ALL INDIA LAW DIGEST 2016
(STATUTORY DIARY)
BOOK REVIEWS/JOURNAL

DISTRUST IN MEDICAL PROFESSION – AN EMOTIVE MISTRUST

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1. Introduction

'All professionals are not idealists' – may not be an amazing lie. Knowledge, science and education may bring with them impatience, obstinacy and violence as a result of misguided belief and mislead trust. On many occasions, 'service' may be rewarded with victimization, loss of reputation and mental and physical injuries. 'To err is human' - phantom visits all organic activities of human business of all segments of life. But every error may not be the result of greed, negligence and professional culpability. To intimidate medical profession by the force of one's own apprehensions and brute strength will boomerang and annihilate the very source of remedy not only for body but also to the mind. Recent incidents of attacks on medical professionals, both nationally and globally, raised concerns of medical services which need an immediate and multi-focal solutions and corrective actions.

Even in advanced, civilized and developed western societies, physicians are increasingly unhappy with their once-vaunted profession, and that malaise is bad for their patients. It may not be a medical morose, but unattended, it may become morphogenic melancholy. The relationship between a doctor and patient is not morganatic but of a natural trust and confidence mutually reposed. Such a reciprocal belief reposed in the human kind has been sustaining the balanced existence of pain and relief of humanity.

2. Professional discomforts and mass violence

Doctors fidgeting to the labs, operation theatres and patient rooms certainly signify the pressure thrust upon them by the ailing patients and their beloved family members. Family members' love for the patients is really invaluable and immeasurable but not at the cost of the patience of the doctors. Such over-zealous and irrational attachment of love for patients exhibited by kith and kin becomes self-destructive and may devastate the system of medical profession itself.

Even American world of doctors are found to be impatient, occasionally indifferent,

at times dismissive or paternalistic, struggling with the loss of their professional ideals. A majority of doctors express diminished enthusiasm for medicine. In a 2008 survey of 12,000 physicians, only 6% described their morale as positive. Eighty-four percent said that their incomes were constant or decreasing. Most said they didn't have enough time to spend with patients because of paperwork, and nearly half said they planned to reduce the number of patients they would see in the next three years or stop practicing altogether[1].

In the halcyon days of the mid-20th century, American medicine was also in a golden age. Life expectancy increased sharply (from 65 years in 1940 to 71 years in 1970), aided by such triumphs of medical science as polio vaccination and heart-lung bypass. Doctors largely set their own hours and determined their own fees. Popular depictions of physicians ("*Marcus Welby*," "General Hospital") were overwhelmingly positive, almost heroic. Now the situation appears to be disheartening and diminishing[2].

Medical advances have transformed once-terminal diseases—cancer, AIDS, congestive heart failure—into complex chronic conditions that must be managed over the long term. Physicians also have more diagnostic and treatment options and must provide a growing array of screenings and other preventative services.

Health stories of Ebola, new food nutrition label rules and the debate on the right to die dominated 2014 and 2015. In 2015, hundreds of health workers died in conflict zones, or while fighting diseases such as Ebola. In Yemen, five health workers were killed and 14 injured in June alone. In West Africa, of the 875 health workers infected with Ebola, 509 died, and Zika started threatening the globe in 2016. All these challenges emboldened the medical professionals to raise about all sorts of barriers, but their valour of service is often scuttled by non-medical human emotive factors – chiefly attacks on doctors, hospital staff and hospital properties. No part of our country is spared from such attacks on the medical personnel.

Referring to the spate of attacks in Tamilnadu during the first two months of 2015, the President of Indian Medical Association expressed concern that doctors and hospitals have become the targets of anti-social elements to gain mileage out of the emotional, physical and financial strength of relatives. He further stated that it is sheer foolishness to blame the doctors and hospital for all deaths that occur in hospitals, and one can never assure 100% success rate in all the medical procedures that are performed in a hospital.

There is a diagonally opposite counter from the public that most of the doctors never consider their profession as a noble one; and display money-mindedness; professional commitment and integrity at the lowest ebb; subject the patients for unnecessary tests to make money and alleged tie-up with drug manufacturers and clinics for tests *etc.*

The roaring dissent and protest of The Maharashtra Association of Resident Doctors (MARD), against the increasing number of attacks on healthcare professionals, received a shot in the arm following the World Health Organisation's (WHO) decision to espouse the cause, and to initiate remedial measures. It is reported that during 2014, WHO received reports of 372 such attacks in 32 countries, resulting in 603 deaths and 958 injuries[3].

