IMA National Satyagreh November 16, 2015

(1700 Branches, 100000 Doctors to Protest)

9.00 A.M. to 11.00 A.M.: Community Service
11.00 A.M. to 12.00 P.M.: Road March & Memorandum

1. Child (Female Feticide / PCPNDT Act)
2. Crosspathy
3. Capping on Compensation
4. CEA: Clinical Establishment Act
5. Criminal Violence / Assault against Doctors

PCPNDT AMENDMENT:-

- The Act has failed to show desired results, rather is backfiring all directly / indirectly, doctors are facing hardships & humiliation. Desired amendments are required urgently.

CROSSPATHY & B.Sc. COMMUNITY HEALTH:-

- Writing Prescription drugs by Non-MBBS people is dangerous to the health of the people.
- We oppose B.Sc. Clinical Health Course, the "Half Baked Doctors". It is a cruel joke to rural patients. It is Govt. sponsored quackery
- Encourage allopaths to serve in rural areas.

CAPPING:-

- Capping on compensation in alleged negligence cases to save doctors from financial terrorism

CLINICAL ESTABLISHMENT ACT:-

- Make amendments for survival of Single Clinics & Small Healthcare Establishments

CRIMINAL VIOLENCE / ASSAULT ON DOCTORS:-

- Central Act needed with deterrent punishment for those attacking Doctors, Health Staff and Hospitals.

AYUSH prescribing modern medicine drugs is injurious to the health of the public

Central Government is envisaging starting one year course for AYUSH doctors and allowing them to practice modern medicine. IMA attended a meeting convened by the Secretary, Ministry of Health and Family Welfare, Govt. of India on 22nd January, 2015 in his office at 6.00 P.M.

Mainstreaming of AYUSH doctors: Back Ground Note by the ministry

The Doctor Population Ratio as per WHO norms should be 1:1000, in India it is 1:1674. Thus, there is overall shortage of doctors in the country which is more pronounced in rural areas. As per MCI, the total number of doctors in India as on 30.09.2014 is 9.32 lakhs. There are 6,86319 AYUSH practitioners in the country out of which 4,46,051 are ASU doctors.

Section 15 of the Indian Medical Council Act, 1956 states that no person other than a medical practitioner enrolled on a State Medical Register shall practice medicine in any State. Any person who acts in contravention of this shall be punished with imprisonment of 1 year or fine of Rs 1,000 or both.

In the case of Dr. Mukhtiyar Chand us State of Punjab, the Hon'ble Supreme Court held that practice of modern system of medicine by ISM qualified professionals is possible provided such professionals are enrolled in the State Medical Register for practitioners of modern medicine maintained by the State medical Council. The respective State Government can notify and give recognition to qualifications eligible for registration in the State medical Register.

The Ministry requested all the State governments vide letters dated 29th May,2013 and reminders dated 20th Novembers, 2013 and 19th March,2014 to consider amending their respective State laws relating to registration of practitioners of modern scientific medicine and provide an enabling provision to allow the enrolment of an ISM professional in the State medical Register maintained for registration of the practitioners of modern medicine by the respective State Medical Councils. Comments were received from some of the States, which are as follows:

S.No.	State/UT	Comments
I.	Kerala	Govt. of Kerala doesn't face any shortage of doctors of modern medicine for posting in PHCs as a large number of medical graduates will be passing out from the colleges in the state in the next few years.
II.	Daman & Diu and Dadra & Nagar Haveli	There is no State/UT Medical Council and, hence, no enrolment of practitioners of modern medicine.
III.	Goa	They strongly opposed the matter.

IV.	Rajasthan	Initiating registration of AYUSH doctors in State medical Register will complicate matters and will dilute the efforts of bringing them into the mainstream.

Under NRHM, services of AYUSH practitioners are utilized for providing essential new-born care services, managing common childhood illness, counseling on family planning methods and most importantly, they render their services as Skilled Birth Attendants (SBA).

Department of AYUSH in consultation with National Board of Examination (NBE) prepared one year curriculum, for bridge course to provide competency to ISM doctors to practice modern medicines in a limited way in rural areas. Ministry requested the MCI to vet the draft curriculum; MCI has vehemently opposed the move.

A meeting was convened to discuss the introduction of a bridge course for AYUSH Doctors on 10th September, 2014 in which it was decided that a bridge course may be prepared keeping in consideration the course curriculum of B.Sc.(CH). It was agreed that a 9 months course (6 months regular and 3 months internship) duration may be developed for this purpose.

Department of AYUSH vides their D.O. letter dated 23.09.2014 made the following objections:

a) **The proposal to allow ASU doctors to only dispense and not prescribe modern medicines is not agreeable to them.**

b) It will make ASU doctors subservient to Allopathic doctors.

c) The decision to develop a Bridge Course of 9 months on the lines of B.Sc. (CH) is a unilateral stand of DoHFW.

Now, on 10th November, 2014, Department of AYUSH has been made a separate Ministry with Sh. Shripad Naik, Minister of State (Independent Charge).

Discussion and IMA Point of view

Government wants that Ayush Graduates with a bridging course should be
1. Entitled to practice and prescribe Modern Medicine Drugs
2. Also be entitled to be included in the State Register as registered medical practitioner upon incorporation of necessary enabling provisions in the governing State Act, in the light of pronouncement made by the Hon'ble Supreme Court in Muktiyarchand case.

3. **Rajya Sabha Question on Ayush practicing modern medicine**

AYUSH practitioners prescribing allopathic medicines: Rajya Sabha, information given by the Minister for Health & Family Welfare, Dr. Anbumani Ramadoss in a written reply to a question in the Rajya Sabha.
The matter regarding qualified practitioners of Ayurveda, Unani, Siddha and Homoeopathy systems prescribing allopathic medicines has been examined in depth by the Hon'ble Supreme Court of India in Civil Appeal No.89 of 1987 Dr. Mukhtiar Chand & Others versus State of Punjab & Others.
Representations have been received from time to time on this matter and accordingly Department of AYUSH entrusted the study of the contemporary acts on medical practice in the light of judgement of Hon'ble Supreme Court in 1987 Dr. Mukhtiar Chand & Others versus State of Punjab & Others and other similar judgements. Drugs can be sold and supplied by a Pharmacist or a Druggist only on a prescription of a Registered Medical Practitioner and who can also store them for treatment of patients.

