

# *News from here and there*

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## **Indigenous medicine versus allopathic medicine**

In August 2011, the Vice-Chancellor of Dr M.G.R. Medical University, the institution which oversees education in all branches of medicine in Tamil Nadu, announced that the modern medicine content would be removed from the syllabus of the Indian medicine courses—Ayurveda, Unani and Siddha. The Central Council of Indian Medicine responded by saying that it would be forced to withdraw recognition of the degrees for Indian medicine being awarded by the university, if this was done. The state government intervened, and the proposed change in the syllabi has been dropped. Asked by the press about the decision, the Vice-Chancellor replied that it was part of an ongoing exercise to restructure the syllabi for all streams of medicine and drop irrelevant portions. The fact that the move was welcomed by the president of the Tamil Nadu Medical Council and opposed by practitioners of Indian medicine points to the divide and mutual mistrust between these 2 groups of professionals.

GEORGE THOMAS, *Chennai, Tamil Nadu*

## **Ethnically tailored diabetes education for South Asians in Canada**

Recent research conducted at the Institute for Clinical Evaluative Sciences (ICES) in Toronto indicates that South Asians in Canada develop diabetes at a faster rate, at an earlier age and at lower ranges of body mass index than their white counterparts. These results validate some of the findings from previous studies. For example, it has been known for a while now that the risk of diabetes among individuals of South Asian descent in Canada is at least thrice that of immigrants from western Europe and North America.

In spite of the higher risk, however, the majority of individuals with diabetes are still undiagnosed and poorly controlled. Suboptimal treatment of diabetes among individuals from India, Pakistan, Sri Lanka and Bangladesh is purported to be due to several factors, such as a lack of knowledge of diabetes, negative beliefs and attitudes relating to diabetes, and non-compliance with lifestyle changes (e.g. diet, weight control and physical activity). These barriers are compounded by a lack of culturally sensitive and ethnically tailored diabetes education programmes across Canada.

The Canadian Diabetes Association (CDA) has been at the forefront of the attempt to change the attitudes of these population groups towards diabetes. The CDA established a South Asian chapter in 2007 to plan and promote education on diabetes in a culturally sensitive manner for individuals of South Asian descent. The CDA has also created a South Asian Education Committee that meets regularly to discuss educational opportunities, and coordinates activities that support the attainment of an optimal quality of life by all members of the South Asian community affected by diabetes. Among the various programmes targeted towards South Asians is 'Just the Basics'. This is a nutrition

resource available at [www.diabetes.ca](http://www.diabetes.ca), which has been developed by the CDA's South Asian Working Group. This is filled with culturally appropriate information and tips for healthy eating, including portion guides in English, French, Hindi, Punjabi and Tamil. The resources additionally provide recommendations on how to increase physical activity and advice on how to follow a healthy lifestyle. Healthy sample meal plans with vegetarian options are also provided.

Provincial governments across Canada are also proactively targeting South Asians. The province of Ontario initiated the much-acclaimed South Asian Diabetes Prevention Program (<http://www.sadpp.com>) in 2009 to prevent diabetes among South Asian communities through outreach and the provision of culturally relevant services at the community level.

While these efforts are commendable, as the number of people of South Asian descent continues to increase—the population is projected to reach over 1.8 million by 2017—the findings of the ICES study indicate that a new urgency is required in attempts to improve and expand ethnically tailored approaches to screening and prevention of diabetes in these high risk populations across the country.

