

LETTERS

Ethical dilemmas of medically unexplained symptoms

Medically unexplained symptoms (MUS) are common across health settings. These are defined as “physical symptoms that prompt sufferer to seek healthcare but remain unexplained after an appropriate medical evaluation” (1). Expectedly, MUS are often associated with significant health-seeking behaviours that add to the burden on health resources.

There are ethical dilemmas in the management of symptoms that are purely subjective and cannot be confirmed objectively. Three key ethical dimensions manifest when a physician deals with a person with MUS. The first is related to communication about MUS. The symptoms cause distress to the patient but the cause is not understood by the physician and no explanation is offered. The difficulty arises in discussing MUS with the patient and family members. They may think that the patient is “faking” or reporting a symptom which is absent or unproven by the examination and investigations. This can cause further distress to the patient with MUS. On the other hand, the uncertainty might lead the patient to wonder whether this is an indication of some dreadful disease. In such situations, health professionals find it difficult to explain (something that has no explanation) and wonder whom to inform – patient or the relatives.

Ethically, the physician should explain with honesty and transparency about the uncertainty regarding MUS both to the patient as well as family members. They need to be explained that investigations have limitations. The physician needs to be empathetic so that the family members do not doubt his/her intentions.

The second ethical dimension is related to investigations. To understand the cause of MUS, physicians would like to repeat investigations or prescribe new, unusual and uncommon investigations. Hence, there is a risk of over-investigation and danger of under-investigation. This needs to be discussed tactfully with the patient and family members to enable them to make informed decisions about investigations.

The third ethical aspect is related to treatment or intervention. In MUS, the treatment is symptomatic to relieve the distress and suffering. Therefore, medications and non-medical therapies need to be used rationally. Use of placebos or multivitamins in MUS is an ethical issue. In such situations, the patient and family may prefer complementary and alternative medicine (though the scientific validity and efficacy of such systems is unproven).

In India, a patient’s preferences and decisions are usually influenced by family members. Ethical dilemmas concerning MUS leave the professionals and families confused. Thus, ethical issues need to be handled sensitively within the framework of the financial constraints and well-being of the patient.

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Reference

1. Richardson RD, Engel CC Jr. Evaluation and management of medically unexplained physical symptoms. *Neurologist*. 2004;10(1):18–30.

MCI circular on research publications: Missing the wood for the trees?

Published online on March 31, 2016.

We read with interest the editorial “Regressive trend: MCI’s approach to assessment of medical teachers’ performance” (1). MCI is the holy cow of medical education, and we are yet to see a detailed critique of its various policies. India lags behind in evidence-based health policies as well as those that regulate education (2). It was not surprising to see the regulations on research publication in the context of promotion. It was shocking that the circular has numerous typos, which erode one’s credibility. Historically, typos have resulted in regime changes and company liquidations (3).

The editorial mentions various kinds of research papers that need to be considered and their contribution to dialogue and knowledge creation. At point “b”, the circular says Original Research Articles and Original Research Papers. Does this not show utter confusion and disregard for academia at the highest levels? Systematic reviews involve a lot of diligent work, and are the basis of evidence-based decisions in clinical care, but are not being considered. Yet they are the first articles that we consult when we make evidence based decisions in clinical care. With current norms, Watson and Crick who published a one-page article on the structure of DNA may not be promoted (4). We submitted an original article which was accepted only as a brief report. We agreed because it was the highest impact factor journal in the subject category in India (5). Yet one of the authors in the article faced an issue in

promotion as this was not considered as an “original article”.

Point “c” talks about national and international societies. However, it is interesting how we can define some journal as national or international; a few “American” journals were published from Pakistan (6). How does naming a journal in a particular way give it legitimacy? A recently published paper showed how ethics committee members did not have adequate research knowledge, and yet they decide on research proposals (7). It is surprising that in the 21st century, many academicians have to face a situation that was faced by Galileo and Darwin eons ago (8).

The editorial rightly elaborates on the issues of authorship and e-journals. Since authorship guidelines place equal responsibility for the paper on all authors, acknowledging only the first two indicates a regressive step. E-journals have been dismissed summarily. This goes against the stand taken recently by a few universities in the USA where they have actively discouraged publication in for-profit journals run by Elsevier (which runs Scopus), etc (9). The international narrative is in favour of open access publications that are free to download in which the “author pays” model is being favoured (10). However, the problem with the open access model is that anyone with an internet connection and a few thousand rupees to spare can start a journal from his kitchen. The MCI probably is aware of these trends, and is trying to discourage them. But by using terminology such as e-journals, it is throwing out the baby with the bathwater.

