

The absent discourse of communication: understanding ethics of provider-patient relationship in six hospitals in urban India

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Received: 06 Sep 2012

Accepted: 14 Jan 2013

Published: 23 Jan 2013

J Med Ethics Hist Med, 2013, 6:2

<http://journals.tums.ac.ir/abs/22985>

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Abstract

Understanding the complexities of a provider-patient relationship is considered to be of critical importance especially in medical ethics. It is important to understand this relation from the perspectives of all stakeholders. This article derives from a qualitative study conducted across six obstetric care providing institutions in the cities of Mumbai and Navi Mumbai, India, over a period of 10 months. Thirty obstetricians were interviewed in-depth to understand what they perceived as the most important aspect in developing a good provider-patient relationship. The study found that while most providers highlighted the point of communication as the most critical part of the provider-patient relationship, they admitted that they could not engage in communication with the patients for various reasons. Obstetric consultants and residents said that they were too overburdened to spend time communicating with patients; providers working in public hospitals added that the lack of education of their patients posed a hindrance in effective communication. However, providers practicing in private institutions explained that they faced a challenge in communicating with patients because their patients came from educated families who tended to trust the provider less and were generally more critical of the provider's clinical judgement. The article shows how provider-patient communication exists as an idea among medical providers but is absent in daily clinical practice. This gives rise to a discourse shaped around an absence. The authors conclude by decoding the term 'communication' – they read the word against the context of its use in the interviews, and argue that for the providers 'communication' was not intended to be a trope towards setting up a dialogue-based, egalitarian provider-patient relationship. Providers used the word in lieu of 'counselling', 'guiding', 'talking to'. It concludes that, despite the providers' insisting on the significance of communication and complaining about its absence, what they desired in reality was not the possibility of a dialogue with the patient or a chance to be able to share decision-making power with the patient, but to be able to provide better instructions and chart out what was best for them in a more detailed way.

Keywords: Communication, Provider-patient, Counselling, India

Introduction

Disbursal of medical care involves two people – the provider of care and the patient. Of these two people at the two ends of the relation, one is sick, diseased, in pain and in need of care and intervention while the other is empowered with the skills and resources to alleviate the suffering. Consequently a power-imbalanced relationship is often set up between these two (1-5). The nature of the relationship between the provider and his/her patient has been variously interrogated and critiqued for oppressing the voice and autonomy of the patient (6). Generating consensus on the definition of an ethical provider-patient relationship is difficult, especially since ethics is context-based, contingent (7, 8), dynamic and changing in nature. Within a modern, liberal framework, the emphasis has remained on the patient’s agency and autonomy (9). But contexts such as India and other parts of South Asia call for a different paradigm to critically evaluate and understand the provider-patient relationship (10, 11), the argument being that the tenets of the liberal and individualistic framework do not necessarily apply to community based, post-colonial contexts.

However, notwithstanding the differences between the western and eastern contexts, an emphasis on communication between the provider and the patient has remained strong in both (5, 12, 13). In fact, in India, especially in the media coverage, one keeps coming across grievances forwarded by patients, their relatives and also civil society organizations alleging that doctors are not communicating enough. The three critical purposes of communication identified are (i) creating a good interpersonal relationship, (ii) exchanging relevant and required information, and (iii) making treatment-related decisions (14). It is understandable that it might not always be practically possible for the patient to understand the criticalities of a medical situation and participate with equal and full knowledge; however, the nature of the dialogue

expects that she be informed to the best of her cognitive and intellectual abilities so that she is maximum empowered to participate and can exercise a state of enhanced autonomy (9, 15).

This is what mostly guides a society’s expectations from medical care providers. However, understanding what providers themselves expect from the provider-patient relation is also of significance, although this perspective is scarcely documented. Having identified the lack of documentation of provider perceptions, the authors conducted a qualitative study among obstetric care providers across six care providing institutions in Mumbai and Navi Mumbai, India. One of the objectives of this study was to understand what obstetric care providers perceived as the most important constituent of an ethical provider-patient relationship. The rationale of the study was that an in-depth and analytic documentation of provider perceptions would offer valuable insight – from an essentially insider’s view – into their perceptions and consequently aid in further informing the discipline of medical ethics, especially in contexts like India where perceptions of care-providers have been scarcely documented.

