Review Article

Legal Responses to Violence against Medicare Service Persons and Institutions during COVID- 19 Pandemic in India

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Abstract:

Background: The COVID-19 pandemic and virility of the violence against medical personnel have been parallel phenomena in Indian public health administration. The safety and security medical and paramedical have been attracting attention for quite a long time. Still, no central legislation has piloted to enhance their therapeutic and surgical acumen in epidemics and pandemics. The health care of the patients and the covenant of Medicare service persons and institutions doctors missed in the myopic perception of the health administration's tilt towards the criminal administration of justice**.** ***Method***: The clasping of 125 years of age epidemic control law and 162 years of age criminal statute stinks the Indian feel in the present context. ***Result***: The significant outcome of the COVID-19 pandemic is showcased in *the Epidemic Diseases (Amendment) Ordinance*, 2020, ensuring harassment-free workplaces for the medical fraternity. The criminal sanction afforded by the 23 state enactments on the protection of medical care personnel and institutions in states in India, but there is no central legislation. Despite the Indian Medical Association's recommendation for the *Protection of Medical Service Persons and Medical Service Institutions (Prevention of Violence and Damage or Loss of Property) Act*, 2017, we witnessed *Epidemic Diseases (Amendment) Ordinance*, 2020 in enhancing the robust workplace for the doctors during the pandemic. The legal strategy camouflaging 'disaster' under Section 2 (d) of *the Disaster Management Act*, 2005 in pandemic and lockdown is sobering but astonishing. ***Conclusion***: The paper locates the legal response to violence against the doctors in the sociology of medicine and medical professions as professional socialization and social system during the COVID-19 pandemic.

Keywords: Violence against Doctors; Security of Medical Workforce; Epidemic Control; Ordinance Promulgation; Institutional Autonomy; Sociology of Medicine; COVID-19 Pandemic.

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Introduction:

COVID-19 pandemic exacerbated violence against the medical workforce and created panic among the medical fraternity for health care operations. The pandemic, with its appalling fallouts, exacerbated the pestilence, pandemic, and catastrophe. India's public authority conjured Section 2 and 2A of the *Epidemic Diseases Act (EDA)*, 1897, Section 188 of *Indian Penal Code (IPC)*, 1860, and Section 133 *Criminal Procedure Code (CrPC),* 1973 to control COVID-19 in India.[1]The government bought

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into the hypothesis of 'disaster' supported in Section 2 (d) of the *Disaster Management Act (DMA)*, 2005[2] during four continuous cross-country lockdowns.[3] Meanwhile, the Ministry of Health and Family Welfare (MoHFW) constrained giving warnings to all states and Union Territories on March 24, April 4, and April 11, mentioning them to guarantee sufficient security to medical care experts and clinical staff. However, it evoked discontentment against the clinical and paramedical experts in their lawful duties in COVID-19 operations.[4] Understanding the weightiness of the circumstance, the state governments implored Section 2 of the *EDA*, 1897, read with Section 38 of the *DMA*, 2005, to ensure non-violence against the medical workforce. [5] There are 141 enlisted cases under Section 188 of the *IPC*, 1860 in Mumbai. [6]The territories of Kerala, Haryana, Maharashtra, and Telangana additionally saw rough assaults on specialists despite the executions of the state *Protection of Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act,* 2007.[7] Realizing the urgency, under Article 123 of the *Constitution of India*, 1950, the President declared the *Epidemic Diseases (Amendment) Ordinance (EDAO),* 2020, on April 22, 2020, to manage the virility of violence against doctors in India.[8]The criminal sanction afforded under the 23 state enactments on the containment of violence against the medical workforce and institutions in India, but there is no central legislation due to myopic perception of the professional socialization of the medical fraternity in society. The paper looks at the inborn indecencies and frontier overlords of the contagion mould of colonial vintage in the contemporary perspective of COVID-19 pandemic-induced violence against the medical workforce in India.

Material and Methods:

The security of medical care personnel is of utmost priority during pandemic[9] and deserves for the therapeutic perception towards COVID-19 patients.[10] The medical care offices have a real job securing medical services as drawn from the WHO database[11] and Reports of *Protection of Health Workers and Emergency Responders*, 2020.[12] Despite the central reference to the *Framework Guidelines For Addressing Workplace Violence In The Healthcare Sector,* 2002[13] and *Corona Virus Disease (COVID-19) Outbreak: Rights, Roles and Responsibilities of Health Workers, Including Key Considerations for Occupational Safety and Health*, 2019 violence against doctors became a viral epidemic[14] and emergency.[15] The difficulties of a drawn-out reaction to COVID-19 focused on the medical clinic faculty, and well-being and security laws and strategies.[16] The *EDAO,* 2020 passed to ensure security to medical workforce and violence against doctors during the COVID-19 pandemic in India[17] and Bangladesh. [18] and south Africa.[19] However, the legal responses to violence against the medical work force should address the individual and institutional autonomy of the clinicians and managerial colleagues from critical assignments and responsibilities[20] in India and Aligarh.[21] The *EDAO,* 2020 passed to ensure security to medical workforce and violence against doctors during the COVID-19 pandemic in India.[22] The legal response to violence against the doctors needs delineation in the methodological framework of the sociology of medicine and medical professions[23] and Non-Medical Healthcare Professionals.[24] The realistic review of culture of violence against doctors subscribes to the pertinent gaps in legal precepts and practices in Indian hospitals and summons legal and policy interventions.[25] The paper laced in concepts and theories of sociology of medical professions to develop a rounded perspective of the violence and security of workplace and culture.

