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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"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

patient may be capable of consent for other civil contracts but not in a position to give a valid consent for a sexual relationship with the doctor, due to transference issues. (This is grey only from a legal viewpoint, not an ethical viewpoint).

As stated in our original paper we excluded sexual harassment, sexual molestation and rape from the purview of our paper as we felt that there is no need to generate an ethical debate on why it is unacceptable. Even though offenders who commit these crimes (if they do admit to them), tend to rationalise their behaviour and say, "The no meant yes," we all know and accept that these acts are crimes. We hope the results of our study will raise awareness on why, in the context of sexual contact in a doctor-patient relationship, a patient's "yes" should still mean a "no".

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Product endorsement by medical practitioners

The National Bioethics Conference felicitated Sunil Pandya, Vasantha Muthuswamy and Chandra Mohan Gulhati for their work in medical ethics (1). Such recognition to deserving mentors will infuse life into the field and project the nobility of medicine in the eyes of the local as well as the international medical community.

We are living in a world where incentives and kickbacks play an important role in the marketing strategy of corporates. Cricket players are sold in the market for their entertainment value, and they abandon the spirit of sport to play for the sake of money. Medical professionals are no different. Their life-saving skills and their medical eminence prompt companies to ask for their endorsement (2). Doctors appear in the media making false claims about medical products, toothpastes and skin creams. Some of them are office bearers of medical associations.

In this world, everything is sold, from medical seats to medical equipment. There are clever sellers and eager buyers in the market. In a world where money seems to laminate the values of life, ethical practitioners bring a ray of hope to us.

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Iatrogenic STD inoculation study

Susan M Reverby has unearthed a glaring example of unethical research, carried out by the United States Public Health Service and co-sponsored by the National Institutes of Health, the Pan American Health Sanitary Bureau and the Guatemalan government in 1946-48 (1). In this study of the effectiveness of penicillin in syphilis and gonorrhoea, 700 Guatemalan nationals including prison inmates, mentally challenged people and military personnel were intentionally infected with various sexually transmitted diseases including syphilis and gonococcal infection. Prison inmates were allowed to have sex with syphilis-infected prostitutes paid by US health officials. There are no records on whether informed consent was obtained from the subjects participating in the trial.

Such studies are carried out very often in both developed and developing nations. The most widely discussed American research experiment that violated ethical codes was the Tuskegee study. This study consisted of observing the natural course of syphilis exclusively in African-Americans between 1932 and 1972, and continued even after penicillin was shown to be effective in treating this disease. The subjects of the study did not receive any treatment for their condition, were unaware of the nature of the experiment, and were misled about the nature and purpose of repeated painful and risky procedures, including lumbar punctures, for four long decades (2).The United States Public Health Service funded this research project, in part. Though the above study was never published, a few investigators have been able to get their papers published in indexed journals (3).

It would be interesting to know the future course of legal action against the investigators in the Guatemala trial. Perhaps such cases of gross unethical practice should be tried in the International Court of Law.

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