Method

This article is based on the in-depth interviews of 30 obstetricians from the study sample. On an average an interview lasted for 60 minutes. A convenient method of sampling along with snowball method was used. The interview team consisted of three social science researchers. The following table (1) shows the range of institutions covered by the sample and it is evident that the study sought to include providers in high-end, tertiary care centres as well as those practicing in small, private individual set-ups often with limited or no emergency support.

Table 1: A profile of the obstetric care providing institutions in the study

Institutions owned by a private individual or a family with around 10 maternity beds	2
Institutions owned by a Registered Charitable Trust and run on the principle of cross-subsidy on a non-profit basis, with around 60 maternity beds	2
Institutions owned by the State or the local civic body and offering free/subsidized maternity care services, with between 100-150 maternity beds	2
Total institutions sampled	6

The rationale for choosing this wide range of institutions was two-fold: (i) the sample is a near representation of the different types of institutions that offer obstetric services in India, and (ii) the different sizes and structures of the set-ups were expected to shore up the differences in how institutional structures inform the day-to-day

practice of obstetric care, day-to-day decision making and negotiations with authorities, and also to see how perceptions of emergency, criticality and ethics change with the context. The following table (2) shows designations of respondents and their hierarchy within medical practice at large.

Table 2: Profile of respondents vis-à-vis their designation

	Public/Civic-run institutions	Private/Non-Profit institutions	Private individual owned maternity homes	Total
Professors/Associate professors	5	4		9
Resident doctors/Post graduate medical students	7	5		12
Obstetric consultants in non-teaching institutions	4	2	3	9
Total				30

A broad idea of the relative positions of each category becomes important – especially the hierarchy between the professor/associate professor

and the resident doctors – as the findings of the study will substantiate. The next table (3) shows a sex-disaggregation of the respondents.

Table 3: Demographic profile of the providers:

	Public healthcare sector	Private healthcare sector	Total
Male respondents	5	6	11
Female respondents	9	10	19

However, since there was no difference in responses between the female and the male providers, data analysis has not been done based on the sex-identity of the respondents. There were differences between the public sector providers and the private sector providers, and the discussion focuses on that.

A semi-structured questionnaire was used for the interviews. The first section of the questionnaire focused on basic biographical details of the respondent while the latter section probed the respondent on themes related to the study objectives. Some of the themes included: issues providers have to deal with on a regular basis, perception of the practice of care in his/her institution, ethical decisions that need to be taken regarding having caesarean section deliveries, induction of labour, administering of epidurals, decisions and challenges of an emergency referral, and the ethics of the provider-patient relationship. This article is based on the providers' deliberations on the final theme – their perception of an ethical provider-patient relationship.

Written informed consent was taken from the heads of all institutions and from the individual respondents. A separate written consent was taken from each respondent for audio-taping the interview; in the few cases where it was not permitted, hand written notes were maintained by one of the researchers on the interview team. Each respondent was handed back a CD of the taped interview. Identities of respondents were not shared with the institution management committees and all names were duly anonymised.

Data, collected over ten months (September 2010 – June 2011), was coded with the qualitative software coding tool Weft QDA. For the primary round of coding, broad codes were identified and

marked, the cues for which were mostly taken from the questionnaire. In the next round the themes were further coded. In order to ensure privacy for the respondents and the six institutions, separate codes were developed.

The study was cleared by the respective institutional ethics committees (IEC) of each institution and by the consultant-owners of the smaller private maternity homes. It was also approved by the independent IEC of the researching organization.

Results

On the issue of what constituted the crux of an ethical provider-patient relationship, most frontline providers emphasized effective communication. It was explained that communication between the provider and the patient is of crucial importance. A healthy provider-patient relation draws its strength from communication. There was a general perception that a lot of untoward incidents – including the very common instance in India of relatives becoming chaotic and rowdy – can be tackled if sustained and healthy communication has been set in place with the patient and her relatives.