MEENAKSHI KASHYAP, *Canada*

## **Innovative measures for improving postgraduate teaching: The Dr N.T.R. University of Health Sciences experience**

Shortage of postgraduate (PG) teachers has been affecting postgraduate teaching programmes in many medical colleges. Dr I.V. Rao, the Vice-Chancellor of Dr N.T.R. University of Health Sciences, Vijayawada, Andhra Pradesh has initiated several innovative measures for the improvement of PG teaching in all specialties in the colleges affiliated to the university across the state. Dr Rao, a vastly experienced Professor of Medicine and an exemplary, dedicated teacher, explained that the 20 specialties in which the PG courses are being held were divided into clinical and non-clinical subjects. Continuing Medical Education programmes (CMEs) were conducted in clinical specialties in one month, followed by the CMEs in non-clinical specialties the next month, so that 6 CMEs were conducted in a year, overall, in both specialties. All the colleges which run PG medical courses were divided into 6 zones, and each medical college in a particular zone conducted the CME by rotation. All PGs in the given zone attended the CME concerning their specialty. In each CME, 3 topics were discussed by guest speakers, while 2 clinical cases were discussed by the professors. Soft-copy records of the teaching material used in all the CMEs conducted across the state were submitted to the university for compilation, to make a yearbook in that specialty at the end of the year. During the 6-month period from January to July 2011, a total of 300 CMEs were conducted in clinical ( $n=150$ ) and non-clinical subjects ( $n=150$ ). Overall, 750 topics were covered in clinical and 750 in non-clinical subjects in all zones put together; 75 topics were covered in all the

zones in each specialty. Furthermore, Dr Rao also explained that the University sent question papers to the colleges for conducting internal theory examinations simultaneously on the same day, once in 6 months, on the prescribed syllabus. He said that the feedback obtained from the students had been encouraging, and most of them felt that such teaching programmes helped to improve their knowledge of the subject and prepare for examinations.

ALLADI MOHAN, *Tirupati, Andhra Pradesh*

#### **Canadian medical resident successfully sues hospital for long working hours**

A long-standing subject of debate in medicine has been the length of working shifts for physicians undergoing training. While there is strong evidence from shift workers and clinical residents that sleep deprivation is detrimental to both the health of the worker and the safety of the patient, one Canadian resident decided to take matters into his own hands.

Dr Alain Bestarwos, a resident at the Montreal General Hospital in Quebec, successfully sued the administration for being made to work excess hours, which was seen as violative of the Canadian Charter. The judge overseeing the case mandated that the hospitals within the region re-arrange their schedule so that residents' working hours came down from 24 to 16 per shift within 6 months.

Interestingly, there have been protests against this both from the hospitals, which have appealed against the ruling, as well as from departments and residents in other disciplines. These restrictive hours can be particularly limiting for those training in surgical specialties, possibly compromising learning opportunities.

This conflict is placed within the context of salary negotiations—Quebec residents are paid on an average 30% less than residents in the rest of Canada. Since July 2011, residents have been protesting by discontinuing teaching medical students, one of the activities they usually engage in. Current reports suggest that the residents may strike later by limiting their clinical service.

Noura Hassan, President of the Canadian Federation of Medical Students (CFMS), stated, 'We believe that a healthy workforce is more likely to provide quality healthcare. Duty hours are a key factor known to have an impact on learner and patient well-being. Studies have shown that residents working 24 consecutive hours are more likely to make medical errors than their counterparts working 16-hour shifts. These data have fuelled the current movement for limitation of resident duty hours. The CFMS supports the movement towards limitation of duty hours to a maximum of 16 consecutive hours. Not only will this have a positive impact on learner wellness, but it will also (and more importantly) improve quality of care for our patients.'

PAMELA VERMA, *Vancouver, BC, Canada*

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*The National Medical Journal of India* is looking for correspondents for the 'News from here and there' section. We are particularly interested in getting newswriters from the north and northeast regions of India as well as from other countries. By news, we refer to anything that might have happened in your region which will impact on the practice of medicine or will be of interest to physicians in India. The emphasis of the news items in this column, which are usually from 200 to 450 words, is on factual reporting. Comments and personal opinions should be kept to a minimum if at all. Interested correspondents should contact SANJAY A. PAI at [sanjayapai@gmail.com](mailto:sanjayapai@gmail.com) or [nmji@nmji.in](mailto:nmji@nmji.in)