

## Medical Ethics

### A consensus document requesting the Medical Council of India to take action on the issue of boundary violations in doctor–patient relationships

#### THE BANGALORE DECLARATION GROUP\*

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We, a diverse group of health professionals and participants of a meeting on ‘Boundary violations in the doctor–patient relationship in India’, convened by the Department of Medical Ethics, St John’s National Academy of Health Sciences, Bengaluru on 25–26 February 2011, came to a consensus on the need for clearer guidelines on boundary issues in the doctor–patient relationship in India and the need to include this topic in medical training. This document is the outcome of our meeting and a draft copy was given to the working group for medical undergraduate curriculum of the Medical Council of India (MCI) in March 2011 with a request to them to take action on this issue. We declare the following: ‘There is an urgent need to teach medical students and sensitize all doctors about boundary issues in the doctor–patient relationship.’

##### Background

Boundary violations (BVs) in doctor–patient relationships are an important concern in India, as indeed in the rest of the world.<sup>1–3</sup> While some countries have recognized this unfortunate facet of medical practice,<sup>4–7</sup> it has received scant attention in India. Both sexual and non-sexual BVs occur in India. As BVs damage the doctor–patient relationship and invariably harm both the patient and the doctor,<sup>8</sup> it is the ethical responsibility of the healthcare

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profession to develop strategies and systems to address this issue on a priority basis in India. At our recent meeting, we discussed the prevention of BVs. It was strongly felt that there is an urgent need to sensitize all medical students to this issue during their training, by including the concepts pertaining to the topic in the medical undergraduate and postgraduate curriculum (Box 1).<sup>1,9,10</sup> Furthermore, there should be clearer guidelines for doctors on boundary issues in the doctor–patient relationship in India.

Ensuring appropriate boundaries contributes to a therapeutic, safe, yet warm and empathic doctor–patient relationship.<sup>11</sup> Although some doctors are intuitively aware of boundary issues in their relationship with patients and can differentiate between acceptable boundary crossings and unacceptable BVs, many have had to learn to negotiate these issues on their own through ‘trial and error’, and some are never fully aware of the ethical issues involved in such boundaries.

We recognize that the MCI already takes into account the issue of ethical conduct by physicians through its Code of Ethics (2002, amended 2010).<sup>12</sup> However, there is a need to sensitize all medical doctors in India more specifically to the issue of boundaries.

##### The importance of awareness

As BVs can be harmful to patients, it is important to sensitize all medical practitioners to this issue. It is important that throughout

#### Box 1: Some concepts in boundary issues in the doctor–patient relationship<sup>1,10,11</sup>

**Boundaries:** These define the limits of the doctor–patient relationship in certain conditions, as this is a fiduciary relationship, wherein the patient entrusts his or her well-being to the doctor.

**Problem conditions:** These include the establishment of a dual relationship between the doctor and the patient, involving areas such as active socialization, the exchange of gifts, business transactions, and romantic or sexual involvement.

**Boundary crossings:** These are minor ‘departures’ in some of the above areas that are neither harmful, nor exploitative. Indeed, in certain contexts they might even be appropriate. Following a boundary crossing there is a return to the usual doctor–patient relationship. An example is the doctor occasionally accepting a box of sweets on behalf of the entire treating team from a patient who can afford it.

**Boundary violations:** In these transgressions, the doctor exploits the doctor–patient relationship for his personal or sexual gain. Boundary violations are invariably harmful. The inherent power differential in the doctor–patient relationship makes the patient vulnerable to abuse and ethically speaking, any ‘consent’ from the patient would be invalid.

their undergraduate training, internship and postgraduate training, medical students should be made aware of the term ‘boundaries’ and how boundary issues may arise in different contexts when practising medicine in order to reinforce these concepts and enable students to understand the practical implications. All practising doctors should also be aware of boundary issues. This can prevent, or at least reduce, the occurrence of BVs. In addition, improving awareness will ensure that if one healthcare professional comes across a BV by another health professional, he or she will be able to more easily recognize, acknowledge and address it. This can prevent the compounding of harm that occurs when BVs are ignored. Improved awareness among doctors will also reduce their vulnerability to false allegations, which can be personally and professionally devastating. All this would require the MCI to have clearer guidelines on boundary issues than the existing one line under ‘adultery or improper conduct’ (Box 2).<sup>12</sup>

