

LETTERS

Boundary violations in patient care: need for evolving professional practice standards and training

The article by Kurpad, Machado and Galgali (1) focuses on an issue which has probably not been discussed in Indian academic medical journals earlier. Nonsexual and sexual boundary violations (NSBV and SBV) certainly occur frequently in doctor-patient relations and this is confirmed by data from the article. The authors have omitted non-consensual acts, such as molestation and rape by doctors, from the purview of their article. The media has reported on patients' complaints of such non-consensual acts (2,3,4).

However, consent can be a problematic concept in doctor-patient interactions in certain circumstances. An example is the case of patients with psychiatric conditions. If the psychiatrist is the person evaluating the patient's ability to consent and is also a participant in unprofessional conduct, such as sexual contact with the patient, then there is clear conflict of interest for the psychiatrist. The psychiatrist might deem the patient as having been capable of consent, though in reality the patient might not have had this capacity, given his/her psychiatric condition. In this case, there might be a thin line between SBV and molestation/rape, and it would be difficult to interpret what happened.

A doctor-patient relationship has a power differential, with the patient often in awe of the doctor's authority and control over the course of the treatment. In such circumstances, the validity of the consent by a patient to any sort of SBV would be questionable. SBV is also probably more common in certain medical specialties which involve frequent invasive procedures such as vaginal and rectal examination (such as surgery or obstetrics and gynaecology) and/or where patients are required to undress for examination (such as dermatology), as compared to other specialties such as ophthalmology or otolaryngology.

Defining what is acceptable behaviour and appropriate physical contact in a particular situation and cultural milieu is part of the process of evolving professional standards of conduct with patients in a specialty. Organisations such as the Associations of Surgeons of India and the Federation of Obstetric and Gynaecological Societies of India should take a lead in this regard. There should also be safe, confidential and reliable mechanisms available at the level of hospitals for patients to report boundary violations, and for follow-up by trained and credible individuals (1). These mechanisms need to be communicated through patient charters and public notices at hospitals.

I also concur with Kurpad and colleagues that orientation and mentorship towards professional conduct in a healthcare setting, and understanding of the need for maintaining boundaries in doctor-patient interactions needs to be included in the curricula for training at all levels of medical education.

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Proud to be the son of a mentally retarded mother

I am a 63- year-old professor who has taught medical students for the past 35 years. My mother is mentally retarded. I always had the feeling that I missed my mother's love for me. I could see glimpses of her love and concern for me during spurts of her longing to see me when I was away from home. I could see her love when she got angry when someone criticised me, even if it was my father. I could see her emotional security in my company. I thought those were enough compensation for the routine tasks that a mother does for her child. My father knew she was mentally retarded, though he learned of this after the marriage. He was not disturbed by the fact. Being a middle class man, for him his conscience became the deciding factor to continue with the marriage and, in the process, father me as his child. He did not encourage friends or relatives to visit or stay with him. The simple reason for his decision was not to subject his wife or his son to ridicule or mockery. He had his elder sister, a widow, stay in the house to take care of the family while he took care of his wife and son. With time, a strong emotional bond developed between him and his wife. That bond became so strong that when my father became physically disabled, she took care of him in her way. What I mean is, in the way that she could understand and help him. That was enough for my father to live. He longed to live longer than his wife so that he could take care of her until her death. He lived a simple social life, restricting his life to his work, home and family. He became a total introvert. He was content with whatever life he had. He was happy to prepare food for his wife and son and do other daily chores of life with a smile and a mission. He was not enamoured by wealth, wine and women. He had all his intoxication in bringing up his son. His wife died before him, and he died afterwards to be buried beside his wife. His life was unique in that he remained unnoticed and unruffled by the

ups and downs of life. He had his mission of life completed by being a living example of a dutiful husband and a responsible father. It is his single-minded devotion that made a man out of me and what I am today, as a humble teacher in a medical school (1).

The story of my life is testimony to the fact that a mentally retarded woman may have the right to bear or rear a child provided that she gets emotional and physical support from her husband or a close family member.

