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NewsLetter

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EDITORIAL

SEXUAL BOUNDARIES IN THE DOCTOR - PATIENT RELATIONSHIP – GUIDELINES FOR DOCTORS ?

In 2010, a landmark study called "The Elephant In The Room" was published in the Indian Journal of Medical Ethics. This study explored the awareness of sexual and nonsexual boundary violations (SBVs and NSBVs) in the doctor–patient relationship in India, with specific reference to psychiatrists and psychologists in Karnataka and highlighted the need for culturally relevant guidelines in India. In recognition of the fact that SBVs are obviously not limited to psychiatrists, a diverse group of health professionals from across India met in St. John's Medical College, Bengaluru, in February 2011. Their background spanned mental health, medicine, surgery, obstetrics gynecology, pediatrics, pathology, research, medical education, and medical ethics. This meeting generated a consensus document "The Bangalore Declaration," which was submitted to the Medical Council of India (MCI).

The Medical Council of India (MCI) adopted 'guidelines on sexual boundaries for doctors' which was framed by the Indian Psychiatric Society (IPS). The guidelines, which were released on the MCI website, are expected to be followed by medical practitioners of all faculties.

1) It is the ethical duty of all doctors to ensure effective care for their patients. This would mean that their own conduct should in no way harm their patient. Sexual relationships between doctors and patients invariably harm both the patient and the doctor. Trust, which is central to an effective doctor patient relationship, is inevitably damaged. In view of the power gradient that invariably exists in the doctor patient relationship, the onus is on the doctor to ensure he or she does not enter into a romantic or sexual relationship with a patient.

2) While the laws relating to sexual abuse in India generally pertain to women, these Guidelines aim to be gender neutral and serve as a guide to a code of conduct on doctors of any gender, and to protect patients of all genders too.

3) Doctors should ensure that they do not exploit the doctor patient relationship for personal, social, business or sexual gain.

4) In view of the power gradient in the doctor patient relationship, doctors are reminded that even 'consensual' sexual activity between patients and doctors irretrievably changes the therapeutic nature of the doctor patient dynamic. This would be detrimental to the patient. This would mean that even if it is the patient who attempts to initiate the sexual relationship, it would be against good medical practice for a doctor to enter into such a relationship. Besides, it can be said that consent in a power imbalanced relationship is not true consent.

5) Any non consensual sexual activity would amount to sexual abuse/ molestation/ rape and doctors would be answerable to the law of the land. (Indian Penal Code laws). Sexual activity with a person less than 18 years of age in India amounts to statutory rape (consent immaterial). The Indian Penal Code states that consent for a sexual relationship with a woman of 'unsound mind', is deemed invalid and amounts to rape.

6) It is obviously important for doctors to take a relevant sexual history and perform appropriate physical examination. This should be done sensitively and documented properly in the notes. If intimate examination is done, gloves should be used, a chaperone present and indication and findings documented in the notes. All this should be communicated properly to patients, to prevent any subsequent misunderstandings. The doctor should not touch a patient inappropriately in the guise of physical examination or sexual therapy, for own sexual gratification.

7) If treatment that requires the patient to be sedated is used (like electroconvulsive therapy, or any procedure that requires anaesthesia), a nurse should be present during the induction and recovery of anaesthesia. This is good medical practice, not just a deterrent to sexual abuse.

8) Doctors are reminded that even a relationship with a former patient is discouraged and could be construed as unethical, If, for whatever reason a doctor feels it imperative to have a romantic/ sexual relationship with a patient, then the doctor should ensure the patient's care is 'handed over' properly to another doctor. It is extremely important that the doctor discuss the issue with at least one senior colleague to ensure that the doctor himself/herself is not entering a relationship due to his/her own vulnerabilities which need to be addressed and the former patient is clearly not being exploited. IPS puts the time frame as 'one year at the very least, after termination of the doctor patient relationship',

9) As doctors are to ensure they do not exploit the doctor patient relationship for sexual gain, it would also imply that these Guidelines extend to protect the family members of patients too. Though these Guidelines pertain primarily to patient, doctors are reminded that similar care should be extended to interactions with students, colleagues and other professionals in the multidisciplinary team- indeed anyone who is in a 'power imbalanced relationship' with the doctor.

