

From India Medical TIMES

(Monday September,2014)

+ NEWS

MCI Quantifies punishment for doctors accepting freebies from pharma companies

Wednesday, December 10, 2014

by [Vidhi Rathee](#)

New Delhi: To deal with the reported nexus between doctors and pharma companies, the Medical Council of India (MCI) has proposed clear punishment for doctors accepting freebies in the form of gifts, cash or travel facility etc from pharma companies.

According to sources, the proposal was passed by the MCI general body and ethics committee and subsequently agreed by the union ministry of health and family welfare, which led to an amendment to the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002 around one and a half year back. However, a gazette notification for the same is awaited since then.

The quantity of punishment has reportedly been fixed according to the amount and nature of bribe doctors receive from pharma companies. For instance, if a doctor takes bribe in the form of gifts, cash or travel facility worth Rs 1,000 to Rs 5,000, it will call for a warning. Bribes worth between Rs 5,000 and Rs 10,000 would call for suspension of the doctor from the State Medical Council for three months; bribes worth Rs 10,000 to Rs 50,000 would call for suspension of the doctor for six months, and bribes worth Rs 50,000 and above would call for the suspension of the doctor for one year.

This is perhaps the first time when MCI has introduced any definite measure of this nature to discourage doctors from accepting bribes from pharmaceutical companies. Nothing about the quantity of punishment was mentioned in the regulations of the MCI till now.

The MCI Code of Ethics only states that doctors should not receive cash or gifts from pharmaceutical companies or allied healthcare industry representatives. And so guilty doctors were usually let off by giving warning and taking an apology from them.

The move is also being hailed as a measure that would bring parity among all cases of bribes that MCI deals with as doctors with influential links had an easy time convincing higher ups.

Speaking about the amendment, Dr K K Aggarwal, senior national vice president of Indian Medical Association (IMA) and member, ethics committee of Medical Council of India, told India Medical Times, "The amendments were passed around one and a half year back but no progress on its implementation has been made so far. I will file a RTI (Right to Information) application soon to track and press for its implementation. There has been a delay due to various administrative issues."

Though the amendment could still take some time before it could be actually implemented, the measure is surely being seen as a long awaited initiative by the MCI in dealing with corruption and bribery in the medical profession.

Dr Mohan Bairwa, senior resident, Centre for Community Medicine, AIIMS, New Delhi told India Medical Times, "Giving warning will discourage the doctors but having some penalty for repetitive offenders could have had a greater impact. In general, I feel it is the moral duty of a doctor not to accept bribes. Rules can only be helpful if they are implemented in spirit."

Doctors also believe that the move, when implemented, will only be a mild step by the medical council and will not have any significant impact on the practice of doctors receiving gifts and bribes from pharma companies.

Dr Ankur Sachan, a general physician based in Kanpur, told India Medical Times, “I don’t think quantifying punishment will change the scenario. First of all, how will the MCI prove that a doctor is taking bribe and of what amount? Bribing doctors is not a new practice, yet how many cases actually get noticed? This is merely a propaganda by the MCI so that no one can point finger on its functioning. These measures will not discourage doctors from accepting bribes; if the MCI really wants to do something in this regard then it should end the association of doctors and pharma

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companies altogether.”

The news of the MCI examining the issue of about 300 doctors allegedly receiving bribes from a major Ahmedabad-based pharmaceutical company is still fresh in the medical circles. With the practice of doctors receiving bribes under fire from all quarters, an early implementation of the amendments could boost the MCI’s image and its intention to curb corruption in the medical field.

by Vidhi Rathee

+ MEDICO-LEGAL NEWS

Delay in Providing support services also amounts to medical negligence

Friday, December 12, 2014

by Vidhi Rathee

New Delhi: Deficiency in providing essential support services, apart from treatment, also amounts to medical negligence on the part of a hospital. Delay by a doctor to act swiftly in referring and providing transport facility to an emergency patient can held him liable for negligence, as stated by the National Consumer Disputes Redressal Commission (NCDRC) in a recent judgment.

The case pertains to Sher Singh who took his son at about 10am on June 6, 2008 to Dr Sanjeet Singh Grewal, proprietor, Grewal Hospital, Ludhiana with a complaint of restlessness and excruciating pain all over the body. The doctor checked the blood pressure and took an electrocardiogram (ECG), which revealed that the patient had suffered Acute Anterior Wall Myocardial Infarction (AMI). As per the prescription slip, the patient was prescribed two tablets of Sorbitrate 10 mg., sublingual/STAT and two tablets of Clavix-AS STAT. He was subsequently referred to Hero Heart Centre, Ludhiana. Instead, the patient was taken to the Apollo Hospital in a car. Unfortunately, the patient died on way to the hospital.

Following the incidence, Sher Singh filed a complaint before the Ludhiana District Consumer Disputes Redressal Forum on the grounds that the doctor wasted 30 minutes in conducting ECG which he could have used to maintain the vital parameters like temperature, pulse and blood pressure. He alleged that AMI was not managed by injecting medicine for opening the arteries and neither oxygen was given nor was an ambulance or assistance of any person was provided while referring the deceased to a cardiac centre.

The complainant pleaded for a compensation of Rs 10 lakh for negligence on the part of the doctor because of which his son could not reach Apollo Hospital in time and lost his life.

The doctor, on his part, contended that neither he was a cardiologist nor was the hospital equipped with necessary infrastructure, like ICU, etc to handle the patients suffering from AMI. He immediately referred the patient to a hospital, which was equipped to manage such cases. It was also pleaded that the deceased was never admitted in the hospital and was given first aid as an out door patient as per the standard protocol. The patient remained in the hospital for barely 5 to 7 minutes.

The doctor also tried to substantiate his point by pointing out that both the Medical Council of India (MCI) and the Punjab Medical Council had earlier dismissed the plea of Sher Singh and resolved him of any charges of negligence.

On evaluation of the material placed on record, the district forum came to the conclusion that there was no negligence on the part of Dr Grewal. Dissatisfied with the order, the complainant filed an appeal before the Punjab State Consumer Disputes Redressal Commission.

After consideration, the state commission directed the doctor to pay Sher Singh a lump sum compensation of Rs 3 lakh within one month with an interest of 9% per annum from the date of the filing of the complaint till realization. The doctor, subsequently, filed a revision petition before the NCDRC while relying on some medical literature in support of his submission that there is no conclusive opinion that the routine use of inhaled oxygen in patients with acute AMI improves pain or mortality.

