Letter from Chennai

THE URGE TO PUBLISH

A few days ago, I was invited to speak at the inaugural function of a journal on gastroenterology. I was assured that I would be at no risk from any virus. It was planned to be a virtual event, and I could speak from the comfort and safety of my chair in front of my computer. However, I declined the invitation. It was only fair that I explain myself to the organizer. I did, and wish to share my reasons with you.

We have a number of international journals in every specialty and in many subspecialties. Clearly, they cannot accommodate all the work done all over the world, and we also have many Indian journals of a high standard in every specialty. I am happy about that and am proud when any work I have done finds a place in the pages of one or other of these. Obviously, one would prefer to publish one's work in a prestigious international journal. If a piece of work does not make it there, we move to a national journal. Some papers are of more relevance to an Indian readership, and there would be no point in putting them before an international audience who might not be as much interested in the topic. As an example, let me cite a paper from my unit at the Jaslok Hospital in Mumbai some decades ago.[1] Those were days before computers were common, and my colleagues did the laborious task of analysing all the urine cultures done at the hospital during a period of 5 years. The Indian pharmaceutical industry had not yet attained the heights it has today, and imports were also tightly restricted. The lesson we learned was that the more we used an antibacterial the less effective it became, and we could see that change even over as short a period as 5 years. Since we were restricted to the drugs available in India in those days, I felt there would be no relevance to a physician in a more developed country and did not attempt to send the article overseas. The work was presented at a national conference first, and the manager of the company that manufactured the drug we found most effective was very keen on having it published in an international journal. He met me and promised to make every effort to achieve this and assured me that his company had great influence with the editors of some prestigious medical journals. The fact is that his product was at that time one of the most expensive antibacterials available in India, and therefore, it was less used. I stayed with my original decision.

It would not be fair to the author of a paper that could find a place in an international or a national journal to deprive him of that prestigious addition to his curriculum vitae and ask him to publish in a lesser-known journal. That means any such journal is condemned from the outset to have only papers of lower quality. When so many of the best journals are available on the web, and with doctors having limited time, why would anyone read these lesser-known journals? I believe the only people who would read them are those who have written in them or their friends.

The most common articles in these (what I call lesser-known) journals of associations of state branches or societies, or of individual hospitals, are the review articles or case reports. A good review is not without value, but it has to be written after an extensive study of the current literature, and preferably by an author who has some personal experience in the subject. I would also expect a review in any Indian journal to cover most of the Indian work. There is no shortage of excellent reviews in many international journals, and I see no point in our repeating that information, especially nowadays when the internet brings the world's literature to our desks. I am disappointed that most of the reviews in lesser-known journals are little better than the lectures we would deliver to our students. A recent issue of the journal of the state chapter of one learned society has not one authoritative mention of the Indian experience of the subjects covered. Even a professor's undergraduate lecture should have firm Indian data, not vague generalizations.

By and large, our hospitals are not as well-equipped as hospitals overseas. Even when investigations are available, the cost is often beyond the reach of most of our patients. However, our advantage is the number of patients each of us deals with. If we document them well and review our data from time to time, we would have a much better understanding of disease as it affects our patients, which is not always the same as in the West. Many of us have our own preferences in therapy, and it would be beneficial to us and our patients to review our results from time to time and see whether we do better or worse than other published studies. If we are doing better, we might convince others to follow our methods, and if our results are not as good, it would be a sign for us to change our ways. That might be worth the time of the reader. A report of a patient who teaches us some important lesson, or which is very rare, is also worth publishing, but it would probably find a place in a national journal. If it does not, it could appear in a lesser-known journal. A journal that lacks any of these is not worth reading, and therefore, should not be published.

COVID GOES TO COLLEGE

Around 2 months ago, Chennai consistently recorded more than 2000 fresh patients with Covid-19 infection every day. After a few days, the number began falling steadily, below 2000, after some weeks below 1000 and gradually down below 500, even 400. Our ministers took credit for this, saying we had obviously done everything right. We do not have a vaccine yet. I am writing this in December 2020. Apart from a lockdown that was lifted quite some time ago, the measures available that can be observed and enforced are the use of masks and social distancing. Face and hand hygiene is something we hope everyone follows, but there is no way you can judge from casual observation whether this is being done. I have been in strict isolation at home for 9 months now, but what I see from my window is that around half the people on the roads wear masks and keep their distance from each other. This is too small a number to generalize, but I read the newspapers every day, and the local news reports of political meetings and rallies carry numerous photographs. Social distancing does not exist at all, and mask usage is <50%.

Despite that, I do not doubt that the numbers are clearly falling. We may not be testing everyone who should be tested and might miss some patients. However, beds are now freely available for any Covid patient who needs hospitalization, while 2 months ago, patients were carried from hospital to hospital in search of a vacant bed somewhere. I must accept government

figures that we have fewer than 400 fresh patients every day and I feel confident that we will be over the crisis before long, though I do not know why. Weeks have passed, and we are not going below 300. Shops are open, and now educational institutions are resuming normal classes in stages. Some have reopened their hostels.

Two weeks ago, we were informed that the Indian Institute of Technology, Madras (IIT-M), had a sudden explosion of Covid infections. Of the 1293 tested, 199 samples were positive. The most important numbers were 179 of 1166 students and 16 of 44 mess workers. Only research scholars and postgraduate students, and a few others had been admitted to the hostels, and so they were not as packed as they would be under normal conditions. They had been admitted in batches, tested for the virus, and quarantined at the guest house for 14 days before being permitted to go to their hostels and resume their research work. The obvious conclusion was that the major risk of infection was from the mess where students gathered, albeit in batches and perforce had to remove their masks. The authorities promptly admitted the patients to a government-run Covid-19 hospital in Guindy (near the IIT-M) and closed the mess, the laboratories and the library. The entire institution was closed to the outside world. No one was permitted to leave the campus or allowed in except to bring in supplies. Healthy students were confined to their rooms, and food was delivered to them there. This outbreak has now been contained, and there are no fresh cases.

With relaxation of restrictions, schools and colleges will resume their activities and students will return to classes. Problems may be fewer in classrooms if students are kept far enough apart. Dr Jacob John, the famous virologist of Vellore, was reported to have said that with proper wearing of masks, a distance of two feet should be adequate. Perhaps, existing classes could be split in two and accommodated in their usual classrooms for at least an abbreviated school or college day, so the morning batch could go home for lunch, and the afternoon batch could have lunch at home and then come to work. Maybe the rest of the lessons would still have to be done online. It may not be a bad idea for students to be made to work more on their own with books or online references to be read, if the teachers would give them assignments and guide them on where they would get the necessary information. This may actually be better for students than the spoon-feeding that is being done now.

As for the noon meal scheme, it must be maintained. It seems clear to me that the only way it could safely be continued would be to give the students a packed, dry lunch and let them eat in different corners of the school premises. The noon meal scheme is essential to maintain the nutritional standards for the students, and it should not be abandoned.

REFERENCE

1 Salgia P, Mani MK, Mukerji S, Sawant M. Urinary tract infections—causative organisms and their varying sensitivity over a five year period. *J Assoc Physicians India* 1984;**32:**1033–7.

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