**Box 2: Statement in the MCI’s current Code of Ethics which deals with ‘improper conduct’<sup>12</sup>**

Chapter 7 Misconduct

7.4 Adultery or Improper Conduct: Abuse of professional position by committing adultery or improper conduct with a patient or by maintaining an improper association with a patient will render a Physician liable for disciplinary action as provided under the Indian Medical Council Act, 1956 or the concerned State Medical Council Act.

*What do medical students and doctors need to know?*

They need to understand concepts such as boundaries, boundary crossings versus BVs and the importance of context.<sup>9</sup> As it is impossible to prepare guidelines for every eventuality, students (by the end of internship) and practising medical doctors should be clear on what is unacceptable or acceptable behaviour, as well as be able to recognize and handle grey areas through their own informed judgement. BVs are traditionally described as occurring in the context of the ‘relationship’ between the doctor and the patient. However, as BVs are sometimes recognized by actions and not intent, there is a need to address other issues, including inappropriate physical examination.

*When, how and by whom do students need to be taught?*

The issues pertaining to boundaries should be taught to medical students in a graded manner, i.e. in a way that is appropriate to the stage of training right through their course. The concept is simple and should be incorporated into the existing subject-specific methodologies. This will ensure that incorporation into the curriculum is simplified and not burdensome to the undergraduate student. For example, an appropriate time to introduce the word ‘boundaries’ is when first-year students are taught about the doctor–patient relationship. Subsequently, when they enter the clinical years, it can be discussed in detail (2 hours of sessions, theory with case vignettes), as part of their medical ethics curriculum.

To ensure that students do not see this topic as being of ‘fringe relevance’, certain types of student interactions with patients should also be discussed in the light of the boundaries, even if only for a couple of minutes. This helps to establish an awareness of and respect for boundaries. The importance of maintaining boundaries can be briefly emphasized when students first deal with ‘live subjects’ during physiology practicals. Certain general issues, such as accepting gifts, self-disclosure and personal

relationships with patients, can be discussed when students are posted in or taught subjects such as general medicine and psychiatry. Subject-specific issues, such as conducting vaginal, rectal and breast examination appropriately, can be briefly touched upon when students are posted in obstetrics and gynaecology, and surgery. Safe physical examination of children and relationships with their caregivers can be discussed as part of the students’ exposure to paediatrics. The training should also touch upon appropriate behaviour during home visits, the need to document indications for invasive procedures, and care while dealing with sedated patients. The topic of boundaries must be re-emphasized during the internship orientation programme and the subsequent clinical postings of internship, as and when appropriate. During postgraduate training, the boundary issues specific to particular subspecialties should be discussed in detail.

*When, how and by whom do doctors need to be sensitized?*

Over the next 2 years, all doctors who are already practising medicine can be given information on this issue through publications in journals, discussions in continuing medical education programmes, and guidelines issued by the MCI and professional bodies. Focused workshops can be held to attempt to delineate the influence of Indian culture, if any, on non-sexual crossing of boundaries versus BVs.<sup>13,14</sup> As it might be impossible (and probably unnecessary) to spell out universally acceptable and culturally nuanced guidelines, doctors should be encouraged to discuss ethically challenging cases with experienced colleagues. In addition, for practising doctors, it would need to be emphasized that these are *guidelines and not rules*. This is important, as even ethical doctors will feel that a ‘rule’ stultifies the doctor–patient relationship and is counterproductive, if it overrides common sense.<sup>9,11</sup> However, the crossing of boundaries in particular contexts might constitute a violation of the law and might make the doctor concerned liable to prosecution.<sup>15</sup>

