scored highest on the corruption scale!

What I mean is there is a need to appreciate that at least half the cup is filled, even while lamenting that the other half is empty.

You do quite a few book reviews. Most of these books find it difficult to get sold. You can try a symbiotic approach: for subscribers of the journal, offer a discounted sale price of the books. It may help all the three parties concerned - the writer to increase sales, the subscriber to get more value for money spent and yourselves in terms of increasing subscriptions.

There is a need to put on the "what is in it for me" cap and plan out an all-win strategy.

This may be a bitter medicine for you, but I think you can allow sponsorship by ethical firms, just displaying their name and logo without any advertising on their products. It is not unethical to do so.

Finally, I have written a book entitled *Trick or Treat*, to be published with the help of the Consumer International-Regional office for Asia Pacific (CI-ROAP), Penang, Malysia. I can submit one chapter per issue of *Issues in Medical Ethics*; there are 52 chapters big and small, and this could go on for a few years as a serial. I can also work out a big discount for your subscribers. This is the least I could do to support your cause.

Dr K R Sethuraman
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Ethics and AIDS vaccine trials: a response

With regard to Professor Sanjay Mehendale's valuable article on 'Ethical considerations in AIDS vaccine trials' (1), could I make a few critical comments?

In preventive HIV vaccine trials, any participant who gets infected as a consequence of his or her participation in such a trial deserves the best proven HIV/AIDS treatments, and not only whatever is locally available. In my view it simply doesn't make sense to suggest that triple therapy would amount to undue inducement to join such a trial, simply because before these people joined the trial they simply had no need for any treatment. How could providing them with the best proven treatment possibly amount to undue inducement, given that the participant wasn't in need of any medication before he or she joined the trial?

The claim that providing best proven therapy is not financially sustainable is an empirical claim which, as of yet, has not been substantiated. It is being introduced by various people with an interest in cheap access to research subjects. The recently released latest draft of a UNAIDS document ('Ethical Considerations in HIV Preventive Vaccine Research') essentially supports this line of reasoning, but only after conceding that after several years of consultations with treatment access activists and researchers from developing countries, a consensus could not be reached. The UN organisation has taken a regrettable stance on this matter. It allows Western researchers to avoid providing their trial subjects with the best proven therapies in case something goes wrong during the trials they conduct in developing countries.

Udo Schuklenk, PhD
Associate professor, University of the Witwatersrand,Faculty of Health Sciences
Johannesburg, South Africa

Reference:

Mehendale S: Ethical considerations in AIDS vaccine trials. *Issues in Medical Ethics* 2000; 7(4):13-15.

The views expressed in this mail are my own.

Pinch of salt

I have been following, for some years now, with great interest, and some amusement, the beliefs of Kothari et al in their crusade against oncologists. Let me state right now, that I enjoy reading their theories - but take them with the proverbial pinch of salt. I refer specifically in this letter to their response to Mamdani's letter on their article (1).

They state, in this letter, that there is evidence "as recently as 1975" that removal of breast cancer often worsens it. My point: 1975 is a quarter of a century ago. It would not qualify as recent in most biomedical circles, although, on a cosmologic scale, of course, things would be different. Important advances have taken place in most fields, especially genetics and immunology, in the last 25 years.

"All cancer therapy is glorified palliation." An impressive statement, backed by sufficient references, at first glance. A close look, though, reveals that all six references are to books written by the same team of authors — Kothari and Mehta. If this is not biasing evidence, what is? I might add, that none of the references are in peer-reviewed, indexed journals.

The authors make a reference to a "small controlled trial" of one patient in each arm of the study. Surely, you're joking, Drs Kothari, Mehta and Kothari? Statistics of this sort are only made use of by toothpaste and cigarette advertisers, not by responsible doctors.

Sanjay A Pai
Manipal Hospital, Bangalore 560 017.

Reference:

1. Kothari ML, Mehta LA, Kothari VM. Evidence-biased therapy. Letter, *Issues in Medical Ethics* 1999; 7(3):70.

Banned formulations

The government of India has banned certain combinations of medicines as being non-rational and one among them is a fixed-dose combination of dextropropoxyphene with any other drug other than anti-spasmodics and/or non-steroidal anti-inflammatory drugs (NSAIDs).