According to Section 2 (ee) of the Drugs and Cosmetics Rules, 1995, Registered Medical Practitioner means a person -

(i) holding a qualification granted by an authority specified or notified under Section 3 of the Indian Medical Degrees Act, 1916 (7 of 1916), or specified in the Schedules to the Indian Medical Council Act, 1956 (102 of 1956); or

(ii) registered or eligible for registration in a medical register of a State meant for the registration of persons practicing the modern scientific system of medicine (excluding the Homoeopathy system of medicine); or

(iii) registered in a medical register (other than a register for the registration of Homoeopathic practitioners) of a State, who although not falling within sub-clause (i) or sub-clause (ii) is declared by a general or special order made by the State Government in this behalf as a person practicing the modern scientific system of medicine for the purposes of this Act.
Hon'ble Supreme Court upheld the validity of Rule 2 (ee) (iii) as well as the notifications issued by various State Governments there under allowing Ayurveda, Siddha, Unani and Homoeopathy practitioners to prescribe allopathic medicines.

In view of the above judgment, Ayurveda, Siddha, Unani and Homoeopathy practitioners can prescribe allopathic medicines under Rule 2 (ee) (iii) only in those States where they are authorized to do so by a general or special order made by the concerned State Government in that regard. Practitioners of Indian Medicine holding the degrees in integrated courses can also prescribe allopathic medicines if any State act in the State in which they are practicing recognizes their qualification as sufficient for registration in the State Medical Register.
KR/SK/95 – RS :

http://pib.nic.in/newsite/erelease.aspx?relid=30117, 20th August 2007

IMA Stand

 In the agenda item No. A-2 (a): MENACE OF QUACKERY, the issue was discussed in the 75th Meeting of the Central Council of IMA held on December 27-28 December, 2014 on Govt. Sponsored Quackery. It was discussed that the Maharashtra Govt. has promulgated an Ordinance permitting AYUSH doctors to practice modern medicine. It was decided that IMA should publicize this as a social evil, malpractice and should take it as a very serious issue. At the same time IMA, along with MCI, should give stringent directions to hospitals and doctors not to appoint AYUSH doctors as RMO / Assistants and strong action taken against those violating the directions".

Provisions in MCI Act Ethics Regulations

Following MCI Code of Medical Ethics and Regulations 2002 dis-allow such practices

1. "7.9 Performing or enabling unqualified person to perform an abortion or any illegal operation for which there is no medical, surgical or psychological indication". The regulations clearly prohibits taking assistance from any un qualified person for surgery, especially abortions.
2. "7.10 A registered medical practitioner shall not issue certificates of efficiency in modern medicine to unqualified or non-medical person": The regulation again clearly talks about that any allopathic doctor shall not appoint any non-allopathic doctor for any allopathic services. As appointing him/her, would amount to issuing a certificate of efficiency in modern medicine.
3. "2.4 The Patient must not be neglected: A physician is free to choose whom he will serve. He should, however, respond to any request for his assistance in an emergency. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving adequate notice to the patient and his family. Provisionally or fully registered medical practitioner shall not willfully commit an act of negligence that may deprive his patient or patients from necessary medical care": The regulation clearly talks about that if there is any emergency, we have to take care of our patients ourselves. We cannot pass on this responsibility to a unqualified persons.
4. "7.20 A Physician shall not claim to be specialist unless he has a special qualification in that branch": The above regulation clarifies that because Ayush Doctors do not have special qualification in allopathy they cannot be treated as allopathic practitioner.
5. "7.19 A Physician shall not use touts or agents for procuring patients": As this regulation we should not use touts or agents for procuring patients. Any non- modern medicine doctor, if assist us in procuring patients, the same will be a violation of the above clause.
6. "7.18 In the case of running of a nursing home by a physician and employing assistants to help him / her, the ultimate responsibility rests on the physician.": This regulation clearly mentions that if any MBBS doctor, appoints any AYUSH Doctor, the responsibility will be of an MBBS doctor and not that of AYUSH Doctor.
7. The Maharashtra FDA has recently issued guidelines regarding prescription where it clearly mentions that another doctor cannot sign on the prescription paper of treating doctor.

THE INDIAN MEDICAL DEGREES ACT, 1916

2. In this Act. **"Western medical science"** means the western methods of Allopathic Medicine Obstetrics and Surgery but does not include the Homeopathic or Ayurvedic or Unani system of medicie and 1(state) means all the territories which immediately before the 1st November 1956 were comprised within Part A State, Part C States.

Provisions in Indian Medical Council Act, 1956

1. Section 2 (f) defines the word 'medicine' as 'medicine means modern scientific medicine in all its branches and includes surgery and obstetrics but does not include veterinary medicine and surgery'.
2. Section 2(a) defines the word 'approved institution' as 'a hospital, health centre or other such institution recognized by a University as an institution in which a person may undergo the training, if any, required by his course of study, before the award of any medical qualification to him'.
3. Section 2 (d) defines the word 'Indian Medical Register' as 'Indian medical registers means the medical register maintained by the council'.
4. Section 2 (h) defines the word '**recognized medical qualification'** as 'recognized medical qualification means any of the medical qualifications included in the schedules'.
5. Section 2 (j) defines the word 'State Medical Council' which reads 'State Medical Council means a medical council constituted under any law for the time being in force in any State regulating the registration of practitioners of medicine'.
6. Section 2 (k) defines State Medical register' as 'State Medical Registers means a register maintained under any law for the time being in force in any state regulating the registration of practitioners of medicine'.
7. Section 11 of the concerned Act deals with the 'recognition of medical qualifications granted by Universities or medical institutions in India' and that 'MBBS qualification recognized by the Medical Council of India with reference to a concerned institution and examining University thereto duly incorporated in schedule A amounts to the registering medical qualification for the purposes of enrolment in the appropriate register maintained by a State medical council or the Medical Council of India as the case may be'.
8. Section 15 of the Act, deals with 'Right of person possessing qualifications in the schedules to be enrolled' and section 15(2) (d) clearly prescribes that **"no person other than a medical practitioner enrolled on a State Medical Register shall practice medicine in any State".**

