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 have admitted you." If the patient says the other doctor has his own small hospital and you are attached to a big hospital, then you may say, "He was thrown out of this hospital," or "He didn't get an attachment in this hospital," or: "In small private nursing homes they do anything," or: "Last week we admitted two of his cases."

This process does not stop in the consulting room. After admission, while taking rounds, you ask the staff (softly but loud enough for the patient to hear you), "Where is the patient admitted for complications from such and such doctor?" Or you ask the RMO, "Do you remember the other two similar patients? Now there is another gift for you..."

Sometimes our script goes to such an extent that when the patient has finished telling you everything, you say, "This is a textbook complication," or: "Thank God you came here alive," or "You are very tolerant. Anyone else would have gone to the consumer court," or: "Now, forget everything that he has done."

Such communication is bound to reflect poorly on the medical profession. If you want a better relationship between medical professionals, you should say:

"See, complications happen. That's why they are mentioned in our books."

"This could have happened even with me. Such complications are very common."

"Nobody wants to harm patients. He has not done anything with an intention to harm you."

"I will phone him personally and discuss your case so that I know exactly what was done and we can manage your case successfully."

"You should not think of going to court. You must concentrate on getting better fast."

"Thinking about courts will not help you in your recovery."

"Everyone responds differently."

"On occasion patients need many procedures for a single problem."

"If you like, you can take a second or third opinion."

"Everyone has good and bad experiences with any particular line of management."

Never let down another doctor, directly or indirectly, at public functions or in conferences.

Medical ethics is easy to follow only if you know how. Remember, the boomerang that you throw is bound to come back and hit you harder.

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PS: Unfortunately, all the anecdotes I recount here are based on my interactions with many doctors.

Don't use great people to sell your drug

There are various methods by which physicians can be influenced by pharmaceutical companies: through drug representatives, free lunches, industry-sponsored trips to exotic locations, gifts, research funds, free conference registration, consulting fees for participation as a guest speaker, financing publication of research articles, etc. Various studies conducted on the influence of these marketing strategies on physicians' drug prescribing behaviour suggest that physicians are influenced by these strategies (1).

One important method by which drug companies influence physicians' prescribing practices is by giving them their promotional literature. In India, medical representatives distribute such promotional literature to physicians during their visits. It is observed that information given in such literature is often incorrect and biased (2).

Sometimes the influence is more subtle. One example is drug promotional material for an atypical antipsychotic, brand name Amival (Amisulpride). On the front of the leaflet the drug's brand name is written in bold, below which the generic name is given in very small letters. This is followed by the indications for its use: "For the positive and negative of schizophrenia". "For the positive and" is written in black on a white background; "negative of schizophrenia" is written in white against a black background. The dosage, other therapeutic claims and references are also printed on the front.

On the back of the pamphlet there is a picture of the American civil rights leader Martin Luther King. Below his picture, his positive qualities are given: his 1963 march on Washington, his Nobel Peace Prize, and his efforts to end poverty and the Vietnam War. This is given in black against a white background. His suicide attempt at the age of 12, his irregular schooling and allegations that he plagiarised some of his academic work are mentioned, in white against a black background.

What message does the pharmaceutical company want to give physicians who read this pamphlet? Is the drug company trying to create an association between Dr King and the condition for which the drug is promoted?

I appeal to the company to withdraw this pamphlet. It is unethical to use a great person like Martin Luther King to sell drugs.

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