publish negative research data, for example, are in keeping with the public interest. However, this principle is not clear on the question of what compensation is to be considered "proportionate with the services provided"?

The five organisations deserve to be congratulated for attempting to put patients first. However, as the framework is a living document, the next step is to clarify the indistinct terms. For example, what exactly is "inappropriate influence"? What is "appropriate care"? What is the "legitimate scientific purpose"?

We assume that the needful can be done to make this new framework serve as an instrument of social justice. Otherwise, it may turn out to be just a rhetorical, if not fallacious, framework.

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Sex education is the need of the hour

An editorial in the *IJME* on sexual assault and the ethical responsibility of health professionals in this context draws our attention to the need to understand and provide solutions to the problem of aberrant sexual behaviours in our society (1). News items about the prevalence of sexual abuse of children by priests in church and such like, and the risk faced by children in such unexpected venues of sexual exploitation point to the need for education. Yet, there is no consensus regarding the inclusion of sex education in school curricula or the method of providing unambiguous sex education, particularly to adolescents. Incidents of the sort mentioned above call into question certain values, such as celibacy, and it appears that any moral principle which goes against human nature fails.

Sex education helps young people to both acquire information on and develop a healthy outlook towards sex and intimate relationships. It equips them to resist abuse and protect themselves from sexually transmitted diseases and human immunodeficiency virus infection/acquired immunodeficiency syndrome (HIV/AIDS) (2). The focus of sex education should be on helping to reduce the risks of potentially negative outcomes, such as unwanted or unplanned pregnancies and infection with sexually transmitted diseases, and enhancing the quality of relationships. Sex education may help develop young people's ability to make decisions over their entire lifetime.

To provide sex education that is effective, young people should be given opportunities to develop their skills, as it can be hard for them to act only on the basis of information. The useful skills with which young people must be equipped are skills related to communication, negotiation, self-assertion, the identification of sources of help, and development of perspectives on sex and sexuality.

In terms of information on relationships, young people should be given an idea of the kinds of relationships that there are, love and commitment, marriage and partnership, and the law relating to sexual behaviour and relationships. Besides, they should be made aware of the range of religious and cultural views on sex, sexuality and sexual diversity.

Educational programmes in school should provide information on and opportunities for the development of the skills of the students, as well as for the clarification of their attitudes. Community-based projects afford young people with opportunities to access advice and information in less formal ways. The mass media, supported by local governmental and non-governmental agencies, can also help to raise public awareness of sexual health issues. At the same time, it must be ensured that the dissemination of sex education does not clash with regional, religious and cultural values.

The values embedded in the sex education curriculum can create a healthy environment which will enable us to face and fight the threat of AIDS in our region, and in which young minds will aspire to a healthy family life.

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From physician to anxious parent

It was 1 am when my wife woke me up, saying that our tiny tot (who was six months old) was shivering and had a high fever. We immediately wrapped him in his blankets and rushed to the paediatric ward of my hospital. Surprisingly, there was less

chaos than usual in the ward that night. I requested one of the senior postgraduate students to examine my baby. Wasting no time, she started assessing all the parameters and told us that the baby's temperature was 102 °F. Meanwhile, the rigours started again and the baby had two bouts of vomiting. In view of the entire clinical picture, the paediatrician advised us to get the baby admitted in the intensive care unit (ICU).

I rushed to the admission counter to complete all the formalities, while my wife stayed back. The baby was put on antipyretic drugs and injectable antibiotics (which I thought were unnecessary). A few blood samples were drawn to ascertain the cause of the fever. These yielded nothing, except showing a raised leucocytic count. Around 3 am, my wife and baby fell asleep, and the baby was calm. Somewhat relaxed and less anxious by now, I started looking around at the other patients admitted in the ICU. Since this was a rural medical college, most of the patients hailed from the villages of central India. There was something disturbing about the ICU. There was no trace of the usual laughter and infectious smiles of babies that enliven the atmosphere. Instead, shrill cries, moans and groans broke the silence of the relatively peaceful ICU from time to time. Laughter, smiles and babbling – the usual signs of a healthy baby – were drowned out by the intermittent beeps and alarms of various monitoring systems. One of the children had various tubes and catheters going in and out of all the possible orifices of his body and seemed to be in a lot of pain. At the other end of the ICU, a few underweight babies had been admitted for supportive care. One of them was grossly underweight, at 1.34 kg, and looked listless. The post-graduate students were regularly monitoring the vital parameters of the critical patients. Somehow, I started comparing my plight as a parent with that of the parents of the other critically ill babies. I, on the one hand, was a doctor who had a knowledge of the science behind illness and diseases, and who was well placed financially and socially, with good family support. They, on the other, were clueless parents who were looking after their babies in the face of a myriad worries (financial problems, crops being washed away by rain, loss of wages, children waiting at home, and flooded homes). Every day, I see hordes of patients thronging to the hospital wards and OPD sections, accompanied by their kin. It is seldom that we doctors are concerned about the worries that subconsciously prey on the minds of these patients. At most, we heave a deep sigh on reading some article on farmers' suicides, their debt burden, crops being washed away by the rain, scanty rainfall, and dry and wet drought. Without giving a thought to the economic condition of these patients, doctors in the government or semi-government set-up are quick to get miffed when they are late for their follow-up or have missed a few pills. It is a fact that the financial condition and social stratum of a patient are decisive factors both as far as adherence to treatment and the regularity of visits to the clinic are concerned. It seems that the white apron donned by physicians makes them impermeable to the agony of patients and their kin.

In view of the high rate of hospital-acquired infections, we considered it wise to obtain discharge on request during the morning rounds. I left the ICU with a healthy baby and was quite relieved. Thus ended my short journey from a physician to an anxious parent with a humbled heart.

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