9. Vide provision included at section 21 the council is duty bound to maintain Indian Medical Register in a prescribed manner which shall contain the names of all persons who are for the time being enrolled in any State Medical register and who possess any of the recognized medical qualifications. The said provision has to be harmoniously read with the provisions incorporated at section23 of the very Act, which deals with 'registration in the Indian Medical Register and mandates that the Registrar of the council may, on receipt of the report or registration of a person in a State Medical Register or on application made in the prescribed manner by any such person, enter his name in the Indian Medical register, provided that the registrar is satisfied that the person concerned possessed a recognized medical qualification'.

10. Resultantly, section 27 of the Act, provides for the 'privileges of the persons who are enrolled in the Indian medical register' to the effect 'that every person whose name is for the time being borne on the Indian medical register shall be entitled according to his qualifications to practice as a medical practitioner in any part of India and to recover in due course of law in respect of such practice any expenses, charges in respect of medicaments or other appliances, or any fees to which he may be entitled'.

11. **Modern medicine can be practiced exclusively by a person who possess recognized medical qualifications included in the appropriate schedule appended to the Indian Medical Council Act and is duly registered with a concerned State Medical Council and resultantly is included in the State Medical Register in terms of the explicit embargo as has been brought out in Section 15(2) (b) of the IMC Act, 1956.** The said position has been fortified in several pronouncements made by the various judicial forums including the one brought out in Poonam Varma vs. Ashwin Patel case by the Hon'ble Supreme Court in 1992.

12. The entitlement of the Ayush Graduates in the State medical register will have another problem. Who shall govern the disciplinary jurisdiction on them in regard to enforcement of ethical conduct and practice as contemplated in the code of medical ethics which is applicable to every registered medical practitioner possessing registering medical qualification in modern medicine?

Supreme Court and CPA Judgments that AYUSH Doctors cannot prescribe allopathic drugs

1. NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION NEW DELHI ORIGINAL PETITION NO.214 OF 1997, "When a patient is admitted in a hospital, it is done with the belief that the treatment given in the hospital is being given by qualified doctors under the Indian Medical Council Act, 1956. It is not within the knowledge of the relatives of the patient that the patient is being treated by a Unani Specialist. We hold that it is clear deficiency in service and negligence by the hospital for leaving the patient in the hands of Unani doctor.

> "As laid down by Apex Court in the above case (Jacob Mathew case) , we feel it is high time that hospital authorities realize that the practice of employing non-medical practitioners such as Doctors specialized in Unani system and who do not possess the required skill and competence to give allopathic treatment and to let an emergency patient be treated in their hands is a gross negligence. We do not wish to attribute negligence on the part of Dr. Rehan alone while the patient was in his charge in terms of directing to pay compensation but solely on the hospital authorities for leaving the patient in his complete care knowing he is not qualified to treat such cases."

> "Supreme Court came down heavily in cases where Homeopathic Doctors treated the patients with allopathic medicines. In Poonam Verma Vs. Ashwin Patel and Others (1996) 4 SCC 332 where a doctor holding Diploma in Homeopathic Medicine and Surgery (DHMS) and registered under Bombay Homeopathic Practitioners Act, caused the death of a patient due to administration of allopathic medicine, the Supreme Court held him being not qualified to practice Allopathy, was a quake or pretender to the medical knowledge and skill as a charlatan and hence guilty of negligence per se. The facts being similar in this case, we hold that there is total negligence in treating the deceased patient." "Thus, we feel that an amount of Rs.7, 50,000/- would be appropriate amount of compensation in face of peculiar facts and circumstances."

2. Dr. Mukhtiar Chand & Ors. Vs. State Of Punjab & Ors., decided by the Supreme Court on 08/10/1998, reported as AIR 1999, SC 468, (1998 (7) SCC 579) K.T. Thomas, Syed Shah Mohammed Quadri, " A harmonious reading of Section 15 of 1956 Act and Section 17 of 1970 Act leads to the conclusion that there is no scope for a person enrolled on the State Register of Indian medicine or Central Register of Indian Medicine to practice modern scientific medicine in any of its branches unless that person is also enrolled on a State Medical Register within the meaning of 1956 Act."

Do Not Employ AYUSH Doctors :

MCI Code of Medical Ethics and Regulations 2002:

- ***"7.9** Performing or enabling unqualified person to perform an abortion or any illegal operation for which there is no medical, surgical or psychological indication".*

The above Regulations clearly prohibits taking assistance from any unqualified person for surgery, especially abortions.

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- The Maharashtra FDA has recently issued guidelines regarding prescription where it clearly mentions that another doctor cannot sign on the prescription paper of treating doctor.

- There are many Supreme Court Judgments which has clearly mentioned that Ayush Doctors cannot prescribe allopathic drugs

NATIONAL CONSUMER DISPUTES REDRESSAL COMMISSION NEW DELHI,
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3. Rajya Sabha Question

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KR/SK/95 – RS :
http://pib.nic.in/newsite/erelease.aspx?relid=30117, 20th August 2007

IMA Stand

1. IMA members should not appoint Ayush Doctors to assist them in their medical/surgical operations.

2. IMA should not assist Ayush doctors if they are performing any surgeries like giving Anesthesia, providing post-operative care and or using them as assistants in providing medical or surgical care.

