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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References

1. Kurpad SS, Machado T, Galgali RB. Is there an elephant in the room? Boundary violations in the doctor-patient relationship in India. *Indian J Med Ethics*. [Internet]. 2010 Apr-Jun;7(2):76-81.
2. Doctor transferred for molesting woman during checkup. *Yahoo India News*. [cited 2010 May 19]. Available from http://in.news.yahoo.com/20/20100508/1416/tnl-doctor-transferred-for-molesting-wom_1.html
3. Singh VV. KEM doc gets bail in molestation. *The Times of India*. [Internet]. 2009 Nov 23 [cited 2010 May 19]. Available from http://timesofindia.indiatimes.com/city/mumbai/KEM-doc-gets-bail-in-molestation/articleshow/5258589.cms
4. Times News Network. Doctor held for molesting patient. *The Times of India* [Internet]. 2008 Mar 30 [cited 2010 May 19]. *Available from* http://timesofindia.indiatimes.com/city/kolkata-/Doctor-held-for-molesting-patient/articleshow/2910831.cms

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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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References

1. Sheriff DS. Lessons from my father. *Am J Med*. 1992 Oct; 93(4): 441-2.
2. Mhatre U. Right to human dignity. *Indian J Med Ethics*. 2010 Jan-Mar; 7(1): 36-7.

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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References

1. Sarbadhikari SN. A farce called the National Board of Examinations. *Indian J Med Ethics*. 2010 Jan-Mar; 7(1):20-2.
2. Poduval M. Diplomate of the National Board: inefficient parallel education. *Indian J Med Ethics.* 2010 Jan-Mar;7(1):22-5.

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".