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LAPSES IN MEDICAL PRACTICE

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ABSTRACT
With explosive increase of population in India, the number of patients too have increased accordingly in both rural and urban areas. To meet this challenge of increasing number of patients in our country large number of hospitals both in public and private sectors have come up. The urban areas particularly in Metro cities have world class hospitals, superspeciality centers, state of the art diagnostic centres and numerous clinics with availability of well trained doctors and high quality services of diverse kind of alternate systems of treatment. However, rural areas due to vast expanse of land and spread out population over long distances lag far behind in health care facilities all over India.The system of medical treatment which is most sought after and popular with masses is the modern evidence based system of treatment famously named as allopathic system. As a natural consequence of increasing demand on health care services and hospitals there has been increase in number of surgical operations, procedures, invasive and non invasive investigations accompnied by heavy workload on OPD services. The last three decades have witnessed great revolution in advancement and application of newer technologies towards diagnosis and treatment of diseases which remained untreated and undiagnosed to a large extent in bygone era. The evolution of definitive, focused and ultra modern state of the art diagnostic and therapeutic instrumentation has made the management of complicated diseases easy and affordable. With coming age of advancement in modern techniques in treating patients with newer kind of high tech gadgetry on the scene both for diagnostic and therapeutic aspects has totally changed the outlook and methodology to Himalayan heights which are available not only in large cities but has outreached to smaller towns as well. Therefore as a result of heavy work load of patients on the hospitals and health care services, lapses within hospitals from entry till finality of treatment do come up and draw public attention. The lapses in hospital treatment donot pertain only to actions of doctors and health care staff but also occur due to the mistakes, attitude, behavior of paramedic staff, adminstrative apparatus and inadequate role of pre-hospital preventive and socio-adminstrative aspects of circumstances leading to ill health.

KEYWORDS: Medical lapses, Medical negligence, Public administration, Professional incompetence, Ethics in medical practice, Health Services, Complications of surgery, Fake drugs.

INTRODUCTION
Late 20th and ongoing 21st century has seen explosive increase in global population specially in third world countries accompanied with more wars, battles, social conflicts, violence, migrations, poverty, deteriorating law and order, increase in aspirations and expectations of masses in all aspects of life.

The economic hardships of masses and costly treatment in private corporate hospitals beyond the reach of uninsured patients, overcrowding in Government public hospitals with limitations of adequate manpower and facilities for investigations and expected standards of treatment has created an atmosphere of mistrust and dissatisfaction among helpless patients who beome agitated and demoralized. This discontentment and hopelessness not only affects the already suffering patients but also damages the happiness and routine life style of family members.

The aspirations and expectations of clientele have gone beyond the legitimate and ethical boundaries of the maximum efforts an health care service provider can do for ailing patients.

The occurrence of lapses and negligence in patient treatment and incidents of lack of proper communication with patients about their illness are on the increase specially due to bodily harm and fatal outcome during treatment.

Medical lapses may be defined as inadequate or

improper treatment due to lack of knowledge, care and mistakes. British legal luminary Sir William Blackstone in 1765 mentioned Mala Praxis as neglect or unskillful management of a physician or surgeon. Old word Mala Praxis gave a new name to it as Malpractice. Since then, in 1794, "the first recorded medical malpractice lawsuit in the U.S. took place in Connecticut where a patient died of a surgical complication.[1]

Medical negligence reflects casual, insensitive, careless and lackadaisical attitude in managing patients which can cause prolonged agony to patients due to wrong treatment which may also result in disability and death.

Such incidents bring untold miseries to the affected family of patient besides imposing financial loss and mental harassment.

Therefore, medical negligence means irresponsible professional conduct in discharge of duties and responsibilities by an individual or a group for the common goal of achieving the best for restoring an ailing patient back to good health by maximum efforts.

The problems

Medical profession demands perfection in art and science of diagnosis of the disease, investigations, treatment and follow up. At times doctor may not be able to make a correct diagnosis because of limitations of availability of fewer investigations. For example, from the early 1970s to the late 1980s, the number of lawsuits in the U.S. alleging failure to diagnose cancer increased by 50%.[2] The most comprehensive definition is "an act of omission or commission in planning or execution that contributes or could contribute to an unintended result".[3] Patient seeks medical help to get cure for disease by placing faith in knowledge, experience, skill and capability of the treating doctor. A trust based on mutual understanding should not be demolished by lack of expertise, mistake, lapses and deliberate false misleading assurances amounting to deception and cheating. There are increasing reports and occurrences of unsatisfactory outcome during and after treatment of the patients in outdoor and indoor settings. In many instances patient reports to hospital in apparently good health but leaves the hospital as dead person creating unimaginable pain and grief to family. This is unbearable and unacceptable by any way and standards of common sense. However it should be understood that no treating doctor would ever be inclined or deliberately create mistakes to harm the patient. There is none in the world who has not erred at some time or the other during the discharge of responsibilities with all the sincerity and efforts. With the best of efforts if the patient lands up in complications or in fatal outcome, this cannot be called negligence or lapse.

There are various factors which are responsible for such mishaps and such unfortunate occasions must be avoided at all costs. Despite the increasing efforts health care institutions and health care workers make to prevent medical errors and adverse events,[4] medical errors are still inevitable.

