Dr John Niederhuber, current director of the National Cancer Institute (NCI), says that the stimulus money will go a long way towards doubling the number of research grants that it approves. In recent times, the NCI has only been able to fund 12% of the grant applications it receives. However, an expanded federal budget will boost that number to 16% and the stimulus injection will further push approvals to 25% of all requests.

An important caveat to remember is that these funds are a one-time infusion of dollars that are to be spent in their entirety within 2 years. There is a major emphasis that the expenditure of funds is to be transparent and to reflect an immediate economic impact with measurable outcomes in terms of jobs retained/created. As such, research funded with stimulus dollars must be completed within the 2-year time-frame, and investigators receiving stimulus funds should be prepared for reporting requirements above and beyond those typically involved with NIH grants.

Critics argue that few projects of true scientific merit can be started and finished in 2 years. Supporters answer that the onus will be on the scientific institutions and investigators to defy the critics by putting the stimulus funds to good use, thus potentially leading to scientific breakthroughs that can give the USA a competitive edge.

The importance of research and science and the need for a stimulus is also perceived in India, as reflected by the recent statements of the Indian Prime Minister Dr Manmohan Singh. National media reported that the prime minister told 4000 scientists at the annual Science Congress in Shillong, Meghalaya, on 3 January 2009 that Indian science needed 'a new generation of role models and leaders'. The Prime Minister noted that, despite government efforts, Indian science is lagging behind not just developed nations, but also newly industrialized states such as China.

Unlike in the USA, in India, under the spirit of Dr Manmohan Singh, India's education and science ministries have planned stimulus over the long term by increasing research fellowship money by 50%. The Prime Minister launched a 5-year, Rs 21 billion (US$ 427 million) scholarship programme for a million 10–15-year-olds, whose funding can continue through graduate school as long as they continue their pursuit of science. A new programme called INSPIRE (innovation in science pursuit for inspired research) is dedicated to select new PhDs for 5-year government or university research positions.

In addition, a Global Indian Network of Knowledge initiative, announced on 8 January 2009, will let expatriates who have given up Indian citizenship return more easily by acquiring an Overseas Citizenship of India card. The government has so far issued nearly 350 000 cards under a similar programme.

These initiatives in both the USA and India represent a small boost for the scientific community, which has long been awaiting recognition and stimulus to move forward at an increased pace.

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Letter from Mumbai

H1N1 INFLUENZA (2009) AND SARS (2002–03)

The advent of H1N1 influenza—now termed a pandemic by the WHO—brought to mind my experience with severe acute respiratory syndrome (SARS). You may recall the appearance of SARS and the terror the corona virus induced in public health workers and, the lay public alike.

I was scheduled to travel to Jakarta via Singapore and then return via Singapore to travel to Seoul and San Francisco at the height of the epidemic. Respected and senior colleagues in my hospital warned me against this route, recommending a flight via London or Frankfurt instead. 'You will not be allowed to enter America if you go through countries suspected of harbouring the virus.' I must confess to some anxiety on being given such a warning, as this was my very first visit to America.

My hosts in Jakarta (with two children) wrote to ask whether I still wanted to come to their city. I asked a simple question, 'Are you and your children continuing to live in Jakarta?' Since they saw no reason to emigrate, I saw no reason to alter my plans.

At Sahar terminal in Mumbai I saw many of our countrymen travelling on my flight to Singapore wandering around with surgical paper masks on their faces. Equally interesting were the masks worn by the officers at the security check points in the holding area from where one enters the aircraft. When I saw passengers and security personnel doff these masks from time to time, place the masks on tables or chairs or even baggage handled by a variety of persons and then wear these same masks, I marvelled at their scientific awareness.

I saw my fellow-passengers on board the aircraft and on reaching the air terminal in Singapore continuing this irrational behaviour of putting on and taking off their masks every few minutes. Not a single official on board the aircraft or at the terminal in Singapore wore any mask of any kind. Had my fellow passengers watched the telecasts of how personnel in Guangdong, Beijing and Hong Kong handled the crisis, they would have seen the special masks used by them. The utter worthlessness of paper masks in preventing viral entry was repeatedly emphasized by health experts in these cities. Assuming there was some role to be played by paper masks in preventing associated bacterial infection, putting on masks and then taking them off, placing them on potentially contaminated surfaces and then putting them on again only invites ridicule.