*Future action on other related issues*

Once the topic has been introduced into the curriculum and guidelines framed, pathways for redressal need to be established/clarified. Institutional heads must take the lead in facilitating the establishment of clear pathways for the redressal of complaints of BVs. These would include complaint procedures, investigative processes, disciplinary consequences of BVs, and provision of compassionate support to the patient and his family. It would also be necessary to find means of handling false allegations, as well as establish mechanisms for the doctor(s) concerned to be able to defend themselves. Lawyers and patient support groups would have to be involved. An important area in prevention is the provision of non-sensationalized education to patients and their caregivers.<sup>16</sup> The assistance of responsible media might be useful in this context. We also hope that the MCI will consider amending the Code of Medical Ethics and specifically mention the importance of being cognizant of BVs in healthcare and preventing their occurrence.<sup>12</sup>

*Suggestions to facilitate incorporation into curriculum*

As of now, boundary issues are not adequately discussed in standard medical undergraduate textbooks. Though this issue is being recognized and addressed, it might take a few more years to make an appearance in these textbooks. Medical ethics has been part of the undergraduate curriculum at St John’s Medical College,<sup>17</sup> Bengaluru. The teaching material on boundaries that is used here can be made freely available online. There is a need to ensure that

some medical teachers in the short term and all in the long term have the knowledge and skills to impart an appreciation of boundary issues to students. This can be achieved in collaboration with regional medical education cells and other organizations which support medical education.

#### *Suggested time-frame for incorporation*

It would be ideal to incorporate the topic into the curriculum immediately. If boundary issues could be made an 'examination topic' within 2 years, it would ensure that students and teachers give the topic due importance.

We, the signatories to this declaration, see it as our ethical responsibility to pledge to work with the MCI and others both within and outside the medical fraternity to minimize the occurrence of BVs in India.

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*Conflict of interest:* None

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#### COMMENTARIES

Since the doctor-patient relationship is unequal and weighted in favour of the doctor, boundaries have been demarcated by ethicists with the intention of discouraging doctors from transgressing them while treating patients. The most obvious boundaries relate to the examination and treatment of women by men doctors. Other boundaries are intended to prevent material exploitation of vulnerable patients by rapacious doctors.

In enlightened countries, these boundaries are discussed, modified over time, taught to medical students and doctors under training, and reinforced by local and national agencies. An example of a means of reinforcement is the periodic publications sent out to all registered medical practitioners in the UK by the General Medical Council. Unethical violation of boundaries by doctors can and does attract punishment in some countries.

The letter by the respected nephrologist, Dr M.K. Mani, in the *Indian Journal of Medical Ethics* (quoted as reference 14 by the Group) highlights the need for the delineation of such boundaries in India. Indeed, the group themselves refer to 'minor departures... which are neither harmful nor exploitative'.

Once there is a general acceptance by ethicists and bodies of medical professionals in India of the boundaries demarcating harmful or exploitative behaviour on the part of the physician, the consensus document forming the Bangalore Declaration should come into force. While logically, the MCI is the agency to take the process forward, past experience with its enthusiasm about

correcting unethical medical practices by doctors suggests that medical colleges and different associations of medical doctors might make faster progress in the implementation of the Declaration.

I am somewhat wary of making information on these boundaries an 'examination topic'. Information on such topics is usually committed to short-term memory and is erased as soon as the student has done well in the examination concerned. It would be far better if this information, along with that on ethics in general, could be assimilated into the character of the student.

Principles of this sort can be instilled in the most effective manner if the malleable students witness the examples of their teachers and role models every day. You will note the efficacy of such practice by Dr K.S. Sanjivi on Dr Mani in his letter referred to above.

SUNIL K. PANDYA

When I was asked to write a commentary on this article, I was not sure if it was worth the effort. The article had a high-sounding, rather self-important title (using the well-tried formula of appending a city's name to a 'Declaration', like the Delhi Declaration or Washington Declaration). It suggested that a genuine problem existed which involved the doctor-patient relationship and finally, it contained a call for action by the MCI.