Many of the unintentional mistakes occure in Emergency Department, Operation Theatre and ICU. There are numerous reasons given by attendants for lapses and negligence on the part of health care providers, for example falls, wrong prescriptions, burns, ulcers, wrong site surgery and wrong person choosen for surgery have been attributed to hospital staff. In Jordan, a study found that 28% of all hospital admissions in Jordan were affected by medical errors, with medication errors as the most common cause, followed by the wrong medical diagnosis and health care associated infections. Wrong diagnosis, infections, bedsores and falls were reported by 21.3, 21.3, 16 and 8% of participants, respectively.[5] In 1999, the 'Institute of Medicine' (now the National Academy of Medicine) published the seminal report 'To Err Is Human: Building a Safer Health System' quantifying the scale of harm associated with medical care in the United States (US).[6]

Despite global advances in healthcare practices, an estimated one in ten patients is still harmed while receiving care.[7]

Not all the wrongs done to human beings by way of treatment can be solely traced to allopathic evidence based medicine and procedures including surgery. Medicine is a noble profession, aiming to serve communities and requires 'mindful practice.[8,9]

In an overpopulated third world country like India which has low allocation of GDP for health sector has lesser number of hospitals, health care providers, trauma centres and has inadequacy of proper facilities, the occurrence of unsatisfactory results and complications do occur because besides scientifically trained doctors the patients are also managed by quacks and unqualified practitoners of who are ignorant about the anatomical, physiological, pathological, pharmacological and focused therapeutic aspects of drug and its effects. The complications due to treatment and lapses in such a diverse and vital environment occure far more frequently under the hands of unqualified medical practioners who generally are rarely questioned or investigated and accounted for their irresponsible conduct.

Lapses of all kinds occurring in hospitals are manifold and can be reduced by taking suitable measures by removing inadequacy of desired knowledge, lack of expertise, lack of experience, non availability of equipment and lack of good working culture. All these measures need guidance and supervision by seniors and dedicated stalwarts.

Existing hospitals in our cities and towns specially in public sector are overcrowded and have deficiency of

manpower, equipment, hospital beds including deficiency of super specialty services.

The dedicated highly specialized exclusive care for patients with trauma, paediatric patients, cancer patients and other patients gets diluted when these patients are clubbed with other patients in General hospitals thus increasing the clientele load in these hospitals resulting in loss of focused attention to most urgent patients. In large to medium sized hospitals with specialist and superciality facilities the OPDs are overcrowded with long queues and long waiting period. At times in many specialities a single specialist has to see 200 patients a day and the OPD may run till late evenings. The waiting period in public sector hospitals for OPD, hospitalization and surgery may be long unless emergency necessitates urgent action. In a overcrowded OPD It is not possible to do full justice to patients who are waiting for hours for their turn to be seen by doctors only to be disposed off without proper examination and satisfaction. Heavy workload in OPDs with gross insufficiency of doctors may result in missing important positive findings in a patient due to shortage of time. Heavy work load on doctors might result in lapses and mistakes on their part and they might miss to write desired investigations and treatment for which the doctor becomes liable to face action. A young lone doctor without supervision can commit serious mistakes in diagnosis and treatment. Often, because of ignorance, wrong and harmful prescriptions are written which can be corrected by making youngsters and inexperienced work under the supervision and guidance of seniors. Each and every prescription and diagnosis made by a resident or intern in OPD must be approved by the senior doctor in OPD. Similarly the indoor patients too should be benefitted by rounds of expert senior doctors which would help juniors gain necessary experience and would also keep the staff alert and prepared besides avoiding lapses.

In a heavily populated country like ours it is common to see more than 100 % bed occupancy in hospitals for which there may not be enough clinical and paraclinical staff and resources which can result in lapses and neglect of patients. Patients often are seen lying on floor and even on roads awaiting admission. Thanks to private health services to lessen the load on public hospitals. The Ayushman Bharat health insurance and other agencies have done wonders in augmenting good health care.

Public sector hospitals are much more busier than Private sector hospitals because of easy affordability which also possess equally skillful and experienced doctors. There is tremendous workload on public sector hospitals due to huge clientele and also due to referalls from far and near hospitals. Thus non availability of beds and overcrowding in wards results in complaints, inadequate attention, lack of care and complications associated with prolonged hospital stay and health care associated infections.

By and large indoor and outdoor management of patients is left to junior doctors who certainly lack experience if not the knowledge. Many of the OPD mistakes are attributed to wrong and faulty prescriptions due mainly to ignorance and lack of knowledge. Medication error is the most common and preventable cause of patient injury and “the rates of medication errors in pediatric settings appear to be up to three times the rates in adult settings, mainly due to parental drug administration”.[10]

