

Atrocities on Doctors and Causes for Rise in Medico-Legal Cases

By Aneesh A. Shahade

IJSER

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INFORMATION

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1. Bachelor's in Commerce from University of Pune.
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I belong to a family of doctors. I originally hail from Karnataka. I have been a sportsman and represented my school and college in Badminton, Table Tennis and I am a student of Shotokan Style of Martial Arts.

ABSTRACT

From being considered living God and messiah of the Society, from being considered a confidante and an intellectual to being threatened, abused and attacked- the life of a doctor has undergone a sea change. In the light of recent events, threat to a doctor's practice is a looming sword that although omnipresent is being swept under the carpet as a passing trend.

The image of doctors was that of a prestigious and charitable individual serving the society relentlessly through the medicine. However, chinks have started appearing in the armor because of a few isolated incidents. Thus, leading to a change in the perspective by which the society views doctors.¹²

India has one government doctor for every 11 528 people and one nurse for every 483 people, figures from a report on the country's health sector have shown.³ The doctor-patient ratio in

¹ <http://www.thehindu.com/news/cities/Thiruvananthapuram/doctors-of-indian-origin-almost-a-brand-in-the-united-states/article4259746.ece>

² <http://www.hindustantimes.com/world/uk-again-looks-at-india-to-meet-shortage-of-doctors/story-turzXU4XinRiKux6kn5DHL.html>

³ <http://www.bmj.com/content/351/bmj.h5195>

India is less than the WHO-prescribed limit of 1:1000.⁴ With such a low ratio, the recent attacks on doctors have struck wide fear within the doctor community regarding safety and well being of their person⁵ and property. To set up an intensive care unit (ICU) takes minimum 3 Lac Rupees as capital investment besides the burden of recurring expenses and competent staff. Such institutions are demolished by hooligans as an act of vengeance over false and frivolous issue.⁶

This is a very complex issue and the solution involves many stakeholders, however, there remains an urgent need to address this problem in order to stem the tide of violence. Not long ago having a physician in the family was a source of significant pride and this tradition was passed down generations. Now, some physicians are actively discouraging their children from a future in medicine.

INTRODUCTION:

According to my observation the perils of medical practitioners, attendants and hospital owners have been seldom discussed. With them being labeled a vulnerable community, we must try and analyze what the issues faced by the medical community are. This shall strike a balance between the dispute raised between the patient and the medical practitioner.

My motivation to take up this issue was when I witnessed a doctor being mercilessly abused for no fault of his.

According to a study conducted by Indian Medical Association (IMA) 4 out of 5 doctors have suffered verbal and or physical assault. Leading by the example one can only imagine the frivolous law suits flying at the doctors for several reasons- be it ignorance, vengeance or mere seeking of political mileage.

The fact of the matter is that ultimately the society is going to be at loss. So with this would be catastrophe the objective of research has been set out to find the causes for medico-legal disputes, however- from a doctor's perspective.

⁴ http://zeenews.india.com/news/health/health-news/doctor-patient-ratio-in-india-less-than-who-prescribed-limit_1551946.html

⁵ An ongoing study of the Indian Medical Association (IMA) revealed that over 75% of doctors have faced violence at the work place

⁶ <http://everylifecounts.ndtv.com/frustration-over-health-care-system-boils-over-in-india-3042>

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CAUSES:

1. Inhuman Working Conditions:

On an average each doctor works for a minimum of 13 hours every day.⁷ Out of which they require intense amount of focus and sharp acumen. They focus is exerting because each case is different from the first and therefore must be taken as a new one. Each case requires intense focus equally also because there is no fixed template of diagnosis. The doctor requires staying alert because emergency cases donot come by invitation. Precise diagnosis must be done early and because prevention is better than cure. Any misdiagnosis can result into grave consequence and may cost a life besides the mental and emotional agony and medical expenses.

The doctors have been long protesting against the inhuman long working hours but alas their cries for help have been rung in futile.

