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Dear Friends
We are striving to improve the quality of the Rural Surgery bulletin and we do have the following suggestion for the types of articles and we have also made publication in the bulletin a peer review process and get the ISSN number. However since it is a rural surgery bulletin you can send your articles in any format that you would prefer and we would try and change into the following formats. So that we can send the soft copy as soon as it is ready.

Original Articles
From 1000-3000 words. When reports of original investigative work, traditional division into sections is suggested: summary (maximum 150 words), introduction, patients/methods, results, discussion, acknowledgements, references. Black and white photographs and line drawings are welcomed if they illuminate the text.

Review articles
From 1000 – 3000 words. These are for continuing medical education and should be informative and contain practical tips.

Official Articles of the ARSI
These are official addresses like the Presidential address and other official information about the organization.

Short Reports
Up to 1000 words, with a maximum of two tables or figures and 10 references. A brief, three sentence summary would be helpful.

Research Letters
For original research work. Up to 700 words with a single table or figure and a maximum of five references.

Case Reports
Up to 600 words (one page of Rural Surgery). No summary is required. The contents should be logically ordered, but division into sections is optional.

Correspondence
Welcomed on any subject, including editorials or articles that have appeared in Rural Surgery. Guidelines for voicing opinions, which need not be orthodox. Letters may also be a suitable vehicle for presenting items of experience or observation that are too brief for Short Reports.

Methods and Devices
Papers describing procedures, techniques or equipment adapted by readers to their own conditions of work are welcomed.

Bio-medical Instruments and Devices
Papers describing bio-medical devices and instruments that help to cut down the cost and help Rural Surgery are welcome. The author’s name, qualifications, position, and place of work should be given.

Any other format
The authors may wish to submit articles in any format that they choose (which is convenient to them). The editorial board would either convert it into the format that suits the article or publish it as such.

References
Vancouver referencing system should be used: references should be identified in the text by superscript. References should include the names and initials of up to six authors. Publications for which no author is apparent may be attributed to the organization from which they originate.

References to electronic documents should contain information for the particular document version that was viewed: including:
• the name of the author or editor, the title of the page
• the title of the site
• the date the page was last updated, or the copyright date
• the date you accessed the page
• the full internet address (URL) of the page (in http://etc.). For an article from an electronic database, include the accession number if possible.

Examples
Website
The rehabilitation drugs are readily available. [14]


Online Journal
The study has shown that periadhesive cardiac surgery mortality... [22]

Available from:
http://bmj.bmjournals.com/cgi/content/full/329/7470/825
ORIGINAL ARTICLE

WOUND CARE: AN INDIGENOUS DRESSING

(excerpts from the paper presented at the 17th ARSI conference at Kollam, November, 2010)

Dr. Shafy Ali Khan SL DNB MRCS, Dr. Firoz Khan MH DNB, Dr. Sundaram P MS
KIMS Hospital Trivandrum

INTRODUCTION

Poor healing of wounds is major concern of any surgical unit. Repeated explorations and aggressive debridement are often required. Skin grafting and amputations might be required too. Topical negative pressure and hyperbaric oxygen are used to facilitate wound healing and are effective. However they are very expensive and not freely available. Hence dressings form the mainstay of treatment. Whether carried out as outpatient or as in-patient, dressing charges form the bulk of the money that the patients have to pay. We present the effectiveness of Low density Polyethylene food wrap material commonly known as “cling film” as a low cost effective dressing material instead of the conventional materials.

THE MATERIAL

It is a thin plastic film [0.01 mm] that was invented in 1953 as a laboratory error. Chemically it is Polyethylene or Polyvinylidene chloride. It is typically used for sealing food items and it clings to the surface and remains tight without the use of adhesives.

REPORTED MEDICAL USES

1. It was used to wrap herniated bowel loops in Gastrochisis [University College London Hospital]
2. For prevention of hypothermia in infants during phototherapy [Singapore Medical Journal]
3. Used for covering burns [in ambulance]
4. To cover donor site after skin grafting
5. Used as condoms in poorer areas of UK

MATERIALS AND METHOD

This was a prospective study for a 3 year period from December 2006 to November 2009 at the KIMS Hospital Trivandrum. Twenty five patients with extensive ulcers due to necrotizing fasciitis who were treated
with LDPE film dressings were included in the study. The initial severity and response to treatment were evaluated using Bates – Jensen wound assessment tool (BWAT). The scores were calculated at baseline and weekly until skin grafting.

RESULTS

There was continuous improvement in BWAT scores. The mean treatment period was 7.5 weeks (3 to 12 weeks). There was no significant incidence of local wound infection.

CONCLUSION

LDPE (Cling film) dressing is an effective and cheaper alternative.
LOW COST TOPICAL WOUND SUCTION SYSTEM & 3 IN 1 MACHINE

Mr. Arun Prasad*, Ms. Danita G*, Prof. K.Rajsekaran**, Mr. Joising** & Dr. J. Gnanaraj**
Department of EIE, K.U.,**SEESHA - KRCH.

In the past wounds were left to heal naturally, this meant that one could dress a wound but could not guarantee that it would heal well. Poor wound healing is a major problem with post-operative patients and diabetic patients. The topical wound suction system aids the healing process and makes the treatment of wounds easier and in some cases faster.

The topical wound suction system works by the principle of negative pressure therapy. It keeps the wound in a moist protected environment and reduces peripheral edema. The wound suction system also simulates circulation of the wound bed, decreases bacterial colonization and increases the rate of granulation.

The negative pressure therapy was discovered by accident in Wake Forest University school of Medicine Salem NC in 1990 while studying stress to tissues. They discovered that when negative pressure therapy was applied, the wounds healed faster and better. Later in 1993 three articles were published on vacuum assisted therapy by Morykwas and Argenta.

Chronic wounds have dead tissue, and since basic cellular functions such as oxygen transport and cellular transduction signaling are at the cellular level, the wound will also have impaired circulation. The topical wound suction system, using negative pressure, improves the circulation of oxygen and helps the wounds heal better. Initially negative pressure is applied for 48 hours continuously followed by an alternatingly turning on and off the suction system till the wound heals. The cycle consists of switching on the suction for 5 minutes and then a 2 minute off period. The pressure generally applied by the suction cups are 125 to 175 mm Hg pressure (50 for diabetic and vascular ulcers).