IMA White Paper on Clinical Establishments (Registration and Regulation) Act, 2010

Clinical Establishment (Registration and Regulation) Act, 2010, hereinafter referred to as CEA has been passed by Legislature to provide for the registration and regulation of the clinical establishments in the country and for matters connected therewith and incidental thereto.

Section 2(c) of CEA defines the term clinical establishment which means hospitals, maternity home, nursing home, dispensary, clinics, sanatorium or any other institutions which offers services, facilities of medical treatment, etc. Thus, the said definition includes all types of clinical establishments.

According to Section 12 of CEA, registration and continuation every clinical establishment has to fulfil the following conditions namely:

a) **The minimum standards of facilities and services as may be prescribed**
b) **Minimum requirement of personnel as may be prescribed**
c) **Provisions for maintenance of records and reporting as may be prescribed**
d) **Such other conditions as may be prescribed**

Thus, if any one independent doctor wishes to start **his own clinic even in any backward or rural area** then also he has to get his clinic registered under the CEA and the said doctor has to fulfil all the restrictions and conditions of CEA.

It is stated that the conditions of registration of clinical establishment as mentioned in **CEA are highly unreasonable and also the said conditions discourages a single doctor to start even a small nursing home in any rural or backward areas of the country.** It is not possible for every small, medium clinical establishment or a single doctor to fulfil all the conditions and maintain minimum standards and facilities and keep minimum personnel.

IMA strongly consider that CEA will affect the continued viability of small and medium health care institutions, which are accessible and affordable to our people.While IMA fully subscribe to the view that the standards of health care have to be improved, IMA fear that the provisions of this act will be counter-productive.

The provisions and conditions of CEA violates the fundamental right of the doctors to practice their profession as enshrined in Article 19(1)(g) of the Constitution of India, 1950 as the restrictions imposed in CEA are highly unreasonable and the same are against the interest of the general public as the doctors will not be encouraged to start their own clinics, maternity home, nursing homes, etc in any rural or backward area of the country. This will in turn infringe the fundamental right of the people the right to life enshrined in Article 21 of the Constitution of India, 1950 which includes right to health and fair and timely medical treatment.

Thus, Clinical Establishment Act and Rules are being enforced without giving proper thought on the after effects which are likely to have on the medical fraternity as the same are likely to adversely affect the health care delivery system in the country, thus in turn affecting the public at large. It is also important to note that the management of medical problem and also the medical

treatment keep changing very fast due to innovations and discoveries in the medicine and technology. Thus, there cannot be any fix standard of medical treatment.

IMA suggests that only through a process of accreditation whereby professionalism is established in the management, and a system is put in place in the treatment, the standards of health care can be improved.

The act should be amended by removing the objectionable clauses and by incorporating a clause whereby if a hospital is accredited through NABH, the institution need only register under the act.

1. **Accreditation rather than licensing** should be the procedure:
– The present Act though it does not admit, has a licensing character.
– IMA suggests that registration and upkeep of standards in health care delivery will be better saved through accreditation process.
– All health care institutions may be mandated to opt for a recognised accreditation process.
– IMA and NABH has already started a unique scheme to assist even small and medium hospitals to gain entry level accreditation and this accreditation process should be recognised by the Government
– The Government should exempt accredited hospitals from the licensing process.
2. **Fixing of rates for services**

Since standards of treatment shall differ from one doctor to other doctor and from one Clinical Establishment to the other, fixing of fees shall not be proper on the part of the Government. It has been noted that in no other profession the professional fees are fixed by the Government. It may further be noted that the legal liabilities of the medical profession is unlimited therefore the fees and the rates cannot be limited. **Thus, the Government should refrain from determining the fee for services provided by hospitals, which are not availing the above government schemes.** The medical profession and the private hospitals have a right to fix their charges for their private patients.

3. **Single doctor establishments should be exempted from the Act**

The Chapter – I, Clause 3©(ii)(e) of the CEA is regarding the single doctor establishment, thereby imposing restrictions and minimum standards to be observed by the single doctor establishments. It may be noted that some of the single doctors in their clinics are working as consultants only without elaborate infrastructure for management of emergency or even first aid. Some of the single doctors have their consultations in their residences. Hence, the single doctor clinics should not come under the purview of Clinical Establishment Act. It is therefore necessary to delete the above clause for considering the single doctor as an "establishment".

4. **Chapter – II, National Council for Clinical Establishments:** It is pertinent to note herein that the maximum numbers of clinical establishments in the country are practicing modern medicine (Allopathy). In spite of this the representation of the medical professionals practicing modern medicine (Allopathy) is in negligible in the National Council. It is therefore, important that the doctors practicing modern medicine (Allopathy) should be given fair and proportionate representation in the National Council.

5. **Chapter – III, Clause 8 (2), Constitution of State Council:** It is pertinent to note herein that the maximum numbers of clinical establishments in the country are practicing modern medicine (Allopathy). In spite of this the representation of the medical professionals practicing

modern medicine (Allopathy) is in negligible in the State Council. It is therefore, important that the doctors practicing modern medicine should be given fair and proportionate representation in the State Council as well.

6. **Chapter – III, Clause 10 (1), Authority of Registration**: When all the process of registration is to be done by the office of the District Health Officer, it shall be appropriate that The District Health Officer be made the Chairperson of the District Registering Authority, and the District Collector or his representative to be a member. Further in the Rules, Clause - 8 (1), the police officer as the member of District Registering Authority also needs to be deleted.

7. **Chapter - III, Clause 12 (2) Regarding Stabilization of Emergency Cases**: Stabilization of the emergency condition is a broad and vague term which will differ from one establishment to the other establishment depending upon the expertise available and the infrastructure facilities of the particular establishment. There are large number of small nursing homes who do not have sufficient capacity and capability to stabilize the serious patients and therefore this clause will be unfairly implemented for these establishments. It is therefore requested that the term "**First Aid**" is to be used in place of Stabilization in the clause mentioned above.