“Communication plays a very important role ... when miscommunication happens, it can be corrected through [communication]. Sometimes patient’s relatives create problems. But I think if we communicate properly, half of the problems are solved easily. So communication is important and administration support also plays important in such cases.”

[Associate Professor in a trust-run private teaching hospital]

Some of the senior obstetricians – associate professors and professors – expressed that the young doctors of today often lack the skills in

communicating with patients and they do not appreciate its importance either. However, communication is an aspect that should not be ignored by young medical students.

"They [providers] should be trained to how to talk to patients, how to behave with patients, on giving them information, [residents should learn] to talk in different ways ... the tone, the language, all are very important."

[Head of the department of a public teaching hospital]

However, when the researchers spoke with the residents, it emerged that most residents placed a premium on communication. A fact unique to the department of Obstetrics-Gynaecology was that patients were not seen only at the time of admission but over a span of several months, thereby allowing providers the time to develop a bond with the patient, get acquainted with her family history and her non-obstetric medical history. For some residents, this particular feature of the speciality had a special appeal. They realised that for sealing this bond with the patient, communication was the cement.

"I should be able to develop a good relation [with the patient], the wave length of the patient should match with the doctor's. It is not only about nine months and then delivering and going. Sometimes she may be requiring some contraceptive advice ... She might want to have some information about something sexual intercourse with her husband. All these things can be taken care of better if the patient has developed that kind of comfort level with the doctor. If I give her that space and that much time, probably she will open up. It will help her as well as me."

[Senior resident in a public hospital]

But despite this insistence on the importance of communication, when it came to the reality of daily practice, a gap emerged. After emphasizing the importance of communication, providers went on to explain why they were not able to focus on communication in daily practice.

Communication impeded: workload and overcrowding

As in several other countries, teaching hospitals in India offer free or subsidized treatment and service to patients. However, after the 1990s (which marked the globalization phase), the healthcare sector got broadly divided into the private and the public; the private is mostly a for-profit sector where the patient's purchasing power decides the quality and coverage of medical treatment/intervention she will receive. The public healthcare sector, though gradually diminishing in scope and coverage, continues to provide free or subsidized services. Nevertheless, with the state also promoting private investors in the healthcare

market, the quality of public hospitals have kept deteriorating for lack of funds and other required resources. This has also led to a division among the patient population – the affluent and economically affording ones avail of the private sector service and the public sector is accessed by the poor who have little or no purchasing power. This does not mean that public hospitals in India are sparsely populated; with over half the country's population thriving below the poverty line, the public healthcare sector – despite its poor resources and low quality – is crowded with patients. The obstetric wards in public tertiary hospitals – in the study sample – saw around 12 to 15 deliveries a day on an average.

Providers working in public hospitals echoed the importance of communication with patients, but added that the large volume of patients did not allow them the time for it. A professor-consultant at a teaching hospital said that there were several reasons why providers could not spend time with patients as desired – *"The work load is too much high ... the patient volume is high in the hospital ... Infrastructure provided is also not very good"* – pointing to the detrimental combination of workload and poor resources. Another provider in this hospital complained that the Out-Patient-Departments (OPD) are always chock-a-bloc with patients: *"An OPD is an OPD, no matter which hospital. Some of us see 100 patients in one slot [of three hours]. It's crazy! How will you talk [to patients]?"* Residents too shared this view:

"Workload is a lot over here. As I have said patients from all over the city and even the country come over here. People from other states are told that [this] is a good hospital, and we do not have a right to refuse any patient. Whichever state the patient comes from, in whatever state and wherever, we have to take the patient. So that way the work load is more, [...] it being a tertiary institute and having other faculties like medicine, blood bank and everything else. Work load increase because of that."

[Senior resident in a public teaching hospital]

Most senior consultants in public hospitals complained about the crowd they have to deal with on a daily basis, along with poor infrastructure. Yet their stress on the desirability of provider-patient communication underlined the importance medical providers attach to it. When we asked them how this issue could then be addressed, they said that residents should take up this duty: *"Residents should communicate [with patients] anyway. They are residential. They are residents, they are here,"* said the head of the department in the public teaching hospital. The point that in general, over the past couple of decades the overall standard of medical graduates in India has deteriorated was especially emphasised by consultant-professors in

teaching medical hospitals. It was mentioned that residents are now more detached from patients than they used to be in earlier generations. As the head of the department of the public teaching hospital said, *“The present generation of young doctors ... It is deteriorating. [...] The doctors who are coming out of medical colleges are turning out worse and worse, knowledge, skills, attitude”*.

