

problems in Tibet'. The Chinese government was predictably furious, but in the eyes of Australians, our Prime Minister could not have done better.

Last week an event occurred in the centre of Melbourne that reminded us about how many Indian people are living here now. Following the brutal stabbing of a taxi driver, who happened to be an Indian student, by a mentally ill HIV/AIDS sufferer, taxi drivers staged a 3-day blockade of Melbourne's main downtown intersection. Almost every taxi driver was Indian. Happily, their blockade was fruitful and their demand for government funding to support the fitting of protective shields around the driver's seat was granted with little argument.

When measured as a proportion of the total population, Australia has the largest migrant population of all countries of the Organisation for Economic Co-operation and Development (OECD) except Luxembourg, and 23% of Australians, or 4 million people, were born in other countries. Of these, about 1%–2% are from India. When they *all* crowd into the Melbourne Cricket Ground (MCG) to support the Indian test team against Australia, one might be excused for thinking that about one-third of all Australian residents are from the subcontinent.

3 May 2008

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* For the full text of the Prime Minister's apology, log on to http://www.pm.gov.au/media/Speech/2008/speech_0073.cfm.

Letter from Chennai

VIOLENCE AGAINST DOCTORS

There has been a sharp rise in violence against doctors, especially in small towns and rural areas. Whenever a person dies, the family and friends assume it is the fault of the doctor and the hospital, and summary justice is administered with a large crowd assaulting the team. Both Andhra Pradesh and Tamil Nadu have seen many such incidents, and the medical community is up in arms.

Following one such incident, the Indian Medical Association (IMA) of Andhra Pradesh (AP) organized a 2-day strike, and successfully forced the government to take action. On 18 December 2007, the Governor of AP promulgated 'an ordinance to prohibit violence against medicare service persons and damage to property in medicare service institutions and for matters connected therewith and incidental thereto'. It defines an offender as 'any person who either by himself or as a member or as a leader of a group of persons or organization commits or attempts to commit or abets or incites the commission of violence under this ordinance'.

Violence too is defined as 'causing any harm, injury or endangering the life or intimidation, obstruction or hindrance to any medicare service person in discharge of duty in the medicare service institution or damage to property in medicare service institution'.

The penalty is also prescribed: 'Any offender who commits any act in contravention of section 3 shall be punished with imprisonment for a period of three years and with fine, which may extend to fifty thousand rupees.' Further, such offence shall be cognizable and non-bailable. The offender will also be liable to pay twice the purchase price of medical equipment damaged or loss to the property, and other provisions of the law could also be applied against him in addition to those under this ordinance.

Will this be deterrent enough? I have not seen any reports of violence in AP hospitals since that day, and hope doctors will be able to get on with their work, free from the fear of physical violence.

Tamil Nadu has not been exempt from this rough justice, and the state branch of the IMA decided to stage a similar protest. In addition to protection against physical violence, the IMA sought protection from the police, who respond to unfounded complaints

against doctors by arresting them. A judgment of the Supreme Court dealt with this matter and gave guidelines for the circumstances under which doctors could be arrested. The IMA wanted the government to issue orders on both these matters. The government had assured the IMA that orders would be passed, but no action had been taken, and the IMA organized a 'Black Friday' protest on 7 March 2008, with all its members wearing black badges. Many doctors joined the protest, but the government has done nothing as yet in response, and the IMA is thinking of more drastic protests, maybe a strike like that of our brethren in AP. It would be sad if the Government of Tamil Nadu failed to respond to what seems an eminently reasonable request.

THE NATIONAL RURAL HEALTH MISSION (NRHM) IN REVIEW

How many of you are aware of the NRHM? I was lucky to be given a copy of the report of the Common Review Mission (CRM), which was charged with the task of studying the working of the NRHM. I cannot effectively summarize the report, which runs into 157 pages, but let me give you a few salient points. The NRHM represents an entirely new direction by the Central Government's Health Ministry. In the past, the Centre ran certain health schemes, but under the new dispensation the money is being given to bolster state health systems. The Centre will now channel more of its resources to poorer states in an effort to bring them up to the standard of the best. The aim is to increase spending from 0.9% of GDP to between 2% and 3% of GDP. It will not just be a question of pouring in money. The states will also be taught how to use the funds effectively. The pillars of the scheme are increased participation by the community in health planning and in the running of local hospitals and primary health centres (PHCs), inculcating management personnel into the system so that overall efficiency improves, making money available where it is needed most, recruiting, training and holding on to health workers of different categories, and setting standards and making sure that the standards are met.