The advantages of a nano-VTU setup is that it has an isolated dual pump system, it is infection free, it weighs less than 2Kg, it occupies less space and it is incorporated with wound therapy unit, it has electronic control and display, the cost of this equipment is comparatively low and it lasts a long time. Another advantage of the nano-WTU is that it can also be used as a nebulizer and pediatric or emergency machine.

<table>
<thead>
<tr>
<th>Nano – Specifications</th>
<th>230V/65W</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrical requirements</td>
<td>450mmHg</td>
</tr>
<tr>
<td>No load vacuum pressure</td>
<td>200mmHg</td>
</tr>
<tr>
<td>Working pressure</td>
<td>&gt;8L/min</td>
</tr>
<tr>
<td>Air outlet flow</td>
<td>&gt;60dB</td>
</tr>
<tr>
<td>Sound level</td>
<td>1.5Kg</td>
</tr>
<tr>
<td>Weight</td>
<td>20 minutes</td>
</tr>
<tr>
<td>On/off cycle</td>
<td></td>
</tr>
</tbody>
</table>

SUMMARY
This low cost (Rs. 6000) unit could be used as Vacuum wound therapy unit, paediatric and portable suction unit and as a nebuliser. This was developed at the Karunya University.

PS ; The unit could be purchased from Silicon technologies (Phone: 098652 85754)
REVIEW ARTICLE

UROLOGY PROBLEMS IN GERIATRIC PATIENTS: BPH

Dr. Madhavan MCh (Urology)
Sankar Institute of Medical Sciences Kollam

INTRODUCTION

The disease burden of Benign Prostatic Hyperplasia (BPH) is on the increase because there is a greater awareness and increase in life expectancy. The fact that effective medical treatment is available and also the presence of minimally invasive procedures have contributed to more people seeking treatment.

BENIGN PROSTATIC HYPERPLASIA

BPH is the most common cause of urinary obstruction in men. Histological evidence of the disease is present in over 50% men over 50 years and in 90% of men above 90 years. Table 1 gives the incidence of symptomatic BPH. Figure 1 shows the transitional zone from which the BPH arises.

SYMPTOMS OF BPH

The symptoms of BPH are collectively known as LUTS (Lower Urinary Tract Symptoms). They are divided into Obstructive and irritative symptoms. The Obstructive symptoms are as follows

- Hesitancy
- Weak stream
- Straining to pass urine
- Prolonged micturition
- Feeling of incomplete emptying
- Urinary retention

The irritative symptoms are

- Frequency
- Nocturia
- Urgency
- Urge incontinence

The other symptoms include Hematuria, recurrent Urinary tract infections and renal insufficiency. Hematuria might be gross or microscopic and is a serious symptom and needs prompt investigation.

TABLE 1: SYMPTOMATIC BPH

<table>
<thead>
<tr>
<th>AGE</th>
<th>INCIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 – 49</td>
<td>14%</td>
</tr>
<tr>
<td>50 – 59</td>
<td>24%</td>
</tr>
<tr>
<td>60 – 69</td>
<td>43%</td>
</tr>
</tbody>
</table>

PATHOPHYSIOLOGY OF BPH

Anatomical or mechanical obstruction accounts for about 60% of the obstruction due to BPH. The alpha one mediated contractions are responsible for the dynamic obstruction [40%].
DIAGNOSIS
For clinical evaluation history and Digital examination are important. Following which the investigations that are recommended include

- Urinalysis
- Renal Function
- PSA
- USG (Residual Urine)
- Uroflowmetry

PSA or Prostate specific antigen is one of the most important tests as it is

- The most widely used tumour marker.
- Revolutionised the diagnosis & Management of carcinoma prostat
- PSA is prostate-specific; not cancer specific.

The normal values are as follows (0 – 4 Normal, 4 – 10 Borderline, > 10 Significant)

TREATMENT
The options that are available are

- Watchful Waiting
- Medical Treatment: Alpha1 blockers & 5 Alpha Reductase inhibitors
- Surgical Treatment: TURP / TUIP
- Open Prostatectomy
- Minimally invasive procedures

The objectives of medical treatment are improvement of symptoms and prevention of disease progression. The risk factors for progression are as follows

- Advanced age (>62 years)
- Prostate size (>30 cc)
- PSA (>1.6 ng/dl)
- Severe symptoms
- Post-void Residual Volume (>39 cc)

(a) (b)

The medical treatment consist of the following

A: Alpha-1 Receptor Blockers (PRAZOSIN, DOXAZOSIN and TERAZOSIN)

- Since alpha-1 receptors are also present in the CVS, side effects like orthostatic hypotension occurs.

- URO SELECTIVE: (Alpha 1A) [Tamsulosin (Dynapres 0.4mg), Alfuzosin (Alfo10mg)]

Tamsulosin or Urimax is the first prostate specific alpha 1 receptor blocker and does not need dose titration and can be given with other antihypertensives. It is given at 0.4 mg daily and unlike Alfuzocin can cause retrograde ejaculation

- 5 alpha reductase inhibitors (FINASTERIDE, and DUTASTERIDE) prevent conversion of Testosterone to Dihydro Testosterone. While Finasteride inhibits type 2 receptors Dutasteride inhibits both type 1 and 2 receptors.

- A Combination of A-1a blocker & 5-AR
• Large glands
• Ankylosis of hip preventing proper position of the patient
• Coexisting conditions requiring open surgery eg. Diverticula, Large calculus
• Severe urethral strictures

There are minimally invasive procedures like transurethral incision of prostate for very small glands and laser therapy. The newer modalities include
• Transurethral Needle Ablation of the prostate (TUNA)
• Transurethral Microwave Thermotherapy (TUMT)
• Prostatic stents
• Transurethral vapourisation of prostate (TUVP)

**EDITOR**: There are many minimally invasive surgeries and treatment. However except for Transurethral vaporization of prostate others are more expensive and does not offer sufficient advantage to offset the cost. A more recent advance is the BiTUR where normal saline is used instead of Glycine or water for surgery thus significantly lowering TUR syndrome. A new vaporizing electrode using Bi TUR technique was developed successfully used at the SEESHA – Karunya Hospital.
ARSI ARTICLE

OUR STRUGGLE FOR CAUSE, AN HISTORICAL PERSPECTIVE; AND A LOOK IN TO THE FUTURE

Dr. R.D. Prabhu
President IFRS and past President ARSI

The first struggle was to get Rural Surgery recognised as a special entity.

True Rural Surgery is the true general surgery in its pristine glory, 'a Cinderella' of the surgical health care; neglected and ignored by the elders and leaders of surgery. However what rural surgery does is more important; it looks after a large section of our national population that is not cared by medical college hospitals, city hospitals etc. Despite the economic rise of India nearly 400 million people in India are still denied basic health care. Rural surgeons attempt to address to this deficiency.