The suggestion that residents should spend more time communicating with patients came in as a double-edged solution to the problems of the existing lack of provider-patient communication and to enhance the communication skills of residents in general. Providers were of the opinion that a lot of violence perpetrated by relatives at the hospitals can be avoided if a prior good relation has been set up with the patient, and so they did not want to compromise on this aspect of a good provider-patient relation.

“We should teach [our juniors] how to talk to the patients, how to respect their feelings. If the patients are asking the same question again and again how to tackle the patients. We write in English so there should be somebody to explain the patients what to do. The doctors should write the prescription and the other person should take up the work of explaining it to the patients. To talk in the patients' language is important. Then the patients would be happy.”
[Head of the department of a teaching hospital]

Communication impeded: residents are too busy

Residents are certified medical graduates pursuing a specialised postgraduation. The residents interviewed in the study were either in their second or their third/final year of postgraduation. Attending to patients in the OPDs and the wards, treating patients, assisting seniors in surgeries and conducting some surgeries form part of their syllabus. Technically the residents are on-call or on emergency duties round the week. They often did not get time to even take a bath a day or have a meal at leisure. Also, given their positions on the lower rungs of departmental hierarchy, negotiating between mandated training and outsourced pressures from seniors was a tough call. In talking of her experiences as a resident in a tertiary level public teaching hospital, a resident shared:

“It was a bit difficult in the first six months. Two to three times I thought that I should leave and go as I cannot handle the pressure. The work load is a lot [...] especially in gynaecology department as we do not have any fixed time. They can call you at any time of the day or night. You could keep working three days or four days. You could not go to your room to sleep.”

[Senior resident in a public teaching hospital]

Added to these impediments was the lack of cooperation from the hospital class-IV staff¹. Residents thus often ended up doing the *“running around”* (going to the blood bank to get a matching blood type, taking the patient for a sonography, etc.) in order to save time. A senior resident said: *“I never interact with servants. It is difficult making people work. We at times yell at them, blackmail them and ... maybe just do the work ourselves.”* Another resident asked rhetorically, having described a typical day at work, *“Where is the time to talk to a patient?”* In this context, where residents were always on a mode of hurrying and running around, their priority became clinically treating each patient, and ensuring that there was no mortality. Doing anything beyond this was a luxury in terms of time, which they could ill afford. Consequently, notwithstanding the importance accorded to communication, in reality it failed to exist as part of normative practice. With both consultants and residents saying that it was not possible for them to expend time or energy on communication, there was an impasse.

Communication impeded: lack of patients' education

According to public hospital providers, the lack of education of patients added to the hurdles in communication. Patients who came to the public hospitals were poor, mostly uneducated and even illiterate. Women who came in for check-ups did not often remember the date of their previous menses, a lot of them did not understand the importance of antenatal check-ups and came to the hospital straight away for delivery, at times with a malformed foetus that could well have been screened earlier. Adding to this was the fact that in so many households in India, till date, the woman – despite being the one requiring the medical intervention – has not much say, and decisions are made for her, usually by the husband or mother-in-law. Explaining the exasperation that such encounters bring on, a consultant said:

“I tell her [the patient], ‘You tell me now, what have you understood?’ Half the time I realize they have not understood only! Either they were not listening or after telling everything they ask me to tell it to their husbands. ... I know these Indian women usually don't take decisions, our society doesn't let the Indian women to take decision and she is brought up in such a way. [...] It's then better that I directly tell her husband what the problem is.”

[Professor in a public teaching hospital]

¹ Class-IV staff, also known as Group-D staff includes the employees of the institution who are responsible for tasks such as maintaining of files, docketing of letters, serving food to the patients, helping with stretchers, taking patients for getting tests done, getting matching blood samples back to the ward, etc.

