agencies. The need for research on a topic is evaluated by the funding agencies. The selection of a research project is governed by the need of the funding agency rather than the interest of the faculty. Therefore, before imposing superfluous rules that are not well thought out on the faculty, the MCI must lay down specific research-related minimum guidelines (if at all it is empowered to do so) for institutions as well, so that some responsibility is shared and meaningful research is carried out. We feel that rather than a healthy initiative for research, the current policy is more of a tyrannical decision that reflects the hypocrisy and ineptitude of the MCI as a national medical regulatory body.

The lack of clear objectivity in the policy document indicates that it is just a desperate attempt to appear professional in the global research scenario and in the process, transferring all the responsibility on to certain individuals so as to create a window of opportunity for shifting the blame whenever the need arises. The institutions and the state governments are totally absolved of their responsibility towards research (3). Looking at the flaws and casualness of the document and the MCI's flippancy regarding a search for a logical and reasonable solution, it seems that the MCI has not succeeded in doing any "original research" on addressing the problem of research in the country. Medical faculty also happen to be doctors with an enormous workload in resource-poor countries like ours and promoting research in such a dictatorial manner will only gradually lead to the demise of medical practice in medical colleges (which are also tertiary care institutions).

The ingeniously percolated idea of perceiving of research as a tool for the advancement of an individual's academic career, rather than a nationalist concept of doing research for the country, could be another reason for regulatory bodies to conveniently come up with such skewed policies. The MCI must take initiatives to instil, in individuals and institutions, the concepts of research integrity and to propagate research as a tool for the nation's development rather than relentlessly trying to create a hostile and autocratic environment in an effort to unnecessarily compete with the West.

Submission of similar work: A letter to the editor of the *Journal of Postgraduate Medicine Education and Research* on somewhat similar lines is under review.

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Should we share the management of acute life-threatening medical emergencies on the telephone?

Daily, I receive 3–4 social media messages regarding the diagnosis, management or clinical dilemmas of acute time-limiting medical emergencies due to snake bite and scorpion sting poisoning. I respond to the caller who has shared clinical signs and symptoms. I also follow up on the progress of the victim. I send pdf files of my publications on scorpion and snake bite.

On the morning of December 13, 2015, I received a phone call from a postgraduate medical student to whom I had already mailed all my publications and also delivered a three-hour lecture on scorpion and snake bite. The case was of a 35-year-old woman, a bakery worker, admitted with a snake bite on her right great toe. The blood clotted within 20 minutes. She had external opthalmoplegia but oculogyric crisis due to autonomic storm which was wrongly diagnosed as external opthalmoplegia and treated as neuroparalytic snake bite poisoning , but no ptosis; the blood pressure was 130/90 mmHg. For neuroparalytic snake bite poisoning, 80 ml (worth Rs 12,000) snake antivenom was given intravenously. But she was still sweating profusely, her extremities became cold, and she had marked tachycardia without any local oedema. She became breathless with SPO_2<90% and pulmonary congestion. The electrocardiogram showed left anterior hemiblock with fascicular tachycardia. Clinically, it was a case of severe scorpion sting with autonomic storm. Within one hour, she developed massive pulmonary oedema with expectorated blood stained froth from nostrils and mouth. She had repeated cardiac arrest, she was resuscitated and intubated and put on a ventilator, with intravenous frusemide, prazosin by Ryle's tube, and inotropic support. Scorpion antivenom of 40 ml was given intravenously in 100 ml of normal saline over 30 minutes. The patient gradually recovered with reduction in heart rate, improved haemodynamically, and was extubated on day 3 without neurological deficit.

In similar instances, I tell physicians in far-off places over the phone the difference between a scorpion sting and snake bite, or the difference between a krait bite and cobra bite (2-5). Villagers, farmers and labourers are more prone to scorpion stings in *wadis* (small hamlets deep inside jungles) where only non-allopathic doctors are available. I have trained these non-allopathic doctors in managing severe scorpion sting, which

has reduced mortality and morbidity (6).

When I discussed these details at a conference, a senior speaker and a high court advocate were totally against giving telephonic medical advice. I leave it to the readers to decide whether or not I am justified in offering medical guidance over the phone in such emergencies.

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Time-bound promotions in Indian medical institutes: a mirage?

Incentives, pay hikes and timely promotions enhance the job performance of an employee. In medical institutes, too, satisfied teachers would train students in a better way leading to better equipped doctors and ultimately, greater patient satisfaction. A study in Malaysia links high levels of satisfaction of employees with good salary, promotions, and incentives (1).

On the other hand, lack of timely promotions would cause dissatisfaction and frustration among employees (2) which leads to lower productivity, eventually raise the costs of medical services (3). Lack of incentives and pay hikes cause resentment among teachers (4). Dissatisfaction with one's job may result in a high level of stress, which could eventually be detrimental to physical and mental health, and could also worsen the quality of life. There are many instances in which medical teachers have left jobs and migrated abroad or even taken extreme steps because of dissatisfaction with their salary and promotion avenues. Dissatisfaction may also lead to an increase in conflict, absenteeism, a low rate of patient care, and a reduction in the quality and quantity of work (5, 6). This is more so in medical institutes, where the health of patients is at stake.

In most government-run medical institutes, one-time selection in the Public Service Commission (PSC) examination is sufficient for all job benefits. For example, if a teacher is selected by the state PSC for the post of assistant professor, he/she need not appear in the state PSC again for the post of associate professor or professor (after completion of the requisite experience). However, in some states, this is not so. A teacher has to appear in the state PSC examination for every post. The teacher has to suffer in terms of promotion and pay hike if the PSC posts are not advertised for years at a stretch, and this could go on for decades. In the meantime, teachers can apply if ad hoc posts are advertised, but then the rules for ad hoc posts are different. Teachers who have the requisite experience and are state PSC-confirmed may or may not be selected, while many others who are not PSC-confirmed get selected. Now, this ad hoc experience may not add up to the continuation of service when a teacher (who was already PSC-confirmed in a junior post) gets state PSC-selected for a senior post later on. Nor is this period counted, as far as a rise in grade pay is concerned. Many medical teachers have suffered on this account. In these states, there are instances of teachers remaining stuck in the post of assistant professor for over 10–15 years and not getting the benefit of promotion or rise in pay band.

It is true that higher posts are fast getting filled up with young faculty. As a result, there is a saturation in the pre- and paraclinical teaching posts and the junior faculty may not get a chance for promotion. Added to this, are the various reservations of posts as per government policies. In some Central government institutes, teachers get time-bound promotions for vacant posts or at least a timely rise in pay band if there are no vacant posts. In other sectors, for example, in nationalised banks, the staff gets timely promotions or a rise in pay band. The case is similar for the administrative services, police services, etc. Then, why should this not apply to medical institutes? Why should medical teachers be the ones to suffer? Are they committing a sin by training budding doctors? Are they not serving patients?

The appointing authorities should give a second thought to all these issues. Until some concrete steps are taken, promotions and pay hikes appear to be a mirage for teachers in these medical institutes.

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