Critical Reasoning Practice

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Crime, health-worker safety and a self-examination

The year 2017 saw heated protests by resident doctors in Maharashtra, following a series of vicious attacks on medical personnel in rather quick succession – as is invariably the case with sensationalised criminal offences. Despite the magnitude of the problem, the solution was straightforward and run-of-the-mill. It meant bolstering security in public hospitals and strengthening legal instruments to bring the malefactors to rapid justice. Similar incidents came and went, with much happening during the COVID-19 pandemic. The knee jerk responses too continued. One is hard-pressed to recall any conspicuous precedents of swift justice.

There lies a deeper problem

It is the case of the grisly death of a promising resident doctor in Kolkata that has taken the country by storm and that has spurred the Supreme Court of India to take *suo moto* cognisance of the happening. However, emerging answers to the issue continue to remain reflexive and simplistic, and possibly reflect an incomplete understanding of the malady beneath. In its proceedings on August 20, the Court decreed the constitution of a national task force to work out measures to strengthen hospital safety. Improved infrastructure and closed-circuit television surveillance, a greater security presence at hospitals, and safe night transport are reportedly some areas that will receive attention.

In the same vein, the West Bengal government has announced the '*Rattierer Saathi* (night companion') programme aimed at improving the safety of women working in night shifts, particularly in medical colleges and hospitals. While such initiatives are critical, they implicitly conflate this issue with archetypal health worker violence, which is initiated by disgruntled patients due to perceived poor health-care services, or women's safety at large. What lurks underneath is the much more insidious problem of corruption of criminal proportions.

Conventional answers to health worker violence, such as improving hospital security and newer legislation, have miserably failed in tackling the problem over the years. These include reasons such as underfunding which are no different than why our health systems continue to remain frail in general. But the extent to which corruption contributes to the overall loss of lives has been vastly under-appreciated. If emerging accounts are anything to go by, there is a strong likelihood of deep-rooted, organised corruption having contributed to the gruesome crime in question, not to mention other incidents and the steady erosion of public health services that may have hitherto gone unheeded. The fact that this concerns an apex health-care institution in an already underfunded state public health system is acutely disconcerting.

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Emerging answers to the issue of health-worker safety continue to remain reflexive and simplistic, and could show an incomplete understanding of the malady beneath

WHO estimates

The World Health Organization estimates that corruption claims nearly $455 billion annually worldwide, more than what it would cost to extend universal health coverage to all. In a good part of the developing world, corruption rather than a lack of funds is what majorly contributes to health-care crises and poor health outcomes. While often sensationalised, the discourse on medical corruption in India has largely concentrated on private losses and malfeasances, while its criminal dimensions have been largely underappreciated. Human resource-intensive health-care systems provide rapid breeding grounds for expansionary corruption, including the worst forms of sextortion, particularly in political systems where underfunding and poor oversight run rife.

In such circumstances, it is hard to conceive how much help would realistically accrue from merely improving the state of health workers' security and hospital infrastructure, even if they are somehow adequately implemented. Being painfully galvanised to the fact that medical corruption can claim the lives of health-care workers in addition to that of patients serves to indicate that the public health system and its drivers may be up for a rigorous self-examination.

Speedy delivery of justice in the Kolkata case is inarguably paramount, for nothing else said or done can ever serve as a consequential deterrent. Needless to say that we have traditionally fallen short in this respect, and the ramifications are for all to see.

The steps that are needed

But the national task force has a job that is arguably more monumental than simply recommending safety measures – which is to devise a potent road map to prevent and arrest medical corruption, particularly in the public sector. Certainly, this cannot be approached solely by a team of medical doctors. It requires expert inputs from public health, medico-legal, and other allied competencies, besides meriting the participation and the sanction of the larger governing and administrative community. And, the strategies so devised have to look much beyond instituting yet another novel legislative tool.

Apart from reforms centering on administrative transparency, accountability, and oversight, effective whistle-blower reporting and protection mechanisms and thorough digitalisation of public management systems are crucial. The need for ombudsmanship and other instruments to minimise political intrusion and manoeuvring cannot be overstated. Inspiration may be drawn from how fellow nations such as Brazil continue to battle political corruption in medicine.

Much also remains to be done in the way of modernising the typical 'control and command' Indian public hospital, which remains steeped in anachronistic ways. While efficiency reasons for such a modernisation abound, their pressing moral and regulatory bases have glaringly presented today and can no longer be overlooked.

Question -1) The passage suggests that the usual response to violence against healthcare workers in India is:

A) Adequate and well-thought-out.

B) Reactionary and simplistic.

C) Focused on addressing the root causes.

D) Directed primarily towards punishing perpetrators.

Question -2) Which of the following best represents the author's view on the correlation between corruption and health crises?

A) Corruption is a minor factor compared to underfunding.

B) Corruption is as significant as underfunding in causing health crises.

C) Underfunding is the sole reason for health crises, not corruption.

D) Corruption has been exaggerated in its impact on health systems.

Question -3) What does the author imply by stating that "emerging answers to the issue continue to remain reflexive and simplistic"?

A) Proposed solutions are well-considered but challenging to implement.

B) There is a need for deeper analysis and understanding of the problem.

C) Solutions are addressing the problem effectively.

D) The issue has been resolved with the current measures.

Question -4) What is the most likely purpose of the author's mention of WHO estimates regarding corruption?

A) To highlight the global scale of the problem.

B) To argue that corruption is only a minor issue in India.

C) To show that India is uniquely affected by corruption.

D) To suggest that corruption is inevitable in health systems worldwide.

Question -5) According to the passage, what is the underlying cause of the "grisly death of a promising resident doctor in Kolkata"?

A) Inefficient hospital infrastructure.

B) Lack of proper night shift safety measures.

C) Deep-rooted, organized corruption.

D) General violence against healthcare workers.

Question -6) Which of the following strategies is NOT suggested by the author to combat medical corruption in the public sector?

A) Increasing hospital security.

B) Thorough digitalization of public management systems.

C) Effective whistle-blower reporting and protection mechanisms.

D) Ombudsmanship to minimize political intrusion.

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