Correspondence

Boundary violations: Our response to the commentaries on the Bangalore Declaration

We wish to correct some of the myths on boundary violations (BVs) in healthcare as applicable to India in relation to the commentaries1–3 published along with our article.3

While the past record of the Medical Council of India (MCI) is not enviable, changes within the MCI in the past couple of years allow us some cautious optimism. The MCI has acted on the draft version of The Bangalore Declaration provided to the (MCI) Working Group for medical undergraduate curriculum in March 2011. Encouragingly, a line on boundaries has made its way into the MCI’s Vision 2015 document and the proposed curriculum 2013 with its emphasis on ethics and professionalism, under ‘Competencies’ 3.5 and 3.5.2 (see below).4,5

‘Competencies

3.5. Professional who is committed to excellence, is ethical, responsive and accountable to patients, community and the profession
3.5.2 Respect and maintain professional boundaries between patients, colleagues and society.7

It is true that medical colleges and associations need to be involved in correcting unethical practices such as sexual BVs, but it may be difficult to take effective disciplinary action without the endorsement of the MCI. The MCI, as the statutory body regulating medical education and practice (directly and through the state chapters), needs to mandate systems to support victims, whistleblowers and even the offending doctor. The offending doctor is important because the punishment should fit the crime and an over-reaction could be unfair, unnecessary and counterproductive.6,7

While we may not remember all that we study for examinations, if boundaries do not make their way into occasional question papers or vivas, students and medical teachers may wrongly assume that the topic cannot be all that important. It is a reality that for many students evaluation drives learning. However, we do concur with the concern that boundary issues should not be reduced merely to a theory topic to be covered for examinations without translation into behavioural change.

The issues raised by Dr S. Nundy have already been discussed in detail in the references cited in our article.

The idea that doctors should not exploit their patients is indeed not new. The Hippocratic Oath emphasizes this point. Unless there is universal awareness on boundaries and BVs in India, the myth that this is an American import will perpetuate, in keeping with the aphorism in clinical medicine, ‘What the mind does not know, the eye will not see’. Today, what seems to be ‘cultural’ is not the absence of BV, but acknowledging its occurrences.8,9

Regarding to mithai or not to mithai, we did clarify this in Box 1 of the Declaration. The bottom line is if it is a boundary crossing, you could accept it, if it is a BV then do not. There are ways to say no without offending cultural sensibilities, just as there are other ways to allow patients to express their gratitude without risking BV. The point is to make doctors think twice before taking a gift from patients. Even the Charaka Samhita written two thousand years ago specified circumstances in which a physician could accept gifts after delivery of a child, recovery from a life-threatening or protracted illness and after success in battlefield.9

In India, doctors are indeed sometimes considered as next only to God. However, a recent commentary in a leading newspaper suggests it is probably doctors who are more likely to still believe in this, rather than patients.10 While agreeing that some patients in India do trust their doctors implicitly, we feel that this places a greater, not lesser responsibility on the medical fraternity to ensure that doctors either live up to this belief, or when they do not, that patients be protected. In the West, the patients’ rights movement spearheaded the shift in the doctor–patient relationship from ‘benevolent paternalism’ to ‘shared decision-making’.11

We all have to acknowledge that ‘future physicians will need broader skills and knowledge than previous generations’.12 To assume that ethics is always intuitive and internally developed and need not/cannot be taught is a common myth. Fortunately, teaching on boundaries can be woven into the existing medical education framework without replacing ‘diarrhoea and meningitis’.

It is true that the best training on ethics for students is to have ethical role models. We aim for the Bangalore Declaration to be part of the overall mentoring process of young medical professionals, not as a replacement.

If we still assume that BVs are a non-issue in India, we risk proving Marshall McLuhan right in saying, ‘Only small secrets need to be protected. The large ones are kept secret by public incredulity’.

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Reference data for height, weight and body mass index

I would like to congratulate Marwaha et al.1 for their paper ‘Nationwide reference data for height, weight and body mass index of Indian schoolchildren’ and their efforts to do this exemplary work on physical growth and development of Indian children. This is a very important study as the previous national-level study2 was done more than two decades ago and a recent one by Khadilkar et al. appeared in 2009.3 Since then there have been changes in socioeconomic conditions including the nutritional pattern, and these are likely to have had an impact on the physical growth and development and nutritional status of children.