One demand of doctors who went on strike in Delhi July was for shorter duty hours. They are unregulated currently, and resident doctors in the capital's public hospitals easily end up working 36-48-hour shifts.⁸ As per the directives of the Honorable Supreme Court in its judgment dated,25.9.87, in writ petition No. 348-352 of 1985, all the State Governments, Medical Institutions and Universities are required to amend their rules and regulations to introduce a uniform residency scheme by 1993.⁹ While in theory and in the rulebook of foreign accreditation agencies this is the norm, in practice it was never followed with resident doctors often forced to do back-to-back shifts, sometimes clocking up to 36 hours without a break.¹⁰ In this connection Ministry of Health & Family Welfare, Govt. of India has sent directive to all states & U.T. administrations vide letter No. S-11014 /3/91/ME (P) dated 05 June, 1992. Unfortunately many States in India refused to obey that orders till date. Presently Resident doctors (Post graduate students in Medical colleges) in India are forced to work 85-105 hrs/week in most of the clinical departments without the protection of any service rules because they are students. This is done under the instruction of the Head of the Departments concerned. Junior doctors pursuing their post graduation course, whose final assessment are in hands of these authorities, i.e. HODs.

⁷ Average taken from working hours of all doctors interviewed.

⁸ <http://indianexpress.com/article/explained/how-inhumanlylong-work-hoursare-killing-youngdoctors-literally-2/>

⁹ writ petition No. 348-352 of 1985

¹⁰ <http://indianexpress.com/article/cities/delhi/cant-make-doctors-work-over-12-hrs-hospitals-told/>

Therefore no one normally risks their career. This way exploitation of this floating population of junior doctors goes on and on the other hand patients suffer routinely and many times even die due to this forced negligence. While stretching duty hours our learned authorities simply forget the proven fact that errors and accidents increases sharply (An exponential graph) in mental and physical work, when duty hours are stretched beyond 10-12 hours continuous duty.

As the graph of errors and accidents increases steeply this 100% increase (24 hrs continuous duty in place of 12 hours maximum limit) in duty hours is sufficiently enough to do blunders and endanger human life.

“A doctor at his 20th-24th hour of continuous duty in Emergency ward, if not able to provide proper care to the patient for whom even a single minute can prove life saving or Fatal. This way if patients suffer than who will be held responsible, the Doctor on duty or the HOD or DME or the Govt.?”

Because doctor is performing unofficial extended hours, and he/she has the reason to state that doctor was not in his/her proper mental and physical condition due to chronic sleep deprivation and exhaustion. In fact this extended hour coincides with the mid night and early morning time, when all those patients who come to casualty irrespective of there diagnosis, feel that if they will delay till morning it may be harmful/fatal to them and most of the times indeed these emergencies are life threatening. With great hope in mid night when they visit hospital for proper care, they find a drowsy, tired, exhausted doctor, who is not even able to examine properly. The general impression becomes that doctor has neglected him, where as patient hardly knows doctor's real condition. After all patients do deserve the proper and efficient care, especially when there is no scarcity of doctors and this duty regime is artificially motivated. The finding of Justice Ranganath Mishra, former National Human Rights Commission, about delay and negligence in treatment of accident victims, are actually related with this illegal duty hour practice. Under growing public demands for health quality services the question which involves life of human beings, cannot be left unanswered.

After approximately eighteen hours of work Doctors have got the equivalent psychomotor dysfunction as having a blood alcohol level of .05. So not only at .05 you're not allowed to drive but at the equivalent level of psychomotor dysfunction you're allowed to look after patients. And by the time you've worked for twenty-four hours you've got the equivalent of having a blood-alcohol level of .1 and that's just ridiculous.

In most of the countries there is a limitation on extra hours, the average over month or quarterly it must be within norms, which varies 40 to 48 hours per week in different countries. In most of the states in India no duty hour's norm exists. Most hospital authorities do not even bother how many hours a junior doctor has worked, and so it increases up to inhumane levels as high as 103 hours in a week.

One should also note that a number of countries have enacted duty hours regulations for doctors. In Denmark, Norway and Sweden, residents work only 37-45 hours per week. In Netherlands, residents' duty hours are limited to 48 hrs per week. France has a 35 hour per week limit.

