

## Research in poor countries: the Guatemalan trials

The news (1) about the patently unethical trials carried out in Guatemala by researchers from the United States underscores the continuing necessity to regulate human research, inspire public trust, and strengthen existing protections for research participants in all countries, rich and poor. This is important given the increased vulnerability in resource-challenged settings of poor countries. Although several decades have passed since the trials were undertaken, they, along with other notorious trials such as the Nazi doctors' trials and the Tuskegee Syphilis trial, remind us that scientific research, while beneficial, requires strong ethical safeguards. Many people in poor countries will see this trial as one more instance of exploitation of citizens of a poor country by researchers from a rich country.

Poor countries must be encouraged to build and maintain robust research ethics systems for the protection of persons who participate in research in those countries, and rich countries must ensure compliance with ethical requirements when they fund research in poor countries or when their researchers conduct research in poor countries. Rich countries must also continue to support efforts to bolster research ethics in developing countries. Such efforts have included those emanating from the Fogarty International Centre of the National Institutes of Health in the United States and the European Developing Countries Clinical Trials Partnerships.

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### Reference

1. McNeil DG Jr. US apologizes for syphilis tests in Guatemala. *The New York Times* [Internet]. 2010 Oct 1 [cited 2011 Feb 26]. Available from: <http://www.nytimes.com/2010/10/02/health/research/02infect.html>

## New stipulations for dealing with pharmaceutical and allied health sectors

The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations (1) was recently amended regarding the relationship between doctors and professional associations of doctors and the pharmaceutical and allied health sector industry. Many of these amendments are not practical. For example, how many readers of this journal have not accepted a single gift from pharmaceutical companies? All of us accept at least a ball point pen. Likewise, very few of us have attended conferences and continuing medical education programmes spending money from our own pockets. Pharmaceutical companies will continue the same practices but unofficially. And many senior physicians will continue to accept sponsored holidays.

Still, the Medical Council of India's amendments are a step forward in an era in which medical ethics has low priority for the medical profession, and the initiative needs to be applauded. But it is up to physicians to adopt these practices, remembering the Hippocratic Oath that we took on completion

of our professional degree. The satisfaction we will derive if we follow the code of medical ethics has no substitute. Most importantly, the image of doctors in today's world will improve, along with the return of the patient-doctor relationship. My request to all members of our profession is to follow the code of conduct in your personal lives.

Always remember: the patient comes first.

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### Reference

1. Indian Medical Council (Professional Conduct, Etiquette and Ethics) (Amendment) Regulations, 2009 - Part-I" (Ref: No.MCI 211(1)/2009(Ethics)/55667) available online at <http://mciindia.org/know/rules/ethics.htm> accessed on 24.8.2010.

## Ailing medical services in India

This was the scene in an accident and emergency department in a tertiary hospital of New Delhi: the patient had sustained poly-trauma in a high-speed road traffic accident, but lay unattended, on the road, because the police had not arrived, and bystanders did not attempt to help the victim for fear of legal consequences. After the arrival of the police, the patient was transported to the hospital. However, without primary medical treatment and without knowledge of the status of his cervical spine, he was repeatedly pulled up and down by laymen. Ultimately he lay in the emergency department, waiting to get treatment. The long queue of waiting patients was being handled by three junior resident doctors and one intern. After some time, it was noticed that the patient was bleeding "somewhere below the waist". That important finding was made not by a doctor; but by the sweeper cleaning the floor of the emergency ward. Thanks to the sweeper, the management of the patient finally began, after losing precious time.

I have been battling with my conscience for long and cannot justify the medical facilities that we offer to our fellow citizens in government hospitals. The hospital in which I work is a tertiary centre in the capital of India. It has a daily census of more than 1,000 patients. Obviously, with this high influx of patients and limited resources, the hospital cannot provide the facilities they do abroad. Still, everyone tries to contribute through his or her own piece of work. So, why aren't we able to provide a minimum standard of care to patients?

Instead of focusing on providing better facilities to patients, our authorities are trying to make the hospitals "beautiful". The hospital does not have even six functioning ventilators for six beds of the ICU, in a hospital of more than 1,000 beds; but there are granite tiles in the corridors. Costly shoe cover machines were installed at the doors of critical care units, and stopped functioning within two months. Couldn't placing the slippers at the entry door have done just as well? Anyone can understand