

## 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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#### **References**

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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