The unexpected death of Libby Zion, 18 yr old daughter of an attorney and writer for the New York Times, at New York hospital in 1984, led to series of investigation that resulted in profound changes in residency duty hours in USA.

In similar situation in London in December 1990 a junior doctor obtained a preliminary judgment from the court of Appeal on a claim for damages against Bloomsbury Health Authority. The court said that health authorities could not lawfully require junior doctors to work for so many hours that there was a foreseeable risk of injury to their health. The Vice-Chancellor, Sir Nicolas Browne-Wilkinson, said: "In any sphere of employment other than that of junior doctors, an obligation to work up to 88 hours in any one week would be rightly regarded as oppressive and intolerable." The doctor had served a writ on the health authority in March 1989 after working a 112-hour week which included a 49-hour shift over a weekend. He felt that his health had suffered so much that he resigned from his job at University College Hospital, London, and gave up medicine for a time.

Great public and media attention was drawn in September 1990 when two doctors in the neonatal pediatrics unit of the Southern General Hospital, Glasgow, were threatened with dismissal for refusing to carry on working 115 hours a week. After two sessions working the 115-hour week, the doctors said that chronic sleep deprivation was severely impairing their medical judgment and putting the lives of new-born babies at risk. In the same month a hospital patient in Middles borough died after a tired doctor gave her the wrong injection. The doctor had been on duty for 30 hours with just three hours interrupted sleep when she gave the fatal injection.

The comments of the acting coroner in the inquest into the death of a New Zealand woman, the innocent party in a car crash, reinforce the importance of addressing the issue of fatigue. The patient survived the accident, but died following a mishap while in hospital. A significant issue

for the coroner was the extent to which the fatigue of one of her doctors may have played a part in her demise. The coroner remarked that there was a growing level of concern, both nationally and internationally, over the hours of work of doctors in hospitals, and suggested that the medical professional bodies address the issue of extended periods of work.

Hope in India, justice will not get delayed until some VIP will die. Negligence and irritative behaviour (due to chronic sleep deprivation) of doctors in government hospitals are known to everyone and the death due to such forced negligence are nothing but routine (!) death of hospitals. In October 2014, Dr Abhishek V filed an RTI query on why residency scheme wasn't being followed in Karnataka and the reasons behind the long work hours. The reply stated that no residency scheme is followed in BMCRI and duty hours are decided by the department heads based on workload."The reply to the RTI query was callous. No leave policies or duty-hour policies are in place. During MCI inspections, post-graduates are falsely shown as residents. Even a circular from the ministry of health, restricting our work hours to 12 a day was ignored by the BMCRI," said doctors.¹¹

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¹¹ <http://timesofindia.indiatimes.com/city/bengaluru/Specialist-doctors-sick-of-poor-pay-and-long-working-hours-see-justice/articleshow/47889420.cms>

2. Poor financial support from Government:

While we jump at the chance to consider clinics as far as empathy, patient care and commitment to philanthropic points, they are organizations worried with incomes and costs like some other business. The stream of incomes can influence how understanding consideration is conveyed as well as the soundness of the clinic itself. Doctor's facility directors work unobtrusively in the background to tend to their healing centers' welfare and money related security. The quantity of patients, their protection sources, the sorts of administrations a doctor's facility offers and the recurrence of utilization of various administrations are only a couple elements that influence healing center incomes and costs.

a. Insurance Billing

Most doctor's facility income originates from charging for patient care administrations. By and large, this implies charging to private insurance agencies and government Medicare and state Medicaid programs. With poor patients, clinics now and then need to bill or work with their area welfare office or divert poverty stricken patients to province healing facilities. Doctor's facilities keep up contracts with a wide exhibit of private welfare arranges, with concurred calendars of repayment for all intents and purposes each sort of therapeutic administration. Medicare and Medicaid order what healing facilities can get for their repayment. At the point when monies are not paid by insurance agencies or government offices, patients are charged.