Over 16 years ago Dr. Krishnan from Thiruvananthapuram had shown:

a. Total hospital beds available in India are 0.6 per thousand population while the WHO prescribes a minimum of 4 beds per thousand.(current figure according to Wikipedia is 0.7 beds per 1000 population)

b. 80% of the available beds are in cities while 70% of the population is in rural areas

c. 80% of the beds in city hospital are occupied by rural patients far away from their homes!

According to the Economic Times (2 Feb. 2010) one million die every year in India because of inadequate health care. 700 million do not have access to specialist care. It does not need great intelligence to say that most of these are rural folk.

Even advanced countries like USA have rural surgeons. The journal “The American Surgeon” (Jan. 1995) printed the speech “Beyond the Scalpel” by Dr. Richard J. Field Junior, Vice President of American College of Surgeons. It was about his experience as a rural surgeon in USA! He exclaimed that rural surgery is a wonderful way of life.

In this age of specialities and super/sub specialities in surgery we need to identify rural surgery with a definition. Initially we defined it as surgery which is performed on patients living in conditions prevailing in rural India. However over the years, we now feel that it is better defined as the “multidisciplinary and affordable surgery performed under resource constraints and on patients living in conditions prevailing in rural India”. 80% of the healthcare cost is borne by the patient in India and so affordability is important.

Many surgeons in India in the past - Dr. Vasant Talwalkar (in ASI) is one name that comes to my mind - did try to bring rural surgery in to the focus but did not succeed as expected. Perhaps the time was not yet ripe for them and also because of lack of understanding of rural surgery, on the part of seniors.

A rural surgeon asked ASI presidents to know how to practice in a rural setup. Sadly
none had any solutions, but all offered a lot of sympathy. Finally, in 1987 Prof. N. Rangabashyam, President of ASI was kind enough to confess that a committee of ASI is needed to look into these problems. He formed the Rural Health Care Committee (RHCC) which later was named Rural Surgery Committee (RSC). This pioneering act of ASI became an important first milestone in the history of rural surgery. The rural surgery was recognised and accepted by ASI.

The next ASI president who purposefully and continuously supported the RSC and the rural surgery was Dr. T.E. Udwadia. As ASI President, he wrote to the ASI office that “rural surgery committee function was an important aspect of ASI functioning”. RHCC is very thankful to him for bringing rural surgery to prominence and always standing with it. His love and high esteem for rural surgery is evident by his decision to include rural surgery as one of the topics in the prestigious symposium during the Golden Jubilee conference of ASI in 1988. Later as an editor he brought out a special edition of Indian Journal of Surgery on Rural Surgery (Vol. 65 No. 1). Even now he is an actively involved member of ARSI. How one wishes there were more like him at the helm of ASI!

Formation of RHCC brought together many rural surgeons and sympathisers from other parts of India. Some of the initial members are:

1. Dr. R.R. Tongaonkar MS, a follower of Gandhian philosophy, who worked along with his doctor wife Ashato started a rural hospital in a remote tribal village Dondaicha in Maharashtra.

2. Dr. J.K. Banerjee MS, FRCS, a follower of Ramakrishna mission, and his wife Dr. Shiprachose to serve the poor people around Delhi by starting a Rural Medicare Centre (RMC) just outside Delhi city. Dr. Antia used to say later that Dr. Banerjee is the very ‘soul’ of ARSI. He also introduced the concept of ‘service’ as an important part of rural surgery.

3. Dr. V.D. Raval a rural surgeon from Patan, Gujrat

4. Dr. Sivasubramaniam MS, a rural surgeon from Settiarpatti, Tamilnadu

5. Dr. Sitanath De FRCS, who had a small rural hospital in Jhargram, a tribal area town in West Bengal, where he admirably performs major surgeries despite his primitive facilities.

Still later many more rural surgeons from across the country joined hands with us. RSC carried on a survey of rural surgeons on the membership of ASI. The findings revealed to the ASI, the true face of rural surgeons. Majority of the respondents had problems similar to the ones faced by me! More than three quarters of the surgeons that responded worked without basic infrastructure, were required to work in branches that they were not trained for, had problems in organising hospital and manpower, and had no training to face the difficulties that they have in their practice. Now the rural surgeons were getting noticed.

**Second struggle was to organise programmes to rural surgeons**

Rural surgeon members of ASI wanted RHCC (RSC) to organise many
programmes through ASI to cater to their various difficulties of the rural surgical practice. But there was neither help nor budget form ASI to organise them. That is why Dr. Banerjee expressed (14 Nov. 1989) that we must have our own independent association. But others were not so keen on taking so bold a step.

What we required was a separate section of rural surgery in ASI. But repeated requests by the RHCC were finally and officially turned down by the Governing Council ASI on 26-12-1991 (!).

At such a time two bright luminaries appeared on the scene.

1. Padmashree Dr. Balu Sankaran, Retired Director General of Health Services G.o.i. and also associated with W.H.O.

2. Padmashree Dr. N.H. Antia FRCS, Retired prof. of Plastice Surgery J.J. Hospital, Director Foundation for Research in Community Health (which reportedly formed the basis for the ‘National Rural Health Mission of G.o.i.’), a member on the advisory committee for health policies of G.o.i. and founder of F.M.R. (Foundation for Medical Research).

Both of them were in agreement with us about the importance of rural surgery for the nation and the rural surgeons section of ASI. They both even requested ASI president to sanction a separate Section of ASI to us. Dr. Antia even expressed that if this request is not conceded, rural surgeons will be “forced to form their own association” (2) ! Some Governing Council members of ASI supported our request. Prof. P Venugopal of Manipal too wrote to ASI supporting our demands. Despite this, during the Annual conference of the ASI in Hyderabad in December 1991, ASI with its best wisdom thought it best to turn down the appeal made by the RHCC to the general body, saying that rural surgery is not a specialty. RSC members were greatly disappointed. Interestingly, three years later, no less a person than Dr. Gazeiry MD, FRCS, Regional Director, Eastern Mediterranean Region of WHO, emphatically said that the difficult practice of rural surgery is such that it must be considered a speciality! By denying the section, ASI unwittingly did a good turn to rural surgery, it pushed the rural surgeons in to forming the independent association. Dr. Sankaran and Dr. Antia also supported and a meeting was convened in Shimoga on 29-30 November 1992 to discuss this. Others who were present in that fateful meeting were Dr. R.R. Tongaonkar, Dr. Mrs. Asha Tongaonkar, Dr. B. Venkatarao, Dr. Ramadas Pai (MS in Rural Surgery). It was unanimously agreed that we will be better off with an independent Association of Rural Surgeons of India (ARSI). This is perhaps the second important mile stone for rural surgery. Looking back now, we all are convinced that this was the right step in the right direction. Rural surgeons could not have progressed so well or had such varied programmes and such useful conferences if it had not had its own association!