1. Dr. *Sandeep Jauhar*, Why Doctors Are Sick of Their Profession, The Wall Street Journal-www.wsj.com/.../the-u-s-s-ailing-medical-system-a-doctors-perspective-1
2. ibid
3. http://www.dnaindia.com/mumbai/report-who-takes-up-issue-of-attack-on-doctors-2115127

The Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2009, which treats any act of violence against doctors, medical staff and medical establishment as a non-bailable offence, carrying imprisonment upto three years and a fine upto Rs.50,000/- so far remained as paper tiger. The Act also provides that the offender shall have to pay twice the amount of damage or loss caused to the property as compensation. Unfortunately, most of the people working in health care and police department are not properly acquainted with the significance of this protective legislation[4].

During November, 2015, a house surgeon in the Casualty Department of KGH, Visakhapatnam, was allegedly assaulted by family members of a patient in the wee hours of Friday. The doctor lodged a complaint with the One Town Police, who took four persons into custody by the evening[5].

The Andhra Pradesh Government in December, 2007 stamped its approval on an ordinance making assault on doctors a non-bailable offence, making attacks on doctors, nursing staff or any paramedic a non-bailable offence and the guilty could be sentenced to three years imprisonment[6].

A recent study undertaken by the Indian Medical Association (IMA) revealed that Indian doctors are at rising risk in the workplace due to the angst of distressed relatives, that over 75 percent of doctors in India have faced some form of violence at work, maximum violence is faced by the doctors when providing emergency services, with as many as 48.8 percent of such incidents reported from Intensive Care Units (ICUs) or after a patient had undergone surgery, and the attacks on doctors occurred during peak or visiting hours and the incidents varied from "physical assault" to verbal abuse but aren't reported unless physicians perceive some risk to their life. Delay in attending to a patient, request of advance payments, or withholding a deceased body until settlement of final billing are a few of the reasons why angry relatives tend to lose their temper and attack doctors[7].

Violence against doctors and other medical practitioners in China has been reported as an increasing problem[8]. National Ministry of Health statistics indicate that the number of violent incidents against hospitals and medical staff increased from about 10,000 in 2005 to more than 17,000 in 2010[9]. A survey by the Chinese Hospital Association reported an average of 27.3 assaults per hospital per year in 2012, up from 20.6 assaults per hospital per year in 2006[10]. In 2012, an editorial in *The Lancet* described the situation as a "crisis" for the practice of medicine in China[11]. Dr. *Michael Davidson*, forty-four year old Director of endovascular cardiac surgery at Brigham and Women's Hospital and father of three young children (Aged 9, 7 and 2) was killed in cold blood

4. http://www.dnaindia.com/mumbai/report-who-takes-up-issue-of-attack-on-doctors-2115127
5. http://www.newindianexpress.com/states/andhra_pradesh/Doctor-Attacked-by Patient%E2%80%99s-Kin/2015/11/07/article3117218.ece
6. http://archive.indianexpress.com/news/ap-ordinance-to-make-attack-on-doctors-nonbailable/251381/
7. http://www.firstpost.com/india/save-others-lives-or-their-own-75-doctors-in-india-face-violence-at-work-says-study-2226444.html)
8. Hesketh, T.; Wu, D.; Mao, L.; Ma, N. (7 September 2012). "Violence against doctors in China". BMJ 345 (sep07 1): e5730. *doi:10.1136/bmj.e5730. PMID 22960376*.
9. "Violence against doctors: Heartless attacks". The Economist. *Jul 21, 2012*. Retrieved 2 November, 2013.
10. Burkitt, Laurie (August 16, 2013). "Violence Against Doctors on the Rise in China". The Wall Street Journal. Retrieved 2 November 2013.
11. Ending violence against doctors in China". *The Lancet* (editorial) 379 (9828): 1764. 1 May 2012. *doi:10.1016/S0140-6736(12)60729-6. PMID 22579308*.

by gunman *Stephen Pasceri*. Dr. *Davidson* had treated *Pasceri's* seventy-nine-year-old mother and apparently there had been some complication and she had died. *Pasceri*, blaming her physician walked into the hospital, sought Dr. *Davidson* out and shot him in cold blood in the very clinic where he used to treat patients.

In September 2013, a lady doctor on call at the Lok Nayak Hospital in Delhi was physically assaulted and apparently threatened with rape by a patient's kin. Her crime: two patients had come in at the same time and she had attended to the sicker patient first, which allegedly upset the other patient's relatives. Earlier this year, 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.

There is an increasing expectation from patients that with modern medicine and technology, a doctor should be able to guarantee a good outcome[12].