The recent ruling of the Supreme Court asserting the right of the mentally retarded woman to decide whether to medically terminate a pregnancy or continue with it, may be a bone of contention (2). In a world full of emotional limitations, society needs to support such women who need our real care and empathy. I am proud of my mentally retarded mother for she gave me a biological belonging and social identity. There are many such women in our society who are given physical shelter. They need physical as well as emotional shelter. When institutions are commissioned to house such women, the concerned authorities must look into whether the place in which these women are housed is safe for them physically and emotionally.

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Do we need two systems for postgraduate medical education in one country?

The articles on the National Board of Examination (NBE) were informative (1,2). We would like to draw attention to the farcical manner in which the entry to the Diplomate of the National Board (DNB) is conducted. Admissions to MD/MS programmes are based on the candidate's performance and rank in the entrance exam. However, admissions to DNB programmes are on the basis of a system that is open to misuse. After a common entrance test, candidates are selected by institutes usually on the basis of an interview. As we are all aware, interviews are extremely subjective and members of the interview board are likely to be influenced by external pressures. The system of entry should be similar to that practised for MD/MS entrances - an all-India entrance test followed by a rank-based counselling.

Suptendra Nath Sarbadhikari's article comments on the low pass percentage of candidates (1). The low pass percentage is a reflection of the unsatisfactory state of affairs at the NBE and their causes need to be examined. This might be related to the type of student who enters these courses - as the entry to DNB courses is not purely merit based. Second, these courses are usually run by institutes that do not conduct undergraduate courses, and the lack of proper teaching might be a reason for

poor results. The affiliation of institutes which are not running proper teaching programmes should be cancelled.

Regarding the conduct of examinations, MD/MS students are subjected to similar treatment, with no emphasis on regular assessment during the training period of three years. Our own theory examination consisted of essay questions, some of them worth 30 marks. The examination should be objective and there should be a system of continuous assessment during the training period. These changes should also be introduced for MD/MS candidates.

Murali Poduval's article notes that the NBE is an alternate, parallel medical education system (2). It is not clear why one country should have two systems of postgraduate medical education. When the government does not distinguish between the DNB degree and the MD/MS degrees, where is the need to have a parallel system? The solution would be to abolish the DNB and strengthen MD/MS programmes so that the country has a single, transparent system of postgraduate medical education that produces good results.

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Why raise questions on the "ethics" of the Gadchiroli trial?

I congratulate your team on publishing the article: "Was the Gadchiroli trial ethical? Response from the principal investigator". Abhay Bang raised some practical questions for discussion with the international community (1). The following are my views in response to this article:

I wonder how researchers from these reputed institutions can raise questions on the ethics of a study which has clearly provided a ray of hope not only for the poor and vulnerable children in India but also for children in other developing countries. Such debates make me feel that the international community fails to understand the importance of this trial to the lives of innocent children; they do not realise the realities of socioeconomic conditions and the health system in remote areas of India. How much could one expect from a man, with limited resources, who really wanted to help deprived children and give life to theoretical concepts like "the right to life"? Even if he had provided "state-of-the-art" health services in the control area of the study, what difference would it have made in the remaining villages across India? I could also not understand the rationale for calling the standard of care provided in Gadchiroli "unethical".

In fact, following the Gadchiroli trials, various studies were conducted in other south-east Asian countries, and all these studies adopted more or less the same model of "home-based neonatal care" that was adopted by the Gadchiroli trials. Further, none of them provided "standard care" as per the norms of the US or western Europe. Baqui et al, from Sylhet, Bangladesh, reported a 34% reduction in neonatal mortality by training female health workers to provide home-based newborn care as per WHO's integrated management of childhood illness guidelines (2). Manandhar et al achieved a 30% reduction in the neonatal mortality rate in rural Nepal by introducing community-based newborn care through women's groups (3). Bhutta et al in Pakistan engaged and trained an existing cadre of women health workers for community-based newborn care. In addition, trained birth attendants or "dais" were also trained for newborn care. They eventually reduced the neonatal mortality rate by around 19% in four intervention villages (4). If the standard of care in the Gadchiroli trial is described as unethical, then I must say that the standard of care provided in all of the above mentioned trials is also unethical.