10) False allegations can occur. It is important for doctors to be alert to warning signals and risk situations. If the doctor finds him/ herself in the midst of an allegation it would be important to reach out to colleagues for support. Support should not mean 'covering up' the issue. If the allegation proves true on enquiry, the colleague should be supported to face the consequences of his or her behaviour.

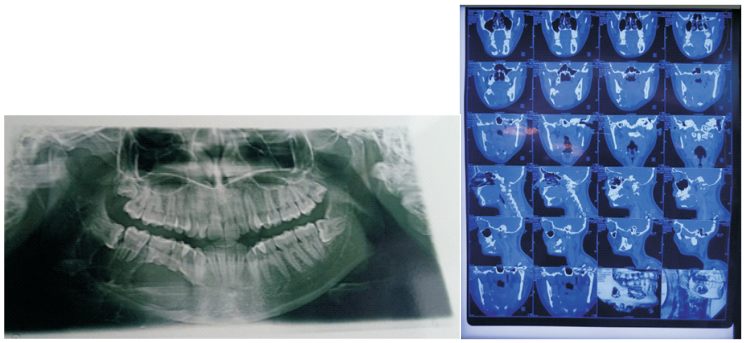
We know that sexual abuse occurs in other traditionally respected groups too, such as teachers, religious leaders, and armed forces. All these systems here a power hierarchy. In Medical profession there are typically two types of doctors who commit sexual abuse of patients and relations. Some are sexual predators, these are criminals in all walks of life. Some are going through personel problems that compromise their judgement. These doctors are situational reactors responding to triggers such as marital discord, loss of important relationship or a professional crisis. Particularly vulnerable are socially isolated middle aged experiencing mid-life crisis and who are eminent in their field. Psychiatrists, Gynaecologists and GP'S are more likely to offend than those in other specialities.

(Continue on Page No. 4th)

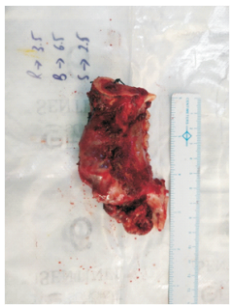
IMPLANT – SUPPORTED REHABILTATION OF A PATIENT WITH MANDIBULAR AMELOBLASTOMA

Ameloblastoma is a slow growing benign tumor of the jaw which is most commonly located in molar region of mandible. It is diagnosed is mainly from tissue biopsy and characteristic finding on x-rays. It is managed with complete excision and reconstruction of the bony defect using avascular free fibular bone graft in order to give cosmetic and functional outcome to the patient. A prosthetic rehabilitation is usually preferable with fixed Dental Implants as removable prosthesis may be difficult to adapt due to the post surgical alteration of the anatomy.

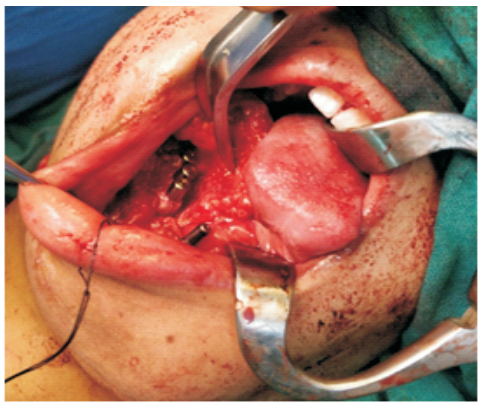
A 22 years old female without any known co-morbidities presented in RGCIRC with swelling in right submandibular region for 1 week. It was insidious in onset and rapidly progressive in nature. CBCT mandible showed expansile radiolucent multiloculated lesion involving body of right hemi mandible. She then underwent incisional biopsy which showed Ameloblastoma.