Another senior consultant in a public tertiary hospital said:

“See, counselling fails when the ideas and beliefs are very strong ... and illiteracy adds to the problem. Medical literacy is low. See, the patients who come here to this hospital, they are not that educated. They come from socially backward families. They have no understanding of what has happened.”

[Consultant in a public hospital]

Public hospital providers held the view that more education would solve the problem since patients would then come having some basic idea about their body, about their pregnancies and about possible obstetric complications. Communication would also be easier with educated patients, especially when providers do not have much time on their hands.

However, private sector providers, who mostly have patients from urban, affluent, educated backgrounds, had a counterpoised view on this issue. For them, education could at times add to barriers in effective provider-patient communication.

Communication impeded: ‘too-much’ access to information

Most patients accessing the private obstetric institutions were tech-savvy and intellectually equipped to look up the internet, go through online medical literature and reasonably comprehend it. They also were more inclined towards consulting more than one provider and come to certain conclusions on their own. And when these independently formed ‘ideas’ became a tool to question the provider’s decision and judgement, it caused much discomfort for the latter.

“Initially people did not have access to medical literature, would come to us and believe what we said. Now situation has become like this that patients have become literate but are half literate. No non-medical person will have complete picture about medical illness. They receive half or distorted information. [...] Their knowledge is half baked. They read up on the internet which only provides a brief account or summary of the disease, if they try to go into details they will not understand. If they have doubts they should consult with the doctor!”

[Head of Department, Private tertiary hospital]

A middle-level consultant added: *“Too much of education becomes a problem. Reading up some stuff on the internet will not help at all.”* From the perspective of these providers, ‘too much education’ and ‘easy access to information’ were creating a situation where the patient was becoming more autonomous than either desired or preferred. It was empowering the patient in a way that was not desired by providers. This meant such patients would ask more questions, be satisfied less easily,

take up a lot more time, and want the provider to be more accountable. It also implied that such patients would trust the provider much less and remain more skeptical of his clinical and diagnostic skills as compared to those who were uneducated, had no access to medical information and so were bound to trust what the provider said. In India, even though medicine gets understood, deployed and practiced as an empirical, evidence-based and objective science, subjective and non-documentable aspects like the patient’s trust and faith in the provider and in his judgement, remain critical for a successful practice of medicine. As a departmental head in a private hospital added: *“Once you come to a doctor you must come with full faith, there can be difference of opinions but when you have full faith you can take decisions.”*

Provider-patient communication: decoding ‘communication’

Having documented (i) providers’ perception of an ethical provider-patient relationship, and (ii) the reasons why no provider could actually communicate with patients, this section will analyze the term ‘communication’ in the context of its use by these providers. It is important to mention here that all interviews with doctors and residents were conducted in English. Occasionally regional phrases were used in some sentences, but the quotes that were analyzed for this research article include no English translation. The word ‘communication’ was used by providers themselves during the interviews.

During a close reading of the contexts in which the term/concept of ‘communication’ was evoked by the providers, it emerged that the term was being used interchangeably with the terms ‘counselling’, ‘guiding’ and ‘talking’. In describing situations that impede communication, in describing how providers would want to communicate in an ideal situation, it emerged that communication implied a mode of instructing patients. Instructions for when to come for the next antenatal check-up, what routine tests to undergo, when to get admitted for delivery, how to take medication, what to do in case some obstetric emergency arose while the patient was at home. Providers told them what was good for them, since these women, especially those in the public hospitals, were believed to be clueless about their own physical well-being and to have no understanding of their bodies.

“When I see a patient in an outpatient clinic I tell her everything about the treatment, about the problems, about the requirements. Usually she will have no clear idea of what’s best for her. [...] Counselling I will have to do.”

[Consultant in a public teaching hospital]

In order to accommodate the volume of patients in public hospitals, patients (especially those who

came in for their antenatal check-up) were often addressed together in groups of eight or 10.

“Counselling is very important, [...] but we cannot afford to give so much time to a patient in the OPD. One to one counseling is not possible. Suppose I have to counsel a patient about contraceptives or sterilization ... What I do in the OPD is to gather maybe a group of patients tell them what to do.”

