

LETTERS

Ethics of pandemic planning in India

Devnani et al discuss various ethical dimensions of the public health measures to be taken when planning for an influenza pandemic (1). In a developing country like India which is diverse, multicultural, over populated and undergoing rapid but unequal growth, ethical pandemic planning must address existing health inequalities.

In India, inequalities in health indicators can be seen according to gender, caste, religion, ethnicity, economic status, and location. To illustrate, children among scheduled castes and scheduled tribes below three years of age are twice as likely to be malnourished as are children of other groups (2). The same is true of access to healthcare. For instance, the rural/urban ratio of hospital beds is 1:15 and the rural/urban ratio of doctors is 1:6 (2). Improving the health of a population and reducing health inequalities will depend upon how effectively the social determinants of health are addressed.

Such disparities pose a greater threat during a pandemic outbreak when there will be increased pressure on scarce resources such as drugs and vaccines. Existing health inequalities are likely to be aggravated if those in power favour their own friends, families or ethnic groups (3,4).

In India, authorities involved in pandemic planning must be required to ensure that healthcare institutions serving rural, low income, isolated and indigenous communities are well equipped to provide the necessary care, and that existing health inequalities are not exacerbated while putting the pandemic plan into action.

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Problems of isolated private hospitals in a rural setting

In the era of the Consumer Protection Act, doctors running small private hospitals in rural settings face unique ethical challenges, especially in acute medical emergencies. I would like to share a few such cases:

1. A 46-year-old advocate, on holiday at a nearby hill station, was brought to our hospital with backache and radiating pain in the left arm. An ECG revealed a 12-hour old inferior myocardial infarction extending to the entire right ventricle. We advised hospitalisation, at which the patient ran out to his vehicle and refused to be admitted, insisting that doctors tell lies to make a profit. His anxious friends prevailed on him to take the aspirin and Clopidogrel tablets were prescribed. Eventually he was admitted and his intermittent ventricular tachycardia was stabilised before sending him to a tertiary hospital in the city. We had some tense hours wondering what to do if he collapsed.
2. A 35-year-old man came to us with complaints of giddiness, suffocation and palpitation. On examination, his pulse was fast and thready; the extremities were cold, with blood pressure of 90 mm hg. On auscultation, marked tachycardia was revealed with a heart rate of 250 per minute with wide QRS complex. We told the relative that direct current (DC) shock had to be administered to reverse the life threatening ventricular tachycardia. While lifting the defibrillator pads, the relative suddenly stopped me, requesting an injection instead. He then took him to another physician who advised the same treatment. Finally, the relative consented and the ventricular tachycardia was reversed by administering DC shock of 200 joules. The reversed ECG showed recent extensive myocardial infarction.
3. A 56-year-old male was brought dead to our emergency room. He had had recurrent chest pain over four to five days and then been found dead in the toilet. The cardiac monitor showed a straight line, but his family tried to pressurise me into giving him DC shocks. On my repeated refusal, the relatives wept and eventually I gave in but to no avail.

In life-threatening situations, it is not easy to insist that a patient receive rational treatment. The results of management of an acute medical emergency are unpredictable, and sometimes grieving relatives become violent. This kind of problem is aggravated in a rural setting, as the individual doctor managing the hospital becomes a target of public anger and frustration and can face long-term stigma after such incidents. At tertiary

hospitals the responsibilities are shared.

The fear of such reactions and of prosecution makes doctors lethargic and passive in such emergencies and a majority of them develop an unwillingness to be proactive. We appeal to your readers to send in their experiences of how they have faced such ethical problems.

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Ethical aspects of operating on seropositive patients.

Infection with blood-borne pathogens has long been recognised as an occupational risk for healthcare workers (HCWs), particularly surgeons and anaesthetists whose work often involves breaching the cutaneous or mucosal barrier, exposing them to blood and other body fluids and putting them at risk of acquiring HIV or other blood-borne infections (1). However, in spite of these risks, systems to protect HCWs are not in place.