In the event, I enjoyed my holiday in Indonesia even more than I had expected for at most tourist sites, I was the only foreigner, SARS having dissuaded others from travelling thither. The absence of crowds permitted a closer study of monuments and the absorption of more information from the tourist guides who gave me undivided attention.

The immigration authorities at San Francisco paid no attention

to the route I had taken and I was out of the terminal and into the city within a short time!

Abraham Verghese described similar irrational behaviour even by those who should have known better. 'My nephew in Singapore tells me that taxi drivers avoid picking up or dropping off people near hospitals. Because nurses were among the first to fall sick in Singapore, a dentist reportedly refused to see a nurse waiting in his office.' (*The New York Times,* 20 April 2003)

What is the basis for such acts? 'Epidemics hit us right at the nexus of self-interest and altruism, that exquisitely uncomfortable spot where our brother's misfortune nudges us just enough that we need to examine it and distance ourselves from it (and, in more highly evolved civilizations, take care of it before it takes care of us).' (Abigail Zuger, MD, *The New York Times,* 25 May 2009)

And now we have the H1N1 infection. Political correctness has dictated avoidance of the term swine flu. (Some would have loved to use the latter term to characterize the source of the virus and chosen victims.) At such a time, it is well to pay heed to a cautionary note sounded in 2003: 'The confluence of invisibility, indeterminacy, and contagion understandably generates anxiety and encourages behaviour that reduces risk of exposure. Yet how are perceptions of risk formed when scientists are still not sure how the pathogen spreads? Notions of transmissibility are highly susceptible to any information at our disposal including media images, official advice and word of mouth.' (Justin Schram, *BMJ* 2003;**326:**939)

Are the media behaving any more responsibly now than they did then?

SECURITY IN PUBLIC HOSPITALS: WHO IS RESPONSIBLE?

A 4-day-old baby boy was stolen from the maternity ward of Sion Hospital in Mumbai this January while his mother was washing his clothes. The alleged kidnapper was a woman who had earlier been talking to the parents of the child claiming to be a relative of another patient in the ward.

The parents were subsequently featured prominently on television, in newspapers and newsmagazines. The Dean of the Sion Hospital, security officers and the police manning the desk in the hospital were variously exposed to public blame and ridicule. The Bombay High Court ordered the suspension of a doctor and nurse of the maternity ward at Sion hospital. (*The Times of India,* 30 January 2009)

The ward houses 160 patients. How a particular doctor and a specific nurse are supposed to ensure the security of each of the patients and their babies round the clock was not specified by the court. It is unclear whether the judge visited the ward at visiting hours and saw the milling crowds around the beds and in the passages and pondered how this doctor and this nurse were to blame for the kidnapping.

Other knee-jerk responses included that from the 'city guardian minister', who directed civic and government-run hospitals in the city to instal closed-circuit television cameras within 3 months (*The Times of India,* 30 January 2009). A little thought would have prompted several questions. How many cameras would one need in a large maternity ward containing 160 patients? Would we need additional cameras in the passages leading to and from this ward and in the passages outside the bathrooms and toilets? Would similar cameras be needed in all the other wards and passages in the hospital and at all the entrances and exits? Assuming, on a conservative basis, that 100 cameras are needed for the entire hospital premises, who is to watch their monitors day and night with unflagging attention throughout the year? Is this practical and cost-effective?

As the media frenzy intensified, so did ill-considered official reactions. On 31 January 2009, *The Times of India* reported: 'A senior BMC official said suspension orders would be issued…the order includes the suspension of Dr Y. S. Nandanwar, the head of the gynaecology department.' (The Brihanmumbai Municipal Corporation runs the Sion Hospital)

Eventually common sense prevailed. The Municipal Commissioner stated that he had never considered suspension of Dr Nandanwar. The court stayed its earlier directive ordering the suspension of the doctor and nurse of the maternity ward.

To the best of my knowledge, the baby remains untraced. Meanwhile, the court, Brihanmumbai Municipal Corporation, 'city guardian minister' and the media have turned their attention to more pressing matters.

Some legal experts who accused the Dean, Professor of Obstetrics and other senior staff members of negligence, invoked the doctrine of vicarious liability. They ignored a primary principle when they failed to prove that there was, in fact, a wrong committed by specific employees, trainees or students. They also ignored the fact that the principal responsibility of medical and paramedical personnel is the provision of competent medical and nursing care to patients.

