abscesses: the right measuring 10.7×5.3×6.6 cm and the left 14.7×7.7×7.9 cm. Bilateral CT-guided percutaneous drainage of the abscesses was done and pigtail catheters were left *in situ*. A pus sample was sent for microbiological investigations. Ziehl–Neelsen stain did not show acid-fast bacilli and GeneXpert was negative for *Mycobacterium tuberculosis*. Non-fermentative, catalase-positive, oxidase-positive Gram-negative bacilli with wrinkled, sticky yellow colonies were isolated from the pus sample. This non-fermentative Gram-negative bacillus was identified as *B. cepacia* by MALDI-TOF mass spectrometry using the bioMérieux VITEK MS system (IVD database version 2.0). The isolate was sensitive to ceftazidime, ciprofloxacin, meropenem and cotrimoxazole. He was treated with oral ciprofloxacin (600 mg twice a day) for 3 weeks. A week after insertion of the pigtail catheters, there was no pus collection and the catheters were removed. On follow-up, he was doing well and had no evidence of recurrence of infection on repeat MRI imaging.

Our patient has several rare and interesting features. These include the primary nature of the abscesses, their bilateral location, large size, an immunocompromised host and infection with *B. cepacia*. Imaging (MRI or CT scan) could establish the diagnosis and define the extent of the abscesses. Percutaneous drainage along with appropriate antimicrobial therapy can be effectively used in the management of such cases. Thus, early and accurate identification of this organism is required for appropriate treatment as it is frequently misidentified as *Pseudomonas* species. This may lead to prescribing inappropriate antimicrobial therapy since this pathogen is inherently resistant to multiple antibiotics. Furthermore, with the increase in interventional procedures and the use of MALDI-TOF-MS-based systems, this pathogen is likely to become more frequent as a nosocomial pathogen. We could not determine the source of *B. cepacia* in this case.

Our report is aimed to draw attention to the accurate identification of *B. cepacia* in clinical samples, upon the isolation and identification in this case in the microbiology laboratory of a tertiary care hospital.

Conflicts of interest. None declared

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Mandatory Reporting of Sexual Offences in Indian Legislation: An ethical dilemma for medical professionals

Confidentiality of health information of patients is an essential part of the Hippocratic Oath, which is based on the principle of ‘Do No Harm’. It states: ‘And whatsoever I shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets.’[1] It forms the basis of a doctor–patient relationship and helps to maintain trust and rapport with the patient during continued medical care. Disclosure of patients’ information against their wishes has several consequences, for example, feeling of betrayal by the patients, breach of trust and rapport with the doctor, deterrence from treatment, dropout from follow-up, stigmatization, discrimination; it is also considered to be professional misconduct. Although mandatory disclosures by law are not considered to be professional misconduct,[2] other patient-related consequences pose problems in ongoing treatment. Mandatory disclosures may also boost the rising incidents of violence against doctors.

Children and women are known to be victims of sexual assault. It is estimated that in India, about 50% of children face some form of sexual abuse, with about 20% of them facing more serious forms, and 8.5% of women 15–49 years of age facing some form of sexual violence.[3,4] It is estimated that about two-thirds of the victims never disclose such violence. Reports have identified several reasons for non-disclosure of sexual violence to the police. These are non-friendly reporting procedures and attitude of the police, lack of knowledge about reporting, avoidance of recollection of traumatic memories and breach in confidentiality during multiple interrogations and lengthy court procedures, fear of stigmatization and discrimination, ashamed of being blamed by society for low morality, acceptance of harassment as part of everyday life, safety of self and family members, fear of revenge from perpetrators, avoidance of separation and dispute among family members, poor financial conditions and feeling powerless.[5–7] Sexual abuse causes physical as well as psychological trauma to the survivors,[4,8] for which medical help is often sought by the victim without reporting to the police.

The Protection of Children from Sexual Offences Act, 2012[9] and the Criminal Law Amendment Act, 2013[10] are major legal developments in India. Their main objective is to reduce sexual violence against children and women and punish the perpetrator. Therefore, these legislations mandate healthcare providers to report information to the police and provide free treatment to the victim. Failure to do so shall evoke punishment with fine or imprisonment or both.

However, such a provision in the law violates a principle of medical ethics, i.e. non-maleficence. Hence, healthcare professionals may face an ethical dilemma while fulfilling their obligations in providing ethical healthcare versus being accountable to the law by reporting such instances of sexual violence to the police without consent from the victim. Such dilemmas may arise when the victim and family provide a sexual history in confidence to the doctor for seeking appropriate care but do not wish the incident to be reported to the police. There may be instances where children or adolescents provide information regarding sexual exploration out of curiosity or get involved in foreplay or even intercourse in agreement with each other. Although child marriage is illegal and prohibited, it is still prevalent in our society. Reporting such instances to the police, of couples who visit a doctor for treatment of an ailment may create an ethical dilemma. Patients suffering from mental illness due to their psychopathology, poor judgement and insight may make false allegations of sexual abuse; they may on proper treatment of their illness retract such allegations. Reporting all such instances at the

initial visit may lead to 'defamation' and serious consequences. Similarly, when sexual abuse has occurred in the past, the victim may not wish to refresh those memories and this too could lead to an ethical dilemma. All the above-discussed conditions are under the realm of these mandatory reporting laws. Irrespective of the consequences, all such conditions, if they arise, have to be mandatorily reported by doctors to the police, to avoid punishment.

Mandatory reporting against the will of a person violates Article 21 of the Constitution, which refers to right to privacy of a person. Further, according to Section 164A CrPC related to informed consent for medical examination, a victim has the right to refusal of whole or part of the examination and treatment procedure. These provisions emphasize the importance of withholding consent provided by law to the victim. According to the 2014 guidelines on medicolegal care of victims of sexual violence issued by the Ministry of Health and Family Welfare, if the victim does not wish to report to the police and desires only treatment then medical professionals should first inform the victim about benefits of reporting to police and if still refused then document the informed refusal.[11,12]

Apart from mandatory reporting, another important provision in the law is to provide compulsory free treatment by all the hospitals to the victim, failure of which shall evoke punishment. Despite limited healthcare resources and an overburdened healthcare system in India, such provisions are essential and a welcome step to meet the urgent healthcare needs of the victim. In addition to their healthcare needs, such victims may also require urgent legal aid. Currently, there is provision of free legal aid by a special public prosecutor appointed by the court, subject to their affordability of a personal lawyer. We recommend that compulsory free legal services should be made available by a lawyer of the victim's choice, similar to compulsory free medical treatment. This will not only empower the victims but also minimize their apprehension and may increase voluntary reporting to the police.

We suggest psychosocial interventions and counselling sessions for less severe offences with the victim, family members and the perpetrator, which might resolve issues in a few cases. Whereas law enforcement and mandatory reporting as the first step for less severe offences may not only lead to criminal charges, punishment and consequences for the offender, but these may also pose various problems (time, money and stigma) to the victim and the family in attending legal proceedings, and can therefore be avoided. The decision to report should be left to the victims and they need to be encouraged to use healthcare facilities without any apprehension. Rather than imposing a penalty on the healthcare professional for not implementing legal requirements, there is a need to train healthcare professionals to address the special medical needs of victims of sexual violence. There are a few published guidelines which may be followed for providing healthcare to such victims.[8,11,12]

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