Dr. Sankaran was requested to be the first president, which office he held for four years and helped ARSI to establish well, and Dr. Antia as the Vice President. Four years later Dr. Antia became president of ARSI for a term, guiding ARSI in many ways and then remained with us to his dying day which
speaks volumes about his love and devotion to our cause.

It must be remembered here that the above meeting would not have taken place if it were not for the generosity of Rural Medical Centre, Delhi (RMC), which bore the total cost of the meeting including air travel. In fact, ARSI is greatly indebted to RMC for sharing its DANIDA funds meant for its own project, for the activities (including initial few conferences) related to rural surgery and the ARSI.

The first conference of ARSI was held in M.G.I.M.S. Wardha in 1993, by the good offices of Dr. Sankaran. The Director there, a Gandhian, Dr. Susheela Nair was the chief guest. Dr. Zafirulla Chaudhary of Bangla Desh who introduced affordable health care in his country was one of the key note speakers. The ARSI was unanimously accepted by the enthusiastic general body.

Many subsequent conferences were organised with difficulties and even with funds from DANIDA, in places without any facilities for conferences, like Jhargram (W.B.), Dondaichha (Maha), Nagapattinam (T.Nad), Udhampur (J & K); but we were used to put up with short comings. Every conference was unique, enjoyable, full of rural surgery information and memorable.

**Struggle for training programmes**

ARSI has many ideas of improving the rural surgical health care; but the different authorities, like Indian Medical Council, Medical Colleges, the government, NACO etc do not co-operate with it. Very few see the problem from rural patient’s point of view. Almost every programme started by ARSI has had obstacles to cross.

1. **C.R.S.**

An important activity of ARSI was to satisfy the demand to train rural surgeons. A planned, structured training course had to be planned. Their important need was practical training in rural hospitals. Dr. Antla approached Ram Takavale of Indira Gandhi National Open University to start such a course in rural surgery. The happy outcome of this was the Certificate in Rural Surgery (CRS). Vice Chancellor of IGNOU Dr. Agarwal and Dr. T.K.Jena of IGNOU must be remembered for their great efforts in CRS programme. So also the Delhi group of surgeons (Dr. Banerjee, Dr. S.K.Basu, Dr. Toor, Dr. Gopalet al) for their efforts to organise meetings to develop curriculum and reading material. Most of the reading material was written by the ARSI members. The discussions also made us conclude that the preventive health care forms an important part of rural health care, and therefore had to be a part of 'holistic' rural surgery too!

One city branch of IMA tried to stop CRS but could not. Medical college heads also viewed CRS with suspicion and legality. A past chairman of a state chapter of ASI declared that CRS is a retrograde step! Many others however, applauded this step. However, CRS course started but not for long. Entry requirement for CRS was post graduate qualification in Surgery; and that perhaps was its undoing. Soon CRS did not get enough students and had to be closed.

2. **DNB RS**

When CRS was launched, late Dr. B. Ramamurthy, neurosurgeon from Chennai and past president of National Board of
Examinations (NBE) felt that this activity is within the ambit of NBE. Later he wrote to Dr. Bajaj, president of NBE on 3 Oct. 1996 about it. Dr. Banerjee and others in Delhi too tried and the result of their efforts was that NBE decided to start DNB in Rural Surgery. Here too we must be thankful to Presidents of N.B.E., Dr. Rajasekharan and Dr. Shyamprasad for their co-operation and efforts in starting the DNB RS. This was again an important third mile stone in the progress of rural surgery in India. Unfortunately, NBE is closely linked with the political ups and downs and DNB RS too is affected by it. Let us all hope that programme continues.

3. Blood Bank Rules

The government of India introduced new Blood Bank rules which resulted in closure of many existing blood banks and threatened rural surgeons using donor to recipient method of blood transfusions (unbanked direct blood transfusion or UDBT) in emergency. Dr. Tongaonkar pleaded with authorities on many platforms that UDBT is acceptable and safe too; but the government has not allowed its use. But the practice continues and saves lives but “unofficially”.

4. Scholarships

ARSI decided to encourage its members to learn new techniques and technologies by offering some financial assistance. A fund was created with the generous donations of the organisers of two conferences in Shimoga and Jhargram. This is the in the Shimoga-Jhargram scholarship fund. The scholarship is a subsidy from the interest earned from the fund. 5. Antia - Finseth Innovation Award

Dr. Antia was keen on identifying useful innovations that may be useful in health care. His friend late Dr. Frederick Finseth, a Hand surgeon from California, USA, had donated a large sum of money to be utilised for some good purpose as decided by Dr. Antia. Dr. Antia decided to use the proceeds of this fund to give away a cash award to the best innovation of the year. The innovation must be relevant to the rural health care in India. This award is called Antia-Finseth Innovation award.

Bulletin

At the very beginning itself, Dr. Banerjee felt that we need a bulletin of the ARSI and he took it upon himself to start one. ARSI made some budgetary sanction but Dr. Banerjee started a 'bulletin fund' with that money; the 'fund has gradually grown with further additions by succeeding editors. He developed it over the initial years and then handed over the editor office to Prof. V.K.Mehta who brought academic touch to the contents. Even later Dr. S.K.Baasu brought in many welcome changes like layout, quality of paper, colour photographs etc. Now Dr. Gnanaraj is the editor. Not wishing to be influenced by the health care industry, the bulletin has kept away from advertisements from it up till now! Our bulletin goes out to all members of ARSI, to overseas members and to African surgeons, free of charge, courtesy DTC.

