LETTERS

Indian Medical Association: time to clean house

The *IJME* editorial in the January-March 2011 (1) issue calls on the Indian Medical Association (IMA) to reform itself in order to be able to play a more proactive role in health activism in the country. As the largest body representing (allopathic) doctors in India, the IMA can use the leverage of numbers and presence across the country to push for much needed health reform. This would be in line with its theme for the year as mentioned on its website (2) "Be in Health, Be active in Public Health." For this, the IMA needs to go beyond its current narrow focus on its primary constituency, doctors in private practice, to a more comprehensive approach to public health in the country.

The recent controversy around the introduction of the Bachelors in Rural Health Care (BRHC) course saw the IMA condemn it as a "move to produce half-baked doctors for the rural population" (3). Interestingly, when the Medical Council of India (MCI) was initially working on the concept of the course, Ketan Desai, who headed the MCI and was actively involved with the IMA had criticised the existing medical education model as being too "urban-centric" (4). It Is not very clear what alternative the IMA prefers to cater to the health needs of the rural population; though it does mention an initiative called 'Aao Gaon Chalen' on its website (2) where local branches have been encouraged to adopt a village each. The Revised National Tuberculosis Control Programme (RNTCP) has also collaborated with the IMA through a public-private mix model to engage with the private sector for tuberculosis control in the country (5).

However, the controversies about brand endorsements by the IMA have cast a shadow over the organisation. The election of Ketan Desai (who continues to be prominently featured on the IMA website) to the position of president elect of the World Medical Association in 2009, as an IMA representative, was also deplorable. As an aftermath of his arrest, Desai's inauguration as incoming president was suspended indefinitely by the WMA in its annual meeting in Vancouver, in October 2010. It is high time the IMA did an organisation-wide introspection and cleaned house.

There is little doubt that the IMA could use its resources, public profile and membership strength to galvanise public health reform in India. It is crucial that, in its 83rd year of existence, the leadership of the IMA takes on the challenge of devising a new path for the organisation that incorporates ethics and a core commitment to equity in healthcare.

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"When a yes should mean no": doctors and boundaries

We thank Dr Bhan for his letter in response to our paper 'Elephant in the room' (1, 2). He has correctly noted that even what might be described as consensual acts of sexual boundary violations (SBVs) between doctors and their patients are not truly so due to the power differential in their relationship. This is why our paper points out that "consensual" acts of SBVs with adults are considered unethical but not illegal -- barring issues around the law on adultery in India at present (3). We refer to "consensual" within inverted commas, as the validity of consent for such acts is questionable because the patient might have said "yes" -- or at the minimum did not say "no" -- because of transference issues. Transference reactions are the attitudes and feelings patients bring into the relationship based on their relationship with significant others in their life. These can arise in any doctor-patient interaction. This is an issue which has been discussed in detail in the publication we quote in our paper (4). Unless doctors are trained to anticipate and deal with such issues, their own "counter transference" can put themselves and their patients at risk. Thus, the doctor will need to understand why these acts are unethical even if the patient does not say no, if s/he says yes or even if s/he seems to *initiate* the act.

These issues are known to arise when non-sexual boundary violations (NSBVs) have "slipped into" SBVs, often in the context of an "emotional relationship" between the patient and doctor (5). However, there are situations like unnecessary physical examination where the patient might not even realise that s/he has been submitted to an unnecessary procedure. These are no different from other acts of sexual abuse. As Bhan rightly points out, medical societies in India need to define what appropriate physical contact is, especially regarding intimate physical examination (1).

Bhan also raised the issue of the capacity of psychiatric patients to give consent. Generally when a patient is acutely psychotic or delirious there is obviously no question of the patient being capable of giving consent. (It is also unlikely that the doctor and patient will get drawn into an emotional relationship with each other at this time). Other situations where issues of consent do not arise are with adults with impaired intellectual functioning or with children. The grey areas would be situations where the adult

patient may be capable of consent for other civil contracts but not in a position to give a valid consent for a sexual relationship with the doctor, due to transference issues. (This is grey only from a legal viewpoint, not an ethical viewpoint).

As stated in our original paper we excluded sexual harassment, sexual molestation and rape from the purview of our paper as we felt that there is no need to generate an ethical debate on why it is unacceptable. Even though offenders who commit these crimes (if they do admit to them), tend to rationalise their behaviour and say, "The no meant yes," we all know and accept that these acts are crimes. We hope the results of our study will raise awareness on why, in the context of sexual contact in a doctor-patient relationship, a patient's "yes" should still mean a "no".