More than 5% of patients with AIDS require surgical procedures, most commonly in cases of peritonitis, non Hodgkin's lymphoma, Kaposi's sarcoma, and appendicitis, and in situations requiring splenectomies or in deliveries requiring a caesarean section.

Exposure to an infected needle, blood or body secretions carries a risk of infection with Hepatitis B (9-30 % with a single percutaneous exposure), Hepatitis C (1-10 % with a single percutaneous exposure), or HIV (0.3 % with a single percutaneous exposure; 0.09% with a mucous membrane splash to the eye, or oro-nasal exposure) (2).

Despite following 'universal precautions', accidental exposure may occur while performing invasive procedures and handling body fluids. Our ART centre has more than 9,800 seropositive patients registered, and over five years, more than 60 HCWs here have been given post exposure prophylaxis (PEP) (2).

The risk of occupational transmission of HIV, HBV or HCV is likely to rise among HCWs in resource-poor settings where universal precautions are not practised and patients may not disclose their test reports even if they know their positive status.

Certain policies must be followed strictly regarding management of positive patients.

1. Immediately after exposure, the HCW should notify the designated supervisor for help in completing the incident report.
2. The patient's blood should be tested for HIV, HBV and HCV (after pre and post test counselling) even if a patient refuses consent, and the results should be kept confidential.
3. Five doses of PEP should be kept in the operating theatre (OT) to be administered within two hours of exposure, routinely, without any panic or delay.

4. If an HCW tests positive, s/he should be allowed to continue working in a different area and receive a special benefit package to cover expenses for treatment, disability and possible loss of life.

Certain general policies must be followed. HCWs with a positive status for HIV and HBV should not work in an OT, or in any department where blood-to-blood contact is likely, to avoid the chances of transmission of blood-borne infections to patients. Although this is not a legal requirement, HCWs must be encouraged to know their HIV status. They should also be vaccinated against HBV and the records maintained confidentially

All OT staff should have a good understanding of risk of contracting infection in the theatre. Simultaneously, special ventilation systems for OTs must be used, and all standard precautions regarding patient preparation, use of protective kits and waste disposal must be implemented.

When operating on known positive cases, separate theatres should be maintained if possible. If not, a minimum of experienced staff should be deployed, excluding students and trainees. Surgical techniques may also be modified to minimise the use of sharp instruments.

No surgery should be postponed on grounds of HIV or HBV positivity test reports. But post-exposure prophylaxis should be available for all HCWs working in the OT, irrespective of their designation. If the patient is seropositive and on ART, his/her viral load and CD-4 count should be retested for better post-operative management. If the patient is diagnosed preoperatively, then after surgery, s/he should be advised to get registered in an ART centre. There may be delayed wound healing in such situations. ART should be re-evaluated and HIV co-infection should be ruled out.

While HCWs must be educated about the protocols to be followed, the importance of being tested when exposed, accepting a positive finding, reporting to superiors, and following up treatment till completion cannot be overemphasised. This applies particularly to new recruits who may be enthusiastic and incautious. There is a considerable lack of awareness among medical and dental postgraduate residents about PEP (3) against accidental exposure to HIV, suggesting a need for training and awareness programmes.

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Pathologising alternate sexuality: shifting psychiatric practices and a need for ethical norms and reforms

Section 377 of the Indian Penal Code, criminalising consensual sexual activity between adults of the same sex, was framed during the British Raj and continued to govern Indian sexual relations until very recently. This law seems to reflect societal attitudes towards alternate sexualities. Such attitudes can affect the self-esteem and quality of life of people in the lesbian, gay, bisexual, transgender (LGBT) community who may then seek help from mental health professionals. Unfortunately, psychiatry has a history of pathologising homosexuality.

Recently, I was consulted by Mr A, a 26-year-old man, who identified himself as gay. A year earlier, when he had been questioning his own sexual orientation, he contacted a reputed psychiatric institute where the psychiatrist told him that his attraction towards men could be controlled, and that he could feel sexually attracted to women, by just completing a course of medicines. The patient quoted the psychiatrist as saying: "I guarantee that you can marry a woman after this treatment." Mr A agreed to take the medications and also started attending weekly therapy sessions at the same institute, but with a different psychiatrist.