3. Should pain overtake reason?

The doctor-patient relationship is a fiduciary relationship governed by high standards of morals and ethics. No doubt, the concepts of "Confidentiality" and "Lack of Informed Consent" violating patient's body being construed as 'medical negligence' in addition to "Duty of Care", it becomes imperative to distinguish between "Medical Negligence" and "Medical Error", the former being not venial and the latter subjected to correction. In this connection, the sane guidelines laid down by our apex Court in many cases are worthy of implementation. The case of *Ms. Ins. Malhotra v. Dr. A. Kriplani and others*, (2009) 4 SCC 705 which referred to cases of *Martin F. D'Souza v. Mohd. Ishfaq,* CA No.3541/2002 decided on 17th February, 2009 and *Jacob Mathews v. State of Punjab and others*, (2005) 6 SCC 1, provides reasonable insight into this aspect, to be carefully followed by the society to ward off unnecessary indictment of doctors for impractical reasons.

Persons who offer medical advice and treatment implicitly state that they have the skill and knowledge to do so as they have the skill to decide whether to take a case, to decide upon the likely course of the treatment, and to administer that treatment, creates an "implied undertaking" on the part of a medical professional (*Venkatesh Iyer v. Bombay Hospital Trust*, 1978 (2) TAC 820 (Bom.)). Doctors in India may be held liable for their services individually or vicariously unless they come within the exceptions specified in the case of *Indian Medical Association v. V.P. Shantha*, AIR 1996 SC 550.

However, there are inherent drawbacks in the adjudication of medical negligence cases by the Court:

1. Judges are not experts in medical science, but rather are lay men. Their dependence on the testimony of other expert doctors also proves defective which may tell upon objectivity and the perfect veracity of the version. Medical testimony is a complicated and technical subject for the knowledge of non-medical judicial minds.

2. Failure to find appropriate distinction between 'medical negligence' and 'medical error' often misleads the judicial reasoning since medical negligence and medical error are found to be inextricable or overlap.

Indiscriminate proceedings and decisions against doctors are counterproductive (*Martin*

12. Sudhir Naik, President of the Association of Medical Consultants http://www.latimes.com/world/asia/la-fg-india-doctor-attacks-20150826-story.html

F. D'Souza v. Mohd. Ishfaq, CA No.3541/ 2002 decided on 17th February, 2009). The view in *Bolam's* case (*Bolam v. Friern Hospital Management Committee*, (1957) 1 WLR 582), was accepted in India in the landmark case of *Suresh Gupta v. Govt. of NCT of Delhi and another*, (2004) 6 SCC 422. However, that case got referred to a Larger Bench of the Supreme Court and finally in the *Jacob Mathew v. State of Punjab*, (2005) 6 SCC 1 and *Shiv Ram v. State of Punjab*, AIR 2005 SC 3280.

In India, after *Pt. Paramananda Katara v. Union of India's*, AIR 1989 SC 2039, in the context of emergent care of medico-legal cases, it was clarified that every injured citizen brought for medical treatment should instantaneously be given medical aid to preserve life and thereafter the procedural criminal law should be allowed to operate in order to avoid negligent death. Similarly, a doctor can provide medical treatment to a child or a person of unsound mind in the absence of parental consent in an emergency basing on the principle of necessity, and taking the spirit of the *Gillick* case (*Mr. 'X' v. Hospital 'Z'*, 1999 CTJ SC (CP)). Though Indian law is not clear on this issue, still exigency may persuade the doctor to disregard parental prohibition. Even in such cases, if arguments of 'medical negligence' are entertained, then catastrophic results ensue in the civilized societies.

Since the 1970s, the growing influence of ethics in contemporary medicine can be seen in the increasing use of Institutional Review Boards to evaluate experiments on human subjects, the establishment of hospital ethics committees, the expansion of the role of clinician ethicists, and the integration of ethics into many medical school curricula[13].

Further, the institute of Medicine as a profession would not subscribe to the means of defiling the institute of human rights or ethical and moral base of the society. For example, The Task Force on Preserving Medical Professionalism in National Security Detention Centers concluded that since September 11, 2001, the Department of Defence (DoD) and CIA improperly demanded that U.S. military and intelligence agency health professionals collaborate in intelligence gathering and security practices in a way that inflicted severe harm on detainees in U.S. custody[14].