The national commission, citing some studies and principles, established that the allegation of medical negligence on the part of the doctor, on account of non-administration of oxygen to the deceased, could not be accepted, more so, when there is no consensus on the use of oxygen, even as a therapy for AMI.

However, the NCDRC, while upholding the order of compensation given by the state commission, agreed with Sher Singh that if an ambulance, equipped to transfer an AMI patient, had been arranged by the doctor on time, perhaps, a precious human life could be saved.

The NCDRC dismissed the doctor's argument that the hospital had only one ambulance, and at that point of time it was transporting some other patient on the ground that no supporting material was brought on record that proves the statement. Instead, the commission declared that neither the doctor nor his staff made any effort to call the emergency department of the PCI (percutaneous coronary intervention) centre to which the deceased was being referred, for arranging an ambulance equipped to ferry such patients.

The national commission reiterated that this was a serious lapse on the part of the petitioners (the doctor and the hospital), amounting to medical negligence and deficiency in service on their part.

In its order delivered on November 11, the NCDRC concluded, "We are of the opinion that though no medical negligence has been established against the petitioners in the emergent treatment of the deceased for AMI but medical negligence and deficiency in service stands proved against them for their failure to transfer the deceased to the cardiac care centre with the required alacrity."

[Read the full judgement](#)
by Vidhi Rathee

NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION NEW DELHI

REVISION PETITION NO.946 of 2013

(From the Order dated 19.12.2012 in First Appeal No. 541/2012 of Punjab State Consumer Disputes Redressal Commission, Chandigarh)

1. Grewal Hospital,
Grewal Lodge, Gill Road,
Near Calcutta Works, Ludhiana
Through its Proprietor –
Dr. Sanjeet Singh Grewal.

2. Dr. Sanjeet Singh Grewal,
Proprietor Grewal Hospital,
Grewal Lodge, Gill Road,
Ludhiana, Punjab.

... Petitioners

Vs.

Sher Singh,
S/o Late Sh. Sarwan Singh,
R/o Akal House,
B-21, 3558, New Janta Nagar,
Gill Road, Ludhiana,
Punjab.

... Respondent

BEFORE: -

**HON'BLE MR. JUSTICE D.K. JAIN, PRESIDENT
HON'BLE MR. VINAY KUMAR, MEMBER**

For the Petitioners : Mr. K.G. Sharma, Advocate
With Dr. S.S.Grewal,
(Petitioner No.2) in person.

For the Respondent : In person.

ORDER

(Pronounced on day of November, 2014)

D.K. JAIN, J. PRESIDENT

This Revision Petition under Section 21(b) of the Consumer Protection Act, 1986 (for short "the Act") has been filed by the Opposite Parties in the complaint, questioning the legality and correctness of order dated 19.12.2012 passed by the Punjab State Consumer Disputes Redressal Commission at Chandigarh (for short "the State Commission") in FA No. 541/2012. The State Commission has overturned the order, dated 28.03.2012, of the District Consumer Disputes Redresal Forum, Ludhiana (for short "the District Forum") in Complaint No. 403 of 2010, dismissing the complaint filed by the Respondent herein. Petitioner No. 1 is the hospital, of which Petitioner No. 2, a consultant physician, and attending Doctor, is the proprietor.

2. Succinctly put, the background facts giving rise to the present Revision Petition are that on 06.06.2008 at about 10.00 a.m., son of the Respondent, aged about 52

years, was brought to the Hospital with a complaint of restlessness and excruciating pain all over the body. Petitioner No. 2 checked the blood pressure and took an Electrocardiogram (ECG), which revealed that the patient had suffered Acute Anterior Wall Myocardial Infarction (AMI). As per prescription slip, the patient was prescribed two tablets of Sorbitrate 10 mg., sublingual/STAT and two tablets of Clavix-AS STAT. He was referred to Hero Heart Centre, Ludhiana. Instead, the patient was taken to the Apollo Hospital in a car. Unfortunately, the patient died on way to the hospital.

3. The father of the deceased, Respondent herein, filed a complaint under Section 12 of the Act against the Petitioners alleging that: (i) instead of wasting 30 minutes in conducting ECG, etc, the vital parameters like temperature, pulse and blood pressure, etc. were not maintained; (ii) AMI was not managed by injecting medicine for opening the arteries and (iii) neither oxygen was given nor was an ambulance or assistance of any person was provided while referring the deceased to a Cardiac Center. It was pleaded that due to the aforesaid negligence on the part of the Petitioners, the deceased could not reach Apollo Hospital and lost his life. A compensation of `10,00,000/- was prayed for.

4. The complaint was resisted by the Petitioners on the ground that neither Petitioner No. 2 was a Cardiologist nor was the Hospital equipped with necessary infrastructure, like ICU, etc. to handle the patients suffering from AMI and as per their policy the patient was immediately referred to a hospital, which was equipped to manage such cases. It was also pleaded that the deceased was never admitted in the Hospital and was given first-aid as an out-door patient as per the standard protocol. He remained in the Hospital for barely 5 to 7 minutes. It was also stated that the Complainant had earlier filed a complaint, dated 18.07.2008, with the Medical

Council of India and Medical Council of Punjab. Both the said Bodies had found that there was no negligence on the part of the treating doctor.

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5. On evaluation of the material placed on record, the District Forum came to the conclusion that there was no negligence on the part of the Petitioners. It observed that the report of the Medical Council of Punjab as well as the Board had opined that the Petitioner No. 2 had acted as was required to be done in the given situation. He did his best to provide necessary aid and had rightly not administered the injection, as the same could be administered by a Cardiologist and the Hospital did not have complete infrastructure to control the complications.

6. Being dissatisfied with the order, the Complainant filed an Appeal before the State Commission. As noted above the State Commission has allowed the complaint with a direction to the Petitioners to pay to the Respondent a lumpsum compensation in the sum of `3,00,000/-, within one month of the receipt of the copy of order, failing which, the Petitioners have been directed to pay interest @ 9% p.a. from the date of the filing of the complaint till realization. The State Commission has come to the following conclusion:-

“In view of above discussion and the law laid down, it is clear that respondent no. 2 doctor did not use proper skill and the knowledge expected from a doctor, to save the life and to ensure that the patient in critical condition reaches the hospital, where his ailment could be managed safely and that amounts to negligence and carelessness on the part of respondent no. 2 doctor. A little lapse on the part of respondent no. 2 doctor caused the loss of a precious life of the only son of the appellant and the respondents are liable to compensate him, although, the death cannot be compensated in any manner. The order passed by the District Forum is based on conjectures and surmises and is liable to be set aside.”