Mr A said that for almost six months, his therapy sessions discussed every aspect of his life except sexuality. After six months when he insisted that they discuss his sexuality, the psychiatrist suggested that the medications would have started to work and he should "try out" the effect by "going and having sex with a girl." When the patient said that he did not know any girl who would agree to this, the psychiatrist suggested that he can go and "try out" with a commercial sex worker. Mr A did as advised but did not succeed. At the next consultation, the psychiatrist encouraged a "retrial...since one cannot infer anything from a single encounter." Mr A "tried" three more times, unsuccessfully. At this point, he realised three things: that he did not get sexually aroused by women, and that his sexual arousal for men had gone down. However, his sexual attraction for men remained unaffected, which was contrary to what the first psychiatrist had "guaranteed" a year earlier. When he went back to the first psychiatrist, he was asked: "Is marriage all about sex?" and advised a combined consultation along with the second psychiatrist. The patient did not go back to see either

of them.

I read the prescription and saw that Mr A had been prescribed amisulpiride, escitalopram, amoxapine, lamotrigine and zolpidem for a full year. Amisulpiride, an atypical antipsychotic is used in the treatment of psychotic disorders. Escitalopram and amoxapine are antidepressants. Lamotrigine is a mood stabiliser used in bipolar depression. The patient denied having any history that could suggest depression, psychosis, or bipolar disorder at any time in his life. He stated repeatedly that the only reason for his consultation with the psychiatrists was the dilemma about his sexual orientation.

This case draws our attention to what some psychiatrists still practise today, thus making it difficult to draw a line on what they can treat and what they cannot or rather should not treat! Anecdotal reports suggest that many psychiatrists now use these classes of drugs under the pretext of helping the patient's depression or stress, possibly with the intention of reducing their overall sexual desire. This is a paradigm shift from the earlier behaviour modification techniques that were claimed to 'cure' homosexuality (1,2).

A common side-effect of all these medications (except lamotrigine) is sexual dysfunction that may include decreased libido, erectile dysfunction and ejaculatory disturbances in men (3-6). Although these medications reduced Mr A's sexual arousal for men, they could do nothing as far as his innate attraction to the same sex was concerned, highlighting the fact that an individual's sexual arousal and sexual attraction towards another individual are governed neuro-biologically through different circuitry.

This case raises the issue of giving false assurances "guaranteeing a cure" when there is no evidence to support such a cure (7). It also highlights how a psychiatrist can breach therapeutic boundaries and suggest that the patient visit a CSW in order to see if the treatment is working. This case could just be the tip of the iceberg and there could be many more such LGBT patients who are misguided about a possibility of curing themselves of their natural sexual preferences?

Such incidents call for urgent reforms in the mental healthcare system, as well as in the wider healthcare system, to make them more LGBT-friendly. Redefining the role of healthcare professionals in these cases is urgently needed (8). An initiative on this front can be taken by national bodies and societies, individual institutes and healthcare providers. This would not only increase clients' trust in the healthcare system but also reduce the burden of their mental health problems.

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Critical perspectives on the NIMH initiative "Grand Challenges to Global Mental Health"

In July 2011 Nature carried a Comment titled "Grand Challenges to Global Mental Health" (1) announcing research priorities to benefit people with mental illness around the world. The essay called for urgent action and investment. However, many professionals, academics, and service user advocate organisations were concerned about the assumptions embedded in the approaches advocated and the potential for the project to do more harm than good as a result. Nature refused to print a letter (sent on 20th August 2011) protesting against the issue, citing 'lack of space' as the reason.

This letter is an effort to critique the initiative through wide participation and consensus.

Background

The largest international Delphi panel ever was assembled in a project starting March 2010 to formulate the 'Grand' Challenges to Global Mental Health project. The panel consisted of a scientific advisory board from the US National Institute of Mental Health who "nominated 594 researchers, advocates, programme implementers, and clinicians...researchers in genetics and genomics, neuroscience, basic behavioural science and neurodevelopment made up just over one-third of the panel. Mental health services researchers constituted another quarter, and a further third were clinical researchers and epidemiologists" (p 28).

