

In fact, following the Gadchiroli trials, various studies were conducted in other south-east Asian countries, and all these studies adopted more or less the same model of "home-based neonatal care" that was adopted by the Gadchiroli trials. Further, none of them provided "standard care" as per the norms of the US or western Europe. Baqui et al, from Sylhet, Bangladesh, reported a 34% reduction in neonatal mortality by training female health workers to provide home-based newborn care as per WHO's integrated management of childhood illness guidelines (2). Manandhar et al achieved a 30% reduction in the neonatal mortality rate in rural Nepal by introducing community-based newborn care through women's groups (3). Bhutta et al in Pakistan engaged and trained an existing cadre of women health workers for community-based newborn care. In addition, trained birth attendants or "dais" were also trained for newborn care. They eventually reduced the neonatal mortality rate by around 19% in four intervention villages (4). If the standard of care in the Gadchiroli trial is described as unethical, then I must say that the standard of care provided in all of the above mentioned trials is also unethical.

However, now we know that the interventions of the Gadchiroli trial have shown the effective way to reduce infant mortality substantially; instead of debating the ethics of the Gadchiroli trials, researchers should come forward and try to mobilise policy makers to adopt home-based neonatal care. I agree with Abhay Bang's challenge to those who call this trial unethical: "Should one wait until the best standards, and the resources needed for using them in the control area, are made available, and allow children to die until such time?"

Kuldeep Kumar, UCL Centre for International Health and Development, Institute of Child Health, 30 Guilford Street, London WC1N 1EH UNITED KINGDOM e-mail: kuldeep.kumar.09@ucl.ac.uk

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Seeking information on doctors and advertising

I would like to approach the readership of your journal through these columns in order to explore an issue that is assuming alarming proportions here in Pakistan. It has become

commonplace for physicians here to appear in commercials, directly or indirectly promoting products. Up till a few years ago we would see professional models dressed in white coats with stethoscopes slung around their necks, pretending to be doctors, promoting products. Gradually one saw young physicians appearing in advertisements, obviously to make some easy money. It is now common to see senior physicians displaying their credentials and institutional affiliations giving what appears to be a public health message, but with the brand name of particular products displayed besides them. Often times the "public health message" is also inaccurate and misleading. Some of these physician models are actually serving professors in leading medical colleges. They have appeared in television and newspaper advertisements, on billboards, and on posters selling products ranging from toothpaste, shampoo and medicated soaps to baby diapers and even socks.

A search of the English language literature reveals practically no material focusing on physicians advertising and promoting products. There is much written on self advertisement, an area already covered by clear guidelines of the Pakistan Medical and Dental Council (PMDC). Another area that has been explored extensively in literature is on physicians associations endorsing products, which also raises major ethical concerns.

There is growing concern among many physician circles about this alarming trend. In response to this concern the Karachi Bioethics Group (KBG) wishes to develop a position statement addressing all aspects of physicians endorsing products which we hope can then become a framework for policy formulation by physicians associations including the Pakistan Medical Association and the PMDC.

The KBG consists of individuals from several institutions across Karachi who have a shared interest in bioethics. The group meets once every two months in their personal capacities and discuss ethical issues. The group has recently launched a set of guidelines on physician- pharmaceutical industry interaction. More information can be obtained from www.karachibioethicsgroup.com.

It would be interesting to learn from your readers if there has been a similar trend in India of physicians willing to become industry poster boys, and if so, what has been the reaction by the public and the physician community.

Aamir Jafarey, Centre of Biomedical Ethics and Culture, SIUT, Karachi 74200 PAKISTAN e-mail: aamirjafarey@gmail.com

Delay in publications: new authors and editorial misconduct

An amendment by the Medical Council of India, in 2009, has introduced, as a criterion for early academic promotion, a compulsory minimum number of publications (1).

Given the many medical colleges in India, one would expect many research publications by medical college

teachers (2) but this is not the case. However, with the MCI's new requirement, a rush of articles will be submitted for publication. One reliable measure of the quality of a research publication in medical sciences is whether the publication is in a journal indexed by Pubmed (3) and such journals are likely to get an increase in submissions. There are several teachers in medical colleges who have fulfilled all criteria for promotion except that they do not have publications to their credit. The increase in submissions may result in delays in publication

Delays in publication may occur because of delays in collecting data, or in analysis, or for other reasons inherent to the type and nature of the research. In addition, delays in the editorial processing of a submitted article may discourage research. All those responsible for delays must take appropriate action.

Authors as well as editorial teams are responsible for the delay in publishing a submitted article. In one study, the time from acceptance to publication took 90 days (4). In another study, the longest delay in the editorial process was caused by the wait for authors to respond to reviewers' or editors' feedback (5). The authors took 67 (SD: 76) days to resubmit their paper following initial feedback, and a further 48 (SD: 79) days after it had been edited (5). New authors are likely to cause delays because they lack experience in writing for publication. They may target the wrong journal; fail to assess whether the information in their manuscript is in line with the editorial policy or the interests of readers of a given journal (6), all of which may result in the rejection of their manuscript. They may not get their article critically reviewed by an expert though this can improve the article; they may not even get it proofread. It is also essential to communicate clearly and speedily with reviewers, something which new authors may find difficult. Still, if new authors are under pressure to publish, as are medical college teachers awaiting their promotion, they will blame the editorial team for delays in publication.

The time taken between the date of submission and the first author contact, either for revision or decision, is reported to be about 60 days (4, 7). Editorial misconduct is another issue. The editorial process can sometimes exceed a year, a cause of great disappointment to authors. The time taken for peer review in local journals is sometimes comparable to review times in larger and more prestigious journals (8) with many more submissions. For the delay in publication, the justification that the journal is a larger and prestigious one is certainly not acceptable. It has been pointed out that undue delay in reaching decisions and communicating these to authors is editorial misconduct (9). Appropriate action should be initiated against editorial teams that delay processing publication.

Online submission of manuscripts is normally fast, relatively easy, and timely (7). Online editorial processing should also speed up publication time. Editors and their teams should devote time and resources to fulfil the responsibility

bestowed on them. Some journals avoid delayed publication of certain articles by publishing accepted articles online, "epub ahead of print." The backlog will also be reduced with an increase in the number of journals and in the number of issues per volume (year) of the journal.

Deepak Herald D'Souza, Associate Professor, Department of Forensic Medicine and Toxicology; **Jyothi Maria Prameela D'Souza**, Assistant Professor, Department of Biochemistry, Yenepoya Medical College, Yenepoya University, Mangalore Karnataka 575 018 INDIA e-mail:deepakdsouza@yenepoya.org, jyothimpdsouza@yahoo.com

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Conflict of interest: *Delays in publications matter to both the authors, as they are looking for early academic promotion, which is possible if there is no delay in the publication of their articles submitted elsewhere.*

Informed consent needs information

Benign prostatic hyperplasia (BPH) is a pathology seen in middle aged or elderly males and can present with painful acute urinary retention warranting immediate relief through per urethral insertion of a Foleys Catheter (1). Transurethral Resection of Prostate (TURP) is considered the gold standard for the surgical treatment of BPH (2). TURP is one of the most commonly performed procedures in urology.

A 58-year-old male patient presented in the emergency room of our hospital in Karachi with acute urinary retention. He had been passing urine comfortably until a few days earlier. Per urethral catheterisation had been attempted at a small town some three to four hours' drive from Karachi. However, catheterisation had failed and the patient was disposed with an 18 G I/V cannula placed percutaneously in the suprapubic region to drain the urinary bladder. At our centre, the suprapubic cannula was replaced by a 16 Fr suprapubic catheter.