I came across two formulations being sold under brand names Spasmo-

Proxyvon and Buta-Proxyvon which contain Acetaminophen/Paracetamol which is being termed as an NSAID and my investigation shows that acetaminophen is anti-pyretic and analgesic and not NSAID. Thus, I feel these two brands belong in the banned category of formulations and the medical fraternity should exercise utmost caution prescribing this combination. According to the drugs controller for Karnataka, acetaminophen is basically an anagesic/antipyretic, its anti-inflammatory property is weak and seldom clinically useful and hence it cannot be classifed as an anti-inflammatory drug under the category NSAID.

Further, *Indian Pharmacopoeia 1996*, an authentic reference published by the ministry of health and family welfare, government of India, has classified it as an analgesic, antipyretic, and not as NSAID.

S Ramananda, Bangalore,

Published in *TheTimes of India*,Bangalore, September 1, 1999.

Blood collection in medical practice

Blood collection in medical practice, blood suckers many.
From mammals: Draculas in folklore, vampires or leeches attack at times, even mosquitoes.
There are in reality always medical vampires: students, researchers and doctors from our fellow humans, under the banner of therapy or diagnosis.

Blood letting, known before Hippocrates as removal of harmful humours
Also believed in letting of demons, existed in some countries and communities for the wrong reasons and without benefits.
Medical history has many such stories.

Blood collection for medical practice: each doctor while on service
After a clinical assessment of the patient, recommends blood tests
With or without reason, regularly and repeatedly or at intervals.

Blood collection for evaluation, very often and more, in intensive care wards
And in teaching institutions. The ill effects on patients: anaemia and infection influenced by the duration of hospitalisation.

Multiple pricks for blood collection are made to confirm illness or to make a diagnosis, and to assess the status and progress.
But every now and then through different sites. Is this not an international harm or an avoidable charm?

Blood collection practices need revision in all aspects:
Replacement of old methods, use of multichannel analysers
and small capillary samples.
Refrain from indiscriminate orders
And plan for a collection in appropriate tubes.

Oh, my dear vampires, assess in every case, the cumulative blood loss.
And decide this before an order, never, never routine ones.
Welcome research or thesis works, but all after discussion and rounds.
Blood collection is always more in multispeciality care.
Finalise the order after negotiation with the co-ordinator and take care in flushing lines to overcome blood loss.

Oh, my medical vampires, recall the quantity of blood loss per day
It seems to be litres in hospitals.
Patients lose more but receive less. Is it justifiable or warranted?
Let us be humane and judicious.

P Thirumalai Kolundu Subramanian, Gizan, Saudi Arabia
A Uma, Madurai Medical College, Madurai.

Superlative service

May I join you in giving a very warm send-off to Dr Sunil Pandya who has undisputably rendered a superlative service to the journal, whose evolution from a mere newsletter to a first-class magazine I have been watching with admiration. Let us hope that Dr Sunil will be with us for quite sometime, guiding the journal.

Dr C N Parameswaran,

Aswini Hospital, Thrissur-680020

National workshop on accreditation of private hospitals

The *Journal of the Qualified Private Medical Practitioners' Association*, Kerala, carries a short report of a national workshop organised by WHO, the government of India and the Medical Council of India, to finalise the minimum standards for registration and accreditation of private hospitals in the country.

The need for regulation of hospitals of all types was endorsed by the workshop, though it is necessary to categorise hospitals according to services provided on location, with separate guidelines. Every state shall have an assessment and accreditation council authorised to draw up minimum standards to be adopted by all hospitals in each state; to inspect and recommend to the government regarding accreditation, and draw optional higher standards for grading of hospitals.

Proposals prepared during an earlier workshop were discussed, and the position in each state was described. The Medical Council of India was authorised to nominate a sub-committee of doctors and legal experts to draft rules for the implementation of minimum standards for private hospitals, to be submitted to the central governemnt, which in turn may present this in the form of a bill at the next parliamentary session. The WHO has offered technical and financial assistance to develop packages for information, communication and training, as well as funding some pilot projects.

QPMPA JMS 2000;14 (2): 35, 44-48.