The panel listed 25 grand challenges including biological, social and genetic factors that needed to be identified and tackled.

While environmental influences and community care were mentioned, the main framework for the project utilised a narrow 'medical' model for understanding mental distress that emphasised treating mental, neurological and substance-use (MNS) disorders through improved understanding of the brain, its cellular and molecular mechanisms. Fourteen MNS disorders were listed including unipolar depressive disorders, alcohol-use, schizophrenia, bipolar affective-disorders, epilepsy, panic disorder, migraine, insomnia, PTSD, and Parkinson's disease. The fact that disorders likely to be linked to adverse experiences

(such as depression) were put alongside known organic pathologies (such as epilepsy) illustrated the lack of inclusion of lived social and political realities in the models for causation and manifestation of mental distress. In addition, while the authors proposed 'understanding root causes, risk and protective factors' including poverty, violence, war, migration and disaster, the essay largely advocated biomedical, clinical or 'social services' oriented measures to alleviate the distress, with no protest, voice or opinion against the root causes listed. They argued that MNS disorders constituted 14% of the global burden of disease surpassing cancer and cardiovascular diseases with a global loss of disability adjusted life years at 148.8 million. This programme is now growing in strength as it is being rolled out internationally (2).

Problems with the Grand Challenges project

The following are some of the main problems with adhering to the 'Grand Challenges' proposal:

- a) We agree about the need to improve mental health in non-western countries, but are concerned about the approach of the 'Delphi panel' as developing appropriate frameworks for mental health requires active collaboration with local communities and with those with personal experience of mental health problems. The Delphi panel was not representative of these stakeholders. The data on which the Delphi panel bases its recommendations is also questionable and could grossly exaggerate the global burden of mental disorders.
- b) The focus on 'molecular and cellular mechanisms' in the brain for the complex problems of living ignores the experiences of ordinary people and the different settings in which mental health problems manifest.
- c) The recommendations overlook indigenous healing, social support networks, rights-based organizations and family support.
- d) The assumption of a global norm for mental health and the idea that deviations can be subsumed within a simplistic biomedical framework is restrictive and disconnected from the real lived experiences of potential service users.
- e) Mental health services should not be dependent on funds driven by pharmaceutical, insurance and other industries with potential conflicts of interest.
- f) The picture of a black girl chained to a tree on the front page of their paper in Nature suggests that rights violations are a more prevalent issue in non-western countries. Mental health service delivery has involved rights violations across the globe (e.g. use of seclusion, restraint, high dose medication).

Instead we propose that protections, in line with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), should be at the centre of developing mental health programmes. These programmes should also be developed in a way that reflects the experience of local communities.

A framework that emphasizes respect for persons requiring services would result in approaches that are interactive and not imposed (as is the case in most Western countries).

If the US-NIMH is concerned about the lives of people in LMI countries it should be in dialogue with representative stakeholders, and not impose solutions identified by non-representative experts.

We the undersigned are concerned activists and practitioners who come from different representative organizations like MFC, Anveshi and CAMH in India, and Survivor Research, ICPN, the UK.

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Psychiatric advance directives: cultural reflections

The article by Sarin et al (1) on the subject of psychiatric advance directives (PADs) raises new problems which are particularly challenging in the Indian context. The debate so far has focused on issues of competence, access, resources and legal dilemmas. What is missing is a discussion on the cultural aspects of mental healthcare for the Indian population.

Advanced directives are anchored in the bioethical principle of autonomy. The concept of autonomy as applied in western biomedicine implies self-determination and individual independence. This may not be the case in a different cultural context (2,3). Sarin et al have rightly pointed out, but not elaborated on, the role of family/key caregivers' preferences and views, and their impact on PADs and decision-making. This is also suggested in research findings on advanced directives in end-of-life care in cultures outside Europe and North America. Thus autonomy may imply "self-sovereignty" and "individual independence" in one culture, but "family-sovereignty" and "harmonious dependence" in another (3).

