the Civil Hospital, Ahmedabad, is equal to, if not more than, that in central institutions. The number of hours of work put in by state medical teachers is also similar to that put in by their counterparts in central institutions. The Standard Treatment Guidelines (STGs) in all hospitals, whether run by the Central government or state governments, are the same, as is the teaching work. Then why is there a disparity in pay? Why should only state medical teachers be deprived? Why not the teachers in degree or engineering colleges? Why has an upper ceiling of pay been fixed only for doctors? Are there any concrete reasons or is it just because it does not suit the bureaucrats? In one of the states, the NPA for the Sixth Pay Commission arrears was treated as notional and deducted in three instalments from 2006 to 2009 (out of a total of five instalments). Why, all of a sudden, did the authorities feel that the NPA should not be paid in full for those particular working years (2006–2009) and should be deducted in arrears? Are there any rules to clarify this deduction? (6).

Are doctors working in the states not subject to risks such as HIV and hepatitis B? Is it only doctors in the central institutes who do night duty and care for patients? Do only central doctors need books to study, and not state doctors? Justice needs to be done and doctors in the state institutes, too, should be given all these allowances.

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