8. **Chapter – IV, Clause 26 Display of information for filing objections:** This clause enables the neighborhoods to file objections on ulterior motives and stall the process of opening of clinical establishments.

9. **Anti-Quackery Measures:** The CEA should have provisions to eradicate quacks, persons illegally practicing in the country and impersonating themselves to be the registered medical practitioner. At present, there is nothing that prevents quacks to practice. More over provision of online Registration (Provisional) without verifying any documents makes all unqualified persons to get these certificates to practice.

10. **Grievance redressal mechanisms** are not legally correct platforms since alternative forums already exist.

– This mechanism will put the already harassed doctors and hospitals into severe stress.

11. The onus of safe transport and the cost involved in emergency case management should be borne by the Government.

12. The clinical establishments act should include provisions for promotion of healthcare institutions. It should be The Clinical Establishments (Registration and Regulation and Promotion) Act 2010.

13. The high penalty rate determined in the law should be scaled down.

14. Many of the rules and clauses only result in closure of small and medium level hospitals which are the backbone of India's health care delivery system along with Government institutions.

15. As per CEA Central Rules 2012: Doctors need to follow standard treatment guidelines as made by the central or the state government. This is against the interest of the general public as the medical profession changes every day. The doctors need to treat the patient as per accepted guidelines and evidence based literature on that day. Government will never be able to update guidelines on a daily basis.

CASES OF PHYSICAL VIOLENCE / ASSAULT ON DOCTORS AND IMMEDIATE NEED FOR CENTRAL LEGISLATION TO PREVENT AND STOP SUCH INCIDENTS AGAINST DOCTORS

Indian Medical Association (IMA) is very much disturbed and concerned from the increasing incidents and cases of physical violence and assault/attack on doctors and their staff, clinical establishments etc.

It is most relevant to understand that protection of doctors and their medical staff, clinical establishment is paramount important as the physical violence, assault or any criminal act on the doctors, their medical staff, clinical establishment, etc. also affects the life of the patients and public at large. If the doctors, their medical staff, etc. are always under a constant threat and pressure from the ongoing violence and assault then the doctors and their medical staff shall not be able to do justice with their profession and also they shall not be able to treat and cure their patients who are under emergency and undergoing risk and danger of their life properly and promptly. Thus, it is in the interest of public at large that such cases of physical violence against doctors must be condemned and controlled and not allowed to happen.

The act of physical violence, assault, attack on doctors, nurses, their staff, clinical establishments, etc. amounts to following criminal offences which are punishable under the provisions of Indian Penal Code, 1860 (hereinafter referred to as **IPC**):

- **Offences Affecting The Public Health, Safety, Convenience, Decency And Morals**
  - **Public Nuisance:**
    - According to **Section 268 IPC**, a person is guilty of a public nuisance who does any act or is guilty of an illegal omission which causes any common injury, danger or annoyance to the public or to the people in general who dwell or occupy property in the vicinity, or which must necessarily cause injury, obstruction, danger or annoyance to persons who may have occasion to use any public right. A common nuisance is not excused on the ground that it causes some convenience or advantage.
    - According to **Section 269 IPC**, a person who commits public nuisance shall be punished with fine which may extend to two hundred rupees.
- **Offences Affecting Human Body**
  - **Hurt:**
    - According to **Section 319 IPC**, a person who causes bodily pain, disease or infirmity to any person is said to cause hurt.
    - According to **Section 323 IPC**, a person who voluntarily causes hurt shall be punished with imprisonment of either description for a term which may extend to one year, or with fine which may extend to one thousand rupees, or with both.

 According to **Section 324 IPC**, a person who voluntarily causes hurt by means of any instrument for shooting, stabbing or cutting, or any instrument which, used as weapon of offence, is likely to cause death, or by means of fire or any heated substance, or by means of any poison or any corrosive substance, or by means of any explosive substance or by means of any substance which it is deleterious to the human body to inhale, to swallow, or to receive into the blood, or by means of any animal, shall be punished with imprisonment of either description for a term which may extend to three years, or with fine, or with both.

- **Grievous Hurt**

 According to **Section 320 IPC**, the following kinds of hurt only are designated as "grievous":-

First - Emasculation.

Secondly - Permanent privation of the sight of either eye.

Thirdly - Permanent privation of the hearing of either ear,

Fourthly - Privation of any member or joint.

Fifthly - Destruction or permanent impairing of the powers of any member or joint.

Sixthly - Permanent disfiguration of the head or face.

Seventhly - Fracture or dislocation of a bone or tooth.

Eighthly- Any hurt which endangers life or which causes the sufferer to be during the space of twenty days in severe bodily pain, or unable to follow his ordinary pursuits.

 According to **Section 325 IPC**, a person whovoluntarily causes grievous hurt, shall be punished with imprisonment of either description for a term which may extend to seven years, and shall also be liable to fine.

 According to **Section 326 IPC**, a person whovoluntarily causes grievous hurt by means of any instrument for shooting, stabbing or cutting, or any instrument which, used as a weapon of offence, is likely to cause death, or by means of fire or any heated substance, or by means of any poison or any corrosive substance, or by means of any explosive substance, or by means of any substance which it is deleterious to the human body to inhale, to swallow, or to receive into the blood, or by means of any animal, shall be punished with imprisonment for life, or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.

- **Act Endangering Life or Personal Safety Of Others**

 According to **Section 336 IPC**, a person whodoes any act so rashly or negligently as to endanger human life or the personal safety of others,

shall be punished with imprisonment of either description for a term which may extend to three months, or with fine which may extend to two hundred and fifty rupees, or with both.

 According to **Section 337 IPC**, a person who causes hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to six months, or with fine which may extend to five hundred rupees, or with both.

 According to **Section 338 IPC**, a person who causes grievous hurt to any person by doing any act so rashly or negligently as to endanger human life, or the personal safety of others, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine which may extend to one thousand rupees, or with both.