There is a more contentious issue related to the dominant form of mental healthcare legitimised by the state, in policy, programmes, and state-sponsored services. Research in mental

healthcare (4-9) has made evident the cultural construction of dominant biomedical paradigms of psychiatric care, and reveals the existence of other types of care that do not rely on biomedical treatment.

However, given the domination of biomedical treatment, requests for other types of care may be interpreted as non-viable. Under the circumstances the clinician may overrule PADs apparently in support of beneficence at the cost of autonomy.

In other words, legal instruments such as PADs may justify cultural bias and further marginalise those who seek mental healthcare outside mainstream medicine. As a result, they defeat the purpose of non discrimination and enhanced mutual acceptability of treatment decisions (1) for which PADs have been designed.

Sarin et al recommend research in PADs around feasibility, acceptability and effectiveness, in the Indian context. This can be advanced by culturally informed research. And, because personal integrity is threatened in severe mental disorders, primarily due to loss of insight, it is important to research these disorders and people's preferred methods for restoration, of integrity. This is because people's preferences relate to PADs in a definite manner.

The paper by Sarin et al is commendable, considering the variety of issues it brings to the fore that may add substantial value to the discourse on PADs. To be a fruitful legal mechanism, PADs should facilitate the aligning of culturally appropriate services with treatment needs.

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Medical humanities: addition to academic burden

I read with interest the articles in the latest issue of *IJME*. Most seem to advocate that teaching humanities to medical students would make them more humane and concerned doctors and would develop empathy towards their patients in their future careers as practising doctors.

I beg to differ. I feel it will only add to their academic burden. Then how can we make doctors more human and less mechanical in their dealing with patients? To do this let us first try and find out why we have become what we are today.

50 years ago when we entered medical school, most of us came from a poor or middle class background and studied in government-run medical colleges. Our peers too were not rich. Our professors rarely flaunted their wealth (if they had any). I remember one of my surgery professors came to the hospital in the city bus. Even our pre med education, with few exceptions was in state schools. As a medical student I did not consider it as demeaning to give a bed pan to a patient or roll a trolley from the ward to the x-ray or to another department. Earning money was important but not an all consuming goal in our training years. The work load during the final year when we did most of the work that is done by the interns of today (if at all they do) made us come into contact with the patients and their socioeconomic background. This contact continued during the houseman years and later when we became doctors.

Many of us became General Practitioners(GPs). Though the craze for specialization had already started; many of us were forced to become GPs because of the urgent necessity to make an early start due to dire socio economic need. As we grew we learnt more about our people and the way they live and often their suffering became partly ours. Practising medicine in the community, in contrast to that within the confines of the institution, is a blessing which took some years for me to realise.

Hospitals are like ivory towers and often far removed from the reality of life that exists outside. The advent of private hospital care has made this problem more acute and private medical institutions have contributed to making the doctor less human. The medical student of today usually (not always) comes from a more affluent class and the ethos of this class is different from that of those from poorer socio economic backgrounds. I have observed with dismay even those who come from this background getting drawn into this vortex of insensitivity, which was much less in my younger days.

A doctor obsessed with specialisation and super specialisation and who keeps the motive of monetary success as the primary object will find it difficult to become a more humane doctor, even if he is exposed to all the humanity topics. Exposure to art, music, drama, social science will not make him a better human being if his primary objective is different.

While agreeing that not all those who come from a poor socio economic background, necessarily become more humane, I feel that the government should not abandon its responsibility for providing medical education and training by delegating it to private players. This will help to some extent. The other measure will be to expose students to community health in a more comprehensive way than is being done now. Get more and more GPs into institutions and let medical students come into contact with family doctors and let them do a stint of family medicine before their specialisation. They will learn more humanities by being with a GP than by doing courses in humanities. Give a higher status to family medicine and take some of the gloss away from the super specialties.

In a society where graft is all pervasive and ethical life has been given the go-by, I agree it is an uphill task to get doctors to behave differently. But loading them with humanities will not meet the objective.

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