The unique services of highly trained, skilled and capable senior doctors particularly the Heads of Departments are not available to guide junior doctors in Emergency Department, OPDs, OTs and even during ward rounds. The ward rounds by seniors lack sincerity, involvement and clinical examination. JRs are seen struggling to allot priority to emergency patients whom to treat first and how. Thus juniors are left alone to struggle with grave emergency which are there in plenty. Many are busy with case sheet writing while patients are struggling for breathe on stretchers itself for hours. This kind of attitude of apathy of doctors trickles down to stll more juniors who become arrogant and non-communicative besides harming the patients due to absence of seniors to guide them. Senior retired doctors can be involved fully in their work, are more knowledgeable, clinically more experienced and more useful and therefore if healthy should be permitted to work regardless of their old age. Retiring them on due date would certainly deprive patients from the benefit of receiving better care and the juniors from vital guidance. In these situations the presence of Senior doctors would make a great difference in improvement of the patient care and would also impress junior doctors to be more sympathetic to patients and their attendants which means a lot in patient care. On the other hand it has been seen on umpteen times in large hospitals including teaching institutes that seniors including HODs donot take rounds of even ICU wards what to talk of Acute and Chronic wards. Single junior resident alone cannot manage patients in Emergency Department and Casualty. These junior or even senior residents remain unguided even in Emergency and Acute wards. Therefore the senior consultants and faculty must spare more time for rounds and show the light by getting involved in even doing dressings, minor ward procedures, suture removal, demonstrating supportive measures like physiotherapy and educating juniors. Patient service and care is the principle objective and therfore a good example has to be set up.

In many institutes junior doctors are not able to take correct decisions and allot priority to emergency patients whom to manage first specially while tackling mass casualties. In many busy large Public Sector hospitals where the emergency patients lie in hospital corridors and even on roads due to lack of space, the doctors and nurses are hard pressed to manage the patients due also to inadequate staff and therfore the responsibility for lapses and negligence lies with the political

adminstration of catchment areas which has not been able to prevent diseases and create suitable hospitals complete with trained staff and equipment. There is much to say about rude and hostile attitude of paramedical lower level male nurses who are ill mannered and totally unfit for nursing care because of callus and inhuman approach towards patients.

It has been observed that the lapses and neglect are much more frquent during weekends and nights than during week days when patient care falls into the hands of juniors, less experienced and who are not guided. In a recent study of a general medicine service that maintains the same staffing ratio on weekends as that on weekdays, researchers found that night or weekend admission was not associated with worse patient outcomes and suggested that consistent staffing, coordinated handoffs, and rotation schedules that protected against discontinuity may facilitate narrowing the gap in disparity.[11]

At such crucial juncture and time decision making and major intervention cannot be left to inexperienced juniors and therefore the presence of experienced senior consultant is a must specially while managing an emergency.

Junior doctors, on the other hand, have their job assignments on the wards and emergency units, where they meet a broad range of cases and problems.[12] Guidance and support is of paramount importance.

Patients from remote inaccessible areas are forced to seek hospital treatment else where in far-flung cities having large hospitals with necessary services. 50 percent of world population lives in remote regions and most of these regions donot have access even to basic investigations, minor surgery and definitive treatment. In absence of experienced consultancy and indoor treatment the health staff including doctors need help to avoid morbidity and mortality due to lapses.

In many remote mountainous regions of India patients donot have road connectivity to hospitals and many die in absence of urgent medical attention. Transportation of patients takes a long-time to shift them to nearby hospitals as the density of hospitals in the region is very low.[13] Therefore availability of atleast telemedicine including tele conferencing can be organised to guide and help doctors. Use of drones to fetch lab samples and carry packs of essential medicines to remote regions have met with great success in few countries.

The doctors cannot be blamed for lack of space and beds in hospitals overflowing with patients but state administrators and political managers should focus on this problems. Doctors and hospital administrators have the responsibility to project their problems for improvement in patient care in writing through established channels. At the same time the concerned higher authorities too must make planned visits to inspect the government hospitals for necessary help they can give for clientele satisfaction. Positive steps for improving health care in public sector would certainly reduce chances of lapses and negligence in public sector hospitals. Now Public- Private hospital care and joint participation under multiple health insurance schemes have changed the scenario of health care for good in many states of India for select huge clientele. In corporate hospitals the patient care and treatment can be called the best. Previous studies have shown that, despite substantial contributions and previous successes, provision of PHC services solely via the public sector providers has its limitation and some potential problems are well-documented (e.g., shortage of human resources, inefficient institutional frameworks, inadequate quality and efficiency due to a lack of competition, particularly in remote and rural areas).[14,15]

State of the art high tech, highly talented professional support in health care is avaiable to patients residing in cities and towns only and people living in vast remote rural areas specially in cold high altitude mountains donot have even basic services. It is here in such remote places lapses and negligence in patient management occurs at the hands of inexperienced in ill equipped hospitals. Non availability of services for evacuation of patients to higher medical centres too is a lapse on the part of state and some thing has to be done about it by Public-Private participation. Time has come for Public Private Participation to solve the problems of patients in remote and disadvantaged regions. Private parties have the built in benefit of quick decision making, availability of finances and possession of human and material resources. In India such collaboration has made it possible to extend state of the art health care to vast number of patients in urban areas only. PPPs formed by governments, international donors, and pharmaceutical companies in India and several African countries were also successfully used to control AIDS and provide diagnostic and treatment services to suspects and AIDS patients.[16,17] One of the solution could be to organise medical camps in remote areas with full component of hospital preferably under Public-Private participation. Alternately Private Corprare Health care sectors can be outsourced the hospital care services in rural and mountainous regions. The governments in third world countries have failed at many places to render health care in rural and mountainous regions because doctors posted there remain absent most of the times and spend their times in cities and health care is left to native Nursing Attendents and paramedical staff. All this happens in collusion with superior health officials and adminstrative officials. Such acts of negligence must be dealt with firmly as per rules and law. Where the population is more dispersed and distances are greater, access to hospital and emergency services may become problematic. Geographical distance could then lead to inequities in access and underutilization of emergency

hospital services among populations in rural or remote areas.[18]