However, I felt that comparing these data with those of any other population in terms of growth and physical status, especially body mass index, may be difficult. This is because of the dearth of statistical data in terms of means, standard deviations, values of L (lambda), M (mu), S (sigma) by age and sex. These values are required for percentile calculations using the following formula:4,5

\[
C_{100}=M(t)\left[1+L(t)S(t)Z_{\alpha}\right]^{1/2}
\]

The value (measurement) of a trait measured on a child of a given age can be transformed into a standard deviation score (SDS). The value of a given centile at a given age can be computed from the L, M and S values for that age.

\[
SDS=\frac{[measurement/M(t)]^{1/2}-1}{L(t)S(t)}
\]

This gap can be bridged by publishing an additional paper based on the same data.1 This would make these data more accessible and do justice to the archived data.

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A more representative sample is required

The article ‘Nationwide reference data for height, weight, and body mass index of Indian schoolchildren’ by Marwaha et al. is a good attempt to provide a reference standard for India.1 However, the following points need to be considered:

1. Not all children in India go to school; also, dropout rates among children rise as they progress from lower to higher classes. A higher dropout rate could be due to low socioeconomic status of the family. Children prefer to drop out of school when they become capable of earning or the cost of education increases beyond their means as they move to higher classes.
2. The assumption that children of lower socioeconomic strata go to government schools is not correct. In many remote places and industrial areas, where the only schools are Kendriya Vidyalayas or other government schools, children of all socioeconomic strata (i.e. children of high officers as well as labourers) study in the same school.
3. The study covers only 19 cities. Hence, it leaves out a large part of India unrepresented. All the states should be represented according to their population.
4. The northeast region comprising eight states has not been taken into account. It would be useful if the names of the 19 cities could be provided.
5. India still lives in the villages. Hence, ideally 60% of the data should be from rural areas and 40% from urban areas. No school from any village or urban slum has been included in the study.
6. One should also consider the ethnicity of the population. Some communities are genetically shorter, an aspect considered by our army and paramilitary forces during selections. Hence, there are chances that normal children of certain communities may be wrongly labelled as stunted.2

Since the sample should be more representative and realistic, one would be skeptical in using these data as a national reference standard for India.

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Investigator-initiated research in India: Nipped in the bud?

Drs Pramesh and Badwe raised an important issue which is at the heart of academic medicine in India. Clinical research is booming in India, although it is not well known that much of this boom is attributable to industry-sponsored research. Moreover, most of this research originates in high-income countries and is targeted at generating products, processes and services tailored to their own healthcare markets. A recent search of the US National Institutes of Health (NIH) clinical trials registry (http://clinicaltrials.gov/) database revealed that only 36% (150 of 422) of the studies being conducted in India were sponsored or funded by public health, not-for-profit agencies from India or abroad. The remaining studies were being conducted by the Indian arms of international multicentric trials based in the West and sponsored by industry. These statistics highlight the paucity of investigator-initiated research on locally relevant questions. This type of research is essential for improving the care of patients affected by illnesses prevalent in India. As discussed by the authors, the proposed compensation guidelines will have little effect on industry-funded trials, but can effectively snuff out whatever little investigator-initiated research is carried out in India.

Some of the components of these guidelines appear to be a knee-jerk response to the sensationalized and often irresponsible reporting of some trial-related serious adverse events by the media. While the purported role of blanket compensation appears to be for the protection of participants in trials, this purpose would be better served by improving the quality and consistency of the ethical review process across the country. Better oversight of the constitution and functioning of independent ethics committees would be one step in this direction.

The number of clinicians engaged in investigator-initiated research is small and there is a risk of the compensation guidelines coming into force without opposition. It is time to mobilize academic institutions to represent these clinicians in the debate to rationalize clinical research guidelines. There is little incentive for clinicians to do any research in India today, and such ill-conceived guidelines may prove to be the last straw for the few motivated individuals who do locally relevant research.

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New AIIMS at all state capitals: Boon for urban and bane for rural healthcare

One important reform in medical education in the post-Independence era has been the establishment of eight new institutions along the lines of the All India Institute of Medical Sciences (AIIMS). In addition, the Union Health Ministry has proposed the establishment of AIIMS-like institutions in all state capitals over the next plan period. This proposal runs counter to the recommendation of the National Rural Health Mission (NRHM) for opening medical colleges in rural and underserved areas.