- **Wrongful Restraint**

 According to **Section 339 IPC**, a person whovoluntarily obstructs any person so as to prevent that person from proceeding in any direction in which that person has a right to proceed, is said wrongfully to restrain that person.

 According to **Section 341 IPC**, a person who wrongfully restrains any person shall be punished with simple imprisonment for a term which may extend to one month, or with fine which may extend to five hundred rupees, or with both.

- **Criminal Force and Assault**

 According to **Section 350 IPC**, a person whointentionally uses force to any person, without that person's consent, in order to the committing of any offence, or intending by the use of such force to cause, or knowing it to be likely that by the use of such force he will cause injury, fear or annoyance to the person to whom the force is used, is said to use criminal force to that other.

 According to **Section 351 IPC**, a person who makes any gesture, or any preparation intending or knowing. it to be likely that such gesture or preparation will cause any person present to apprehend that he who makes that gesture or preparation is about to use criminal force to that person, is said to commit an assault.

Explanation- Mere words do not amount to an assault. But the words which a person uses may give to his gestures or preparation such a meaning as may make those gestures or preparations amount to an assault.

 According to **Section 352 IPC**, a person whoassaults or uses criminal force to any person otherwise than on grave and sudden provocation given by that person, shall be punished with imprisonment of either

description for a term which may extend to three months, or with fine which may extend to five hundred rupees, or with both.

- According to **Section 355 IPC**, a person who assaults or uses criminal force to any person, intending thereby to dishonor that person, otherwise than on grave and sudden provocation given by that person, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

- **Offences Against Property**
  - **Mischief**
    - According to **Section 425 IPC**, a person whowith intent to cause, or knowing that he is likely to cause, wrongful loss or damage to the public or to any person, causes the destruction of any property, or any such change in any property or in the situation thereof as destroys or diminishes its value or utility, or affects it injuriously, commits "mischief".
    - According to **Section 426 IPC**, a person who commits mischief shall be punished with imprisonment of either description for a term which may extend to three months, or with fine, or with both.
  - **Criminal Trespass**
    - According to **Section 441 IPC**, a person whoenters into or upon property in the possession of another with intent to commit an offence or to intimidate, insult or annoy any person in possession of such property, or having lawfully entered into or upon such property, unlawfully remains there with intent thereby to intimidate, insult or annoy any such person, or with intent to commit an offence, is said to commit "criminal trespass".
    - According to **Section 447 IPC**, a person whocommits criminal trespass shall be punished with imprisonment of either description for a term which may extend to three months, with fine or which may extend to five hundred rupees, or with both.

- **Offence of Defamation**
  - According to **Section 499 IPC**, a person who by words either spoken or intended to be read, or by signs or by visible representations, makes or publishes any imputation concerning any person intending to harm, or knowing or having reason to believe that such imputation will harm, the reputation of such person, is said, except in the cases hereinafter expected, to defame that person.
  - According to **Section 500 IPC**, a person who defames another shall be punished with simple imprisonment for a term which may extend to two years, or with fine, or with both.

- **Offences of Criminal Intimidation, Insult and Annoyance**
  - According to **Section 503**, a person who threatens another with any injury to his person, reputation or property, or to the person or reputation of any one in

whom that person is interested, with intent to cause alarm to that person, or to cause that person to do any act which he is not legally bound to do, or to omit to do any act which that person is legally entitled to do, as the means of avoiding the execution of such threat, commits criminal intimidation.

Explanation- A threat to injure the reputation of any deceased person in whom the person threatened is interested, is within this section.

- According to **Section 504 IPC**, a person whointentionally insults, and thereby gives provocation to any person, intending or knowing it to be likely that such provocation will cause him to break the public peace, or to commit any other offence, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

- According to **Section 506 IPC**, a person who commits, the offence of criminal intimidation shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both;

If threat be to cause death or grievous hurt, etc- and if the threat be to cause death or grievous hurt, or to cause the destruction of any property by fire, or to cause an offence punishable with death orimprisonment for life, or with imprisonment for a term which may extend to seven years, or to impute, unchastity to a woman, shall be punished with imprisonment of either description for a term which may extend to seven years, or with fine, or with both.

If any person commits any of the above mentioned offence, then the doctors and their staff can lodge a police complaint under Section 154 of the Criminal Procedure Code and get the FIR lodge against the said offender.

Apart from the above mentioned remedy under IPC/CrPC, around 15 States and Union Territories in India have their respective State/UT legislations on the issue of physical violence / assault of doctors. However, the said legislations framed by the 15 States / UTs are not effective and also there is no awareness about the same either amongst the doctors or the concerned police authorities.

IMA feels that it is imperative in the larger interest of public health that a common act is framed and passed in the Parliament to curb this menace. Even in war, hospitals, doctors and paramedics have immunity against attacks. But now we find that in very flimsy grounds, anti-social elements who have a grudge against a hospital, utilise certain situations in the clinical institutions to seek vengeance, perpetuating vandalism. This cannot be allowed in a civilised society. This has to be considered as a crime against the helpless patients who are still in the hospital under treatment.