b. Research and Teaching

A few healing centers, especially university and educational foundation facilities, get government, state and private give subsidizing. For the most part, stipends subsidize medicinal studies and test systems; in spite of the fact that now and again doctor's facilities get them for capital changes important to convey new and better administrations to their groups.

c. Labor Costs

As of 2008, wages and benefits made up 59.5 percent of community hospital expenditures, and other labor costs accounted for an additional 10.6 percent, according to the Hospital Association. Clearly, in a service-based business delivering patient care, human capital is the primary form of capital in daily use.

d. Tests and Technology

Between 2006 and 2008, hospitals spent \$12 billion on medical imaging, according to The Boston Globe. Advances in technology help doctors make better diagnoses or at least rule out potential problems. But this also creates a very high set of expenses in the form of tests and technologically assisted procedures. Surgical robots, CT scans and new arthroscopic equipment are just a few of the other technologies that fall under this umbrella.

e. Liability Costs

In today's legal environment, hospitals have to protect themselves. Mistakes can happen, and despite health care providers' and administrators' best efforts, things sometimes go wrong. Professional liability insurance accounted for approximately 2 percent of hospital expenditures in 2008, the Hospital Association reports.

f. Supplies and Capital Expenses

Supplies make up about 15 percent of the average community hospital's expenses. Of course, these costs are offset through billing to patients for supplies used in the course of their treatment. Capital expenditures can be a huge part of a hospital's outlays. However, the amount and percentage of the budget can vary dramatically by hospital. A hospital undergoing a major expansion or construction project may have very large capital expenditures, while other hospitals may buy just a few new pieces of equipment, making their annual capital expenses fairly low. Nonprofit hospitals often fund capital-expense budgets for expansions and facility renovations through donations, and therefore the expenses do not come from their general operating budgets.¹²

Hospital expenditure includes recurrent expenditure and capital expenditure. Recurrent expenditure is money that is spent on goods and services that are consumed during the year, for example, salaries. Capital expenditure includes money spent on buildings and large pieces of equipment.

The government's low spending on health care places much of the burden on patients and their families, as evidenced by the country's out-of-pocket (OOP) spending rate, one of the world's highest. According to the World Health Organization (WHO), just 33 percent of

¹² <http://smallbusiness.chron.com/categories-expenses-revenues-hospital-business-setting-4882.html>

Indian health care expenditures in 2012 came from government sources. Of the remaining private spending, around 86 percent was OOP.¹³

The statistics for India's health infrastructure are below that of other large countries. The U.S. has one bed for every 350 patients while the ratio for Japan is 1 for 85. In contrast, India has one bed for every 1,050 patients. To match bed availability to the standards of more developed nations, India needs to add 100,000 beds this decade, at an investment of \$50 billion.¹⁴ Also, India's expenditure on health care information technology (HIT) is considerably low. Hospitals in India will need to increase their IT spend considerably to provide improved and patient-centric service.¹⁵ The shortage of qualified medical professionals is one of the key challenges facing the Indian health care industry. India's ratio of 0.7 doctors and 1.5 nurses per 1,000 people is dramatically lower than the WHO average of 2.5 doctors and nurses per 1,000 people. Furthermore, there is an acute shortage of paramedical and administrative professionals. The situation is aggravated by the concentration of medical professionals in urban areas, which have only 30 percent of India's population. Many patients, especially those living in rural and semi urban areas, are still receiving services from unqualified practitioners. The industry needs an additional 1.54 million doctors and 2.4 million nurses to match the global average.¹⁶

With medical tourism on the rise, and India requiring 100,000 beds each year for the next 20 years at over \$10 billion per year (as per a Yes Bank-ASSOCHAM report), safety has become the number one priority.

