the same Indians/ humans. And therefore we will need to have monitors to monitor the monitors.

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Challenges of collaborative research

In 2009, as a supplement to a National Institutes of Health (NIH) -funded collaboration between the Indian Council of Medical Research (ICMR) and the NIH, a formative study was conducted with 30 HIV-positive people and 18 HIV-related service providers to understand sexual risk-taking, HIV-related disclosure, and other behavioural patterns among HIV-positive individuals in Baroda, Gujarat. One goal of this research was to determine how to adapt a counselling intervention which had been tested in the United States, in order to make it culturally and linguistically relevant for PLWHA(People living with HIV/ AIDS) here.

We identified several challenges in the course of our work.

Initially it was decided to compensate each PLWHA Rs 1,000 per day for their daily wages and transport expenses. We had to reduce this to Rs 500 per day per participant, following ICMR guidelines. However, the PLWHA with whom we interacted wanted monetary benefits in return for giving in-depth interviews.

Though the study had already been reviewed by the NIH, the University of North Carolina and the ICMR, it had to be reviewed and cleared by the institutional review board (IRB) at the Medical College of Baroda. This took roughly one and a half years. Our foreign investigators came twice to India for this purpose. We believe that this delay was because research is less common at the Indian site and the IRB here met infrequently. Second, the IRB had little experience of reviewing joint/ collaborative research protocols.

A number of our budget items were rejected. For example, a separate private cabin was proposed for taking in-depth interviews, and password-protected computers were to be used for data entry and maintaining records in confidence. However this proposal was rejected by ICMR and so we had to use the institutional investigators' cabin and computers for these purposes. This is not an ideal condition for maintaining privacy and confidentiality. A laptop had to be sent from the US for our research associate to maintain and monitor data. Finally, the ICMR rejected salary support for the principal investigators (Rajendra Baxi and Sangita Patel) on the grounds that they are government employees, and also cut the budget for supplies.

The high levels of HIV-related stigma made it challenging for study staff to record interviews with HIV-positive people, though they were willing to be interviewed.

For extension of this project and to triangulate our findings we proposed a qualitative study on HIV prevention needs in Gujarat. It was approved by NIH but rejected by the ICMR on the grounds that this was not our national research priority, and this type of study could be done locally without foreign funding. Since the NIH cannot release the grant without ICMR clearance, further study is not possible.

However, we learned a great deal from this experience, and communication between the US and Indian collaborators has been very good.

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Doctor v/s doctor: always a lose-lose game

Doctors are only human. On occasion, ethics takes the backseat, sometimes unintentionally, sometimes 'intentionally'.

In life everyone wants to prove his or her one-upmanship. And in this process we spoil medical relations.

Our role as doctors is not only to protect our patients - we must also protect the 'other doctor'. In short, it's important how we talk before our patients.

Let's analyse how we inadvertently start playing the game of doctor v/s doctor.

When a patient who has been seen by a junior doctor comes to our clinic, we comment indirectly about his lack of experience by saying, "He is a budding doctor." Or we show total ignorance of his skills, sometimes even his competence, and say, "He was my houseman. When did he start private practice?" We may even go to the extent of doubting his qualifications, saying, "He is from a 'deemed university'," or "I know how he got admission to medical college. How did you land up in his hands?"

You are in your consulting chamber and a patient tells you that he had been to another doctor earlier. You refuse to even glance at the case papers and tell the patient to forget all about the previous doctor. Or you spend a full 45 minutes in studying the case papers, implying that a complication had occurred, and then say, "I don't understand anything."

Sometimes you even digitally scan the papers, prepare slides and present them in 'scientific' conferences.

If a patient says the other doctor is attached to a big hospital and you have a small set-up, you downgrade his skills by saying, "He has to show a certain number of cases, that's why he must