However, now we know that the interventions of the Gadchiroli trial have shown the effective way to reduce infant mortality substantially; instead of debating the ethics of the Gadchiroli trials, researchers should come forward and try to mobilise policy makers to adopt home-based neonatal care. I agree with Abhay Bang's challenge to those who call this trial unethical: "Should one wait until the best standards, and the resources needed for using them in the control area, are made available, and allow children to die until such time?"

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Seeking information on doctors and advertising

I would like to approach the readership of your journal through these columns in order to explore an issue that is assuming alarming proportions here in Pakistan. It has become

commonplace for physicians here to appear in commercials, directly or indirectly promoting products. Up till a few years ago we would see professional models dressed in white coats with stethoscopes slung around their necks, pretending to be doctors, promoting products. Gradually one saw young physicians appearing in advertisements, obviously to make some easy money. It is now common to see senior physicians displaying their credentials and institutional affiliations giving what appears to be a public health message, but with the brand name of particular products displayed besides them. Often times the "public health message" is also inaccurate and misleading. Some of these physician models are actually serving professors in leading medical colleges. They have appeared in television and newspaper advertisements, on billboards, and on posters selling products ranging from toothpaste, shampoo and medicated soaps to baby diapers and even socks.

A search of the English language literature reveals practically no material focusing on physicians advertising and promoting products. There is much written on self advertisement, an area already covered by clear guidelines of the Pakistan Medical and Dental Council (PMDC). Another area that has been explored extensively in literature is on physicians associations endorsing products, which also raises major ethical concerns.

There is growing concern among many physician circles about this alarming trend. In response to this concern the Karachi Bioethics Group (KBG) wishes to develop a position statement addressing all aspects of physicians endorsing products which we hope can then become a framework for policy formulation by physicians associations including the Pakistan Medical Association and the PMDC.

The KBG consists of individuals from several institutions across Karachi who have a shared interest in bioethics. The group meets once every two months in their personal capacities and discuss ethical issues. The group has recently launched a set of guidelines on physician- pharmaceutical industry interaction. More information can be obtained from www.karachibioethicsgroup.com.

It would be interesting to learn from your readers if there has been a similar trend in India of physicians willing to become industry poster boys, and if so, what has been the reaction by the public and the physician community.

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Delay in publications: new authors and editorial misconduct

An amendment by the Medical Council of India, in 2009, has introduced, as a criterion for early academic promotion, a compulsory minimum number of publications (1).

Given the many medical colleges in India, one would expect many research publications by medical college

teachers (2) but this is not the case. However, with the MCI's new requirement, a rush of articles will be submitted for publication. One reliable measure of the quality of a research publication in medical sciences is whether the publication is in a journal indexed by Pubmed (3) and such journals are likely to get an increase in submissions. There are several teachers in medical colleges who have fulfilled all criteria for promotion except that they do not have publications to their credit. The increase in submissions may result in delays in publication.

Delays in publication may occur because of delays in collecting data, or in analysis, or for other reasons inherent to the type and nature of the research. In addition, delays in the editorial processing of a submitted article may discourage research. All those responsible for delays must take appropriate action.

Authors as well as editorial teams are responsible for the delay in publishing a submitted article. In one study, the time from acceptance to publication took 90 days (4). In another study, the longest delay in the editorial process was caused by the wait for authors to respond to reviewers' or editors' feedback (5). The authors took 67 (SD: 76) days to resubmit their paper following initial feedback, and a further 48 (SD: 79) days after it had been edited (5). New authors are likely to cause delays because they lack experience in writing for publication. They may target the wrong journal; fail to assess whether the information in their manuscript is in line with the editorial policy or the interests of readers of a given journal (6), all of which may result in the rejection of their manuscript. They may not get their article critically reviewed by an expert though this can improve the article; they may not even get it proofread. It is also essential to communicate clearly and speedily with reviewers, something which new authors may find difficult. Still, if new authors are under pressure to publish, as are medical college teachers awaiting their promotion, they will blame the editorial team for delays in publication.