[Senior resident in a public teaching hospital]

When the researchers were asked if a patient is allowed to ask any specific question during these group sessions, the resident said that she can if she wants to, “but they do not.”

Discussion

Providers in the study stressed on the ethical importance of developing a relation with the patient that is based primarily on communication. They also explained why they were not able to attain such a relation. Reasons included issues related to lack of infrastructure and of other resources, problems of overwork, volume of patients, lack of education of patients and also at times the patients' access to easy information on clinical issues. An analysis of the context in which providers used the word 'communication' led the researchers to argue that it was used synonymously with counselling, talking and instructing. This peculiar usage of the word is important, since, as the researchers argue, it throws light on the nature of the provider-patient relation that providers want to develop.

Theories in philosophy explain communication between two people as a dialogic, two-way mode of exchange of information, views and decisions. Consequently, communication is expected to bring about a balance in power and knowledge between the two people involved. It is also supposed to have both these people alternate their roles as listener and speaker (17, 18). Counselling, on the other hand, is usually a one-way flow of instruction, guidance, suggestion and help (19). In the counselling model, there is a knower and a known. The knower is the one with access to more knowledge, who wields more power. In comparison the person who is the known lacks in knowledge that pertains to her state of being, her illness, her body, and so has less control of the situation. The knower is expected to be sympathetic and concerned about the well-being of the known, and to decide the right and correct course of action for the latter (17). The British Association for Counselling and Psychotherapy described the process of counselling as “*an interaction in which one person offers another person time, attention and respect, with the intention of helping that person explore, discover and clarify ways of living more successfully and towards greater well-being*”. So in counselling, the patient – who plays the role of the known – is

bereft of decision-making capacities and power over her body. What the authors show is that when providers used the term communication, they were not talking about a power-balanced, egalitarian relation with the patient, where the agency and authority for decision-making was to be shared with the patient. The providers were actually talking about counselling; it was an expression of regret over the fact that they could not afford more time and resources to better instruct the patients. The providers wanted to satisfactorily guide patients on their problems, course of treatment, clinical dangers, prognosis, antenatal and postnatal care, contraception and sterilization. The article showed that, despite providers' insisting on communication and complaining about its absence, what they desired in reality was not the possibility of a dialogue with the patient or a chance to be able to share decision-making power with the patient, but to be able to provide better instructions and chart out what was best for her in a more detailed way. Clinical decisions were made either between providers or between the provider and the hospital management. “*Decision-making is a discreet event*” (16) and neither patients nor their relatives were allowed to be part of the discretionary process. In the existing frame of things, the best interest of the patient was expected to be known only by the provider.

Conclusion

Understanding providers' perceptions of the coordinates of an ethical provider-patient relation is critical in mapping the holistic picture of provider-patient interface. While patients' perceptions of the relationship have been studied, mapping the providers' perceptions in the Indian context has rarely been done and more such studies need to be conducted. This qualitative study represents the perceptions of a section of providers who practice obstetrics in hospitals in urban India. It is intuitively felt that perceptions of providers – of the same issue – would be very different in a rural context.

A limitation of the study is that even within the urban space, the sample did not include tertiary superspeciality corporate hospitals. This particular category of care providing institution has come to shape India's healthcare sector in a major way, especially over the last two decade. The study did seek permission from some of these hospitals for access, but permission was not granted by any of them. The authors have concluded from informal sources that the dynamics of clinical practice and of care would have shored up yet another dimension to the ethics of provider-patient relationship in the corporate multispeciality hospitals. A second limitation is that despite all intentions and even attempts, the researchers failed to go back for a second interview with some respondents. This was

largely because of the tight schedules of the respondents who, though keen, could not spare the required time for a second round of interview. The researchers are of the opinion that certain issues might have been even better analysed with further interaction with respondents. However, this also opens up scope for further research into this area of enquiry.

Acknowledgement

The authors want to acknowledge Nobhojit Roy, Sundari Ravindran, Aditi Iyer, Helen Sheehan, Emma Pitchforth and Fatima Castello for their suggestions at various stages of the study and during the writing of this research article. They would also like to acknowledge the Wellcome Trust, U.K for funding the study.

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