

I would like to point out some similarities regarding corruption in healthcare, between India and Peru, two middle-income countries in different continents. According to Transparency International, India and Peru have a Corruption Perception Index of 3.1 and 3.4, respectively (<http://www.transparency.org/country>). This same entity provides the Global Corruption Barometer, in which statistics show that 85% of surveyed Peruvians assess as "ineffective" the current government's actions in the fight against corruption; whereas in India, this opinion is held by 44% of surveyed Indians. In both countries, many cases of corruption are due to overcharging for supplies, infrastructure and new equipment, and to favours that benefit only a few.

Statistics from the Global Corruption Barometer (<http://gcb.transparency.org/gcb201011/>) indicate that in India, 21% of people have come into contact with medical services, and 26% of them have paid a bribe in this kind of institution in the last twelve months; on the other hand, for Peru it is reported that 72% of people have come into contact with medical services, and of them only 4% have paid a bribe. These differences are perhaps a clear indication that, where there is more corruption, less people may have the willingness to go to a health facility. However, this hypothesis should be further explored in different contexts, in order to arrive to a solid conclusion.

Corruption is a global problem, and definitely affects a population's health (3), no matter where. Therefore, it should be included as a research topic worldwide, and among global health researchers, in order to fully understand the relationship between corruption and health, and its determinants (4).

The key is to develop strong programmes and strategies created to address the characteristics of corruption in a country, and that will prevent problems within the health care system, in matters of access, inequity and outcomes (1, 2). These anti-corruption strategies should be based on theory, developed according to the evidence and adapted to suit the specific contexts where they are to be applied (1).

Rodrigo M Carrillo-Larco, Alberto Hurtado School of Medicine, Universidad Peruana Cayetano Heredia, Lima, PERU. E-mail: rodrigo.carrillo@upch.pe

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Void in the sphere of wisdom: a distorted picture of homosexuality in medical textbooks

Homosexuality is not a new issue in western medical literature; but an empathetic approach to it in the medical literature in India is a recent phenomenon (1, 2, 3). Equality in providing

healthcare is not being practised, as evidenced by homophobia among doctors (4,5), more so in the Indian sub-continent where religious and social biases contribute to denying proper healthcare to the homosexual - as well as the lesbian, bisexual and transgender - community. The attitudes of young medical students are more amenable to change, and can be better oriented towards providing equitable healthcare, irrespective of the sexual orientation of patients (6). Here the question arises: "What does our curriculum teach about sexuality issues?"

We highlight the misleading information given in the textbooks widely followed by the students of the West Bengal University of Health Sciences. The most affected subjects are physiology, psychiatry and forensic medicine. According to the physiology textbook, in puberty "there develops attraction to opposite sex." (8). This clearly promotes heterosexuality as the only norm. Some forensic science textbooks state that homosexuality is an "offence", homosexuals "may be psychologically imbalanced", and they are "egoists", who "disregard society" and pose a "social, moral and psychological problem". (9) The term "crime of homosexuality" has been used (9) and "treatment of homosexuality" has been suggested (9). Some books say "AIDS infection is commonly transmitted by unnatural sex acts with the homosexuals" (9) and call sodomy "a sexual offence" which is most popular and widely practised among homosexuals (10). This portrays same sex behaviour as an inferior form of sexuality. In spite of a long debate on the controversial term 'gay bowel syndrome' as it indicates a link between homosexual activity and gastro-intestinal disease, it is still referred to in a standard microbiology textbook (11). A widely followed textbook of psychiatry uses terms like "cross-gender homosexuality" and "ego-dystonic homosexuality" (12).

We suggest substantial revision in the undergraduate medical syllabus and textbooks as these are the main sources of knowledge for doctors. If distorted information is provided from the start of their medical education, any seminars or discussions will be in vain. An unbiased discussion of concepts like sexual behaviour, orientation, identity, sex and gender are much needed. Specific diseases which affect homosexuals must be highlighted rather than providing the "treatment guidelines of homosexuality" (3). Policy makers, educationalists, authors and thoughtful readers must come forward to fill this void in the sphere of wisdom and forge a better patient-doctor relationship.

Subhankar Chatterjee, Fifth Semester Student, MBBS, R.G.Kar Medical College & Hospital, Kolkata, INDIA, e-mail: chatterjeeaspiresubhankar.92@gmail.com **Subhasish Ghosh**, Fifth Semester Student, MBBS, Medical College, Kolkata INDIA

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Looking away does not make things vanish

We wish to comment on the report by Al Faisal and colleagues published in *The Indian Journal of Medical Ethics* (1). In that report, the authors claim that economic sanctions imposed in 2011 were the reason behind the devaluation of the local currency, interruption of power supply, scarcity of medical supplies, and degradation of sanitation systems. Nowhere to be found in the report, however, is a description, albeit brief, of what those sanctions are and how they led to these effects. No evidence of cause and effect was presented, no suggested mechanisms, and most grave, no consideration for the interplay between sanctions and an all-out civil war situation that interrupted every sphere of economic activity in the country (2). Such biased and unscientific analysis flies moreover in the face of known facts about the Syrian economy. The political and economic isolation of the Syrian regime is not new, but has allowed Syria, in the past, to ward off most of the global economic crisis of 2008, and will certainly make it more resilient to economic sanctions *per se* (3). What is most disturbing in a report about the wellbeing of Syrians in the current conflict still is the lack of any reference to the role of the Syrian regime in inflicting death and hardship on its population. This role has been documented repeatedly by UN agencies, credible media outlets, and the international community, and was behind the mostly regime-targeting sanctions to begin with (2,4,5).

Syria marks a unique case in modern history, where a war is waged by an armed-to-the-teeth regime against its own people

with 'all gloves off'. International treaties, norms, and moral constraints of conduct all cease to apply to how the Syrian regime is facing the uprising of people that is approaching its two-year mark (6). The wounded are followed to hospitals to be killed or kidnapped, the dead are mutilated and delivered to their families on the condition that they do not hold funerals, captives are tortured and summarily executed, and civilian areas are indiscriminately bombarded (2,6-8). Furthermore, a distinct hallmark of the Syrian regime's crackdown on the uprising has been the targeting of healthcare facilities and workers. Since the beginning of the uprising, doctors, health professionals and first responders were targeted and killed for nothing else but performing their professional duty towards victims of the conflict (9). The horror stories and scenes emerging from Syria are just the tip of the iceberg in a country that continues to be largely closed to the international press and relief agencies, and where communication and services are usually unavailable in areas of active military operations (2).

To be able to ignore and omit all that and single out sanctions as the cause for the suffering of Syrians requires much more than the talent of distortion.

Wasim Maziak, Professor and Chair, Department of Epidemiology, Florida International University. Director, Syrian Center for Tobacco Studies, FL 33199 USA e-mail: wmaziak@fiu.edu Adam Coutts, Faculty of Human, Social and Political Sciences University of Cambridge, Cambridge UK Fouad Fouad, Syrian Center for Tobacco Studies and Faculty of Health Sciences, American University of Beirut, Beirut, LEBANON

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