Urban trained doctors are oriented to serve in urban areas only even if they belong to rural areas. A separate cadre of doctors could be dedicated and trained to serve in rural areas. Such doctors agreeing to serve in rural areas must receive some incentives in the form of cash, good housing and change period from rural services to urban health centres for three years during secondary school studies of children between 14 to 16 years of age.

Ruralites suffer from lack of desirable health services as compared to their city colleagues, being poorer, less educated and are unaware of health insurance in many places and above all do not have adequate health services as good as their city counter parts receive. Rural hospitals are less well equipped and not manned effectively. The greatest incentive to attract experienced doctors for rural service is enhanced pay and allowances with additional provision for yearly two months training and education in higher centres to acquire more skills in use of newer technology. Rural hospitals must be equipped at par with urban hospitals, the doctors should be provided with good accomodation and doctor couples should be posted together.

Other alternative to improve health services in rural and mountainous areas is to post doctors in such remote places for three months each by rotation with incentives of high pay and rewards. Such services must be mandatory and the doctors choosen for the brief rural attachment must be GPs and highly skilled specialists. This proposal should be voluntary at first but if not responded to then it should be made obligatory and compulsory.

To provide health cover in remote mountainous regions and inaccessible regions extraordinary steps can be taken where no such facilities exist and health care is either non-existent or lies in the hands of medicants. Denying health care to most needy in our remote regions itself speaks of negligence and lapse of our policy makers. These problems can be sorted out by outsourcing of health services by government to Private Corporare world on contractual basis. Yet another alternative is to organise mobile medical camps on regular basis.

In many countries it has been observed that excellent job has been done during war and peace by pooling up vehicles which are used as mobile hospitals. More over improvised prefabricated structures can be utilized to deliver full health cover on six monthly basis in different places.

Lack of modern teaching methods

One of the many serious problems which nation is facing is because of brain drain of highly experienced and trained doctors to the advantage of advanced nations. Even those doctors who have been educated and trained in state sponsored institutions find their escape to nations where they are better paid and looked after well.

This practice should be stopped and doctors who studied in Government institutes in India must not be allowed to leave the country. It has also been observed that many doctors and specialists working in Government institutes go abroad on scholarships and training in newer and advanced techniques but ultimately manage to stay in foreign countries causing not only financial loss to country but also result in deficiency of doctors in parent country. Recruitment of physicians from less-industrialized countries began in the 1960s, coincident with the advent of universal health care coverage in a number of industrialized nations, which created a relative physician shortage.[19]

This migration of doctors to affluent nations continues unabated. Migration of health workers ‘Brain drain’ is defined as the movement of health personnel in search of the better standard of living and life quality, higher salaries, access to advanced technology and more stable political conditions in different places worldwide.[20]

This too is a lapse on the part of authorities as they have not been able to stop this escape of doctors from poorer countries to rich Western countries thus causing shortage of doctors in developing countries. Doctors from low income group of countries of Asia and Africa move to Western countries for better quality of life, better working conditions, more pay and even for political and social hardships they face in their country of origin.

Another issue which results in lapses, negligence and unsatisfactory treatment is continuation of age old method of teaching and training of young doctors. Despite studying for long years in Medical College a freshly turned out doctor is not fully equipped to handle any life threatening emergency or disease unless a doctor had been exceptionally brilliant student and hard working trainee during internship. The extensive super and sub specialization to tackle multiple diseases in a single patient means patient has to make numerous visits to hospital and to various consultants. The patient now is not treated as a whole but is examined and treated in parts organwise. This leaves scope for mistakes and confusion by voluminous number of medicines prescribed by many consultants which at times are duplicated. There is no system of coordinating and justifying the multiple prescriptions. Thus the training and making of a doctor from Medical College needs upgradation, reforms and change of duration of time schedule of teaching and training so that a doctor comes out a fully functional and very well experienced healer who would manage the patient as one living entity and not a machine whose parts have to be rectified by different set of people.