Rapid developments in the medical field in the last century have revolutionized the field of medical practice. It is now possible to diagnose diseases faster and more accurately using advanced diagnostic techniques. Medical management has become more effective with refined medications having more specific actions and fewer side effects. Surgical treatment has moved towards less invasive modes of management with lesser morbidity and faster recovery. Among all these developments, the medical profession in India is at crossroads facing many ethical and legal challenges in the practice of the profession. The medical fraternity is becoming more and more dependent on technology and market forces tend to influence decision making by the doctors. The fundamental values of medicine insist that the doctor's obligation is to keep the patients interest above everything else. The important issues of autonomy, confidentiality, justice, beneficence, and non-malfeasance are key factors that should guide the daily decision making by the doctor[15].

It leaves no doubt or suspicion that right from the Hippocratic's oath, medical ethics and regulations of Medical Council on the

13. Lakhan SE, Hamlat E, McNamee T, Laird C (2009). "Time for a unified approach to medical ethics". Philosophy, Ethics, and Humanities in Medicine 4 (3): 13. doi:10.1186/1747-5341-4-13. PMC 2745426. PMID 19737406.

14. http://imapny.org/medicine-as-a-profession/interrogationtorture-and-dual-loyalty/

15. Joseph Thomas, Ethical and Legal Issues in Medical Practice, Indian Journal of Urology : IJU, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2779956/)

professional conduct of doctors and other health care workers to castigating Court commands on the medical services, enough control measures and guidelines on medical profession exist abundantly, and there is no need for the society to let loose violence on one or two medical mishaps that may crop up involving no intentional and dishonest malice of medical staff.

4. Medical melodrama in modern societies

For all the angst over medical malpractice litigation in developed countries like the United States, very little has been written about it in the developing world[16]. Developing countries account for more than 80% of the world's population, but they are often an after-thought in comparative health law literature[17].

One treatise of *Timothy S. Jost*[18] referred to the state and fate of medical malpractice in Canada, the United Kingdom, France, Germany, Japan, and Australia, and also materials and case law from China, Haiti, India, Peru, and Venezuela, among others, but focusing mostly on the countries listed in the text. Another notable source is the "International Encyclopedia of Medical Laws"[19] which includes monographs on several developing countries including China, Hungary, Malaysia, Peru and Uruguay. Developing countries have different health policy predicaments that require their limited attention and resources. Developing countries may not have the luxury of worrying about medical malpractice[20].

Some of the factors that contribute to the medical malpractices are given below:

(1) Poverty:

Poverty is perhaps a meta-factor that belies many of the problems[21]. Developing countries struggle with poverty and resource constraints in a way that developed countries simply do not. Indeed, lower income countries often lack the basic resources "to afford even some of the most effective care." India, in spite of being tagged as 'developed country', is subjected to the same fate of just developing countries.

(2) Other Health Priorities:

Developing countries are often beset by other health policy priorities, which can relegate patients' rights to a secondary or even tertiary concern. HIV/AIDS, malaria, SARS, swine flu, and other infectious diseases plague countries like India, China, and many African nations.

(3) Scarcity of Physicians:

Developing countries often struggle with very low ratios of health care professionals to the general population, which likely contributes to the reluctance to over-regulate them. The World Health Organization (WHO) identified fifty-seven countries that face crisis-level shortages of health care professionals, many of which are low-income, developing countries. These countries have an average of 1.1 doctors per thousand residents, compared to 13.2 in the United States.

(4) Immature Health Care Systems:

Developing countries often have immature, underdeveloped health care systems. Their public insurance schemes are often weak and underfunded, leading to significant out-of-pocket spending. According to a survey of Mark Pauley, out-of-pocket

16. Dieter Giesen, International Medical Mal-practice Law
17. 218 Drexel Law Review. Vol.4:217
18. Readings in Comparative Health Law and Bioethics (2nd. Edition – 2007)
19. Herman NYs. Ed.2010
20. Nathan Cortez, *International Health Care Convergence: The Benefits and Burdens of Market-Driven Standardization*, 26 WIS. INT'L L.J. 646, 693 (2009).
21. *Julie M. Feinsilver*, Cuba as a "World Medical Power": The Politics of Symbolism, 24 LATIN AM. RES. REV. 1, 4–6 (1989).

spending ranged from 38% to 84% of all health care spending, with many countries in the 50–60%, whereas the out-of-pocket spending accounts for just 13% of all health spending in the United States.

(5) Regulatory deficits:

The functioning of regulatory bodies in developing countries cannot match with the standards of the functioning of developed countries. For example, in India, the regulatory bodies like Medical Council of India, Consumer Rights Commissions *etc*., could not function to the satisfaction of the public either in regulating the medical services, drugs manufacturing *etc.*

(6) Insignificant Private Insurance Markets:

An underappreciated regulatory deficit in developing countries is the lack of a robust private health insurance market. Private insurance can act as a channel for regulation. In developed countries like the United States, both public and private insurers often use their contracts with health care providers to "pursue regulatory objectives" such as patient safety and quality outcomes. Insurers often leverage their purchasing power to protect their customers-patients.

