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Boundary violations and the "curtain of culture"

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"The life of the patient and the soul of the physician are always at risk"

Rabbi Samuel Edels, 14th century Talmudic scholar

Kurpad *et al* (1) must be commended for raising an issue that is largely neglected in healthcare settings in developing countries. While boundary violation (BV) is an important issue in any clinical encounter, it assumes special significance in developing country settings: the relationship between the doctor and patient is heavily unbalanced towards the former and there is absence of any ethical or legal framework to address such issues.

The fact that about a third of their study sample (51/163) responded to the postal questionnaire on a sensitive issue such as BV is actually quite encouraging: it may represent the general opinion of mental health professionals not only in Karnataka but in India as a whole, and hence their responses highlight a worrying trend.

In 59% of cases the "source of information" was other colleagues, but 51% also knew of at least one case of sexual boundary violation (SBV) that was not investigated. This is both worrying as well as an opportunity. Worrying, because it may mean that little is being done to address this issue in India; but also an opportunity in that if mechanisms can be put in place to report such violations, they can be better controlled.

Unfortunately, the "curtain of culture" thinking continues to pervade and justify many actions that clearly need to be condemned and controlled. Gift giving and socialisation "initiated by the patient" are examples of how some respondents used culture to justify such acts. In fact these are the very areas where the seeds of boundary violations are sown which, left unchecked, lead to more serious violations. Kurpad and colleagues are right in stating that "not all non-sexual BV (NSBV) lead to SBV, but nearly all SBV have started with NSBV."

Why should "culture" be an excuse for what are clear boundary issues? The important question is: does accepting gifts or socialising with patients in India (and other developing countries) lead to better treatment outcomes of conditions such as depression and schizophrenia or hypertension and chronic renal failure?

What we need are clear instructions that patients should be made aware of, right at the outset of the clinical encounter: for example, it should be made clear to the patient that the doctor does not accept any gifts or invitations to patients' social functions. Accepting a token gift, such as a box of sweets at the end of the treatment on behalf of the treating team, as the authors suggest, may be permissible but anything of more value than that should be strongly discouraged. As long as the doctor remains consistent in his approach, most patients will respect and respond positively to such instructions.

Boundary violation is only one of the many bioethical issues that need to be addressed in healthcare settings in developing countries. They also include conflict of interest issues, gift giving, maintaining confidentiality, informed consent, and research ethics amongst others. Only 10% of the respondents surveyed felt that the topic was taught to, or discussed adequately with, medical students. There is therefore an urgent need for a comprehensive bioethics programme which should be a part of the regular medical curriculum at the undergraduate level. This is currently missing from the undergraduate programmes of medical schools in developing countries. This should be supplemented by bioethics courses throughout the post-graduate years as well.

At the same time, along with the training and teaching of medical students and physicians, legislation and codes of conduct must be established. Where they exist, they should be applied rigorously. One without the other would be largely ineffective in addressing this important issue.

Reference

1. Kurpad SS, Machado T, Galgali RB. Is there an elephant in the room? Boundary violations in the doctor-patient relationship in India. *Indian J Med Ethics*. 2010 Apr-Jun; 7(2): 76-81.