¹³ <http://www.livemint.com/Opinion/pl58bANi9zaF0AR2MkUYuN/Fixing-Indias-healthcare-system.html>

¹⁴ Challenges in Indian Healthcare industry – Pratap Reddy, Apollo Hospitals
(<http://www.dnaindia.com/money/column-government-spending-andprivate-investments-in-healthcare-is-need-of-the-hour-prathap-c-reddy-2005322>)

¹⁵ <http://www.vibrantgujarat.com/images/pdf/Healthcare-Industry-new.pdf>

¹⁶ Fortis Healthcare Ltd – Annual Report March 2014 - http://www.fortishealthcare.com/pdf/Fortis_AR_2013-14.pdf

3. Poor Doctor-to-Patient Ratio:

Today's question is a straightforward one. What number of patients can a doctor find in one day and still be careful? Try not to misunderstand me; I'm all for effectiveness. Be that as it may, we have to perceive when endeavors at proficiency get to be "medical sloppiness" or, to be perfectly honest, malpractice.

With human services approach and protection repayment what they are today, it's normal to experience doctors seeing forty, fifty, and even at least sixty patients a day in the outpatient setting. Truly, however, regardless of how encountered the specialist, regardless of how technologically streamlined the practice, and one doctor can't keep up medical precision at that frantic a pace. Numerous doctors get a kick out of the chance to think they can in light of the fact that they figure out how to see each patient on their timetable and do their thing. However, in many occurrences, great medicine can't be practiced in five to seven minutes.

A few specialists plan patients like clockwork, paying little respect to the issue and everything offsets. In a 9-5 day with a hour for lunch, that leaves 7 hours at 4 patients for each hour or 28 add up to patients. A few specialists will see as few as 15 patients in a day, some will see 40.

A typical error by patients is to compare time went through with the specialist to nature of care. Once in a while the finding can be made in seconds and the treatment rendered in under 5 minutes. Some of the time the patient needs somebody to converse with and the correct finding is not as vital. The trap is making sense of who needs what and giving that administration. Protection pays so little nowadays that time is a genuine extravagance that not very many specialists can bear. That is the reason attendant drug is turning out to be so well known.

4. Self-Medication

According to the WHO's definition, self-medication is the use of drugs to treat self-diagnosed disorders or symptoms, or the intermittent or continued use of a prescribed drug for chronic or recurrent diseases or symptoms.¹⁷

Let us look at the individual living in metropolitan city spending on entertainment. This included a movie and a dinner at a restaurant. However this sum is pittance when compared with the sum he spends on health. People are weary in general to pay for a good consultation at the hands of a senior doctor but donot mind paying the same amount for entertainment.

Like said before focusing on the proportion we can without much of a stretch infer that the normal specialist is exhausted and underpaid merely because of the remnants of socialism which perceive the field of medicine as a charitable service and not as a part of commerce. Additionally, different personal stakes have urged uninformed personalities how they are being conned upon. These personal stakes frequently do this to secure their advantage, not understanding the long haul ramifications of this on the general public.

Background:

Self-medication is one of the major health concerns worldwide and World Health Organization has laid emphasis on correctly investigating and controlling it. There is much public and professional concern regarding self-medication practices, which has dramatically increased in the last few decades, especially in the developing countries. Hence, this study was designed to study the prevalence and practice of self-medication practices in an urban area of Delhi, India.¹⁸

Medication by Pharmacy graduates without prescription is growing at an alarming rate. Self-medication is prevalent among pharmacy graduates with 67% of respondents using atleast an antipyretic as self-medication in the six-month period preceding the study. Crocin and antibiotics were the drugs most commonly used drugs for selfmedication. The common sources of

¹⁷ WHO (2000) Guidelines for the Regulatory Assessment of Medicinal Products for Use in Self-Medication., Geneva. Available: <http://apps.who.int/medicinedocs/pdf/s2218e/s2218e.pdf>.