We have devised our own publication guidelines for our institution. These are available online and guide us in our interpretation of these rules (11). As with science and education, these policies will evolve and respond to issues over time. We hope the MCI will take note of these, and refine its circular.

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References:

1. Bandewar SVS, Pai SA. Regressive trend: MCI's approach to assessment of medical teachers' performance. *Indian J Med Ethics*. 2015;12(4):192–5.
2. Bhaumik S. Health and beyond... strategies for a better India: incorporating evidence to strengthen health policy. *J Family Med Prim Care*. 2014;3(4):313–17.
3. Cameron Fennell. The high cost of small mistakes: the most expensive typos of all time [Internet]. Six Degrees Market Research and Branding Agency, 2015 May 11[cited 2015 Nov 15]. Available from: <http://six-degrees.com/the-high-cost-of-small-mistakes-the-most-expensive-typos-of-all-time/>
4. Watson JD, Crick FH. Molecular structure of nucleic acids. *Nature*. 1953;171(4356):737–8.
5. Sethi, A, Patel D, Nimbalkar A, Phatak A, Nimbalkar S. Comparison of forehead infrared thermometry with axillary digital thermometry in neonates. *Indian Pediatrics*. 2013; 50(12): 1153–4.
6. Plunk V. Who's afraid of peer review? *Science*. 2013;342:60–5.
7. Tamariz L, Medina H, Taylor J, Carrasquillo O, Kobetz E, Palacio A. Are research ethics committees prepared for community-based participatory research? *Journal of Empirical Research on Human Research Ethics*. 2015;10(5):488-95. doi: 10.1177/1556264615615008.

8. Raty Syka. The scientific revolution: opposition to Galileo and Darwin [Internet]. Western civilization as we know it. 2008 Mar 16 [cited 2015 Nov 15]. Available from: <http://chnm.gmu.edu/history/faculty/kelly/blogs/h100sp08/2008/03/16/the-scientific-revolution-opposition-to-galileo-and-darwin/>
9. Lambert C. The “wild west” of academic publishing: the troubled present and promising future of scholarly communication [Internet] *Harvard Magazine*. 2015 Feb [cited 2015 Nov 15]. Available from: <http://harvardmagazine.com/2015/01/the-wild-west-of-academic-publishing>
10. Massachusetts Institute of Technology [Internet]. Open access publishing support [cited 2015 Nov 15]. Available from: <https://libraries.mit.edu/scholarly/mit-open-access/open-access-at-mit/mit-open-access-policy/open-access-publishing-support/>
11. Charutar Arogya Mandal [Internet]. Institutional Research Group (Policies) [cited 2015 Nov 15]. Available from: <http://charutarhealth.org/institutional-research-group>

Interpretation: a confounding factor

With reference to the article “Passive euthanasia in India: a critique”, authored by Ms Rohini Shukla and published online on August 5, 2015, I would like to make a few comments and highlight the following points. First, the author notes that Section 309 IPC has been decriminalised. This is not so since there has neither been any amendment to the IPC, nor has any ordinance been passed regarding the matter. Attempting suicide is still an offence in India. Second, the author observes that withholding life support is an act of omission and withdrawing life support is an act of commission and the terms have been used interchangeably by the Hon’ble Court, although there is a subtle difference between the two terms. With reference to the author’s view, can we not debate that *inaction is also a kind of action*, especially when it takes place with a knowledge of the consequences that can ensue? Third, The Hon’ble Court has mentioned the “low level of ethical standards to which our society has descended, its raw and widespread commercialisation, and the rampant corruption”. It is no secret that the moral standards in society have deteriorated. This observation was made in the context of the possibility of the misuse of the law to permit euthanasia in Indian society. Whether or not a doctor should be allowed to choose the means of ameliorating the suffering of his/her patients can open a Pandora’s box and I believe that was the reason why the court refrained from commenting on the same. Fourth, the court has appreciated the effort of the staff of KEM hospital and the love and care shown by it to the patient, Ms Aruna Shanbaug. This was done to highlight that the staff members were the next best family available for Ms Aruna Shanbaug and that their opinion had to be considered since the victim could not express her wishes. Whether the life of Aruna Shanbaug was actually “so miserable as to not be worth living” was for her to tell and is not for us to interpret. Interpretation is one of the biggest confounding factors that leads to ethical dilemmas, hindering clear directions on euthanasia.

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