It would be in interest of all and benefit of patients specially to train students to become all round doctors

trained and experienced to manage a patient as whole which would enable our hospitals in remote areas to give full fledged all system treatment. This experiment has been successfully implemented and observed when Surgeons were self trained in performing General Surgery, Caesareans, Hystrectomies, Craniectomy, minimal invasive surgery for fixation of fractures, laproscopic procedures, ERCP and also were experienced in successfully managing medical diseases like Diabetic ketoacidosis, eye, ENT and Skin disorders. Such fully trained complete doctors have been highly successful in remote areas where facilities of superspecialists are not available. During wars and battles such Surgeons and the trauma surgeons are remarkably more useful than a Superspecialist Surgeon who cannot go beyond managing a single organ in an patient who has polytrauma and is in shock. Therefore instead of churning out a GP from Medical Colleges, time has come to turn out doctors who are more widely trained, educated and rotated among all specialities and the period of trainimg thus should be extended to atleast eight years. Such doctors are useful to patients who are saved from visiting various consultants and are managed effectively by an all-round single doctor. In remote mountainous inaccessible places the services of superspecialists are unimaginable. In small towns and remote places however a well experienced all round doctor who is good in one discipline will be good in all disciplines particularly in hospitals in far flung remote areas with logistic and man power support to doctor. I had the chance of working in a tertiary care hospital after becoming a Surgeon where I was compulsorily exposed to variable period in Orthopaedics, Urology, Reconstructive Surgery and even in conduction of Caesareans. It later proved life saving in remote mountainous regions where I was posted. Similarly a polytrauma specialist who is a General Surgeon also has been more useful to tackle polytrauma from head to foot rather than an organ specialist Surgeon who might resort to abdominal surgery first and before fixation of fractures by orthopaedic Surgeon or thoractomy or Craniectomy by a Neurosurgeon. Thus a trauma surgeon is more conscious and effective in alloting priority and management to a patient with polytrauma rather than an organ specific specialist Surgeon. Trauma surgeons are more competent to allot priority and offer resuscitation and urgent surgery where a challenge of mass casualties are encountered.

We have seen nil mortality at the hands of Surgeons trained to manage grievously injured polytrauma cases.

The reasons of lapses, negligence and the factors responsible for causing damage to patients due to treatment are varied and diverse. Firstly there is a definite decline in standards of selection of students who should become a doctor and would be eminently suitable for the highly humane profession. Medical profession not only needs compassion from doctors but also demands from would be doctors excellence in knowledge, experience, capability to work hard and relentless disregard for personal comforts. Outright gain and profit are not the prime objectives of a medical student. Doctors must possess and practice exceptional tolerance and should work with dedication for days together when ever required. Good conduct, sympathy, professional excellence, adequate knowledge should be the divine qualities of a doctor.

Doctors should be gentle, polite, soft spoken, kind, communicative, impartial and energetic.

These characteristics of a doctor have principle role in making of a doctor who will commit no mistake or less mistakes.

But who should not become a doctor. A student who is not interested to become a doctor should not be forced to become one. But very rich parents force their unwilling children to become doctors by paying heavy fees to Private sector teaching institutes. Such a student who has least interest in becoming a doctor will neither be regular in attending classes nor will he become a good doctor. Such a person will commit lapses and damage the patients. Yet another category of students who should not become doctors are those who are temperamentally not suitable to become doctors because of aggressive and violent behavior and indulge in brutish ragging. These must be removed from medical institutions and should be given no chance to play around with lives of patients. It has been seen that many rouge and violent students under influence of alcohol or even without it have indulged in merciless beatings of juniors causing death of innocent students. Instances of use of iron fisted knuckles have been reported in torture. In one case the only child was beaten to death leaving his grieving parents in distress. Such criminals should not only be expelled permanently from medical institutions but also must face law for committing heinous crime. What kind of a doctor a brute will become. To keep medical profession clean and blame free only those students be permitted to continue medical studies who have a crime free record.

Doctors must possess sound health without indulgence so that their ill health does not affect their day to day duties and good performance and thus should be subjected to mandatory health check up atleast once a year inclusive of investigations.

What can go wrong in hospitals

Though hospitals are rendering yeoman service to sick and diseased but cases of lapses and dissatisfaction are on the increase. Public Sector government hospitals are overcrowded and have poor doctor patient ratio and face heavy work load both in OPDs, Indoor departments and Emergency and Trauma departments. Due to heavy rush of patients in OPD numbering in hundreds per doctor, it is not possible to do full justice in terms of history taking, clinical examination and management. The Judgement has to be hundred percent accurate though

full satisfaction of patient may not be always possible. Missed diagnosis and lapses in asking for investigations may occure due to heavy traffic of patients. Many lapses occure due to lack of guidance to junior doctors in OPDs, Wards and Emergency Departments as senior doctors donot sit along with them to teach, guide and monitor.

Without observations junior doctors start writing wrong prescriptions and also mismanage both medical and surgical emergency cases. Guidance of seniors is a must and therefore all Heads of Units and HODs too must go around the wards including Emergency Wards and other wards with chronic patients.

It is not unusual to see the Head of Unit suddenly getting up from the OPD on pretext of attending an admin or academic meeting leaving youngsters to their own devices.

Therefore all academic and admin meetings should be held either in the morning or late in the evenings which should not interfere with clinical functioning and cross consultation.

Another problem which comes in way of good health care delivery is poor educational background of paramedics who are actually the foot soldiers of medical care. It is the Nursing Staff, the Nursing Assistants and Hospital Attendants whose approach to patients, their humane approach with dedicated service makes all the difference. Doctors cannot remain on the bedside of patients all.the times. It is the Nursing and Paramedical Staff who will carry out the orders of doctors to logical conclusion.

The good or bad impression of the hospital is created by treating team which can be for good or bad. In humane services like health care one and all must be sympathetic and helpful to patients and their attendants. Those who donot possess kindly temperament can safely be asked to call it a day and instead should be asked to choose some other profession.