Hence the present Revision Petition.

7. We have heard Learned Counsel for the Petitioners and the Complainant, who appeared in person. Essentially, the stand taken by the parties in the pleadings was

reiterated. Petitioner No. 2 relied on some medical literature in support of his submission that there is no conclusive opinion that routine use of inhaled oxygen in patients with acute AMI improves pain or mortality.

8. Thus, the question for consideration is whether the alleged failure to: administer oxygen to the deceased; give thrombolytic therapy for early reperfusion to manage AMI and provide Ambulance amounted to medical negligence and/or deficiency in service on the part of the Petitioners?

9. What constitutes medical negligence, based on the touchstone of Bolam Vs. Friern Hospital Management Committee, (1957), 1 WLR, 582 (the Bolam's test), is well settled through a catena of decisions of the Hon'ble Supreme Court, including in Jacob Mathew Vs. State of Punjab & Anr. (2005) 6 SCC 1, Indian Medical Association Vs. V.P. Shantha and Ors., (1995) 6 SCC 651 and Kusum Sharma & Ors. Vs. Batra Hospital and Medical Research Centre & Ors. (2010) 3 SCC 480. Gleaned from these judgments, broad principles to determine what constitutes medical negligence, *inter alia*, are: (i) Whether the doctor in question possessed the medical skills expected of an ordinary skilled practitioner in the field at that point of time; and (ii) Whether the doctor adopted the practice (of clinical observation diagnosis – including diagnostic tests and treatment) in the case that is accepted as proper by a responsible body of professional practitioners in the field. In this connection, in Jacob Mathew(supra), a three Judge Bench, elaborating on the degree of skill and care required of a medical practitioner quoted Halsbury's Laws of England (4th Edn., Vol.30, para35), as follows:-

“35. The practitioner must bring to his task a reasonable degree of skill and knowledge, and must exercise a reasonable degree of care. Neither the very highest nor a very low degree of care and competence, judged in the light of the particular circumstances of each case, is what the law requires, and a person is not liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operation in a different way...”

10. We shall, therefore, examine the allegations of medical negligence on the touchstone of the aforementioned broad principles.

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~~11. Regarding the first alleged act of negligence, viz. non-administration of oxygen,~~ it would be apposite to refer to some medical literature on the issue. In Cochrane Database of Systematic Reviews, the Authors have concluded that there is no conclusive evidence from randomized controlled trials to support the routine administration of oxygen to patients with AMI to improve pain or mortality. In the guidelines issued by the European Society of Cardiology for Management of AMI, although it is suggested that oxygen (by mask or Nasal prongs) should be administered to those who are breathless, hypoxic, or have heart failure, explaining as to how oxygen therapy might work, it is observed as follows:-

“The rationale is that providing oxygen to a patient with AMI may improve the oxygenation of the ischaemic myocardial tissue. The reasoning has strong face validity but there is a lack of a clear supporting evidence. A systematic review of human studies, including non-randomised studies did not confirm that the oxygen administration diminishes acute myocardial ischaemia. Indeed, some evidence suggested that oxygen may increase myocardial ischaemia (Nicholson 2004). Another recent narrative review on oxygen therapy (Beasley 2007) also sounds a cautionary note and references a randomized controlled study (RCT) conducted in 1976 (Rawles 1976). This RCT showed that the relative risk of death was 2.89 (95% CI 0.81 to 10.23) in the group receiving oxygen compared to the group receiving air. While this is suggestive that oxygen may be harmful, the increased risk of death could easily be a chance finding.”

It is also observed that there is pressing need to review whether oxygen currently used in routine practice is doing more harm than good.

12. Yet another paper on “Oxygen Therapy in Acute Myocardial Infarction – Good or Bad”, published in August, 2013 reads as under:-

“Most patients with acute coronary syndromes (ACS) receive oxygen therapy as part of their emergency treatment, initiated by paramedics during transfer and before their first contact with a physician. A survey

among physicians involved with acute myocardial infarction cases found that 96% of their patients with ACS received oxygen therapy. About 50% of all responders believed that oxygen decreases mortality, 25% thought it helps to relieve pain and 25% thought it has no effect. Many therapies and interventions are not based on proven benefit, but on anecdotal evidence, expert opinion and tradition. This is especially true for oxygen therapy, which is usually not questioned and has been used for over 100 years. We could argue that as long as it does no harm, it does not really matter whether we continue to provide oxygen in these situations. However, is it really harmless.?

From a physiological perspective treating ACS patients with oxygen may seem reasonable. In ACS there is a lack of myocardial perfusion and consequently a lack of oxygenation of the myocardium. Therefore, it seems logical to increase the oxygenation of the blood reaching the jeopardized myocardium by administering oxygen therapy. However, another theory argues that oxygen may increase microvascular resistance, leading to reduced coronary blood flow thus reducing cardiac output and increasing radical oxygen species, which can have multiple negative effect including radical oxygen species, which can have multiple negative effect including increased risk for arrhythmias and cell damage leading to heart failure.”

13. In light of the above, we find it difficult to accept the allegation of medical negligence on the part of Petitioner No.2, on account of non-administration of oxygen to the deceased, more so, when there is no consensus on use of Oxygen, even as a therapy for AMI. We are also unable to agree with the Respondent that the decision of the Punjab Medical Council, taken in the Council meeting, dated 20.09.2009, opining that “After going through the record of case, no negligence was found against the treating doctor (Dr. Grewal). Case be filed”, needs to be ignored. According to the Respondent, as per the information obtained by him under the Right to Information Act, 2005, the Council had not examined the question as to why oxygen was not administered to the deceased. At this juncture, we do not propose to go into the merits of the said report, more so, when there is no established research base, suggesting/recommending oxygen administration to diminish AMI.

14. Now adverting to the allegation that having noticed from the ECG that the deceased was under AMI, Petitioner No.2 ought to have injected some thrombolytic agent to 'dissolve' clots, following coronary thrombosis, in order to open the infarct-related artery to carry blood supply to the heart muscles. The stand of Petitioner No.2 in this behalf is that he being a General Physician and the Hospital not equipped with the requisite equipment to manage and treat AMI cases, he immediately prescribed two tablets of Sorbitrate and Clavix AS, which according to him, is the standard protocol to be observed when a patient is suspected of AMI and is to be transferred to a cardiac center for Percutaneous Coronary Intervention (PCI). It has been his categorical assertion that without adequate monitoring facilities, it is not advisable to administer any thrombolytic substance.