Considering the matter on merits, the following steps appear necessary to prevent further tragedies of this kind.

1. Restrict access to wards and other areas in the hospital to patients, a maximum of one attendant per patient and authorized, identifiable hospital personnel. Visitors should be strictly restricted, regulated and monitored. In most western hospitals no relative is permitted access to the patient except during visiting hours. This is possible as nursing care is of very high standard. We need to reach that standard.
2. Personnel trained in ensuring security and detecting criminal behaviour must do the regulation and monitoring. This step implies training of high quality imparted to well-equipped security officers. These officers must be adequately supervised and held responsible for lapses.
3. Doctors and nurses have their own tasks to perform. These pertain to the medical needs of the patients. They cannot and should not be expected to play any role as regards security.

These and other similar steps will involve curtailment of the movements of friends and relatives of patients. It is necessary to educate the public at large on the need for such steps and invite suggestions and opinions on how they can be implemented to improve security without any deterioration in the care of the patient.

VIOLENCE AGAINST DOCTORS AND OTHER HOSPITAL PERSONNEL BY RELATIVES OF PATIENTS

In February 2009, patient services at the King Edward Memorial Hospital in Mumbai were affected with 700 doctors from the Maharashtra Association of Resident Doctors (MARD) calling a flash strike after 5 of their colleagues were roughed up by the kin of a patient who died a day earlier. (*The Times of India,* 11 February 2009)

The patient had died within minutes of admission to hospital. The provocation for the assault was stated to be the delay in releasing the body to the family. Explanations that such a death warranted an autopsy and permission from the police to release the body after the post-mortem examination report were provided

to them, but fell on deaf ears. This and other similar attacks led to renewed representations to the state government resulting in the passage of an ordinance in April 2009. The ordinance prohibits attacks on registered medical practitioners, nurses, medical students or paramedical staff at medicare centres. Offenders will have to pay a fine of Rs 50 000 or face imprisonment of 3 years, or both, and—based on the assessment of the court concerned—pay double in compensation for the damage done.

The Maharashtra Medical Services Persons and Medical Institutions (Prevention of Violence and Damages or Loss of Property) ordinance also allows patients to approach a redressal forum with complaints. The forum will comprise a government official, a doctor from a medical association and a member of the general public. As the chief minister pointed out, 'The new ordinance will protect doctors even while ensuring protection for patients.'

The activities of this forum will be watched with keen interest.

THE PRACTICE OF MEDICAL SPECIALTIES: AN IMPENDING DANGER

Commercial laboratories with branches throughout India are centralizing their facilities. Histology slides, for instance, from all over India are sent to one city where a team of pathologists reports on them in an assembly line. These pathologists are taken from medical college departments. While they earned Rs 40 000 each month in their teaching hospitals, they are now offered Rs 70 000 per month or more.

As a consequence, these laboratories are able to slash rates and yet make profits. This may prove a damper to pathologists practising by themselves. Their incomes are likely to show a downward spiral. Many may be forced to close shop.

Other queries are being posed.

How efficient is the quality control on such centralized diagnoses? Is it possible for an assembly line to investigate satisfactorily a complex disease? When an individual neuropathologist of the calibre of Dr Darab Dastur found it necessary from time to time to go to the ward and see the patient for himself to provide an accurate histological diagnosis, I wonder how an assembly line will perform when the patient is hundreds of kilometres away and the clinical data supplied is scanty or substandard.

With increasing numbers of large corporate hospitals and laboratories sucking in the best of available talent from public sector medical colleges and hospitals, will there be a worsening deficiency in the quality of teaching, patient care and research in the latter? Governments and municipal corporations claim they are unable to raise the emoluments of their professors and other staff members to levels comparable to those in the private sector. A major hindrance is the mental barrier in the administrators' minds to paying anyone under their control salaries higher than those earned by themselves.

I leave it to more competent minds to consider these and other issues and offer solutions.

SUNIL PANDYA

Obituaries

Many doctors in India practise medicine in difficult areas under trying circumstances and resist the attraction of better prospects in western countries and in the Middle East. They die without their contributions to our country being acknowledged.

The National Medical Journal of India wishes to recognize the efforts of these doctors. We invite short accounts of the life and work of a recently deceased colleague by a friend, student or relative. The account in about 500 to 1000 words should describe his or her education and training and highlight the achievements as well as disappointments. A photograph should accompany the obituary.

—Editor