International activities

At about this time, ARSI came to the notice of German Society for Tropical Surgery (they called it DTC in Germany). Dr. Gabriele Holoch (a Trauma surgeon) and Dr. Thomas Moch (Anaesthesiologist) contacted ARSI. This
contact was the fourth milestone. It became the most fruitful alliance of ARSI. It has led to many of our members visiting Germany for participation in DTC conferences exposing ARSI on international platforms. Thanks to DTC, many African surgeons like Dr. Kibatala (Tanzania), Dr. Mubangizi (Uganda), Dr. Moses Okech and Dr. John Wachira (Kenya), Dr. Obuyo Awojobi (Nigeria) participated in our conferences. Dr. Peter Reemst from Holland, Dr. Zuckerman from USA and many other surgeons from abroad were already attending our meetings. This international representation prompted Dr. Thomas Moch to suggest formation of the International Federation of Rural Surgery, a resolution that was unanimously passed during our Ujjain conference in 2005. This certainly is an important fifth milestone. All the foreign delegates supported this move.

The rural surgery and ARSI had got international recognition soon. They had attracted the attention of other international surgical bodies like Holland group of Surgeons, Mithofer Centre for Rural Surgery in USA, Britain, Australia, Canada, etc. Many of surgeons from those countries chose to be our overseas members. We now know that USA and UK too are interested in promoting rural surgery in their own countries.

ARSI is on firm grounds now. But we need to consolidate our position and spread the philosophy to wider regions of India and globally.

What about the future of Rural Surgery? A struggle too?

The health care is changing.

1. People are becoming more and more aware of their consumer rights.

C.P.A. allegations are increasing. When anything goes wrong, lawyers are ready to point out to the shortcomings in the hospital set up, and a rural hospital is always an easy target with its shortcomings.

2. The nearby town and city practitioners and hospitals are spreading their tentacles of unethical practices like “kick backs” (unethical fee splitting) to the rural areas. This diverts rural patients to them.

3. The more worrying development is that the government is gradually going away from its responsibility of peoples’ health care. It has encouraged insurance schemes to take over its responsibility. (Medical insurance was proposed by Subir Chatterjee in the editorial of Journal of I.M.A. of May 1990). Most of these schemes mean a ‘cashless’ treatment to the patient. This attracts many patients to those schemes. In our own state of Karnataka, there are hundreds of such schemes by general insurance companies; in addition, in there is “Yashasvini farmer’s” insurance which gives a cover for up to Rs.1,00,000 for a premium of Rs.120 only, and “Sampoorna Suraksha” by Shri Dharmasthala Rural Development project which gives a cover for up to Rs.25,000 for a family of five members for a premium of Rs.800 only. All these schemes drive the patients away unless the rural hospital is included in the scheme. That unfortunately is a tricky part. The insurance agencies
themselves select the hospitals; and their requirements and conditions are usually difficult for a true rural hospital to satisfy.

4. The state governments are gradually bringing in medical establishment rules, pollution control rules and other regulations which are against the functioning of rural establishments!

5. The only nice thing about the future is that rural people are earning better than before in many parts of India.

Let us start preparing ourselves to face these challenges and the future.

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**Antia-Finseth Innovation Award**

Innovations and innovative ideas help to simplify and Indianise health care and such simplification often reduces the cost of the services. Many innovations are the brain-children of ordinary people who may even be illiterate. Hence to recognize and encourage such people, a cash award of Rs. 10,000 is offered to any body, medical or non-medical person, whose innovation or an innovative idea is useful in rural health care.

Please send your applications to

**Dr. Rajesh Tongaonkar**
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PRESIDENT’S SPEECH ON 19TH NOV AT KOLLAM, KERALA

Dr. Sanjay S. Shivade. M. S. Farsi

Dignitaries’ on the dias, Chief guest of the function, the secretary of ARSI, Dr. Rajesh Tongaonkar, The organizing secretary of the conference Dr. Jacob John and his team, all the respected senior members of the ARSI, delegates, friends, ladies and Gentleman

At the outset, Let me first congratulate Dr. Jacob John for arranging such a wonderful National Event at such a small place in this beautified great land of coconut trees! I know, he has taken immense pains to arrange this and make it a memorable day today. We all are happy and joyful with his hospitality and gesture.

Let me revise the history of ARSI. Association of Rural Surgeons of India took birth in 1992 with only a handful of dedicated Rural surgeons. Late Dr. N.H. Antia, Dr. Narang, Dr. R.D. Prabhu from Shimoga Karnataka, Dr. Banarjee & Mrs. Banarjee from Rural Delhi, Dr. Sitanath De from West Bengal sat together to take a pledge to serve and solve Rural India. Now Association is a very strong body of over 500 members scattered all across the country. ARSI united all the Rural surgeons in the country and is instrumental in solving our rural problems.

70% of India is in Rural areas more than 80% post graduate practice in Urban India. This is a prominent disparity. Our mentor late Dr. Antia used to call this as Bharat. The Health problems of Rural India are different.

Malnutrition, Poverty, Illiteracy, Poor Health Awareness, Poor Infrastructural Facilities like roads and transport, Vehicles and Ambulance, ... all added to this poor economy! No specialization. Rural community wanted a Doctor who would treat all their problems. While most of us practice in rural areas, we had no qualified anaesthetist, qualified pathologist, sonologist, trained nurses, irregular electricity timings, and so on... but this is the specialty of Rural Surgeon. He is a community Surgeon, a need based Surgeon. He has developed a part of practicing all branches of surgery i.e. Gen. Surgery gynaecology, orthopaedics, ENT, anaesthesia. Some of our members are doing specialization practice in urology, oncology, laparoscopic surgeries, plastic surgery and even cardiothoracic surgery in Rural areas!

With a pride and smile all of us have accepted this Rural practice by choice and not by chance. We have examples before us. As Gandhi ji said

“Do not read my words, read my Life”.

Late Dr. N. H. Antia, Great plastic surgeon, Padmashri, member of planning commission of India set up an example by training the locals from a small village. It was a classical experiment with truth. Dr. R.R. Tongaonkar despite an illustrious carrier having topped in all M.B.B.S. & M.S. exams in one of the most prestigious medical college, B.J. Medical College Pune, opted to practice in Rural Maharashtra just by one sentence of his father. “What is told by Mahatma Gandhi,
do and serve village people and so he did. Banarjee couple served in mouflic Delhi Dr. Sitanath De in Rural Bengal, Dr. George and LalitaRegi in deep down sittilingi forest of Tamil Nadu, I know that every Rural surgeon is an example by himself in his homepitch! Dr. K. C. Sharma another versatile surgeon from Jammu, is also a scientist. We never have regrets while practicing in rural areas. We never feel shy when our city colleagues have more shine on their shoes and speech!

Friends, Let me share with you what the organization is doing. ARSI felicitate anyone, even a non medico, doing innovations which are for the benefit of rural population. Mahatma Gandhiji has said

"I would prize every invention of science made for the benefit of all".