It is the need of the hour that appropriate and suitable central legislation is promulgated which provides the following measures:

i) Provision to be made providing deterrent punishment to offenders who cause such violence and assault on the doctors and their staff, clinical establishments etc. and to provide for immunity in favour of the doctors **while on work and duty** as in case of government/public servants under the provisions of the Indian Penal Code, 1860. Any person causing physical violence and assault on the doctor on duty must be punished in similar manner as causing attack on a "public servant".

a. Section **186 in The Indian Penal Code:** 186. Obstructing public servant in discharge of public functions.—whoever voluntarily obstructs any public servant in the discharge of his public functions, shall be punished with imprisonment of either description for a term which may extend to three months, or with fine which may extend to five hundred rupees, or with both.

b. **Section 189:** Threat of injury to public servant: Whoever holds out any threat of injury to any public servant, or to any person in whom he believes that public servant to be interested, for the purpose of inducing that public servant to do any act, or to forbear or delay to do any act, connected with the exercise of the public functions of such public servant, shall be punished with imprisonment of either description for a term which may extend to two years, or with fine, or with both.

c. Complaint had to be filed under Section 195 CrPC

ii) One Central Legislation with respect to Medicare Service Persons and Medicare Service InstitutionsSuitable be framed as the present State Legislations are not sufficient enough to punish the offenders.

iii) Provisions to be made in Indian Penal Code in providing deterrent punishment to offenders who cause violence and assault on the doctors and their staff, clinical establishments etc. for audio-video recordings at the time when the patient is informed and explained by the doctor about the medical procedures and process to be performed on the patient and when the consent of the patient/guardian/close relative etc. is obtained.

iv) Provisions to be made in Indian Penal Code in providing deterrent punishment to offenders who cause violence and assault on the doctors and their staff, clinical establishments etc. for doctors and their medical staff to put on a small camera on their dress on work/duty to film and record the incident of any assault, attack etc.

IMA calls for quality drugs to be made available to the public at affordable costs

As it was clearly established through various studies and as reported by the Planning commission's High Level Expert Group Report (HLEG) report on Universal Health Coverage for India, almost 70% of out of pocket expenses incurred in health care is directly due to the cost of drugs and this is more among the poorest quintile. Therefore, the government should spend more resources in making drugs affordable to the population-at least to the tune of 0.5% of GDP. Government should open more Jan Aushadi stores and establish a drug distribution system catering to both public sector and private sector hospitals

Essential drug list should be revised and published periodically. Drug manufacturing and distribution should be guided by the essential drug list. Very strict laws and penal provisions should be in place to curb irrational combinations and preparations. More drugs should be brought under the price control mechanism. Mechanism of adverse drug reaction monitoring should be made more effective. All companies should market the drugs in generic name.

Government should return to the old system of cost-based drug pricing and should do away with the current system of market-based pricing.

This will rationalize the cost of majority of the drugs and will also help to avoid cartel formation.

Govt should ensure the quality of each batch of medicine, and this requires adequate funding to establish more testing labs in the country. Drugs should not be allowed to move to the market before the quality is tested for each batch.

Govt policy should be to facilitate domestic drug manufacturing companies to undertake drug research and innovation, to invent new molecules to preferentially address diseases, which are predominantly prevalent in our country. Just like techno parks, govt should invest and facilitate common facilities for drug research and quality control

Govt should also take steps to open and functionalize the closed down vaccine manufacturing units in the public sector and also sick drug manufacturing units in the public sector.

A National sample survey, 2014 has shown that 40% of our population depends on single man clinic and small rural hospitals for their health needs. It is observed that these small and medium level hospitals are closing down due to financial non viability. IMA demands that the government to support these hospitals financially through a program of 'aided hospitals'

To attract modern medicine practitioners to serve in rural areas, IMA suggests the following:

• Government to identify difficult areas (primary health centers where doctors are not available for more than 3 years)

• To develop a package to attract doctors to these areas by offering higher salary, accommodation preferably at headquarters with transportation, weightage for PG admission for

those serving in difficult rural areas (up to 30% weightage), admission of children to central schools

• To post minimum of three MBBS Doctors in PHCs instead of the present system of posting one MBBS doctor

• To utilize the service of private practitioners in the locality on a retainership/contract basis

• To utilize the services of foreign degree holders (Russia/China Indian graduates) as trainees under the supervision of PHC doctors up to 3 years or till they get registered

• Population covered by PHCs to be revised from existing 30,000 to 20,000; presently up to 1.5 lakhs population is covered by one PHC

• To get orientation of rural health problems, and to motivate them to work in rural areas at least both undergraduates and post graduates should spend 3 to 6 months in a rural set up, under graduates should get training in PHC during their Community medicine posting and also as part of vertical integration at clinical postings. The post graduates can work at least 3 to 6 months in CHCs along with or under the supervision of specialists. The period for preparation of thesis for this can be reduced to 6 months.

IMA demands amendments to the PCPNDT Act

The PNDT Act came into being in 1994 with the purpose of improving the altered sex ratio in India. It was further amended in 2003 as the PCPNDT Act to regulate the technology used in sex selection. The Act banned preconception and prenatal sex determination. Its intent was to curb the actual act of sex selection and female feticide by regulating the use of ultrasound technology. WHO in its recent publication has clearly declared that restricting technology was not the way forward.

However, despite the Act having been in existence for over 20 years, the altered sex ratio in India has not changed. Instead, it has had two major negative consequences:

• In its current form, the implementation of the PCPNDT Act has deprived the community of life-saving and essential ultrasonography which has now become an extension of clinical practice for all specialties globally, being a well-known non-invasive, cost-effective and accurate diagnostic tool.

• The current PCPNDT Act has made it extremely difficult for ultrasound clinics to ensure complete enforcement. Doctors and other medical professionals are being put to extreme hardship while performing routine and essential scans. Due to this, many qualified doctors are opting not to do PNDT scans, thus creating a shortage of experts trained in ultrasonography.

As the PCPNDT Act has not resulted in the improvement of the falling sex ratio, social rather

than medical interventions will be required to handle this issue effectively. The Act is being used to punish doctors for minor offences such as clerical errors in the filling of forms, thereby resulting in doctors being prosecuted and ultrasound machines being seized and sealed.

IMA demands the following amendments:

• The Act needs urgent modification to allow unambiguous and easy interpretation. The "Rules" need to be simplified and implemented uniformly across the country, and adhoc changing of rules by each local authority should be strictly prohibited. New rules must be logical and should apply to the entire country only after due discussion with the representative bodies. Time should be given for implementation of the new rules.

• The Act is to be directed only towards Obstetric Ultrasound and not any other applications of ultrasonography.