The time taken between the date of submission and the first author contact, either for revision or decision, is reported to be about 60 days (4, 7). Editorial misconduct is another issue. The editorial process can sometimes exceed a year, a cause of great disappointment to authors. The time taken for peer review in local journals is sometimes comparable to review times in larger and more prestigious journals (8) with many more submissions. For the delay in publication, the justification that the journal is a larger and prestigious one is certainly not acceptable. It has been pointed out that undue delay in reaching decisions and communicating these to authors is editorial misconduct (9). Appropriate action should be initiated against editorial teams that delay processing publication.

Online submission of manuscripts is normally fast, relatively easy, and timely (7). Online editorial processing should also speed up publication time. Editors and their teams should devote time and resources to fulfil the responsibility

bestowed on them. Some journals avoid delayed publication of certain articles by publishing accepted articles online, "epub ahead of print." The backlog will also be reduced with an increase in the number of journals and in the number of issues per volume (year) of the journal.

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Conflict of interest: Delays in publications matter to both the authors, as they are looking for early academic promotion, which is possible if there is no delay in the publication of their articles submitted elsewhere.

Informed consent needs information

Benign prostatic hyperplasia (BPH) is a pathology seen in middle aged or elderly males and can present with painful acute urinary retention warranting immediate relief through per urethral insertion of a Foleys Catheter (1). Transurethral Resection of Prostate (TURP) is considered the gold standard for the surgical treatment of BPH (2). TURP is one of the most commonly performed procedures in urology.

A 58-year-old male patient presented in the emergency room of our hospital in Karachi with acute urinary retention. He had been passing urine comfortably until a few days earlier. Per urethral catheterisation had been attempted at a small town some three to four hours' drive from Karachi. However, catheterisation had failed and the patient was disposed with an 18 G I/V cannula placed percutaneously in the suprapubic region to drain the urinary bladder. At our centre, the suprapubic cannula was replaced by a 16 Fr suprapubic catheter.

I learned that the patient had undergone TURP five years earlier at another centre and was unhappy about the minimally invasive approach adopted by the surgeon. I explained that the retention was most likely secondary to "re-growth of prostate" or urethral stricture (3) and added that the risk of repeat prostatectomy is around 5% in one year, 10-12 % in five years and 20% in 8-10 years (4). I further explained that although the incidence of repeat prostatectomy is higher with TURP than open prostatectomy, the latter has higher morbidity and costs (1). The patient who was now comfortable laughed and said, in Urdu, "Doctor Sahib, for me these figures stood out as 100%. Open surgery was suitable for me, because in case of blockage in passing urine it takes very long from Khuzdar to Karachi.... Had I been treated with open surgery, I would not have to go through a repeat operation on my gland."

It is difficult to comment on the appropriateness of surgery in this case. Certainly decision making in such a scenario is complex. Still, it is necessary to point out the importance of obtaining truly informed consent.

An ethically valid informed consent has seven necessary elements: a "capable decision maker" (the patient), the patient's voluntariness, disclosure, recommendation, understanding, decision and authorisation. In practice, however, informed decision making is often incomplete (5). In one study, just 9% of decisions met "quite reasonable criteria". The understanding of the patient is least frequently assessed (1.5%) and uncertainties and alternatives to the proposed plan of management are rarely discussed (6)

Patients need to be given the information they need to make decisions. This includes explaining the prognosis, treatment options, and possible complications. International guidelines are relevant but their application is not enough. Nor will sensitivity to cultural and social values suffice for decision making. Decision making goes through a complex process of interaction between the physician and patients - or physician, patient and patient's family depending on the nature of the illness and the patient's socioeconomic background and cultural values. So, while suggesting options, the physician needs to be patient centered, elaborating on issues which

may be important to a particular patient. They should consider issues such as basic healthcare access, availability of transportation and also look for ways to overcome such problems within the patient's means.

In this case, the surgeon followed international recommendations but the patient was not mentally prepared for the possibility of re-growth of the gland and retention of urine. Nor was he informed that in case of symptoms of urinary retention, he should visit the nearest hospital early rather than in an emergency. He should also have been told about the option of open surgery and the reason that international recommendations were against it.

The process of acquiring informed consent is complex. It is not always possible to resolve conflicts in decision making, in this case weighing international recommendations versus the patient's desire based on his conditions and socio-cultural issues. But what is important is that the physician show sensitivity to patients' choices and wishes and their cultural values.

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