Singh AR, Singh SA. Medicine as a corporate enterprise, patient welfare centered profession, or patient welfare centered professional enterprise? *Mens Sana Research Foundation* monograph series 2006; 3 (4-5): 19-51.

The INN system

This editorial supports the international campaign for international non-proprietary name drugs. In 1950, the World Health Assembly asked the WHO to develop the INN system, to name drugs in such a way that they would be recognised and pronounced correctly anywhere in the world. An editorial reproduced from *Prescrire International* notes that the INN system is "another means of providing patients with sound, honest information, of explaining why a specific drug treatment has been chosen, and any monitoring that is needed… It makes things clearer for everyone, helps to rationalise drug use, reduced waste and prevents confusion and accidents."

The BODHI editorial suggests that arguments against the INN system are essentially in support of irrational and unethical practice. "A suspicion of an underlying system of give and take between the prescriber and the producer cannot be ruled out."

Editorial. Let's join the global campaign. *BODHI* 2006; 13 (1): 1-2.

Will international accreditation benefit Indian patients?

This columnist reports on the growing trend of Indian hospitals to apply for accreditation by the Joint Commission International Accreditation of Health Care Organizations (JCIA), as part of the efforts to promote themselves as destinations for medical tourism. Some new standards will definitely help patients and health care personnel – hepatitis B immunisation, universal precautions and responses for needlestick injury, documentation, and so on. However, the author suggests, some changes will only push health care costs up further, with no real benefit for the Indian patient. Some examples: replacing all mercury-based thermometers and blood-pressure equipment, replacing the resin-based deioniser used in dialysis with a membrane deioniser, and doing away with formaldehyde as a sterilising agent. "The state of the art is not compatible with the state of our purse. Can we not adopt all that is good and within our financial capacity in the JCIA recommendations, and put on hold those that will cost too much? We will not get the coveted imprimateur of the JCIA, but the average Indian will be able to come to us for treatment."

Mani MK. Letter from Chennai. *Natl Med J India* 2006; 19: 44-5.

CORRESPONDENCE

The essence of the 'art' of medicine

The article by Neha Madhiwalla and Nobhojit Roy (1) is a timely analysis of the growing attacks on doctors and hospitals, mainly in Mumbai. The authors identify the lack of communications skills in trainee doctors, especially in sharing bad news, as one of the main factors. This clearly points to the need for communication skills to be included in the medical training given to students.

It is common practice in western medical and dental schools to teach students how to handle difficult situations with patients and their families. An example is the Schulich Medical and Dental School's clinical skills programme in Ontario, Canada (2). The programme uses "standardised patients" to train and evaluates the students on how they handle various simulated situations.

The Medical Council of India recently announced plans to revise the MBBS curriculum and include communication skills as part of first-year training (3). The proposed changes have been sent to state governments for comment. As planned, medical education units in colleges, often defunct, should be given the responsibility of organising training in skills for communicating with patients and relatives. This would also help in dealing with patient perceptions, a need highlighted by Sunil Pandya in a 2001 editorial (4).

A lot of medical training and the way we learn to interact with patients come from observing peers and seniors. During my training, the most popular clinical faculty members and the ones with the longest queues at the out-patient department were not necessarily the ones who were the best technically, but the ones who were congenial and interacted with patients in a respectful manner. That for me was the essence of the "art" of medicine.

Many other factors have led to the rising violence in medical settings, as highlighted in the article, including a lack of infrastructure and frequently malfunctioning equipment, as was evident in the recent problems with the morgue cooling plant in Sassoon Hospital in Pune (5). This is an example of a situation that can lead to anger and provoke violence among waiting and grief-stricken relatives.

It would have been interesting to study whether there is any difference in the responses gathered at teaching hospitals as compared to peripheral hospitals. More space could also have been given in the article to the perceptions of patients. The article should provoke critical thinking among all of us, but especially among hospital administrators and medical college deans.

Anant Bhan, *Flat 405, Building A-11, Planet Millennium, Aundh Camp, Pune 411 027 Maharashtra, INDIA e-mail: drbhan@sify.com*

References

1. Madhiwalla N, Roy N. Assaults on public hospital staff by patients and their relatives: an inquiry. *Ind J Med Ethics.* 2006; 3: 51-54.
2. Dundas K. Dental dilemmas. *Rapport* 2006 ;1: 6-7. [cited 2006 June 25]. Available from: http:/www.schulich.uwo.ca/rapport/volume1.pdf
3. Seshagiri M. Hey doctor brush up your English. *The Times of India* 2006 Jan 25. [cited 2006 June 25]. Available from: http://timesofindia.indiatimes.com/articleshow/1386150.cms
4. Pandya SK. Doctor-patient relationship: the importance of the patient's perceptions. *J Postgrad Med* 2001; 47:3-7.
5. Kashyap SD, Shelke G. Sassoon stinks of the dead. *The Times of India* 2006 June 23. [cited 2006 June 25]. Available from: http://timesofindia.indiatimes.com/articleshow/1672606.cms