In hospital practice actions may go wrong due to diverse reasons like inadequate skill and experience of treating team, lack of knowledge and to decide what one can do and what one cannot do. There is an old dictum and that is do no damage at first, if there is any doubt about assessment of the patient then it would be better to consult more experienced and knowledgeable person. No harm in that.

One gets a correct answer when one places the self in some one else's position.

Many cases of lapses occure in hospitals because of inadequacy of trained man power, lack of equipment, absence of proper asepsis and sterilization and insincerity of staff.

Doctors and hospital owners also indulge in practice of bribing touts who fetch them patients which amounts to malpractice and unethical conduct. Some doctors prescribe medicines only to be procured from laymen who are agents without known credentials. So is the case for advising investigations to be conducted at a specific unauthorized center.

The greatest problem is lack of awareness of what the hospital needs to do which can only be found out by rounds and visits, patient surveys and regular inspections.

Examples of some mistakes, lapses, negligence and harm done to patients.

1. A young doctor conducts an operation which he had never performed in past. The patient lands up in complications and a senior comes who handles the situation. The first doctor has committed a mistake by operating upon a patient without taking into confidence his seniors and did not ask for guidance.

2. A reluctant Surgeon was requested to operate a person with perforated appendix with severe peritonitis but he did not operate the patient. Neither he referred the case to some one who could have tackled the grave emergency which could have saved the life of patient.

His colleagues too requested him to operate the patient to save his life but he fraudulently obtained unwillingness from the dying patient.

3. A well equipped hospital received a serious emergency patients but was not able to manage the services of specialist doctor due to shortage. This was a system failure.

4. A Senior Surgeon operates upon an elderly patient a case of Gall Stone disease whose abdomen is already scarred by previous surgery. He takes up the case for laparoscopic cholecystectomy against the advice of his colleagues. The Senior Surgeon lands up in difficulty nevertheless he continues with laparoscopic surgery where as he should have converted the procedure to open surgery.The patient dies due to complications. This is a case of lapse and failure of judgement and not listening to advice of his colleagues. Message is clear that the wise counsel of colleagues should always be valued and considered for better good of patient. Therefore, the choice of procedure must be weighed in light of good chances of successful outcome or possible risk. One must know when to operate and when not to operate and what kind of approach will benefit the patient most regardless of personal ego.

5. There is an instance of a middle aged patient developing severe Ac Pancreatitis and was being managed in a tertiary care hospital with conservative measures. The patient was discharged on request to

another tertiary care hospital for further management. At the dead of night Residents undertook the patient for ERCP without informing the senior faculty and the relatives. The patient started bleeding which the Residents could not control. The help of senior consultant cum faculty was requested who some how controlled the bleeding and patient was discharged to home with the advice to report again for review. The patient lost his life while reporting back to hospital for review. This episode explains the poor control of HoD over his staff and irresponsible behaviour of Residents

6. There are instances when sympathomimetic drugs have been administered to patients undergoing major surgery resulting in bleeding and cardiac arrest.

7. There are examples of patients developing ischaemia and gangrene of upper limb due to tight synthetic POP cast.

In one case a patient with undisplaced fracture of forearm bone was given POP cast after he had sustained injury. The Orthopaedic Surgeon was cautioned by HoD to replace the POP cast by a POP backslab to avoid tourniquet effect by possible oedema due to injury and venous obstruction. The Orthopaedic Surgeon ignored the advice due to overconfidence. The next day during round the patient was found to have frank gangrene of hand and forearm which had to be amputated. This was a case of criminal negligence on the part of treating doctor.

8. In yet another glaring disregard for life a doctor operating upon a trauma case abandoned the patient midway and left the OT with a lame excuse and instructed the OT staff to call some other doctor to operate the case. This superspecialist was found to have gone to operate another case for consuderation. The replacement Surgeon took time to come as he was already busy elsewhere.

The patient lost his life. This episode shows that the concerned doctor was not only negligent but also had disregard for human life and its basic ethics. He was unfit to become a doctor.

9. A patient with Acute Myeloid Leukaemia was being managed with chemotherapy which was stopped by a doctor resulting in rise of Neutrophil count. However, the patient was asymptomatic and was referred to a cancer hospital for BMT. During hospitalization the patient developed mild fever. All investigations were normal and cause of fever could not be established. The patient was subjected to CECT chest and abdomen including CT Head multiple times all of which were normal. During the course of treatment he was administered numerous antibiotics, variety of antifungal drugs, host of antiviral drugs, sepsivac and medicines were procured from unknown, unauthorized persons.

His Serum Lactate levels reached more than 7 mmol per litre. The HoD admonished the Residents for needless repeated CT scans within one week and for infusing multiple drugs including Amphotericin B without indication. The patient died in hospital before he could be taken up for BMT after incurring expenditure of 18 lac rupees for 15 days hospitalization.

10. A case of intertrochanteric fracture of femur was dealt with by THR. Before operation a query was raised for necessity of THR while acetabulum and neck of femur were intact and the advice for fixation by plate and screws was suggested. HoD turned down the advice and went for THR only. During surgery the sub trochanteric femur was shattered due to hammering and THR failed. The broken fragments of subtrochanteric femur and the stem of prosthesis were positioned with the help of cerclage wire. Patient lived up with limp and broken cerclage wires.