Dr. Antia and Dr Finseth have contributed an award. ANTIA - FINSETH INNOVATION AWARD. ARSI promotes young rural surgeons to undergo specialized training by giving SHIMOGA JHARGRAM FELLOWSHIP every year. Yearly conferences bring us together to exchange our experiences, skills, problems and share each other on a common platform where everybody is equal. Today I am president but I am one amongst you all

ARSI leapt a step further and with German tropical society, East African surgeons, surgeons from Canada, Netherlands, United States, Bangladesh sat together and have formed International Federation of Rural Surgeons. Recently we had a memorable conference at Ifakara Tanzania.

ARSI shared a platform with east African Surgeons and promoted to form their National Rural surgeons Associations. ARSI was instrumental in carving them the by laws, rules and regulations as ARSI is very strong established and experienced body.

ARSI is instrumental in carrying forward another important programme i.e. DNB (Rural surgery) everyone has heard now that Rural surgery is a specialty and not merely a general surgery.

ARSI has some more feathers to its Hat. We fought a successful legal battle as we had no blood Banks. We were doing UDBT to save thousands of lives. Government put a ban on this. But we asked for an alternative of satellite centres. And now all over India satellite blood banks [or storage center more appropriately] are working. The poor in this country got justice. Dr. Reddy and, Dr. Tongaonkar promoted use of deep indigenous mosquito mesh to repair Hernia. This mesh went all around the world and became very popular. A mesh for hernia costing just 45 paisa!

Mahatma Gandhi has said"

"MORE FROM LESS FOR MORE"

More is health care delivery, efficiency from less is from less costly, limited resources and for more is for many, that is for mass populations. What more Gandhian philosophical example you want?

We have a regular quarterly ARSI Bulletin, Dr. Gnanaraj, Dr. Basu, Dr. Gopal are doing excellent job in getting the bulletin a new font and figure.

We still have certain challenges. The consumer protection, law, the Bombay Nursing Act, the Biomedical waste management law is changing the social mind-
set. We are in search of simpler solutions to such problems. Getting trained paramedics according to Nursing Council of India is difficult in Rural India. We have planned to chalk out a programme and get our own paramedics certified. Recently there is a lot of wanted and irrelevant issues are introduced in it. I do agree that every Rural surgeon must update his knowledge, his demands of the community. It is the need of the hour. We go to our Urban colleagues and learn something and apply is to our conditions. I would give one example. Open drop Anaesthesia was rampantly practiced 30yrs back. Now almost everywhere Boyle's apparatus is seen. Such changes are a must. A computewith internet will provide immense knowledge. Almost everything is there in it. We must improvise. National accreditation committee should be hand in glove with ARSI. Rather ARSI is the right body to decide about the norms of the accreditation. Recently a German student Katherina Weighle surveye dover 15 Rural Hospitals across the country and has published her report in our journal. She has made appropriate conclusions. Rural surgeons must master newer techniques, and recent advances in surgical diversities. Diseases are changing. Early diagnosis and specific treatment modalities will come. Operating a huge ovarian cyst is easy but diagnosing and treating unruptured ectopic would be more fascinating.

Friends, to conclude, Rural Surgery is a specialty. To become jack of all and master of surgery is still a further specialty. Rural surgeon is not only a surgeon; he is a community physician, a social worker and a socio-medical scientist and always an innovator. I am proud of all our colleagues for they are doing a marvelous contribution towards serving the Rural India. As Mahatma Gandhiji once said

“Real Wealth is health and not pieces of gold or silver.”

We have all gathered in this hall for a commitment. That is PINK REVOLUTION of Health. ARSI has shoulder this to the Gen next. We shall keep our promise with same principles.

Shimoga- Jhargram Scholarship

ARSI encourages the members to learn newer technologies like ultra-sonology, endoscopies etc. that are found to be useful in rural practice. Any young member of ARSI who wishes to go away and learn such a technology, or anything that will be useful in rural practice, is offered this scholarship.

Please send your applications to
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Kollam - Kerala Nov. 2010
MEDICAL JOURNALISM IN RURAL SURGERY

J.K. Banerjee Farsi,
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The definition of “Journalism” according to the Webster’s dictionary is, “the collection and editing of material of current interest for presentation through news media”. Also “an academic study concerned with the collection and editing of news or the management of a news medium”. And a third meaning, “writing designed to appeal to current popular taste or PUBLIC INTEREST”.

Medical journalism, as we see today, across the world is evolving in a certain direction. Serving high tech medicine, and propagating the interests of the healthcare industry. And which alienates it from health care providers serving 5 billion of the world’s total seven billion population. Today, is I go through any standard international medical journal, I do not find more than 25% of the published articles, sometimes even less, of any use to my practice in an Indian rural setting. And I am sure it is the same for our African friends as also for the SAARC countries.

Again, writing a paper in any standard, western type, medical journal which pertains to development of rural surgery, is totally blocked by high tech applications, such as advanced statistical analysis, advanced laboratory investigations etc., to which most of the rural surgeon have no access. Also there is always an element of publication bias of all these journals. And, as a result, the rural surgeon around the world, has no access to documenting his experiences.

Thus, today just as we need to develop the concept of rural surgery, as a backup support, we also need to have a journal of our own. If we go back to the definition of journalism, it is imperative to do so in “PUBLIC INTEREST”. The rural surgeon, as we see today, serves the largest chunk of population across the world. Essential and appropriate health care is more important to him which he delivers with his limited resources. And networking with other colleagues in this type of practice is essential for him to grow and meet the exacting needs and aspirations of his patients today.

I would venture to apply the term medical journalism not only to develop a journal but also for rural surgeons to attend as many conferences in our own country and other countries as possible presenting papers on different aspects of rural surgery. I presented the first paper entitled “Reflections of surgical economy in a developing community” in the first international conference of surgical efficiency and economy in Lund University in Sweden in 1987. To my surprise I found my name making headlines in the local papers the next day, and I was called in a press conference the next day, where, the journalists asked me the first question “Dr. Banerjee, have these surgeons learnt anything from you”. Prof. Stig Bengmark, the
organizing chairman, came later to Delhi as an invited orator for the ASICON 1987, when we were having our first meeting. He came in our meeting and said nobody will care for you unless you put your foot down and assert yourself against the mafia. The mafia will prevent you from your serving the people.

