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.

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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.

I learned that the patient had undergone TURP five years earlier at another centre and was unhappy about the minimally invasive approach adopted by the surgeon. I explained that the retention was most likely secondary to "re-growth of prostate" or urethral stricture (3) and added that the risk of repeat prostatectomy is around 5% in one year, 10-12 % in five years and 20% in 8-10 years (4). I further explained that although the incidence of repeat prostatectomy is higher with TURP than open prostatectomy, the latter has higher morbidity and costs (1). The patient who was now comfortable laughed and said, in Urdu, "Doctor Sahib, for me these figures stood out as 100%. Open surgery was suitable for me, because in case of blockage in passing urine it takes very long from Khuzdar to Karachi.... Had I been treated with open surgery, I would not have to go through a repeat operation on my gland."

It is difficult to comment on the appropriateness of surgery in this case. Certainly decision making in such a scenario is complex. Still, it is necessary to point out the importance of obtaining truly informed consent.

An ethically valid informed consent has seven necessary elements: a "capable decision maker" (the patient), the patient's voluntariness, disclosure, recommendation, understanding, decision and authorisation. In practice, however, informed decision making is often incomplete (5). In one study, just 9% of decisions met "quite reasonable criteria". The understanding of the patient is least frequently assessed (1.5%) and uncertainties and alternatives to the proposed plan of management are rarely discussed (6)

Patients need to be given the information they need to make decisions. This includes explaining the prognosis, treatment options, and possible complications. International guidelines are relevant but their application is not enough. Nor will sensitivity to cultural and social values suffice for decision making. Decision making goes through a complex process of interaction between the physician and patients - or physician, patient and patient's family depending on the nature of the illness and the patient's socioeconomic background and cultural values. So, while suggesting options, the physician needs to be patient centered, elaborating on issues which may be important to a particular patient. They should consider issues such as basic healthcare access, availability of transportation and also look for ways to overcome such problems within the patient's means.

In this case, the surgeon followed international recommendations but the patient was not mentally prepared for the possibility of re-growth of the gland and retention of urine. Nor was he informed that in case of symptoms of urinary retention, he should visit the nearest hospital early rather than in an emergency. He should also have been told about the option of open surgery and the reason that international recommendations were against it.

The process of acquiring informed consent is complex. It is not always possible to resolve conflicts in decision making, in this case weighing international recommendations versus the patient's desire based on his conditions and socio-cultural issues. But what is important is that the physician show sensitivity to patients' choices and wishes and their cultural values.

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