Benefits of vaccines should not be denied to any individual for lack of resources and the need of the affordable vaccines cannot be over emphasized in the current time. New recommendation on TCV is not likely to reduce the coverage as only single dose is recommended as of now whereas TPV needs to be given every 3 years. Moreover, TPV cannot be used to provide protection in children up to 2 years of age. Rather, the number of people receiving typhoid vaccine will become higher as new recipients (children up to 2 years of age) will receive TCV. Typhoid vaccination is also expected to serve as an important tool to curb antimicrobial resistance. Large-scale, more aggressive typhoid vaccination programs in children up to 15 years of age have the potential to reduce the overuse of antimicrobials, thereby reducing antimicrobial, resistance in many bacterial pathogens [4].

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Facilitating Behavior Modification of 'Problem Resident': A Paradigm Shift in Approach

We read with keen interest the recently published article in *Indian Pediatrics* about 'problem resident' [1].

The insights and ideas given in the article can be enriched by further understanding following perspectives on human behavior and its modification, in general:

1. The deviant behaviour that causes problems in patient care is not just because of individual but also majorly due to group culture, norms, resources and leadership, including behaviour of other residents/faculty, and leadership style. Hence remedy will lie in dealing with group behavior besides individual behavior. The entire focus of the article [1] seems to be on rectifying the individual. Some research needs to be done where one should examine whether certain departments recurrently have more 'problem students' than other departments. This research will prove or disprove our hypothesis that group dynamics also creates 'problem students'**.**

2. Behavior change and modification, both at individual and group level, requires professional expertise, and cannot be managed by doctors alone: hence, without professional help it may not succeed.

3. Public shaming process may happen when group consensus technique mentioned for recognition of problem resident will be used, besides violating confidentiality. It contradicts the later mention of confidentiality requirement in the paper.

4. If real long-term solution is sought, behavioral competencies like taking responsibility, and learning attitude, emotional intelligence, self-discipline *etc*. should be formally taught using experiential methodology during undergraduate and postgraduate training. It should be incorporated by Education Council if Medical Council of India wants to get doctors as per their expectations (mentioned in paper at the beginning) in terms of human qualities. Further, the teaching staff also needs training in building their skills in emotional sensitivity and management of feelings besides leadership skills.

5. Classification in terms of knowledge, skill and attitude makes the issue too complex to be solved. Briefly, knowledge and skill deficit do not cause problematic behaviour, whereas attitude does. And attitude is too vast a subject involving beliefs, values, evaluation, understanding and feelings. Feelings are the outcomes of attitudes and hence easy to work with. It makes the correction path simple and easy to implement**.** Enable these people to deal with the uncomfortable feelings more

functionally [2]. This is also a long drawn out process of learning through professional trainers/ therapists.

6. Skill deficits such as language, communication etc. do not create 'problem students' whereas inability to take constructive feedback may–if the student is highly defensive. Normal defensiveness is there in all of us. Here again student is said to be a problem, whereas inability to take constructive feedback can also be due to judgemental communication by the feedback giver too.

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AUTHORS' REPLY

1. We agree that deviant behaviour of an individual can result from lacunae in the group dynamics, deficits in the system, or lack of team leadership. The same has been acknowledged in the draft and has been discussed under the section on problems pertaining to teachers and problems pertaining to system. These factors pertaining to resident, teacher or system are considered as 'predisposing factors' and not 'causative factors. Hence, the problem that we encounter could have been predisposed by one or more than one factor. Nowhere in the draft, do we intend to blame an individual for the 'problem' in the 'problem resident'.

2. For the lack of trained experts, it may not be practical to seek professional help for every small issue at hospital. There is a need to develop awareness among the teachers who need to be sensitized on how to tackle the issues at their level. Professional help would definitely be required when it cannot be handled by the teachers or the program director. The same has also been acknowledged in the draft.

3. Group consensus among faculty members in a closed room discussion of faculty members does not lead to public shaming. It clearly intends to clarify if it is an individual faculty's opinion or is it that the same issue has been encountered by other faculty members as well. This does not breach confidentiality of the student. This step often takes care of unnecessary harassment of the student based on single person's opinion. Thus, it is essential to reach a group consensus before remedial actions can be planned.

4. Medical Council of India has commenced Attitude and Communication (ATCOM) module in this regard to train undergraduates. This should probably address this concern.

5. It would be good to look at the article from the perspective of medical teacher rather than a behavioral psychologist. Article did not intend in-depth discussions of psychology behind attitudes, beliefs, values that are well beyond the expertise of the authors or the scope of the article. We believe that a simple classification like deficits in knowledge, skill and attitude does not add complexity when looked from the perspective of medical teachers.

6. I would bring back the attention of the reader to 'predisposing factor' and not causative factor. No where do we mention that deficit in communication alone or lack of ability to take constructive criticism leads to problems in a problem resident. We believe that lack of these essential skills like effective communication often adds fuel to the fire.

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