15. In order to evaluate the rival stands, it would again be necessary to refer to some medical literature/ guidelines on the point. In an article by Experts on Cardiocare STEMI (ST elevation myocardial infarction), published recently in the Journal of the Association of Physicians of India, a Plan of Action/Protocol Flow Chart for early Reperfusion and Pharmaco-invasive approach in patients diagnosed as STEMI, the following line of action is suggested:

"1. First Medical Contact (FMC) at the level of General Practitioner or Consulting Physician in private clinic/OPD.

- All patients of chest pain/suspected of AMI on clinical diagnosis should receive prophylactic dose of 350 mg soluble/ chewable aspirin (non enteric-coated) immediately.
- Immediate ECG recording (if available) and confirm the diagnosis of STEMI (if possible).
- Clopidogrel (300 mg if patient age ≤ 75 years or 75 mg if age > 75 years) and Statins (Atorvastatin 40-80 mg) should be administered after confirmation of STEMI by ECG.

- In order to achieve early reperfusion and obtain best benefit outcomes, it is very important for the GP/ Physician to take time dependent decision and transfer immediately (preferably by ambulance) to the nearest reperfusion capable centre (PCI Capable centers/ hospitals where fibrinolysis is possible) to avoid any further delay in STEMI treatment.

(Note: GP to avoid referring the patients to diagnostic centers as they take 3-4 hours of precious time for ECG reporting that may add to delay in timely intervention).

- GP/Physician needs to maintain a list and contact details of nearby PCI Capable centers/ Non PCI hospitals for quick and immediate plan of action and to avoid delays in transfer. Also, encourage the patients to carry baseline ECG if recorded.
- GP/Physician should quickly apprise the patient/relatives regarding condition of the patient and gain their confidence towards preparedness for fibrinolysis/primary PCI. This aids in patient information, reduces the apprehension and time for decision and avoids further delay in treatment.”

16. The article, stated to be based on the opinion of over 150 experts from across India and belonging to different medical specialists, including interventional cardiology, recommends a time guided ‘Protocol/Plan of Action’ for early fibrinolysis and implementation of a Pharmaco-invasive approach even at the level of general practitioners, non-PCI’ hospitals/nursing homes with intensive care facility.

17. What emerges from the article is that the recommended plan of action, in so far as it relates to administration of medicine, by a general physician or consulting physician, dealing with an AMI emergency at a non-PCI capable hospital is: (i) before confirmation of STEMI by ECG prophylactic, a dose of 350 mg soluble/chewable aspirin; (ii) after confirmation or even before, a dose of Clopidogrel 75 gm for a patient >75 years; and (iii) statins. In the present case, admittedly immediately after the ECG, Tablets, Sorbitrate and Clavix-AS were given to the patient. Statins are not considered to be life saving drugs. Tested on the touchstone of the aforesaid

recommendations, and in the absence of any material on record to show as to whether or not any thrombolytic substance could be administered even in the absence of adequate monitoring facility, we are of the opinion that immediate non-administration of fibrinolytic therapy alongside the contemporary adjunctive medical therapy, no medical negligence, as propounded in the decisions referred to above, can be attributed to the Petitioners on that account as well. We hold accordingly.

18. We shall now consider the third allegation, viz. non-availability of ambulance for transfer of the deceased to the nearest PCI center. In the Complaint as well as in the affidavit, filed as evidence, it was specifically pleaded that the Petitioners had failed to provide an ambulance for shifting the deceased from the Petitioner hospital to the Cardiac Center, and thus, the delay in the process proved fatal. The averment was denied in the affidavit filed by the Petitioners by merely stating that the hospital had only one ambulance, and at that point of time it was transporting some other patient. Except for the said bald statement, no supporting material was brought on record. As a matter of fact, it was stated in the affidavit that "Just on listening that ambulance may take some time, the patient was taken away by the Complainant in own conveyance to the Cardiac Centre of own choice". It is manifest from the statement that, on their own showing, Petitioner No.2 or his staff did not make any effort to call the emergency department of PCI to which the deceased was being referred, for arranging ambulance equipped to ferry such patients. Having himself diagnosed that the deceased was under AMI attack, Petitioner No. 2 ought not to have waited for his own ambulance, if at all he had one. Knowing fully well that each minute, if not second, in the given situation was precious, he should have ensured that the deceased was transferred to a Cardiac Center as quickly as possible. We are convinced that on facts at hand, the Petitioners had failed to act swiftly, expected even from a general Practitioner or consulting Physician and a Non-PCI capable

hospital. Alas, if an ambulance, equipped to transfer an AMI patient had been arranged by the Petitioners on time, perhaps, a precious human life could be saved. We are of the opinion that this was serious lapse on the part of the Petitioners, amounting to medical negligence and deficiency in service on their part. Thus, we uphold the finding of the State Commission on this issue.

19. To sum up, we are of the opinion that though no medical negligence has been established against the Petitioners in the emergent treatment of the deceased for AMI but medical negligence and deficiency in service stands proved against them for their failure to transfer the deceased to the Cardiac Care Center with the required alacrity.

20. For the foregoing reasons, we sustain the finding of medical negligence on the part of the Petitioners as recorded by the State Commission, though slightly on a different line of reasoning. Resultantly, the Revision Petition fails and is dismissed accordingly.

21. It was pointed out that 50% of the decretal amount, deposited by the Petitioners in terms of order dated 05.04.2013, has already been released to the Respondent. If that be so, the balance amount of compensation, as awarded by the State Commission, shall be paid by the Petitioners to the Respondent within four weeks of receipt of a copy of this order, failing which, the said amount shall carry interest @ 9% p.a. from the date of filing of the Complaint till realization.

22. The Revision Petition stands disposed of with no order as to costs.

PRESIDENT

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(D.K. JAIN, J.)

MEMBER

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(VINAY KUMAR)

Yd/ar

The State of medical professionals in India

Monday, September 8, 2014

Part 1 **Part Head** By Dr Kamal Mahawar

The state of medical professionals in India needs urgent attention if we value our health and want a health force for tomorrow which will not only be of highest quality but also work honestly and ethically to protect patients' interests. There was a time when medicine and engineering were the only professions worth aspiring for in India, as these were the only areas where one could expect to earn a decent sum and live with dignity. No more. Things have now changed and practicing medicine in India is not a coveted career anymore.



Dr Kamal K Mahawar

What you get after a basic primary medical qualification that takes at least two years longer than even the 4-year engineering course (It took me six years to obtain medical registration from the date I started including Internship) is nothing what you can expect in other walks of life. In other areas, you are now a full-fledged professional but not in medicine; here you only truly begin your training after qualification.