11. A Surgeon successfully tackled the incisional hernia by laparoscopic approach but failed to fix the mesh resulting in recurrence due to inexperience.

12. Some doctors donot co-operate with their colleagues due to diverse interpersonal behaviour and have a negative attitude of letting down others. In one such instance a HoD did not permit a senior experienced Surgeon to operate a traumatized patient in OT.

As a result the patient was taken up for Surgery under LA in ED which involved repair of cut tendons. The patient made good recovery and had excellent anatomical and functional outcome. The behaviiur of HoD was improper and sly.

In yet another instance an young anaesthesiologist gave Inj of a sympathomimetic drug to a patient undergoing operation under spinal anaesthesia to raise blood pressure if at all it was on the lower side. An alert Surgeon took note of it as the patient started having unusual bleeding. The anaesthetist accepted his mistake who should have raised the low blood pressure by first giving adequate intra venous fluids as blood pressure after spinal anaesthesia has the tendency to fall which should first be managed by fluids and not by sympathomimetic drugs straight away.

13. A Surgeon is called to see a female patient having pain abdomen in a Family Ward by a Medical Consultant, a Gastroenterologist. Surgeon examines the patient and after examination asks for an urgent X- Ray Chest. The X Ray Chest shows both lung fields having extensive opacities, a frank case of milliary tuberculosis. A diagnosis missed by Physician as pulmonary pathology specially of Diaphragmatic pleura at times does present with referred abdominal pain.

14. An elderly patient gets admitted to a tertiary care hospital for investigations of hoarseness of voice. The patient's vital parameters and investigations were within

normal limits. Patient was subjected to panendoscopy and multiple biopsies from larynx, lung, oesophagus and stomach with fatal outcome.

15. Examples are many like leaving instruments, drains and gauze pieces in abdominal cavity, inadequate excision of malignant tumours, irrational and extended chemotherapy, missed diagnosis, delayed examination of patients specially in emergency situation, casual and inadequate clinical examination, extending hospitalization without justification, asking frequent investigations with hazardous outcome. There are instances of CECT being asked for time and again without any benefit which would be harmful to patients. The basic lapses within hospitals are due to human and material factors. Lack of punctuality, callus and lackadaisical attitude, inexperience, consultants specially seniors not giving best and most, inadequate knowledge of the subject, lack of co- operation among staff, procedures going wrong, too many and too less medications and investigations harm the patients.

16. Great harm is being done to ignorant and illiterate patients by quacks and unqualified healers who dispense medicines even to serious patients which causes needless delay in approaching hospitals for appropriate and early treatment. It is not uncommon for patients with bony injuries having fractures, dislocations and displacements being treated by laymen passing off as bone setters.

The health services in third world countries remain unregulated, unquestioned and without direction. These countries have neither accurate data nor the authentic statistics of morbidity and mortality of diseases which result in faulty decision making to improve the health services.

Lapses by quacks and unqualified persons

It is a well known fact that all over the world persons who are some how in trade of assuming the role of dispensing medicines of bizzare nature or those who have elementary experience of working in health set up as assistants, technicians, paramedics and medicants are playing with the lives of ignorant and gullible patients. Cases are on record where unqualified, inexperienced technicians pose as Surgeons and undertake major and minor surgery only to harm and cause death of patients.These incidents occur even in metro- cities where despite adequate and state of art facilities are avaiable at affordable cost, the innocent patients are mislead to undergo treatment in ill reputed hospitals. Sadly such hospitals are permitted to function even after these hospitals have been warned and punished for wrong doing in past.

How can we tackle lapses and negligence in Health Services

A well functioning and universal availability of all round preventive and therapeutic care for diseases and infirmity is basic need of human beings. Needless to say that first necessity to achieve this goal is dire necessity of complete literacy of masses which is still a distant dream for third world countries and remote inacceible regions of earth. An educated and well informed public understands better the value of leading healthy life style.

Healthy life style means avoiding use of harmful edible items and indulgence in bad habits like smoking, drinking alcohol, consuming intoxicants, idle life style, overcrowded dwellings and increased urbanization and shift of larger number of people from rural areas to urban areas which results in tremendous load upon insufficient number of hospitals and resources specially in public sector hospitals. Such heavy load on hospitals results in inadequate attention and care to both indoor and outdoor patients which does not get reflected upon the responsibilities of state but gets diverted as lapses on the part of doctors and nurses.

Many of the lapses and complications are the result of inadequate staffing pattern in health services, lesser number of hospitals and fewer hospital beds, inadequate equipment generally in public sector hospitals. The annual budget allocation for health services for 2023-24 stands at 89155 Crore rupees. The budget expenditure reached 2.1 percent of GDP in FY 2023 whereas Britain and EU spend more than 12 percent and 8.1 percent of GDP on health respectively. More funding for health means more hospitals, more staff, more equipment and better expertise therefore lesser problems and quantum jump in patient satisfaction.