To encourage equal access to rural healthcare as well as medical education, we suggest that AIIMS-like institutions be established in the rural and underserved areas, e.g. in an underdeveloped district of each state, preferably in a central part of a state rather than the state capital. The healthcare infrastructure in the state capitals is already relatively better than that in other parts of the states. Thus, the AIIMS-like institutions proposed to be set up in the state capitals will again be urban-oriented healthcare institutions that will be a ‘boon for urban healthcare’ but a ‘bane for rural healthcare’. Geographically, almost none of the state capitals is centrally located and this would make it difficult for people from all places in the states to access the services of the institutions. The geographical distance is an important criterion while facilitating equal access to healthcare. This is especially true when serving a rural population. The people from the rural and underserved areas of each state have difficulty accessing the healthcare services available at the state capitals. If all the state capitals were at an equal distance from all parts of the states, then the proposed AIIMS-like institutions might have provided the states’ population with equal access to healthcare.

To make another point, an alternative name may be considered for the proposed institutions. To preserve the heritage of the Indian Institute of Science (IISc), Bengaluru in the scientific field, the government named IISc-like institutes ‘Indian/National Institute of Science, Education and Research’ (IISER/NISER). Similarly, keeping in mind the contribution and heritage of AIIMS, New Delhi in the field of medical education and research, the proposed AIIMS-like institutions could be named ‘National Institute of Medical Education and Research’ (NIMER) or ‘National Institute of Medical Sciences’ (NIMS).

I plead for a review of the urban-centric healthcare policy of establishing AIIMS-like institutions at state capitals and advocate a change to a rural-centric policy, under which such institutions are centrally situated and cater to the underserved areas.

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Eye and body donation: A proposal for a single window

Worldwide there are 180 million visually disabled people, 80% of them are in developing countries. The National Survey on Blindness (2001–02) in India revealed 0.9% blindness due to corneal opacity requiring almost three million corneal transplants annually. Among the different measures adopted by WHO and the Government of India to eradicate corneal blindness is rehabilitative keratoplasty, which has been fairly successful.1–3

In spite of repeated campaigns by the media and the national eye donation fortnight, eye donations fall far short of the need—43 000 in 2009–10 and 41 000 in 2010–11; only 30% of these were harvested successfully.4,5

With only 50 of 666 eye banks in India working at acceptable standards, the Eye Bank Association of India has suggested incorporating different government and non-governmental institutions as well as medical colleges throughout the country as cornea collection centres to meet the demand.4,5

There are over 300 medical colleges in India.6 All departments of anatomy accept whole body donations for educational purposes. If the body donation form could include the provision for eye donation, these departments too could be used as cornea collection centres. However, some additional infrastructure would be required in the anatomy departments too.

In India, where blindness is a major problem this move could go a long way in increasing eye donations.

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MCI and NEET-PG: Understanding the point of view of medical graduates

The Medical Council of India (MCI) notification of 21 December 2010 states that from 2013 onwards there shall be a single eligibility-cum-entrance examination, namely, the ‘National Eligibility-cum-Entrance Test for Medical Postgraduate Courses—MD/MS/Diploma (NEET-PG)’.1 Another notification of February 2012 states that in determining the merit of candidates who are in government service, weightage of marks may be given by the government as an incentive.2

We interacted with 123 interns who had completed their internship in March 2012 to understand their views and apprehensions about these recommendations. All the students were given a semi-, open-ended questionnaire with questions related to internship and the MCI recommendations regarding the postgraduate (PG) common entrance test. A total of 121 (98.4%) interns felt that internship was essential at the end of graduation and 115 (93.5%) considered the duration of 1 year to be an adequate period for this. Doing internship and preparing for PG entrance examinations simultaneously was considered to be stressful by 111 (90.3%) of the respondents (Table I).

The advantages of a single, national-level entrance examination as mentioned in the MCI vision document3 such as ensuring uniformity, convenience and saving of resources were appreciated by the students as well. However, there were some concerns about a single examination, which need to be addressed.

It is known that medical students are under stress due to their busy and demanding schedule, academic pressure, continuous evaluation, vast syllabus, exhausting working hours, etc.4 The timing of the entrance examination before internship is an important decision and an attempt to reduce stress.