In contrast, providers in developing countries often lack such incentives. A study of India and China found that private insurance is an "underused" regulatory mechanism in both countries. As noted above, a large chunk of health spending in these countries is out-of-pocket. In India, "only 3–5% of Indians are covered by any form of health insurance."

(7) Weak Civil Societies:

If a country cannot regulate its health practitioners—or if its efforts are not legitimate, institutionalized, and above all enforced, then the public might fall back on civil society and civil institutions for support[22]. Unfortunately, many developing countries lack strong civil societies to account for their regulatory deficits. The media can be crucial at uncovering and raising public awareness of medical negligence, and fortunately, some developing countries, such as India, have a relatively strong media. But not all developing countries can count on their media in such a manner. In addition, the media often relies on Court decisions and other formal adjudications to inform them of medical malpractice. Accordingly, such circumstances amplify the need for patients in developing countries to have a genuine avenue for redressing their medical complaints[23].

(8) Patients as Regulatory Sentinels:

Rounding out this picture, patients in developing countries are less equipped than patients in the developed world to act as regulatory sentinels, uncovering and reporting medical negligence. Patients in these countries are less able to access, process, and understand information about the medical care they receive. Patients in poverty are even less likely to have the requisite literacy, education, and financial resources to challenge their doctors. Some believe that medical professionals unethically exploit these imbalances. If patients cannot appraise the quality or value of the care they receive, then they are much less likely to serve as early sentinels. Developing countries thus lack a key layer of patient surveillance on practitioners.

Compounding matters, residents of developing countries may be reluctant to sue because they are either unaware of their legal rights, feel powerless to invoke their legal rights against medical professionals or institutions, or have other cultural aversions to litigation. There is significant reluctance to

22. *Jennifer Prah Ruger*, *Global Health Governance and the World Bank*, 370 LANCET 1471, 1473 (2007).

23. 226 Drexel Law Review [Vol. 4:217]

sue, widespread distrust in Courts, and general atmospheres that seemed to reinforce these misgivings rather than counteract them[24].

5. Fair admission

In fair and honest admission, the observation cited in Section 4 are universal and find firm stay in Indian scenario too. Keeping in view of the reasonably developed system of medicine, hospital managements and functional overview medical institutions and professionals by statutory bodies, and particularly backed by cogent judicial pronouncements which balance the interests of the service providers and service receivers *i.e.*, doctors and patients objectively and in the interest of society and State, remedial tools in civil, criminal and consumer regimes, it cannot be accepted that an aggrieved family member of an ill-fated patient be excused for his emotive outburst and violence against the medical staff. Attention on the following aspects is a need of the time:-

(i) The provisions of the statutes like The Maharashtra Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2009, and Andhra Pradesh statute of 2008 should be strictly implemented.

(ii) The penal provisions must be more severe, that the sentence extending upto 7 years and the fine upto Rs.One lakh should find place in the Statutes, and award of punitive damages for property damaged by the accused/assailants.

(iii) There must be a State regulation directing fixing of C.C. cameras in all blocks of hospitals to watch the performance of the hospital staff and to identify the miscreants in case of any attack.

(iv) A time-bound disposal of the grievances shall be guaranteed legally in all spheres of dispute resolution.

Idealism of Medical Service is not to be represented in the form of professional mendicancy.

"Always laugh when you can. It is cheap medicine."— Lord *Byron*

DISCOVERY OF TRUTH IS ONLY BY EVIDENCE

By

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Evidence includes everything that is used to determine or demonstrate the truth of an assertion. Giving or procuring evidence is the process of using those things that are either (a) presumed to be true, or (b) which were proved by evidence, to demonstrate an assertion's truth. Evidence is the currency by which one fulfills the burden of proof.

In law, the production and presentation of evidence depends first on establishing on whom the burden of proof lays. Admissible evidence is that which a Court receives and considers for the purposes of deciding a particular case. Two primary burden-of-proof considerations exist in law. The first is on whom the burden rests. In many, especially Western, Courts, the burden of proof is placed on the prosecution. The second consideration is the degree of certitude proof must reach, depending on both the quantity

24. *Nathan Cortez*, A Medical Malpractice Model for Developing Countries, (2011) https://drexel.edu/~/media/Files/law/law%20review/...2011/Cortez.ashx?