The review mission comprised 26 officials of the health department, 4 officials from the states, and 20 non-official members,

3 being former union health secretaries and the rest public health experts from leading public health institutions. This team divided itself into groups that visited 2 districts in each of 13 states: 1 district chosen by the state concerned, the other selected by the review mission. Each district was inspected for 2 or 3 days, and then the group finally met and produced the report.

The gist is that there has been an improvement in the performance of the health system, with increasing attendance at the medical facilities and better quality of care. There is no constraint on funds now, but many states have been unable to utilize the funds placed at their disposal. Even Bihar, acknowledged by the CRM to be one of the weakest performers, has improved its performance beyond all expectations. Block PHC OPD attendance rose from 39 per month 2 years ago to 2500 per month now. Deliveries in government institutions rose from 7000 in October 2006 to more than 100 000 in October 2007.

Are you getting impatient? Why is all this being listed in a Letter from Chennai? Let me come to the point. In almost all the aspects studied by the CRM, Tamil Nadu came at the top of the list. This was reiterated by the Union Health Minister at a press conference he held on a visit to Chennai. While feeling proud of our achievements, I could not help feeling depressed, because if Tamil Nadu, with all its failings, is the best of the pack, how bad must be those states that are considered really bad? The Health Minister wants many aspects of Tamil Nadu's programme to be replicated in other states, especially in 18 (he did not name them) he said were particularly backward. The NRHM seems to be an

initiative that has yielded results, and we can hope things will get better.

SORRY, WRONG NUMBER

On 17 March 2008, the Director of Public Health and Preventive Medicine, Chennai, issued GO (Ms) 90, introducing a grievance redressal system in government hospitals. Recognizing that 'corruption is one of the important reasons for the delay in provision of care', the GO announced the introduction of a 'Grievances Redressal System in all Government Hospitals in the state'. This would cover all government hospitals, from PHCs to medical college hospitals, and would be manned 24 hours a day, 365 days a year. The existing ambulance control room would be used to receive grievances and suggestions through its toll free number 1056. Panels of officers were nominated for this purpose, at the city and district levels. Wide publicity was given; the newspapers of 8 April 2008 carried the information that the system 'has been put in place'. I was delighted. I firmly believe that if we could eliminate corruption from the working of our government institutions, we have all the arrangements, the rules and the infrastructure for an extremely efficient system that would rival the best anywhere in the world.

I set out to test the system. Soon after the advertisement when I called the number provided, I was told to 'Please check the number you have dialled' and, for good measure, this message was repeated in Tamil. I wish the implementation of our systems would also improve.

M. K. MANI

Letter from North America

ARTIFICIAL HEART IN ASIA

'Artificial heart is the ultimate evidence that medical profession has lost its "heart and soul" and became mechanical.'

This quote caught my eye while reading a blog. Artificial heart has been in the news both in Asia and in the USA for the past couple of months. In the USA, Robert Jarvik, the inventor of an artificial heart, participated in multiple television and newspaper advertisements promoting the use of atorvastatin (Lipitor), Pfizer's cholesterol lowering drug. Pfizer reportedly spent US\$ 258 million on the Jarvik-Lipitor campaign and paid Dr Jarvik US\$ 1.35 million (annual sale of Lipitor US\$ 12.7 billion). In January 2008, the US House of Representatives' Energy and Commerce Committee began investigating the Jarvik-Lipitor advertisements as part of a larger inquiry into the use of celebrities to promote prescription drugs. In February, Pfizer cancelled advertisements after the committee's investigation was widely covered in the American media. In India, Asia's first artificial heart was implanted in Narayana Hrudayalaya, Bangalore on 20 March 2008. The surgery was performed by a team of doctors under the guidance of their collaborators from the University of Minnesota, USA invoking curiosity among the media and public.

The use of mechanical circulatory support for heart failure management dates back to 1950 with the invention of the intra-aortic balloon pump (IABP). Since its first reported clinical use in 1968, IABP has been widely used in the management of advanced ischaemic heart disease complicated by cardiogenic shock; the largest experience was reported from the Massachusetts General Hospital and included 4000 patients. Extracorporeal membrane oxygenation (ECMO) is another advanced technology, commonly used in neonatal and paediatric units, which uses conventional cardiopulmonary bypass technology to support the circulation with continuous non-pulsatile cardiac output and extracorporeal oxygenation. Ventricular Assist Device (VAD), now a commonly used circulatory support device in North America, is a mechanical blood pump that serves to augment the function of either the left or right ventricle. VADs are used as a bridge to myocardial recovery in acute heart failure, a bridge to heart transplantation in chronic heart failure; and as long-lasting therapy for end-stage chronic heart failure, also known as destination therapy. These devices are surgically implanted and commonly require cardiopulmonary bypass to implant. The devices could delay the need for a transplant by 10-15 years. The US Food and Drug