CORRESPONDENCE

Consent for intimate examinations

Twenty students are huddled around a patient trying to auscultate a cardiac murmur. Others try to percuss the chest of a patient with emphysema, oblivious of the patient's agony each time the plexor strikes the plexime-ter. An elderly gentleman complaining of difficulty in passing urine finds that all the students in the depart-ment will perform rectal examinations to feel his en-larged prostate, apparently unaware of the discomfort this could cause. The primigravida in the pangs of labour finds she is subject to a succession of students estimating the dilatation of the os in a per vaginal examination.

Such memories came back to me when I read an article on the ethics of having medical students learn through intimate physical examinations (1). Students responding to a questionnaire described how they had performed intimate examinations, including on sedated patients, without consent; often, many students examined the same patient. The report generated a heated debate on the eth-ics of such examinations for teaching purposes.

How many medical colleges in India even have written policies and guidelines on the subject? Once I asked a class of third-year medical students what they under-stood of medical ethics. Eight out of 20 said they had never heard of the term. What would their experiences be on learning how to conduct physical examinations?

This blasé attitude is common in our outpatient depart-ments. Students are enthusiastic about developing their skills even as they ignore the patient's perspective. To-day, people challenge the notion that such practices can be justified because of the need to train students. Patients cannot be used as teaching aids without their consent. They must be treated with dignity.

Reference

1. Coldicott Y, Pope C. The ethics of intimate examina-tions—teaching tomorrow's doctors. *BMJ* 2003;**326:** 97–101.

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Sponsored conferences

In India drug companies are the major sponsors of local, state and national medical conferences, paying speakers and their travel and accommodation costs, as well as in-dividual registration fees for certain doctors.

We approached a chemist's shop and obtained the pre-scriptions written over one month by four physicians in this area. Three of the four, who are known to be spon-sored by a particular drug company on various tours, turned out to be major prescribers of this company's prod-ucts. The fourth physician, who prescribed cheaper prod-ucts, is not invited to such functions at all. Further, this doctor has been ostracised by his own colleagues.

Few doctors raise their voices against sponsorship by drug companies. Sponsorship is flourishing like a disease, par-ticularly in cities. The industry must have its wings clipped.

Reference

1. Bhan A. IMA meetings: down in the dumps. *Issues in Medical Ethics* 2003;**11:**60.

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Patients' rights

A recent visit to the United States included visits to den-tists, general medical practitioners, consultants and uni-versity hospitals. Three things impressed me *vis-à-vis* the rights of patients.

Most doctors have displayed their consultation charges in the waiting room or at the receptionist's desk. Second, all hospitals have information on patients' rights dis-played clearly in wards, waiting areas and lobbies. These rights include the right to refuse treatment, to a second opinion and to privacy. It is clear that patients are in-formed of their rights before treatment or surgery. Third, HIV, HBsAg and HCV tests are not done on patients. It is felt that if the patient's immune status should be declared, so should the surgeon's, because either can infect the other.

I am writing this particularly to highlight the controversy raised in India over the display of medical fees, and on the compulsory testing for HIV status, something that all of us do preoperatively.

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