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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