¹⁸ WHO guidelines for the regulatory assessment of medicinal products for use in self medication, 2000. www.who.int/medicines/library/qsm/whoedm-qsm-2000-1/who-edm-qsm-00_1.htm. (<http://apps.who.int/medicinedocs/en/d/Js2218e/>)

information about medicine for minor ailment were the chemist or drug store owner. Antimicrobials were also taken without consulting a doctor. It can be concluded from this study that internet and email can be used as an effective research tool for conducting health outcome research studies in India. It is the moral duty of all pharmacy students to avoid self medication. Pharmacy graduates have sound knowledge about medicines but not in diagnosis of a disease. Government should insist on drugs being supplied by the pharmacist or chemist only on a valid prescription. A strict drug control must be implemented, rationally restricting the availability of drugs to the public. These measures would surely help in achieving the goal of complete patient safety and solving the drug related issues due to self medication. Limitations of the study: In this study, the sample size was too small to represent whole population. The other limitation was the confounding variables and chances of recall bias as few questions were regarding the past practice on self medication. Further studies on the prevalence, the factors influencing and the appropriateness of self medication are required to be conducted with a sample large enough to represent the whole population.¹⁹

Recent study conducted by World Health Organization in India, which concluded that 53% of Indians take antibiotics without prescription.²⁰ Cough/cold, fever and headache were the most common ailment for which respondents took medicines without prescription.

In the present study doctors reported that patients take antibiotics as long as they are not well. Self medication of antibiotics is one of the main reasons for antibiotic resistance in India. Nimesulide which is banned in western countries and in India in children below 12 years of age due to its well known adverse effects is still found to be used by reported to be used by several patients without prescription. WHO strictly discourages the use of Nimesulide and aspirin, which is suspected to cause severe damage to the liver and brain in children suffering from chicken pox and flu.²¹ Nimesulide is easily available over the counter without prescription in India. The main reason for self medication among patients is common notion of not consulting the doctor for

¹⁹ <http://www.ijddr.in/drug-development/an-online-exploratory-study-of-self-medication-among-pharmacy-graduates-in-india.pdf>

²⁰ 53% Indians take antibiotics without prescriptions: WHO. Press Trust of India, New Delhi April 6, 2011. Available from: URL: <http://www.businessstandard.com/india/news/53-indians-takeantibiotics-without-prescriptions-who/131368/on>. Accessed on: 21 June, 2011

²¹ Right choice of medicine for children. Living Deccan Herald, Feb 06 2004. Available from: <http://www.deccanherald.com/deccanherald/feb06 2004/liv7.asp>

minor illness. Convenience of buying medicines over the counter from nearby drug store was the second most common reason for self medication.²² Most of the patients receive knowledge about the medicines for self medication from their pharmacist or druggist. This finding was in accordance with the results of the study conducted in Bangladesh by Islam MS. in which majority patients sought advice from chemist or druggist to take medicines for minor ailments. Several patients used doctor's prescription for prior illness as a source of information for self medication for similar ailment. One important finding of this study was that patients used the medication without prescription and gave same medication brought without prescription to their family members also for similar kind of ailments. This practice may lead to adverse drug reaction as dose prescribed in children and adults are always different. Though, pharmacy graduates knew that even after having sound knowledge of drugs, self medication might lead to complication- Self medication was found to be prevalent among pharmacy graduates. According to doctors interviewed than half of the respondents' pharmacist or chemist never asked them for a prescription before selling the medicines.

World Health Organization has defined self-medication as "use of pharmaceutical or medicinal products by the consumer to treat self-recognized disorders or symptoms, the intermittent or continued use of a medication previously prescribed by a physician for chronic or recurring disease or symptom, or the use of medication recommended by lay sources or health workers not entitled to prescribe medicine."²³

Self-medication is associated with risks such as misdiagnosis, use of excessive drug dosage, prolonged duration of use, wastage of resources, and increased resistance to pathogens.²⁴ Further there is an increase in the promotion of self-medication products, which has enhanced consumer and patient awareness of the availability of products.²⁵

Despite these drawbacks, self-medication is an important component of primary health care.

²²) KRISHNAN D. Drugs over the counter: An Indian Perspective. Available from:
http://leda.law.harvard.edu/leda/data/773/Krishnan06_redacted.rtf

²³ WHO. Guidelines for the regulatory assessment of medicinal products for use in self-medication. Geneva: World Health Organization; 2000. Available from: <http://www.apps.who.int/medicinedocs/en/d/Js2218e/>. [Last cited on 2013 Dec 28].