• The word "Offence" under this act has to be clearly defined. The word Offence should only mean the "actual act of sex determination or female feticide".

• All other clerical/administrative errors should be classified as non-compliance (and not an offence). Strict penalties can only be imposed for the actual act of sex determination or female feticide and not for other errors. There is a need to redefine "what amounts to sex determination" as mere evidence of clerical error does not amount to sex determination. "Imprisonment" rules should be for the offence (of sex determination or female feticide) & not for non-compliance.

• Inspections should be conducted yearly instead of every 90 days. No NGO can conduct "raids" on doctors' premises and there should be no impediment to doctors doing their practice during inspections.

• Ultrasonologists should not be restricted to working in only two centers.

• The doctors should have the right to report on those seeking sex determinations and action must be initiated against them immediately.

IMA seeks increase in budgetary allocation for health :

It is the obligation of the state to provide free and universal access to quality health-care services to its citizens. India continues to be among those countries of the world that have a high burden of diseases. The various health program and policies in the past have not been able to achieve the desired goals and objectives.

High-level expert group (HLEG) on Universal Health Coverage (UHC) constituted by Planning Commission of India submitted its report in Nov 2011 for India by 2022. The recommendations for the provision of UHC pertain to the critical areas such as health financing, health infrastructure, health services norms, skilled human resources, access to medicines and vaccines, management and institutional reforms, and community participation. Planning commission has estimated that 3.30 lakh crores has to be spent in 12th FY period (2012-2017) to achieve the goal of UHC by 2022. We are already into the third year of the 12th FYP and yet only a meager proportion of this amount has been budgeted so far on an annual basis

It is believed that an important factor contributing to India‘s poor health status is its low level of public spending on health, which is one of the lowest in the world. In 2007, according to WHO’s World Health Statistics, in per capita terms, India ranked 164 in the sample of 191 countries. This level of per capita public expenditure on health was less than 30 percent of China’s (WHO, 2010). Also, public spending on health as a percent of Gross Domestic Product (GDP) in India has stagnated in the past two decades, from 1990–91 to 2009–10, varying from 0.9 to 1.2% of GDP

Government should increase the public expenditure on health from the current level of 1.1% GDP to at least 2.5% by the end of the 12th plan and to at least 3% of GDP by 2022. Government should ensure that a minimum of 55% of health budget is spend on primary, 35% on secondary and a maximum of 10% on tertiary care services (as proposed by National Health Policy 200), as against the current levels of 49%, 22% and 28% respectively.

The Twelfth Finance Commission provided grants to selected states for improving health indicators, but in effect, they recommended that the grants cover only 30% of the gap between the state‘s per capita health expenditure and the expenditure requirements assessed by them for each of the state. This should go up to at least fifty percent of the gap. Additional transfers from the central government to selected states have to be directed toward primary care and the first level of secondary care by strengthening the related health infrastructure and personnel. This is important not only to facilitate basic primary and secondary care but also to reduce the burden and expenditure share at the tertiary level.

The estimated additional expenditure requirement just to provide subcenters, health centers, and community health centers according to the norms is estimated at 0.6% of GDP. There are additional administrative expenditures and requirements for providing health facilities in urban areas, and these could add up to another 0.4%. Thus, a minimum of one percent of GDP will be required in the medium term (next 1 to 2 years) to ensure minimum levels of health care as per the norms.

There should be an increase in spending for public procurement of medicines from 0.1% to 0.5% of GDP. Government should bring in legislation to discourage pharmaceutical firms from using trade names in marketing. Drugs should be available only in chemical name; which will help to bring in uniformity. At the same time there should be strict mechanism to monitor and ensure that drugs available in the market are of good quality. Government should invest in establishing drug-testing laboratories in each state. In addition, government should support and rejuvenate the existing public sector drugs and vaccines manufacturing units

General taxation plus deductions for health-care from salaried individuals and taxpayers as the principal source of health-care financing should be used, and no fees of any kind be levied for the provision of health-care services under UHC. Insurance is not a panacea and government should refrain from promoting health insurance as the best solution for health care problems in the country.

Government should introduce a health cess (0.5%) as a component of the existing VAT system and the new Goods and Services Tax (GST) that is proposed. There should be additional health cess for sweetened beverages, tobacco, alcohol and cars. This will raise revenue for the government and at the same time will also act as a measure to discourage the use of these products

Water, hygiene and sanitation are the cornerstones for effective public health protection. Government should not only increase allocation to these areas, but also ensure that the money is spend properly and time-bound Government should move to a system of 'purchasing' secondary care services from private sector until it can provide these services by itself. This will help to prevent out-of-pocket expenses for a large section of population and also can reduce the burden on tertiary care.

The reimbursement scheme for health care should be extended to all people working in organized sector and not just to central government employees. This will help to relieve some pressure on the public health systems on one side, and will help to give more options for people in the organized sector.

The present schemes such as JSBY, RSBY, JSY etc. are run by different ministries and departments. The Budget should facilitate convergence among the various stakeholder ministries/departments so that we can evolve a comprehensive social security package

Public and private sectors should not move as parallel systems, but should complement each other. Public private partnership in health should be promoted. At present, the facilities in private sector are underutilized at one end, whereas public sector lack in facilities to cater to the needs. Government should design special programs in discussion with professional associations like IMA to optimally utilize the resources- both in the public and private sector. This will include sharing of the resources in private sector like CT, MRI scans etc. for patient care in public sector.

Services of family doctor/single man private clinics should be optimally used on a retainership basis, at least in places where government doctors are not available at PHCs, until government is able to recruit and sustain regular doctors.

Government should increase the allocation for health awareness programs. A repository on health information should be created and disseminated using the social media. Non-communicable diseases and health needs of the elderly need urgent attention. Government should increase the allocation to these areas significantly. National programs for NCD and care of elderly should be introduced in all the districts within the next two years. Telemedicine should be given importance, with simultaneous investment in increasing the availability of trained and qualified human resources.

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