The vast majority of qualified Indian doctors are then left to fend for themselves in a market where they are competing with quacks alongside established practitioners. There are no jobs for them to go to and very few hospitals to work in at a decent wage. The public sector rural hospitals don't offer any opportunity to learn and practice decent medicine and little surprise then that these doctors don't want to work there. Moreover the state of rural infrastructure is such that even people living in villages are migrating to cities. For those lucky enough to find highly competitive places for specialist training, it can easily take another ten years or so before they can practice as an independent consultant.

The vast majority of these fresh pass out doctors are then forced to open their own clinics at a ripe age of 24-25 where they not only have to look after the expectations of a family but also establish their own career with little support from anybody else and needless to say very little training. Moreover they then cater to a population, which is not only largely poor but also insensitive towards health needs. The same people who wouldn't think twice about spending many thousands of rupees on a casual dinner can be seen in extreme "pain" when shelling out a few hundred rupees as a doctor's consultation fee. As one doctor succinctly put it to me recently, "they will happily pay thousands for dinners, tests and procedures but not for consultations".

You can't really blame these young professionals if they then have to follow the "established norms" of the professional medical practice in India to survive. In such an environment lack of knowledge and training, unethical practices, poor standards, lack of accountability, unholy nexuses (with laboratories, hospitals, and drug companies), and medical politics thrives. One doesn't wish to condone these activities but simply understand the underlying causes better so that they may be rectified.

If we wish our doctors to work ethically and practice cutting edge evidence based medicine, we have to value their talent and effort. It is not beyond the means of what is perhaps the third largest economy in the world to develop such systems. There is little doubt that the model of smart cities is finding some support amongst the population and planners. It is our responsibility to ensure that a viable medical facility is a part of every such new township. It should not only cater to the people within but also surrounding villages to become viable. Another option could be to revive the existing primary healthcare systems in rural areas with help from local leaders, private businessmen, and social workers. We also urgently need mechanisms to regulate remuneration of private doctors more tightly as aberrations on either side are too common in a non-functioning market. Finally, to improve the standard of service, we should set up adequately paid locally funded training opportunities for those wishing to go into general practice.

Once we have these mechanisms in place, and only then, society should rightly expect doctors to be more competent and more accountable. That will be a long arduous process but a beginning has to be made somewhere. I think as a starting point every district should develop their “Mortality Boards” under the auspices of Indian Medical Association. These boards should discuss all mortalities in the area, learn lessons, and then disseminate the learning into its members. The serious and repeated offenders should be reported to Medical Council of India. Please keep following this column as in the next article we will discuss in some detail the character and functioning of such Mortality Boards.

Dr Kamal Mahawar
Senior Consultant in Bariatric and Metabolic Surgery
Indraprastha Apollo Hospitals, New Delhi

Don't demoralize and blame Doctors

Saturday, December 6, 2014

by [Dr Ashok Mittal](#)

One after the other tragedies in surgical camps indicate that for the time being all surgical camps whether tubectomy (female sterilization), eye camps or any such medical camps in which surgery is done in a remote place in camps should be stopped and restarted only after a thorough workout to ensure safety norms.



Dr Ashok Mittal

Death of 19 women in Chhattisgarh recently due to spurious drugs containing rat killer medicine, and now 60 people losing eye sight following cataract surgery in Punjab are very unfortunate and worst of the worst instances of negligence on the part of all those authorities who are supposed to ensure that everything is up to the mark before asking a surgeon to conduct the camp.

Loss of vision after cataract surgery was also reported in a camp held in Chhattisgarh two years ago. Few years ago in Rajasthan similar tragedies occurred in eye camps at Kishangarh and another at Beawer.

The surgeon is responsible only for the surgical complications if any, occurring during or after the surgery that too, if the proper facilities were provided to him and he approved those facilities. The surgeons should have enough courage to say no not only to such camps rather in a hospital too, if they find that the conditions are not suitable. In that case it is better to transport the cases to an institute.

There are instances when unforeseen problems arise during surgery e.g. electricity failure while performing an operation. The surgeon at that time uses whatever light source available to save life; he has to bear the heat of the OT during operation and fury of attendants if any untoward complication or death occurs.

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Free surgery camps should be banned across the country like the Orissa government has done. They should be conducted only if the infrastructure, equipments, operating conditions, medical staff, drinking water, hygienic food and safe lab-tested drugs etc are available as per the standards laid down. These facilities should be checked and certified by a team of eminent doctors having members like one from AIIMS, one from a corporate hospital, one from IMA and the operating surgeons etc. Then only such medical camps should be allowed to conduct operations.

The camps till now are being organized on a call by a politician or a philanthropist to mark some family event or by an NGO. In one way, it is good that someone is sponsoring the camp as a part of charity, but that does not mean that the organizers (not doctors) forget that they deal with human beings. May be they are poor, downtrodden, uneducated, socio-economically backward or whatever, our Indian constitution has provision of right to equality, right to health and life and right to live with dignity. In camps we find that there are hardly any facilities of indoor beds, privacy, toilets, safe drinking water. The question is if such basic facilities are not available then expecting a reasonable medical set is beyond imagination at such camps. It seems that all the constitutional provisions have been forgotten.

Who is responsible to verify that preoperative and operating conditions and postoperative care will be justified in a proposed camp? It seems that as on date nobody bothers. It is just a blindly permitted routine event, where it is sure that everyone is a gainer. Risk of mortality or morbidity if at all has to be borne by the poor patients.

What is the basic aim behind organizing these camps? Is it for making money by the private service providers, is it to strengthen the vote banks of the politicians, is it for making TA/DA by the government machinery or is it for completing the targets of an NGO? Whatever it is the first and the foremost basic aim should be Service to Humanity.

If there is any compromise on human life, everyone responsible should be taken into account for a stern action otherwise we must STOP these killer camps for the sake of humanity.

Dr Ashok Mittal

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Categories: OPINIONS

Tags: [AIIMS](#), [Cataract Surgery](#), [Dr Ashok Mittal](#), [IMA](#), [Medical Camps](#), [Medical Negligence](#), [Surgical Camps](#), [Tubectomy](#)

OPINIONS

Once noble ,now medicine is heartless profession'

Tuesday, December 2, 2014

by [Proloy Bagchi](#)

In the midst of the ongoing controversy over deaths of 13 women in Chhattisgarh after their tubectomy procedure another massive case of professional misconduct by doctors was reported the other day from Delhi. For the common man medical treatment is increasingly becoming dicey, given the proclivity of medical professionals towards illegal gratification sought and taken from the pharmaceutical companies and prescribing medicines that may or may not be necessary but for which one has to pay unscrupulously hiked prices.