²⁴ Kiyangi KS, Lauwo JA. Drugs in the home: Danger and waste. World Health Forum 1993;14:381-4.

²⁵ World Health Organization. Role of the Pharmacist in Support of the WHO Revised Drug Strategy. World Health Assembly Resolution, 47.12; 1994.

There are some advantages of self-medication like treating minor symptoms and ailments that do not require medical attention and thereby decreasing the burden on delivering health care. However, there are several critical issues that must be explored before promoting the potential benefits of self-medication. Any self-medication product should be safe for use. This implies the availability of appropriate consumer information and avoidance of any delay in diagnosis and treatment of diseases not suitable for self-medication.²⁶

Since the individual bears the primary responsibility for using self-medication, they should be able to recognize the symptoms they are treating, to determine that their condition is suitable for self-medication, to choose an appropriate self-medication product and to follow the directions for use of the product as provided in the product labeling.²⁷

As per drug laws applicable to India, self-medication are permitted for over-the-counter (OTC) drugs, but in India there is no specific list of OTC drugs. The OTC Committee of the Organization of Pharmaceutical Producers of India is working toward the promotion of responsible self-medication and creating awareness in the general public as well as the government.²⁸ Self-medication in modern pharmaceuticals seems to be a field in which information is scarce and only a very little information has been available about self-medication and its major determinants, especially in developing countries.²⁹ Hence, the present study was designed to study the prevalence of self-medication and its pattern in an urban area of Delhi, India.

²⁶ Abosede OA. Self-medication: An important aspect of primary health care. Soc Sci Med 1984;19:699-703.

²⁷ World Medical Association (WMA) Statement on Self-Medication. Available from: http://www.chpa.info.org/issues/WMA_SelfMedication.aspx.

²⁸ Organization of Pharmaceutical Producers of India (OPPI). Available from: <http://www.indiaoppi.com/IndiaOTCpharmaProfile2011.pdf>.

²⁹ World Health Organization. The use of essential drugs. World Health Organ Tech Rep Ser 1983;685:44-5

5. Lawlessness and Legislative Lethargy

The remnants of the past refuse the leave this nation. Physical attacks on doctors are relatively rare in America, but unfortunately commonplace in India.

A patient in the casualty/emergency room or Intensive Care Unit (ICU), in a critical state succumbs to their illness. The doctor delivering the bad news is assaulted by the patient's family members.

A doctor was assaulted in Allahabad and the infrastructure in the ICU damaged by relatives of an eighty-year-old patient who apparently came in with multi organ failure and died in the hospital. The tragedy is that the brunt of this senseless violence is often borne by junior doctors who are on call at night, when these attacks are more prone to happen. This is very disheartening and can demoralize the future doctors of our country. Some of the reasons attributed for the violence include misunderstanding between physicians and patients or their families, cost of medical care and a delay in attending to the patient.

On October 16, Dr Karma Bhutiya, an orthopaedic resident at Pune's Sassoon hospital, was roughed up by a police constable who was there with a patient. According to Bhutiya, he had accidentally brushed past the constable. This had enraged him so much that he slapped Bhutiya several times and even beat him up with a stick.

In the wee hours of September 25, relatives of three-year-old Abu Sufian, who succumbed to dengue at KEM hospital in Mumbai, attacked three doctors in the paediatric ward with wooden sticks and hospital chairs.

Dr Sandeep Amale and Dr Kiran Naik, doctors at Lifeline hospital in Panvel, were assaulted in April by relatives of a 75-year-old woman who had died after receiving treatment. The relatives broke Amale's nose and he had to be admitted to the intensive care unit (ICU)..

According to a study conducted this year by the Indian Medical Association, 75% of surveyed doctors in India have suffered some form of physical violence while on duty. Almost half of

these assaults were reported from ICUs. Angry attendants of patients have hurled chairs and abuses at doctors, and rampaged through the wards breaking medicine bottles and overturning tables

In India, the patient-doctor ratio is already low — 1 per 1,000 — so why is this scarce critical resource under attack?