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Product endorsement by medical practitioners

The National Bioethics Conference felicitated Sunil Pandya, Vasantha Muthuswamy and Chandra Mohan Gulhati for their work in medical ethics (1). Such recognition to deserving mentors will infuse life into the field and project the nobility of medicine in the eyes of the local as well as the international medical community.

We are living in a world where incentives and kickbacks play an important role in the marketing strategy of corporates. Cricket players are sold in the market for their entertainment value, and they abandon the spirit of sport to play for the sake of money. Medical professionals are no different. Their life-saving skills and their medical eminence prompt companies to ask for their endorsement (2). Doctors appear in the media making false claims about medical products, toothpastes and skin creams. Some of them are office bearers of medical associations.

In this world, everything is sold, from medical seats to medical equipment. There are clever sellers and eager buyers in the market. In a world where money seems to laminate the values of life, ethical practitioners bring a ray of hope to us.

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Iatrogenic STD inoculation study

Susan M Reverby has unearthed a glaring example of unethical research, carried out by the United States Public Health Service and co-sponsored by the National Institutes of Health, the Pan American Health Sanitary Bureau and the Guatemalan government in 1946-48 (1). In this study of the effectiveness of penicillin in syphilis and gonorrhoea, 700 Guatemalan nationals including prison inmates, mentally challenged people and military personnel were intentionally infected with various sexually transmitted diseases including syphilis and gonococcal infection. Prison inmates were allowed to have sex with syphilis-infected prostitutes paid by US health officials. There are no records on whether informed consent was obtained from the subjects participating in the trial.

Such studies are carried out very often in both developed and developing nations. The most widely discussed American research experiment that violated ethical codes was the Tuskegee study. This study consisted of observing the natural course of syphilis exclusively in African-Americans between 1932 and 1972, and continued even after penicillin was shown to be effective in treating this disease. The subjects of the study did not receive any treatment for their condition, were unaware of the nature of the experiment, and were misled about the nature and purpose of repeated painful and risky procedures, including lumbar punctures, for four long decades (2).The United States Public Health Service funded this research project, in part. Though the above study was never published, a few investigators have been able to get their papers published in indexed journals (3).

It would be interesting to know the future course of legal action against the investigators in the Guatemala trial. Perhaps such cases of gross unethical practice should be tried in the International Court of Law.

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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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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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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

the hidden benefits behind these heavy purchases. To top it all, whenever the health minister visits the hospital, everything is in place, and things are made to seem orderly. A hospital does not become beautiful by these shams, but only by lowering the mortality and morbidity rates.

Similar examples can be seen in the wards, where most of the oxygen-dispensing ports mounted on the walls leak constantly when connected to the tubing for oxygen inhalation for the patient. The patients' attendants are unaware that most of the oxygen from the ports is not going to the patient; they are satisfied with the mask over the face of their patient, so the nursing staff and doctors are also at peace. But the final results are tragic.

The hospital authorities cannot alone be blamed for the sickness of our health system. The defense budget of India is more than Rs 1 lakh crore for the year 2010-2011, while the health budget is merely Rs 23,000 crore. The government can spend at least half of the defense budget in the health sector, as more people are dying inside the country than on its borders.

It is easier to go along with a dirty system than try to change it. But we cannot shrug our shoulders and shirk our responsibilities. The system is made up of people like us. We must rise above thinking only of ourselves and move ahead with the motto of "country first". And we have given this enough thought; we must stop our endless discussions and finger-pointing. It is time to act.

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Photographing patients: an emerging unethical trend

It is increasingly common to find medical students taking bedside clinical pictures or videos of patients. It is not unusual to find even groups of students doing this, during or after a clinical class. The recent surge in the usage of cell phones with cameras, and the increasing lack of sensitivity to patients' feelings, are responsible for this behaviour. These photographs are taken either without the patient's consent or with casual verbal consent without an explanation of its implications. Patients may not be in a position to object to the practice because of the stress of the illness, or the fear that the medical student would treat them badly if they express any objection. Students may also justify such acts in settings where patients get treatment for free. This concept of presumed consent as a moral obligation in return for free treatment is unacceptable. This amounts to nothing but patient abuse.

There is always a chance that these casually taken pictures can land up in a presentation, uploaded on the internet, and disseminated or published in a journal. All these are against ethical norms. It is worth remembering that patients have the right to object to being photographed. Medical students should be aware of the potential ethical and legal issues associated with this behaviour. Photographs should be taken only after giving a clear explanation of the purpose of taking a photograph, and obtaining appropriate written informed consent.

Though the code of conduct of the Medical Council of India states that physicians should not publish photographs of their patients without their consent, this should be considered even before taking such photographs (1). It is necessary to create awareness regarding this issue, and to ensure that patients are not abused in this manner. Senior faculty members are responsible for the ethical conduct of students doing research under their supervision (2). It is also the duty of medical teachers to educate and take vicarious responsibility for the ethical behaviour of their students.