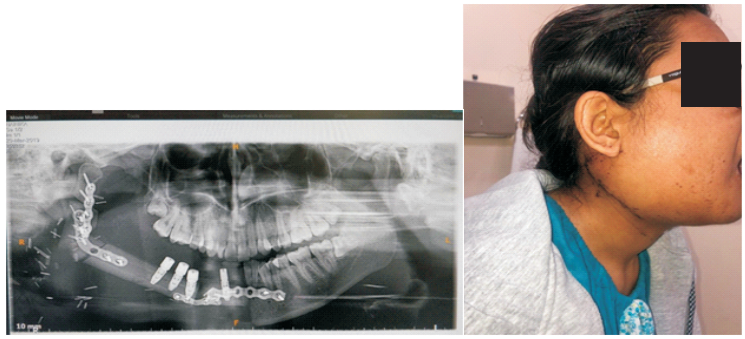
She underwent surgery for right segmental mandibulectomy with WLE of buccal mucosa (intraoral excision with small incision in the neck for anastomosis of free flap in order to maintain cosmesis) + right level II node sampling + Recon by free fibula flap after the execution of osteotomy. The microsurgical anastomosis of the peroneal arteries and of the peroneal veins with the facial veins was carried out. The case was handed over to Dental Surgeons for assessment of Dental Implants.



Sites for four implants were prepared with dedicated drills with respect to the existing bone and its consistence. 3 Nobel Parallel conical connection implants of 4.3X10 mm diameter & height were placed in the posterior region, other 1 of 3.75X11.5mm was placed in the anterior region.



Finally, the screws were applied. Following the execution, the flaps of periosteal were released to allow a greater elasticity of the flap. The crowns will be placed after 6 months of follow up.



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(Department of Head and Neck Surgery)
Dr. Rajan Arora, Dr. Kripa Shankar & Dr. Hemant
(Department of Reconstructive Surgery)
Dr. Puneet Ahuja & Dr. Sheetal Bhalla
(Department of Dental Surgery)

VACUUM ASSISTED BREAST BIOPSY

Vacuum-assisted breast biopsy (VABB) is a safe and minimally invasive procedure in which a sample of breast tissue is removed for examination. When breast imaging shows up very small abnormalities too small to be felt, vacuum-assisted core biopsy assist to obtain samples in such cases.

Through a small incision or cut in the skin, a special biopsy needle is inserted into the breast and, using a vacuum-powered instrument, several tissue samples are taken. The vacuum draws tissue into the centre of the needle and a rotating cutting device takes the samples. The samples are retrieved from the centre of the biopsy needle following the procedure and sent to a laboratory to be examined by a pathologist. This procedure can be done on OPD basis and needs no admission or general anaesthesia.

There are various ways in which this needle can be inserted into the breast under image guidance (ultrasound, mammography and MRI). Pre-requisites are similar to other biopsy procedures such as blood coagulation profile and CBC. Risks are also similar such as haemorrhage, swelling or infection but very infrequent.

Indications:

1. BIRADS 3 lesions.
2. BIRADS 4/5 suspicious lesions with diameter <5mm

3. Resection of definitely benign lesions such as fibroadenomas <3 cm or cysts - **SCARLESS SURGERY**
4. Intraductal lesions such as papillomas
5. Discordant results after core needle biopsy.
6. Mammography detected suspicious microcalcifications

We need to understand that VABB is not only approved for BIRADS category 3 lesions, but also provides good consistent results for small category 4 and 5 lesions.

The pathological results obtained with VABB are more than promising. The false negative rate was only 0.1 % in a study published by Seung Hyun Lee et al in 2014. Also, the understimation of high risk lesions and ductal carcinoma in situ was 3.1% and 13.8% respectively as compared to surgical biopsy. So, it reliably helps to stratify patients for various types of cancer treatment.

It reduces the re-biopsy rates in small lesions, reducing the patient anxiety and discomfort.

VABB also provides an additional advantage of placing the marker clip at biopsy site with high accuracy through the same incision. The marker clips help in identifying the location of abnormality in breast after its complete removal by VABB.

It is a revolutionary tool for young girls with breast fibroadenomas who are looking for scarless removal of benign breast lesions.

In conclusion, VABB is an accurate and safe method that can help the decision-making of the diagnostic process and can be an alternative for excisional surgery in some therapeutic circumstances.