Doctors say that majority of such attacks are reported from government hospitals which deal with very high volumes of patients who come typically from impoverished backgrounds and have little or no knowledge of healthcare. "They feel that if their patient has been admitted to the ICU, then no matter what the condition, the doctors will cure him or her," says Dr Dheeraj Mulchandani, a Mumbai-based surgeon who survived an assault during his residency days at Rajawadi general hospital in Ghatkopar. "An auto rickshaw driver was once brought to the ER very late at night with a head injury, and he died. His friends and relatives threw chairs at us," recalls Mulchandani.³⁰

In the absence of any government directive, hospitals are opting for temporary solutions. At Lifeline hospital in Panvel (where Amale and Naik were attacked) doctors are now being pushed to counsel more, and more guards have been hired. "If we spot a group which is likely to cause trouble, we inform the police," says Dr Janardhan NC, medical superintendent at the hospital. The management at Delhi's state-run Dr Ram Manohar Lohia hired eight marshals in June. A senior official at the hospital was quoted in a TOI report saying, "All are tall and heavily built. Their job is to sit inside the emergency round the clock and ensure order".

Sion hospital in Mumbai was also reported to have hired 40 bouncers this May after a class IV worker was manhandled by an attendant for not changing a patient's diaper on time. Anubhav Khiwani, who runs security services firm Denetim in Delhi, says he has received a number of queries for bouncers this year from private hospitals and clinics. But more guards can only help to an extent, argue doctors, and the need of the hour is a change at policy level.

³⁰ <http://timesofindia.indiatimes.com/india/75-per-cent-of-doctors-have-been-attacked-at-work-by-disgruntled-attendants-study-says/articleshow/49533759.cms>

There is an increasing expectation from patients that with modern medicine and technology, a doctor should be able to guarantee a good outcome.— Sudhir Naik, president of the Assn. of Medical Consultants

The Prevention of Violence and Damage to Property Act is a mere façade lacking any strong whip to set a deterrent example and instill confidence within the doctors.

The Bombay High Court Friday asked the state government to issue a circular and sensitise the police to invoke the Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage of Property) Act, 2010, in cases of assault on doctors. However, even after the directive has been issued, the implementation of the directive has been poor.

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Conclusion of Study:

The objective of the study is to highlight the issues faced by doctors. The implications of problems are far reaching and shall affect the society in a manner colossal and beyond repair. Medical Tourism in India is fact growing and these issues need to be resolved on a war footing to not just protect the Medical Tourism but to improve the domestic condition as well. The issues discussed have raised an alarm throughout the world in various universities where implications too have been discussed.

The doctor today does not enjoy the prestige and security he once enjoyed. The doctors are fast losing their heart from within the practice and have begun to reap short term benefits of commercialization and corporatization.

Maligning the reputation of a doctor, verbal abuse and physical attacks on doctors, destruction of property has become a trend and the cries of doctors are falling on deaf ears.

One alarming trend among doctors due to this social phenomenon has given rise to a fear within the doctors minds- fear regarding reputation, fear regarding protection of property and most importantly fear regarding one's safety.

The Doctor's Protection Act has not been touched by a ten foot pole merely because of Legislative lethargy and rampant corruption. Also, the pleasing of voters does not permit the welfare of the medical community mainly because of the deeply entrenched Nehruvian model of socialism which is not just a relic of the past and obsolete but is now an inflammable social issue waiting to self-destruct.

This fear has led to doctors refusing to accept emergency or complicated cases. How long can this buck be passed on? Who will ultimately take up the case? And will HE be safe in case the patient succumbs to the illness?

These questions have run deep into the roots of society so much so that unless a drastic measure is taken up it shall result into the ultimate collapse of the medical system in India to the point of no resurrection and the profession of Doctor shall be exterminated in a manner beyond repair.

India is exporting fine doctors who are serving their society. Until what time must this brain drain continue? Until what time shall we lose our best talent merely because we could not provide them a healthy environment to flourish in?

The society needs to be questioned and their mind set altered which in turn shall favour them or else we must prepare for a catastrophe.

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