Again, in the 37th world congress of surgery in 1997 in Acupulco, Mexico, I had the privilege of being an invited speaker. My presentation was “Limited resources, the concept of rural surgery”. I presented what the rural surgeons were doing in India to meet the healthcare needs of the impoverished population. At the end, to my surprise, there was a standing ovation by about 150 surgeons from the audience. And the comment “congratulations to Indian surgeons for taking this bold step”. And a comment by the famous American surgeon Prof Nyhus, “we are gone, now they are going to teach...”. I kept on getting invitations and applauses in many conferences afterwards. And then came the upsurge from the DTC. Dr.Prabhu, Dr.Tongaonkar, Dr.K.C.Sharma, Dr.Baasu and others, all had the same experience.

Thus, conferences are a good media to propagate our concept not only to other countries around specially of the developing world, but also stimulate the younger generation into becoming rural surgeons of the future.

Albeit updating is equally important. But let me assure you that at the CME level for practicing rural surgeons, colleagues, who have already advanced their technology step by step are the best teachers. And for that purpose too, our journal should be the best adjunct to high tech books and articles. And it is now developing another role, that of teaching the postgraduates into many aspects of our approach which do not get any place in the standard journals of surgery across the world.

The aim of any scientific writing should be to benefit humanity in some way or the other, through its readers. Specially in the field of medicine, it should be able to help the reader to think and apply it in practice in his own area of work. Instead of saying “refer the patient to a higher centre” which only increases the plight of the patient and his family. It is unfortunate that the present generation of medical journals precisely hints in this direction to the rural surgeon. And that is why, we need to evolve a relevant form of journalism which will help the reader in finally benefiting the majority population around the world through its readers. In doing so, our journal may not confirm to the Vancouver style of presentation or use sophisticated investigations or sophisticated statistical analysis. We do not need to look for international recognition or indexing by any western bodies like PUBmed or Medline. Just as the practice of a rural surgeon increases by his skill and word of mouth, in the same way, our journal/newsletter will pick up readership across the world by the impact of its efficacy as a back up tool in the service of the rural surgeon. This has already started happening.

Albeit, basic statistical data and analysis has to be there. The basis of this has to be a good clinical presentation, minimum basic investigations, some relevant references, and finally the results properly
documented. It is through our type of journalism that we have brought out many new applications. The mosquito net hernia mesh, Dr.Ghaisa’s respirator and such other applications. The importance of paramedic training, preservation of the techniques of open surgeries and simple anaesthesia in absence of sophisticated equipment. All this is very very important for the well being of the five billion population round the world which rural surgery professes to serve at least for the next hundred years. And then comes the role of high-tech applications with limited resources and at an affordable price by the rural community. In short, essential health care development for the entire world population through the readers of our journal is what I envisage happening in the 21st century through proper guidance of this journal.

Today, the rural surgeon through his practice with limited resources, develops, I venture to say, a far greater clinical acumen and judgment than his corporate counterpart. I can quote a very long list of this. Over the years, he develops a great intuitive faculty much to the benefit of his patients. It is very important to document all this as well. Networking with colleagues not only of one country but with other countries and continents will go a long way in improving patient care and human happiness around the world. Our thrust has to be therefore to increase its readership across and also activate them into writing both articles and letters to the editor. The DTC is a great support in this direction.

Robert Virchow had said “medicine is a social science”. Which means that it has a social responsibility. Present day spurt of industry based technology and its associated greed of profit is alienating medicine from its social responsibility. The late Dr.Antia once showed me a paper clipping from the Guardian, of London, a long article which mentioned that 50% of the research articles published in any standard medical journal today is fake and industry oriented. Our journal should be able to keep itself clear of this public disrepute of medical journalism and set new standards.

All over the world, the increasing gap between the rich and the poor, are making the politicians to shout about CSR, corporate social responsibility. And we have seen some corporate houses doing wonderful work in that direction, supporting NGO movements into health care and other economic activities. The total approach of rural surgery is a combination of health care technology and the profession’s social responsibility. And this has to be brought out boldly through our practice of journalism.

When we started our newsletter first in 1993, I as the first editor, had the experience of editing articles sent to me written in long hand in a bunch of papers torn from a notepad. We then held symposia on how to write a paper, spent enormous time on editing etc., not to speak of fund raising to keep it going. And the annual conferences, where personal contacts imploring the rural surgeons to document their experiences went on. The second editor, Prof.V.K.Mehta then of MGIMS, Wardha, took it up after four years and published it regularly for the next six years. During this period, he enriched it by his dedicated professorial expertise. And
after this because of his personal problems, we requested Dr. Baasu to take over. And today we can all see its wonderful growth, budding into a journal. Articles from all over the world, with a wide international circulation, thanks again to our dear friends in the DTC and Africa.

Having traced our history, and looking at its present status, I venture to say that with a little effort, it could be easily turned into the one and only “International Journal of Rural Surgery”. And let me tell you, if we don’t take this step today, someone else will start one somewhere tomorrow. We have the experience of initiating the IFRS. Now let us start the IJRS, Int. Journal of Rural Surgery. This is essential to fortify our movement. And in future, let us start publishing a say, Clinics in Rural Surgery in the pattern of Recent advances series of specialities published by others, This could contain relevant articles from our journal, and may be some more.

Summing up therefore, medical journalism in rural surgery should now comprise of the following:-

1) Upgrade our newsletter to an International Journal of Rural Surgery together with a paradigm shift.
2) Use conferences both National and International as a media to proclaim our determination of meeting the social responsibility of the medical profession voluntarily. Both the Indian and Tanzanian Conferences were great successes.
3) Produce teaching material in the form of say, Clinics in Rural Surgery, may be biennial or so for the future.

There was a time when it was said that pen is mightier than the sword. Today the scene has totally changed. Albeit, we can venture to give a better place to journalism in the medical world through our efforts and make it at least an “adjunct” to our sword for erasing the stigmas invading our profession in the 21st century.

*Based on a paper read in the 16th National Conference of Rural Surgery, MGiMS, Wardha, in 2008

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**USE OF NEWSPAPER AS STERILE DRAPES. A NO COST SOLUTION.**

Dr. Anamay

An innovative use of old newspapers has been in use at our hospital. Autoclaved news papers are used in place of fabric drapes of minor procedure like catheterisation, excision of small skin lesions, wiping hand after scrubbing and many other purposes.