Proloy Bagchi

The two cases mentioned above show some similarities. The deaths in Chhattisgarh were initially reported to have been caused due to botched up operation by the surgeon who was otherwise a reputed professional. Since the entire blame was being heaped on him he went underground and was eventually arrested. In the meantime, however, autopsies revealed that the deaths were not really caused by the surgical procedure but by the post-operative medicines that were administered to these unfortunate women. They were given locally manufactured brand of ciprofloxacin, a commonly prescribed antibiotic, and ibuprofen, a pain killer. Analysis of the antibiotic revealed that it contained poison that is used to kill rodents. The other relevant fact that was revealed that there was no need to procure the drug locally as the same was available in the hospital stores suggesting some link-up between the local manufacturer and the hospital administration.

The other case that has been reported to the Medical Council of India has put as many as 300 doctors under investigations for prescribing drugs of a particular pharmaceutical company when cheaper alternatives manufactured by better-known companies were available. The doctors were, in exchange, being paid substantial amounts of money and were being gifted cars and flats and were also being offered all-expenses-paid foreign pleasure trips. The investigations have been initiated on the basis of an anonymous complaint from Ahmedabad. All the doctors have been asked to produce copies of their bank accounts and passports and present themselves with their originals.

Of late, the reputation of the medical profession - once upon a time considered noble - has taken a severe hit due to the indiscretion and the dishonest ways of many of its members. Perhaps increasing materialistic culture in the country has enticed even the best of medical professionals to cross the ethical line and forget the Hippocratic Oath. It was not so earlier. Five or six decades ago there were hardly any specialists; most patients used to go for succour to general practitioners - medical graduates or even licentiates. None ever recalls any ethical wrong-doing; the physician may have gone wrong in diagnosis but one never heard of commissions from diagnostic clinics or from drug manufacturers. In most cases, the doctor used to have an attached dispensary that dispensed medicines. The development of specialities and super-specialities, upgrading of investigative tools and surgical methods and equipment have, while promising far better healthcare, mixed a lot of poison in the curative potions. Modern hospitals are generally mammoth organisations full of specialities, super-specialities and their concomitant highly qualified physicians and surgeons. Not only the hospitals are exceedingly large, the salaries paid are also astronomical. In order to, perhaps, even to break even these hospitals, their physicians and surgeons tend to compromise on the ethical content of their profession, breaching the Oath that they were sworn to.

In India today there is a race to become (at least) a rupee billionaire (a crorepati). Half a century ago even a hundred thousand rupees were beyond the reach of many. In the absence of a rat race, the professionals retained and maintained the nobility of their profession. Today, in the highly competitive and acquisitive environment, doctors - physicians and surgeons - are also in that race. Armed with a degree obtained after maybe bribing his way to a medical seat, paying a huge capitation and other fees to go through a medical school, then spending years in graduation, post-graduation followed by studies for a doctoral degree a medical student is ready to enter his profession, mostly, deeply indebted. As practicing in government institutions does not quite meet the requirements to

square off his commitments, the private, or even better, the corporatized healthcare institutions are found attractive. It is, inter alia, here that the ethical compromises commence.

Receiving a handsome package, he is asked to generate revenues for the corporate house that runs the establishment. The game starts when a patient is viewed not as a human needing succour but as a revenue generating medium. He is asked to go through several needless investigative procedures, he may be admitted as an in-patient quite needlessly and administered drugs that cost the sky, and occasionally gratuitously put under the knife or on the ventilator. I recall a case of a corporate hospital where a lower middle-class boy was kept on the ventilator even after he had died only with a view to claiming a fat bill. In another case a man was subjected to an angioplasty and a stent was placed at the site of the arterial blockage. However, a year later during an angiogram of the same patient in a public healthcare institution of repute the stent was not visible. Obviously, the stent in question was never implanted though the cost was recovered in full. A corporate hospital in the South was caught over-charging for a stent to be used on a patient whose relative knew exactly how much the hospital had paid for it. Reports have appeared of hospitals charging for hip implants that were obtained free on bargains such as buy-one-get-one-free. The hospitals seldom mention in the discharge certificates the particulars of the implants disabling patients from claiming damages in case the implants cause problems later, which they frequently do. Things have become so bad that even Pappu Yadav, a supposedly shady leader, has called doctors “executioners”.

Dr David Berger, an Australian medical practitioner, writing in the British Medical Journal said that bribes and kickbacks oil every part of India’s healthcare machinery. He had come as a volunteer physician in a small charitable hospital up in the Himalayas. “A model of iniquity”, the healthcare system, he says, is highly privatised extending the facility of latest technological medicine to higher strata at a high price leaving around 800 million people in the hands of inadequately provided and ill-equipped sub-standard government hospitals or, worse, quacks. At 70%, the out-of-pocket expenditure on healthcare in India is higher than even in the US. The editor of the journal Fiona Godlee had recently urged for stopping corruption in healthcare or else other nations could turn away Indian doctors. A campaign against the evil is being launched starting from India.

Apparently, India is not the only country where such unethical practices are rampant. Highly disappointed in the way the healthcare system functions in the US an Indian-American physician, Dr Sandeep Jauhar, has, in a candid mea culpa, called it a “heartless profession”. For raising revenues of the corporate hospital, doctors now have very little time for patients as they have to check many more than what was actually the practice earlier. He has blown the whistle on American medical practice which he says has “become pitiless, mercenary, money-ripping vocation where doctors treat patients as revenue generators rather than as human beings”. They keep patients in hospitals longer than necessary, order needless tests and cozy up with predatory pharmaceutical companies to sell dangerous drugs.

Another Indian-American, Dr Surya Prakash, has confessed that in the changed environment medical practitioners have increasingly lost that vital human emotion of “empathy” for their patients. If that is so in the US, perhaps, it is truer in India.

The author, Proloy Bagchi, is a retired Indian civil servant and currently lives in Bhopal.

Why do successive governments promote quackery? – by Dr Neeraj Nagpal

Monday, December 15, 2014

by [Dr Neeraj Nagpal](#)

Providing employment to its youth and providing health to its citizens are two responsibilities no government can avoid. Since none of these objectives can be achieved with the meagre resources, which are allotted to them, our political masters come up with innovative schemes whereby these goals may seem to be fulfilled without the government having to spend any money. These schemes help the government to claim that they are pro people when they seek votes. ‘Health for all’ or ‘Health Degree for all’ we need to decide what is our slogan and then we should all strive to achieve it. Our leaders who promote quackery in India themselves rush to the top most specialists of modern medicine, preferably at the cost of exchequer, abroad for their own even minor ailments.