The disparity between the cities and rural areas in terms of number of hospitals, patient transfer facilities, equipmentation, staffing and availability of drugs must be improved. Rural areas have virtually no tertiary care hospitals and donot have adequate trained staff and specialists and therefore ruralites are at the receiving end of miseries overall specially in health care and education. Specialist and superspeciality health care facilities are generally confined to urban centers. Private sector hospitals are predominantly urban phenomenon which provide state of the art health facilities of world class standards. Therefore rural areas too need such advanced facilities where lapses can be minimized due to non-availability of human and material resources.

The human factors

Due to rampant ignorance, illiteracy and poverty patients fall victims to treatment by quacks, half baked professionals and even non professionals. Many doctors who are not well trained, undertake operations for which they are neither experienced nor possess adequate knowledge and end up damaging the unsuspecting patients. It is therfore mandatory for health agencies and appropriate government departments to keep a watch on such doctors and hospitals. There is absolute need for continuous medical education programme and upgradation of education so that lesser mistakes are committed. Treating patients without ample knowledge

is like driving a vehicle without training and skill which would result in disaster. Any how doctors must keep themselves upgraded and updated by reading and learning. It is the responsibility of senior doctors and authorities to run and arrange daily academic activity even in all non-teaching hospitals as well. The nursing and paramedical staff too be re- educated at their level by experienced clinicians and teachers.

Another major field which requires attention is communication and guidance of patients and attendants from arrival in hospital till discharge from the hospital. For the patients hospitals are not pleasing places to visit and are definitely unfamiliar with site plan and about persons and places where and whom to visit for ailment and investigations. Therefore, adequate number of PROs must be detailed to approach the visitors for their queries, guidance and difficulties. The staff which is appointed must be educated to be co-operative, courteous and helpful. The administrators, Directors and Medical Superintendents of the hospitals must be trained well and should also check the genuinity of educational qualifications, experience and eligibility of doctors and technical staff to eliminate fraud and deception. The professional competence, ethical and quality of treatment given to patients must be assessed by independent statuary body covering all small and large hospitals which must include visits to patients and scrutiny of case sheets having records of treatment being given, investigations done and progress of the cases. The meticulous record of procedures and operations conducted be recorded and monitored. The reliability and capability of professionalism in hospitals should be audited on daily basis. Patients taking more time than expected among treatable cases should be discussed.

Meticulous record of suitability of drugs to be exhibited to patients must be ascertained. It should be ensured that expired and near expiry drugs must not be used on patients and should be screened and destroyed as accidental use of these medicines can be harmful to patients.

Persons with doubtful professional qualifications and persons with assumed identity must not be permitted to work as doctors as many such conmen work in some hospitals or even independently. Incompetent and inexperienced professionals must be prepared first to upgrade their skills and must not be authorized to work independently and be kept under supervision till they gain sufficient experience. All procedures being undertaken be supervised if possible. Young inexperienced residents and junior consultants must be permitted to work only under close watch. Regular power and water supply should be ensured round the clock so also the ventilation and upkeep of premises. Operating surgeons must examine and peruse the documents of patients before undertaking procedures.

Hospital infections which can kill patients must be controlled and prevented by laid down SOP and unjustified use of antibiotics must be prevented. Use of obsolete and malfunctioning equipment must not be permitted. It should be ensured that hospitals must have ideal operating conditions. The authorities must not permit patient care and treatment in less than ideal settings. After surgical procedures each and every count of foreign object must be accounted for to avoid harm to patient and litigation. Robotics in surgery must be controlled to avoid mishaps. There are cases where patients have landed up with complications due to Robots conducting radical surgery resulting in destruction of external sphincter during radical prostectomy, the patient becoming incontinent for life.

To avoid mishaps and lapses in patient care there can be no compromise with knowledge, competence, experience, preparedness and quality.

CONCLUSION

The lapses and negligence in medical practice are generally the result of man made inadequacy in terms of knowledge, experience, patient care, lackadaisical attitude, deception and misplaced confidence in one's own capability and being careless in conduction of duty and discharge of responsibilities towards patients. Such lapses may result in death, injury, disability and complications to patients besides grief and mental trauma to patient's relatives with consequent economic hardships.

The problems may arise due to delay in giving necessary treatment, giving wrong medicines, faulty surgical technique, treatment by inexperienced unqualified persons, lack of timely intervention deliberately to hide mistakes, leaving foreign objects in the body during surgery, referrals to substandard hospitals, inadequate antisepsis resulting in hospital acquired infections, wrong decisions and even choosing normal limb or site for procedure.

There is need to regulate haphazard health services which need more outlay of GDP for improvement of health care, more hospitals all over country, more hospital beds, more doctors, more nurses and trained staff so that dependence upon quacks and ignorant medicants is reduced. There is definite role for continuous training modules for health care personnel and CME for doctors and nurses on regular basis. Statutory autonomous bodies with competent professional component must be involved for monitoring the working and professional excellence of individuals and hospitals which should also include inspection of instruments and equipment. It is desirable to encourage the public- private participation to further improve health care services. India has done very well by extending free health care services to several millions of poor families under various schemes like *Ayushman Bharat Pradhan Mantri Jan Arogya Yojna* named as PMJAY. However large number of needy patients in tribal, mountainous

and rural areas too need to be extended this noble scheme.

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