This innovation offers a no cost alternative to fabric drapes by cutting down cost of fabric and laundry.
METHODS AND DEVICES

ZERO COST SCROTAL SUPPORT / SCROTAL BAG-research letter
Vijay Renuke - Tutor,
YatindraKashid – Associate Professor.
NaziaShaikh - Resident
Department of General Surgery,
N.D.M.V.P.S.'s Medical College, Nashik.
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ABSTRACT:-
It is our personal experience that readymade scrotal supports are not easily & readily available in hospital pharmacies. Patient's relatives often face difficulties to procure readymade scrotal supports.

Also, most patients are from rural areas & belong to lower socio-economic strata. They already have incurred heavy expenses during the course of their hospital stay – on hospital charges, drugs & other materials, investigations, transport, etc.; therefore, they cannot afford to spend any more & are quite helpless.

The other problem is that as they are from rural areas, they don't know, or rather, they cannot find the proper places in the cities to buy scrotal supports.

Conventionally, scrotal support is given by bandages, & its application requires a qualified person and skill. Even when applied properly, it is bulky and ungainly. Also it makes ambulation uncomfortable for the patient. And, in spite of proper application, it often comes loose and gets dismantled. It gets soiled easily, and cannot be washed, but has to be re-made and re-applied. This increases the cost of dressing materials used, which is borne by the patient.

"Necessity is the mother of invention"
"Where there is a will, there is a way"
"Whenever there is a need, there arises a solution"

With these considerations in mind, we devised a scrotal support / scrotal bag, which can be easily made, with absolutely no cost, using materials which are readily available in a hospital, like used Urosac plastic covers, I.V. set covers &tubings, or any other thick plastic bag.

MATERIALS: -
1. Empty thick plastic bag like IV set bag or urobag cover.
   (Any thick plastic bag can be used)
2. Plastic tubings of the used I.V. set,( or Strings or strips made from roller bandages or Cotton, Lace or Naadi or ribbon, whichever is easily available in the hospital premises, can be used ).

PROCEDURE FOR PREPARATION:-
- Take coverings of I.V. set or urosac as per requirement of size of dressing (scrotal).
- Cut at one end and roll its edges so that desired size is achieved.
- Make multiple holes or rents for proper ventilation.
- Apply strings of IV set tubing at two ends of bag for support.

TECHNIQUE OF USE :-
- Tie the I.V. set tubing around patient's waist. Soft cushion can be provided with gauze pieces or cotton on the inner surface of bag.
- Now apply scrotal bag to scrotum and secure it to string around waist for desired support. Amount of scrotal elevation/support can be adjusted as per requirement.

ADVANTAGES:-

1. The most important advantage is the cost - which is almost 'ZERO'.

2. It can be prepared easily from discarded I.V. set bag/cover; used IV set tubing, roller bandages etc.

3. No special manufacturing is required. No special training is required to prepare it.

4. Additional advantage may be reduction of Bio-Medical Waste, as plastic and other material is re-cycled, at least temporarily.

REFERRANCE:-


Rural Surgery 2009; 5 (2): 17
PS: Although it is a good idea it does not achieve the important function of elevating the scrotum as does the traditional coconut bandage nor does it apply sufficient pressure.

Editor
LETTERS TO THE EDITOR

Dr. Sanjib Kumar Mukhopadhyay

The article by Dr. SK Baasu (Rural surgery 5:4, 2009) and the response to it by Dr. Sitanath Dey (Rural Surgery 6:2, 2010) deserve a little more discussion. The summary is as follows.

Dr. SK Baasu

1. Medical science and technology is expanding rapidly
2. Medical professionals need to be updated for providing better patient care
3. Attending CME for this involves cost
4. This could be passed on to those marketing such advances
5. To prevent misuse of such sponsorship, an Accreditation Council of our organization could help in providing evidence-based yet cost-effective medicine rather than go on alleging and ethical overdosing.

Dr. Sitanath Dey

A. There are time-tested ways in which ARSI has managed to arrange CME on its own
B. ARSI has continued to provide rational medical care at affordable price.

How do we reach a logical conclusion?

Swami Vivekananda “Nothing comes free in this world except your mother’s love”. We need to agree that both the Pharmaceutical giants and bio-medical engineering companies spend a lot of money on research. Like any other promotions for consumer products they present only the positive aspects.

Medical institutions teach through books and demonstrations and a qualified person is expected to have basic knowledge of most of the subjects and in depth knowledge of some subjects. Some however stop studying after they qualify. They also start for getting Handsome {nowadays even beautiful} representatives of the manufacturing companies come to the rescue. They provide ready references and other incentives to learn [from ball point pen to car to foreign trips]. Unfortunately the doctors often use the newer expensive products without verifying whether they are rational, cost effective or scientific. The companies use renowned doctors with convincing power to mesmerize the poor doctors. For instance the use of microionized progesgtrone in early pregnancy has become rampant. Its imaginary benefit of treating abortion and protecting even otherwise normal pregnancy has been highlighted in thousands of CMEs. One of the manufacturing companies is the chief patron of many Obstetrics and Gynecology conferences. The product has become the second best seller next to Calcium. There is no mention of this medicine in text books and there are references to this product being irrational, unscientific and potentially harmful.

When learned persons start accepting bribes it would become difficult for the “Accreditation Council” to remain free of
corruption. The recent news about the arrest of the President of the MCI is a good example. Where do we stand now? The MCI has been dissolved. The ICMR (Indian Council of Medical Research) rather than funding projects like “Epidemiological studies on length of Penis of Indian Men (ICMR 2002) should fund projects to study the newer medicines and gadgets.

Doctors who wish to gain knowledge should do so, on their own rather than look for sponsorship. They can set aside 1 or 2 percent of their income for this. We must be able to protect the vulnerable and marginalized groups in our society from the dazzle of lightening in medical technological thunderstorm in such a way that it helps in their struggle for existence. I look forward to ARSI on this mission

DEBATE ON RURAL HEALTH

Dr AbhaBhatnagar
Rural Medicare Centre
Village Saidulajaib Delhi

Our country is divided into Village, town, city and Metro and they vary from a small settlement to a business hub. Village does not mean lack of basic amenities. Why should we equate it with illiteracy and lack of everything?

Health care in villages is part of a network of various issues and cannot be tackled as a separate entity. It should be combined with measures of general uplift. Sporadic attempts by Government would be lost in the galaxy of problems.

Truncated medical courses are going to produce nothing but official quacks in cities of super-specialists because of the irresistible desire for money found in cities. Already there is no dearth of chemists and alternate medicine practitioners who practice allopathic medicine based on mere superficial association with qualified doctors. So this idea of producing official rural doctors is not going to serve the rural population but further increase the concentration in cities.