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Are doctors justified in refusing to give emergency treatment?

Every doctor has been called upon, at some time, to provide emergency life saving treatment, especially in road accident cases. Unfortunately, doctors are often reluctant to attend to emergencies (1), harbouring apprehensions about having to visit police stations, being called to court repeatedly as witnesses, sometimes facing long and unnecessary cross examination, and losing earning hours.

Private practitioners are under the impression that "medico-legal" emergencies are to be dealt with only by government doctors and usually refer such cases to a government hospital. Government doctors have no option but to attend medico-legal cases.

According to the law, any doctor who provides first aid in an emergency case will not be held liable or negligent in case any mishap occurs after that patient leaves his care (2). The Supreme Court has held that (3):

The police, the members of the legal profession, law courts and everyone concerned will also keep in mind that a man in the medical profession should not be unnecessarily harassed for purposes of interrogation or for any other formalities and should not be dragged during investigation at the police station and it should be avoided as far as possible. Our law courts will not summon a medical professional to give evidence unless the evidence is necessary and even if he is summoned, attempt should be made to see that the men in this profession

are not made to wait and waste time unnecessarily. It is also expected that where the facts are so clear it is expected that unnecessary harassment of the members of the medical profession either by way of requests for adjournments or by cross examination should be avoided.

In another judgement (4), it was held that the amount of care, skill and caution expected of a reasonable and prudent medical practitioner in normal times and during an emergency may not be the same.

A three member commission headed by Justice M Jagannadha Rao has drafted a bill (5) pertaining to private hospitals and practitioners and the treatment of accident victims and emergency patients. According to the bill, hospitals cannot refuse care to an accident victim even on the ground that it was a medico-legal case. At the very least, they must provide emergency treatment and transport, with medical support, to another hospital, seeking the help of the police if an ambulance is not available. Doctors or hospital administrators who refuse emergency treatment face six months' imprisonment and a fine of Rs 10,000.

On the whole, irrespective of legal concerns, doctors should not refuse emergency treatment, at least on moral grounds.

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Occupational health problems from "standing jobs"

The shopping complexes or malls that are being set up all over this country are creating new occupational health hazards. Enter a mall in any city today and the sales persons will be standing, waiting to serve you. There is a belief that standing to serve is part of their job. We do not stop to think about the fact that these people stand for eight to ten hours every day at work.

When I once went to the ladies' room in a big branded mall, the woman whose job it was to keep the toilet clean was complaining to her co-worker that she wanted to quit her job. Before coming to work, she cooked and did other household tasks. After standing the whole day at work, she was exhausted and found it difficult to take care of her children. She told me that her monthly pay was Rs 3,000.

The situation of those working in malls in the sales section is similar. Workers with jobs that require standing for long periods, without access to a chair, are far more likely to be relatively poorly paid.

There are many health problems caused by prolonged standing. It can cause soft tissue injuries, swollen or painful feet and legs, planter fasciitis, varicose veins, knee problems, low back pain, neck and shoulder stiffness, poor posture (and its effects), restricted blood flow, muscle soreness and fatigue. It can increase the chances of developing knee or hip arthritis. In the case of pregnant women, prolonged standing for more than three hours at a time increases the chances of pre-term delivery and reduced birth weight.

Such health problems caused by prolonged standing are greater when the person cannot move around much, or when it involves working on hard surfaces and/or wearing unsuitable footwear. Saleswomen in malls are expected to wear heels and this unsuitable footwear itself causes many health problems. Heels more than five cm high can force the body forward and the buttocks back because in order to keep their balance, women have to tense up and lean slightly back. This can cause shortened calf muscles and knee and back problems and increase the chances of falling.

However, workers may be reluctant to occasionally sit down at work; for fear that this will be interpreted as laziness by managers, or rudeness by customers.

Small changes at the work station can make it possible to reduce the requirement to stand. People who work at such jobs can be provided a stool to sit on and rest periodically. Salespersons should be allowed to wear low heeled footwear. They should also be allowed to move around when they are not dealing with customers.

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NOTE

The Clinical Trials Watch (CTW) factsheet is based on data downloaded every six months from the Clinical Trials Registry-India, and has been published in the October 2009, April 2010 and October 2010 issues of IJME. CTW is compiled by the Centre for Studies in Ethics and Rights, Mumbai. At the time of compiling the factsheet to be published in the April 2011 issue of the journal, it was noticed that the CTR-I had made changes to, and cleaned, the data in the registry. CTW will be printed in the July 2011 issue, after accounting for all these changes.