Dr Neeraj Nagpal

Promoting quackery by training 1 lakh matriculates for one month to become proficient in the practice of primary care and giving first aid is one such hair-brained scheme recently floated by Punjab Government. Once licensed to practice modern medicine and give first aid it is logical to expect them to start small clinics in rural areas and suburban slums as “Doctors”. The government does not have to spend any money to employ these youth and simultaneously can claim that it is providing 1 lakh healthcare providers to its citizens. The problem arises when some rational citizen asks a question: “How can someone who is trained for one month provide services similar to someone qualified after five and half years training?”

Now the union government is reportedly planning to introduce ‘The Recognition of New Systems of Medicine 2014 Bill’ to recognize practitioners of electro homeopathy and other similar systems as recognized systems of medicine. Within a few years these practitioners will soon become another army of “Doctors” who will be treating patients with modern medicine. BSc (Community Health) is another three-year programme of rural doctors in modern medicine which is on the anvil.

There are other ways the government achieves this goal, one example of which is promoting and authorizing those who are qualified in alternate systems of medicine to practice modern medicine as they have done in Maharashtra and are trying to do so in Haryana. Punjab Medical Council does not act against such crosspathy despite evidence provided to it. It is a worst kept secret that alternative medical systems and the so-called AYUSH do not work in majority of medical situations. This is the reason why all AYUSH practitioners prefer to use the modern system of medicine to treat patients. The honourable Supreme Court in the case of Mukhtiar Chand vs State of Punjab and also in the case of Bhanwar Kanwar vs Dr R K Gupta has penalized Ayurvedic doctors for using allopathic drugs. In the case of Poonam Verma vs Dr Ashwin Patel the SC held that “A person who does not have knowledge of a particular system of medicine but practices in that system is a quack and a mere pretender to medical knowledge or skill, or to put it differently, a charlatan”. The government, however, still promotes this crosspathy because to be successful entrepreneurs without need of government jobs, the AYUSH doctors need to practice modern medicine. If the government were to concede the demand of MBBS doctors that crosspathy should not be allowed it would have an army of AYUSH unemployed at its hands.

There is also the issue of colleges awarding MBBS degree like Chintpurni and many others being derecognized by the Medical Council of India (MCI). This is despite the fact that the infrastructure and faculty in these colleges is much better than the best AYUSH college in the country. The training is far more rigorous and standards high for those who opt for MBBS over any AYUSH degree. In fact, those qualifying through common pre medical entrance examinations opt for MBBS course even in the worst college, followed by Dental and then by AYUSH courses in the best colleges. The reason why MBBS was the first choice of students opting for a medical course was because modern medicine is the only recognized system of medicine worldwide which is well researched and reproducible. Homeopathy has been proven to be no better than placebo and declared so by many governments in Western countries and in Australia. Our question is simple that since graduates are permitted to practice modern medicine by the government why are norms for colleges granting MBBS degree so stringent? Why should not their norms be reduced to match any AYUSH degree college since both have to practice modern medicine only?

Reducing medical training in modern medicine to the level of technical and skill training like for plumbers, electricians and automobile mechanics as imparted by ITI (Industrial Training Institute) and similar institutions is the

prerogative of any government. Our request, however, is very simple. There is no point our training MBBS graduates, using stringent international training programmes, who are valued and can practice and earn their livelihood abroad but not in this country.

Our suggestion, under the circumstances, is that we should have only one graduate medical degree BISMS (Bachelor of Indian System of Medicine and Surgery) in which a limited training and exposure to modern medicine be provided to those who graduate, sufficient to make them good general primary care physicians. Scrap all other degrees like MBBS, BAMS, BUMS, BHMS and so on and so forth. All institutions providing any of these degrees should henceforth be brought under a National Health University which would award only BISMS. Criterion for setting up colleges for award of this degree should be reduced from stringent criterion as laid down by the MCI and should be similar to that of any electro homeopathy or AYUSH college as exists today, graduates of which are sought to be permitted to practice modern medicine by the government. In postgraduation Ayurveda, Homeopathy, Unani, Sowa Rigpa, Yoga, Electro-homeopathy may then be introduced to promote genuine research in these areas, as the government desires.

Dr Neeraj Nagpal
Convenor, Medicos Legal Action Group
Ex-President, IMA Chandigarh

Don't Force young doctors to serve in rural areas

Wednesday, October 8, 2014

The acute shortage of doctors in India, especially in rural areas, is a nuisance for the government, a problem that has not been successfully tackled till now. The forced compulsion of one year of rural service after five and a half years MBBS course, just to be merely eligible to apply for a PG seat is however a futile, ineffective and vastly unpopular method to fill this shortage. The primary reason being no priority was given to students voluntarily opting for rural service, in PG entrance exams. Also worse, it would made it much more difficult for them to prepare for the PG entrance test when they are in a very demanding job without adequate facilities. Not surprisingly, the new government has decided to scrap the proposal of one-year compulsory rural-service after completion of MBBS and asked the Medical Council of India (MCI) to include it instead as a part of the PG course.

But that alone is not the solution. There has been a nationwide agitation under different banners like 'Save the Doctor' and 'Doctors for Villages' etc with medical students and established doctors from premiere medical colleges, hospitals protesting actively against numerous other problems which are evident even to the common man with average intelligence. Lack of proper infrastructure at primary health centres (PHCs), unhygienic sanitation, shortage of medicine and emergency equipment, malfunctioning labs, absence of lab assistants, nurses and experienced doctors for mentoring, adequate security of female doctors, deprivation of residential quarters due to unavailability etc are the most common and undeniable laggings which require immediate addressing.

There is undoubtedly an utter dearth of qualified allopathic doctors throughout the country. Considering the norm of one doctor per thousand, there should be a minimum of 12 lakh doctors for 120 crore Indians. However, currently there are only around 7 lakh allopathic doctors in India. There are just a meagre 32,000 sanctioned posts of MBBS doctors roughly with 50,000 new MBBS graduates every year. The government needs to find a permanent solution for this immense shortcoming instead of making scapegoats out of budding doctors. Temporarily posting them in rural areas will not serve any purpose unless they willingly subscribe to the same.