Another objective served by this change is restoring the importance of internship as a period of training instead of being a period of preparation for the examination. Internship is meant for hands-on experience for skill-oriented training. The present structure of medical education undermines the usefulness of internship. At the end of internship, the students face an extremely competitive PG entrance examination for limited number of PG seats. The assessment and supervision during internship are perfunctory and a high score in the PG entrance examination is essential to obtain a residency position.4 The students devote little effort to achieve the goals of the internship experience and instead spend most of their time in preparing for the entrance examination.5,6

The distribution of doctors in India remains highly skewed towards urban areas. A number of incentives have been given to doctors to enhance rural recruitment and retention. Monetary compensation such as financial incentives for those working in difficult areas, and workforce management such as rotational posting in difficult areas have been tried.7 Delivery of good quality medical services in rural areas is the ultimate objective of the incentive of giving additional weightage for service in rural areas is the ultimate objective of the incentive of giving additional weightage for service in difficult areas that contributed to determining the merit of the candidates. Hence, careful implementation of this policy is needed to prevent malpractice. The provision of better facilities and improved living conditions in rural areas cannot be overlooked.

A few other issues mentioned by the respondents also need to be considered. The students should be made aware of the tentative schedule of examinations at the time of admission to medical college. From the year 2016, a licentiate examination will be conducted at the end of internship and the marks secured in this examination will be included for PG seat allotment. For this, the currently neglected issues of the quality of training, supervision and assessment methods during internship need to be clearly outlined and put into practice.

It is not only conducting the examination at the national level that will be a challenge but other issues also need to be addressed, viz. making students aware of the single national level examination at the
Table I. Responses to the questions regarding Medical Council of India (MCI) recommendations for NEET-PG

<table>
<thead>
<tr>
<th>Question (number who answered the question)</th>
<th>Yes n (%)</th>
<th>Reasons for agreement/points raised</th>
<th>Reasons for disagreement/points raised</th>
</tr>
</thead>
</table>
| Should there be a single national entrance examination as proposed by MCI? (n=119) | 52 (42) | • Would increase the number of seats and therefore increase the success rate  
• Multiple examinations result in repeated stress, overlap of dates, need to travel and increased expenditure; hence a single examination would be more convenient  
• Uniformity in question paper and assessment | • As the number of students competing for the seats would increase, the increase in seats will not be of much advantage.  
• A single examination would mean that a candidate gets only one opportunity. If a person is sick on that day or does not do well then she/he loses an entire year. There should be a second chance.  
• Students should be made aware of the single national-level examination during undergraduate (UG) so that they are prepared to take the national-level examination.  
• How will uniformity in the conduct of the examination all over India be ensured?  
• As the quality of PG education varies in different states, PG seats in states should be reserved for students from that state. |
| Should the NEET-PG be conducted at the exit of final MBBS examination and before internship? (n=121) | 65 (53) | • Doing internship and preparation for PG entrance simultaneously is stressful. As these would not overlap, the students will be able to do internship sincerely  
• As the knowledge gathered in the UG days is fresh at the end of the final year MBBS they will be better prepared for the examination  
• As students will not have time to study after MBBS they will need to prepare through their UG days | • At least 1 year is needed to revise and consolidate one’s knowledge before appearing for the PG entrance examination.  
• Some questions in the PG entrance examination are based on practical experience and the experience during internship is helpful in answering these.  
• As the final year of MBBS is very hectic, appearing for the PG entrance examination immediately thereafter would be very difficult.  
• The rat race one sees during internship would begin in the UG years with no one being interested in attending clinics and it will become a ‘multiple-choice questions’ oriented medical education. |
| Should there be a skill-based examination on completion of internship? (n=117) | 91 (74) | • Assessment of skills and the outcome of the internship training are also important. Such an assessment would be holistic as entrance examinations mainly focus on theory  
• Interns would get an opportunity to correct their mistakes which would help them in their future practice | • Interns do not learn much during internship and hence such an assessment should not be done.  
• If interns fail in such an examination they will lose an opportunity to study further.  
• There should be a grading system for assessment of interns. The current method of supervision and assessment should not be considered for allotting PG seats.  
• As government rules require working in rural areas there is no need to give additional marks.  
• These doctors would study less and yet get a seat.  
• It would lead to backdoor entries and corrupt practices. |
| Should candidates who have put in two years of rural service be given additional marks in the NEET-PG? (n=97) | 73 (75) | • This would be an incentive for doctors to work in rural areas  
• Will not be able to prepare for PG entrance examination during their stay in rural areas and hence they should be compensated by giving additional marks  
• As have served the community they should be given additional marks | • As the quality of PG education varies in different states, PG seats in states should be reserved for students from that state.  
• As the knowledge gathered in the UG days is fresh at the end of the final year MBBS they will be better prepared for the examination  
• As students will not have time to study after MBBS they will need to prepare through their UG days  
• Doing internship and preparation for PG entrance simultaneously is stressful. As these would not overlap, the students will be able to do internship sincerely |

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