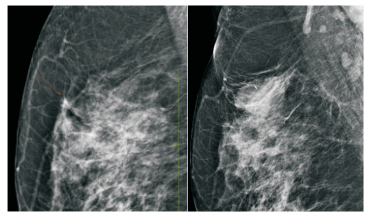

Image 1

Image 1: Illustrating new asymmetric density (3-4mm in size) in upper quadrant of right breast in known case of CA breast. VABB was performed under USG guidance and revealed high grade DCIS. A metallic marker clip was placed at the site of biopsy for localization.

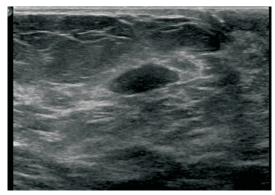

Image 2

Image 2: USG image showing small lesion in central quadrant right breast. USG guided VABB was preformed.

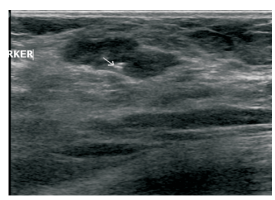

Image 3

Image 3: USG image post procedure showing irregular post op cavity containing hemorrhage with small metallic clip in the centre. Follow up after 1 month revealed regression of post op cavity, no residual lesion and metallic clip at biopsy site.

Dr. A. K. Chaturvedi, Dr. S. Avinash Rao & Dr. Rishu Singla
Department of Radiology

From the Desk of the Medical Director

***Rajiv Gandhi Cancer Institute & Research Centre,* Niti Bagh**

SUPERBUGS AND THE PHYSICIAN – BE SMART !
ANTIMICROBIAL STEWARDSHIP

Superbugs as we all know are drug resistant bacteria and as per the Centre for Disease Control and Prevention (CDC) data every year more than 2 million people get infected and many thousands die. It is therefore a major public health problem that affects patient outcomes and cost and demands swift action. The horizon for development of newer antibiotics is bleak hence we need to make all out efforts to reduce / delay development of resistance.

Antimicrobial Stewardship is a program that promotes the judicious use of antibiotics. This is all the more important because it is believed that nearly 50% of antimicrobial use is either inappropriate or unnecessary (CDC).

Act **SMART** (Solution to Manage Antibiotic Resistance Threat) and remember -

- Fever is a common symptom for infections and not necessarily caused by bacterial infection.
- **Reduce** - Do not use Antibiotic in case of viral disorders
- **Restrict** - Do not jump for Meropenem / Imipenem or linezolid
- **Rational -** Use antibiotics only if indicated and modify according to culture reports
- **Rotate** - Adopt Antibiotic cycling/ Antibiotic Vacation

Goal is to prevent antimicrobial overuse, misuse, and abuse in both the hospital and the outpatient setting .

Be Smart with Resistance and Follow Antimicrobial Stewardship

Dr. Gauri Kapoor, MD, PhD
Chairperson - Infection Control Committee

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One of the things about sexual abuse by doctors is that it is not a common thing but it is certainly a very serious thing. The fiduciary relationship between doctors and patients includes 3 things – Expectation of trustworthiness, unequal power relationship and interaction occurring in privacy. So the doctors breach of fiduciary and not the patient's consent is the central issue regarding sexual misconduct. The ethical doctor - patient relationship depends upon the doctor creating an environment of mutual respect and trust in which the patient can have confidence and safety.

Realistically, one knows that having guidelines would not necessarily stop abuse, but it could at least be a deterrent.

Dr. A. K. Dewan
Director - Surgical Oncology

9th CHEMOPORT TRAINING COURSE

The Department of Surgical Oncology, RGCIRC successfully organized the 9th training course in Chemoport Insertion on 13th – 14th May 2019 at RGCIRC, Rohini, Delhi. This 2 days course was held for doctors from various oncology centres who desired to learn this technique. It entailed interactive sessions by the faculty of RGCIRC as well as hands on training in the operating rooms. The topics covered were Chemoport Insertion, Hickman's Catheter Insertion, Pediatric Port, Arm Port and Peritoneal Port Insertion. The course was highly gratifying and we received an excellent feedback.



Architect's Impression of RGCIRC (post expansion)

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