Various methods can be tried and tested to resolve this issue at hand. There were suggestions to start a new three-year BSc-CH (Community Health) degree course, whose graduates would serve in rural areas. This was vehemently opposed by doctors and experts alike, and correctly so, because promoting MBBS for urban people and BSc-CH for rural population is not a great idea, as it may create double standards in treatment culture, which can lead to utter chaos and confusion.

Even the new government's latest decision to introduce one-year compulsory rural service as a part of the postgraduate medical course is not without its flaws. This is opposed on the ground that for one year, the PG students would be deprived of studying, acquiring skills that would help them later practice as a specialist. Also, many PHCs, by their very nature, won't provide avenues for PG students to learn or practice their specialized skills. Further, if we increase the PG course duration by one-year, it will unnecessarily lengthen the study duration which is already more

than nine years - five and half for MBBS and three for PG, not to mention the years spent between the two for PG entrance test preparation. The seemingly ever-declining interest of school students in medicine as a career option will only be further bolstered by such measures.

Another idea is to start 50-seat MBBS medical colleges at district level by upgrading the existing district hospitals and train the students mainly as general practitioners (GPs) in a way to make them more suitable for the local needs. This will address the uneven spread of medical colleges in the country, bring more doctors in the system and encourage the medical students to learn more about the diseases/problems at the local level. If necessary, these seats may be reserved for meritorious students within the district so that they continue to serve locally. A major concern in this regard is finding enough teachers for these medical colleges. However, it should not be much of a problem for clinical subjects, as district hospitals already have necessary doctors. For the non-clinical subjects like Anatomy, Pharmacology etc one teacher might be assigned to 2-3 adjoining district medical colleges with travelling/accommodation allowances etc. The conduction of supervised video lectures from experts all over the country may also be probed and adapted depending on results and response.

For achieving the same, a substantial amount of the financial budget needs to be allotted and expended for a complete makeover of the medical facilities, thus popularizing the desire of doctors all over to happily serve wherever they are posted. This should not be too much of an ask, especially when we have been spending almost twice the money allotted to the health sector for minority welfare, around 20 times for the agriculture credit scheme and much larger amounts for urban development and loan waivers. However, it remains to be seen whether these old political gimmicks are finally abandoned and the real problem at hand is dealt with once and for all amidst innumerable promises.

Categories: EDITORIAL

Tags: [BSc-CH](#), [Compulsory Rural Service](#), [Doctors for Villages](#), [GP](#), [MBBS](#), [MCI](#), [Mini Medical Colleges](#), [PHC](#), [Save the Doctor](#), [Shortage of Doctors](#)

HEALTHCARE QUALITY & ACCREDITATIONS NEWS

of conduct for hospitals, nursing homes soon

Monday, September 22, 2014

by [Vidhi Rathee](#)

New Delhi: Soon hospitals and nursing homes discriminating against patients on the basis of their socio-economic status, overcharging them, taking cuts from pharmaceutical companies or denying treatment to poor patients will be under scanner of the Indian Medical Association (IMA).

The largest voluntary organization of allopathic doctors is framing self-regulated code of conduct for hospitals and nursing homes in order to curb the increasing corruption and bribes in the sector.

The codes, which were deliberated at the 44th national conference of the IMA held recently in Mumbai, will be broadly based on four principles - Safety Norms, Quality, Affordability and Accessibility.

Dr K K Aggarwal, senior national vice-president, IMA, told India Medical Times, "As of now, there are no code of conduct for hospitals and nursing homes. They function freely and indulge in such practices that lower the confidence of a patient in the sector. Keeping that in mind, we decided to clearly notify what is "ethical" and what is "unethical" for a hospital or a nursing home to do, leaving a little room for confusion. We are doing this with the help of Association of Healthcare Providers (India)."

"The codes will be self-regulatory, any hospital or nursing home found working against the codes or indulging in unscrupulous practices will be barred from the (IMA) membership," he said.

Dr Niteen V Dhepe, medical director, SkinCity Postgraduate Institute of Dermatology, Pune, told India Medical Times, "As far as implementing code of conduct to curb unethical practices is concerned, it is a right step but if these codes of conduct are meant to direct financial functioning of a hospital, they will be imposed rather than self-regulated."

“Treating the underprivileged and providing health services to the poor should be the supreme responsibility of the state. Putting that as a moral obligation on private hospitals is like shrugging off its responsibility onto someone else. The rules should be in good spirit and not contradictory to the system. Overarching codes will diminish a level playing field,” he added.

Part 1 Part Head

~~According to reports, the codes will also include suggestions like including patient friendly exercises and special programmes and facilities for elderlies in a hospital. Preference for generic drugs, preparation of a list of NGOs and philanthropists whom patients can approach for help, will also find a mention in the codes.~~

Dr Kamal Mahawar, senior consultant in bariatric and metabolic surgery, Indraprastha Apollo Hospitals, New Delhi, told India Medical Times, “This is a step in the right direction. These codes will help guide hospitals to tread their way ethically. Overcharging patients is totally wrong and taking huge commissions and a cut from pharmaceutical companies is a matter of disgrace.”

“Also, doctors advertising about their private practice is not fair. Let’s hope these codes bring some uniformity across hospitals and nursing homes in India,” he said.

by Vidhi Rathee

Update

IMA has constituted a committee of six members to draft a Bill within one month in which they are requested to incorporate the punishment to be given to the owners of health institutions and diagnostic centres. The names of the committee members are: Dr Narendra Saini, Dr Vijay Agarwal, Dr K K Aggarwal, Dr Alex Thomas, Dr Y P Munjal and Dr Devi Shetty. Dr Vijay Aggarwal will be the convener of this committee. [Source: eMedicalNews]

New Delhi-based medico-legal expert Dr M C Gupta has made an interesting observation on this development. He writes:

“The idea is great.

However, it raises a great question:

i)-The code of conduct for hospitals, as yet non-existent, is supposed to be self-regulatory without force of law. The IMA proposes to bar from membership those who violate the code. Wonderful!

ii)- The code of conduct for physicians, promulgated in 2002 as the “MCI Code of Ethics Regulation”, which has force of law, is often violated by members of the IMA but the IMA has never cancelled their membership.

QUESTION-Why should one take seriously the IMA’s statement that the IMA membership of those who violate a legally un-enforceable self-regulatory code of conduct will be terminated when the IMA does not terminate the membership of those who violate the legally enforceable 2002 regulations?

NOTE-The only instance that I know of where a show cause notice of termination has been issued during recent years is the case of Dr K V Babu, who has violated no code of conduct.

Will the IMA answer the above question?” [Source: Quality of Medical Education]

Categories: Healthcare Quality & Accreditations, NEWS