What bothered me was that I did not know exactly what the

doctor–patient boundaries were and how they might be ‘violated’. Did the authors mean that we should distance ourselves from our patients, with whom we have a fiduciary (trust-cum-financial) relationship, and not be interested in anything else about them other than their disease?

It all smelt of being a non-issue and seemed, like many other medical problems we waste our time working and writing on here, to be derived from the US experience and to be of ‘fringe relevance’ to us (to use the authors’ own words).

The relationship between doctors and patients in India is completely different from that in the USA. Here, patients trust their doctors more (the doctor often being told that he is next to God) and there is much less equality between the two individuals, with the doctor assuming the role of a benevolent father figure. The so-called boundaries will also, therefore, be very different.

A sexual association with a patient is obviously wrong both in

the USA and India, but is accepting a small box of *mithai* proffered in gratitude for what was done, attending a wedding in a patient’s family or giving his (or her) upper arm an affectionate touch a boundary violation?

The authors’ demands include classes on boundary issues for undergraduates, interns and postgraduates. As if they are not already overburdened with more important matters like how to treat diarrhoea or diagnose meningitis in a child!

I think the students’ attitude in this respect is moulded entirely by how their teachers behave. If a student sees his mentor treating a patient with dignity, compassion and competence, that is all that is necessary for her/him to learn about what a proper doctor–patient relationship should be. A Bangalore Declaration with a course on boundary violations will only be a poor substitute.

SAMIRAN NUNDY

## Medical Education

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### Medical education in India: A need to think differently

RAGHUNANDAN KOTHARI

#### INTRODUCTION

The medical education system initiated by the British in India has not changed much. There has always been a shortage of trained medical personnel and there is a need for many more healthcare centres in several far-flung areas of the country. Though the doctor:population ratio has improved from 1:6300 in 1947 to 1:1700, there is a mismatch in services in rural and urban areas.<sup>1</sup> Even the National Rural Health Mission (NRHM) has not been successful in achieving the desired change.<sup>2</sup> Medical education should suit the changing perceptions of health in society, the trend to consult specialists, commercialization of health services and the availability of state-of-the-art superspecialty services.

#### THE PRESENT STATUS

With 330 medical colleges in India, about 35 000 students graduate every year<sup>3</sup> after five and a half years of study. As almost all MBBS students plan to do a postgraduation, the first degree is a step towards becoming a specialist. In the present MBBS curriculum, many things are taught that are not of much use in later years when a person specializes in a particular area. The 1-year internship, a phase of training in which a student is expected to acquire skills to function independently,<sup>4</sup> is used to prepare for various entrance examinations, often by joining coaching classes. Many a time students get neither the subject of their aptitude, nor the institution of their choice, with 100 multiple choice questions (MCQs) deciding what and where they should study. Aptitude, an important factor, is

given no consideration at all. They spend another 3 years on a postgraduate (PG) degree. Thus, at least eight and a half years are required for becoming a specialist. During specialization, much of what was learnt during the undergraduate (UG) course becomes redundant. The PG training at many centres does not meet the minimum standards, with the result that candidates neither gain confidence nor develop the practical skills to start working independently. A large number of PGs then enrol for some fellowship or short course to acquire skills that they could not obtain during their PG training. Another fallout of this long journey of hard work, as well as high investment in terms of money and time, is that many meritorious students now avoid medicine as a career.

A large number of private medical colleges and deemed universities have come up in recent years and they have their own criteria for admission. Often, factors other than merit govern admission to these colleges. It has been estimated that there is a 30%–40% deficiency of medical teachers in India, and due to this, unhealthy practices are followed to meet the required numbers during inspections conducted by the Medical Council of India (MCI).<sup>5</sup> One often reads reports in newspapers about fake teachers, deficient infrastructure, colleges admitting more than 50% students under the management quota,<sup>6</sup> etc.

#### MORE CHANGE NEEDED

Efforts are being made to change the present system. These include increasing the number of UG and PG seats, reducing infrastructural requirements for starting new medical colleges, increasing the teacher:student ratio for PG from 1:1 to 1:2,

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