away with the previous precedents. It also possibly arose from an increasing perception of 'neglect' of the AIIMS by the government. Could they have adopted a different course of action and still hoped to achieve a just resolution of the dispute? Having failed to elicit a response from various government functionaries, members of Parliament and ministers, whom they approached to explain their predicament, they had few other choices. Also, the government had acceded to pay-related demands of two other sections of healthcare workers (nurses and paramedical personnel) in the recent past only after they had gone on strike.

The government

As the prime decision maker it had the maximum ability to resolve the dispute. Having accepted the previous precedents as correct and setting up a committee to decide the pay scales of the faculty, it should have continued to follow the precedent and accepted the committee's recommendations. However, if it felt that it had made a mistake it should have corrected it prior to setting up the committee or before the committee gave its recommendations.

Resolving disputes in the health sector

With the dispute clearly defined it should have been possible to put into place a mechanism to arrive at a just, well argued, amicable solution. Unfortunately, neither does such a mechanism exist nor was any attempt made to create it to solve this dispute. While disputes are bound to occur, the need to resolve them without recourse to an agitation is of paramount importance. The lack of a process to resolve disputes is the prime reason for the increasing number of agitations in the health sector. Necessarily, this process would need to be such that the 'agitated' and the 'agitator' would both have confidence in obtaining a just solution.

Occupational health and medical ethics

Murlidhar, V : Manual for health-care workers (HCW's) on blood-borne viral occupational disease. Participatory research in Asia (PRIA), 42 Tughlakabad Institutional Area, New Delhi 110 062.

A manual detailing measures to prevent the transmission of blood-borne viruses in the health-care setting benefits health workers, patients and the general public. In the absence of such protective measures, the health worker is at risk of infection while performing various procedures, and the infected worker poses a risk to patients. Inappropriately discarded hospital waste also exposes the public to infection.

Occupational health is a medical ethics issue. The health-care industry's commitment to resources protecting its workers from occupational illness reflects the importance it gives to the people who provide care. In this country, many health-care institutions place a low priority on protective equipment for their staff. Shortages of basic protective equipment are routine in public health services. It is common to find laboratory workers handling blood specimens without gloves. Few hospitals offer their staff the Hepatitis B vaccine free of charge. A small minority of hospitals follow guidelines on infectious waste disposal. All this emphasises the powerlessness of health-care workers as a group.

In the case of blood-borne infections such as HIV, the absence of basic protective equipment also reinforces irrational and discriminatory testing practices on patients. Hospitals which routinely test their patients for HIV without their consent may give the impression that staff welfare is a concern (1), though this practice is both unethical and useless.

The manual presents a wealth of information on three subjects: the epidemiology of occupationally-acquired, blood-borne infections (HIV, HBV and HCV), preventive practices, and specific measures for post-exposure prophylaxis. This last subject is discussed in detail in relation to HIV.

The epidemiological information presented in the manual, on the risks of transmission of blood-borne viral infections, comes from health-care settings in developed countries.The author notes that there is anecdotal evidence of occupationally-acquired HIV infection among health-care workers in Mumbai, Ahmedabad and Vellore, and that two cases of occupationally-acquired HIV infection have been reported in a major medical college hospital, but provides no further details. The author mentions that such incidents are hushed up in India.

What are the ground realities of such occupationally-acquired infections in India? It is very likely that many health-care workers are exposed to, and infected with, these and other pathogens in the course of their work. It is also more than likely that such infected workers receive little or no treatment from their employers. This subject deserves discussion in the manual.

The discussion on personal protective equipment, decontamination and sterilisation could benefit from comments relating ideal circumstances to ground realities. There is also a need to differentiate between the responsibilities of the health care institution and those of the health-care worker.

A great deal of information has been packed into less than 40 pages. The manual would benefit from editing and designinputs. Essential instructions on prevention and post-exposure prophylaxis should be presented in simple charts in order to be of benefit to the health-care worker.

Sandhya Srinivasan

Reference :

Mandani Bashir: Routine pre-hospital admission HIV testing. *Issues in Medical Ethics* 1999 April-June; VII (2): 41-43.