Ethical Clearance: Not Required

Results:

The COVID-19 pandemic exacerbated the violence against the health professionals in the myriad of contagion uncertainties of diagnosis and prognosis. In the past as well, the Indian Medical Association estimated that 75% of doctors' victimology by intimidation, abuse, and assault.[26] The disincentive and demoralization of medical professionals often paved stress, anxiety and depression besides defacement of collective image and identity. The *Protection of Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage to Property) Act*, 2007 implemented by the state of Andhra Pradesh and replicated in 23 states in India to enhance the deterrent value against violence.[27]

These enactments invariably make violence and damage to property to medi-care persons and institution as cognizable and non-bailable offence besides the double recovery of the price of damaged goods. The deterrent value of the law can be gauged from the imprisonment for 3 years and with fine up to ₹ 50,000. The Indian Medical Association draft of the *Protection of Medical Service Persons and Medical*

Service Institutions (Prevention of Violence and Damage or Loss of Property) Act, 2017 set tone and tenor of the legal reform and social change but lost its vision. It eventually cloaked under the extension of vintage module of the *EDAO,* 2020[28] as criminal administration than that of deepening of health governance structure in the present circumstances.[29]

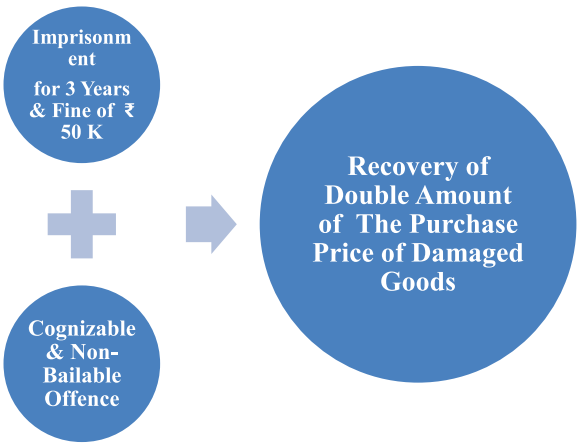
3.1 ***Culpability and Compliance in Epidemic:*** The *ED*, 1897 stretches out to India's entirety and Section 2 enables State Governments to take extraordinary measures and endorse guidelines for any contagion control.[30] The *ED(Amendment) Act*, 1938 federalised contagion liability to the provincial Government under Section 2A.Section 3 punishes any individual who defies an isolate request following Section 188 of the *IPC*, 1860 and Section 133 *CrPC*, 1973 with culpability, detainment and fine up to Rs. 1000.[31] In *J. Choudhary* v. *State of Orissa*, the Orissa High Court applied Section 3 of the *EDA*,1897 and Section 188 of the *IPC*, 1860 against a specialist who denied cholera immunization. The Orissa High Court put to the side the expectation of the specialist and rebuffed for noncompliance by summoning Section 3 of the *EDA*, 1897 and Section 188 of the *IPC*, 1860. Section 4 of the *EDA*, 1897 looks to inoculate local officials against lawful activity while acting following earnest duty. The execution of Section 3 of the *EDA*, 1897 and Section 188 of the *IPC*, 1860 manifested in *J. Choudhary v. State of Orissa,* wherein the Orissa High Court fixed quarantine liability against a doctor who refused inoculation in the wake of the epidemic of cholera.[32] The Court delineated that 'an intention to cause harm is not relevant as mere knowledge of the order gives sufficient cause for liability of committing the offence' under Section 188 of the *IPC*, 1860. Notwithstanding the bonafide and malafide intentions of the doctor in refusing cholera vaccination, the Court invoked Section 3 of the *EDA*, 1897 and punished the doctor for disobedience of contagion. It is to be noted that Section 4affords immunity to the public servants against any legal action while acting in good faith during quarantine enforcement. Later on the Calcutta High Court in 1904 in *Ram Lall Mistry v. R.T. Greer* held that payment of compensation will not be covered under the ambit and scope of the *EDA*, 1897.[33] It was only the Supreme Court of India which has revitalized the law in the case of *Dr. Jerryl Banait* v. *Association of India* in the context of the *EDAO,* 2020 in the midst of rising violence against doctor during COVID-19 period.[34]

3.2*Protection of Medical Service Persons and Institutions:* The legal protection of medical service persons and institutions employs stringent criminal sanction under the 23 state enactments in India but there is no denying the fact that a central legislation ideally suited in the times of epidemic and pandemic.[35] The Ministry of Health and Indian Medical Association has been engaging to robust legal framework and blue printed the *Protection of Medical Service Persons and Medical Service Institutions (Prevention of Violence and Damage or Loss of Property) Act,* 2017.[36]

Table-1: State & Union Territories Enactments on Medicare Persons and Institutions

State	Act
Andhra Pradesh	Protection of Medicare Service Persons & Medicare Service Institutions (Prevention of Violence & Damage to Property) Act, 2007
Delhi	Delhi Medicare Service Personnel & Medicare Service Institutions Act, 2008
Punjab	Punjab Protection of Medicare Service Persons and Medicare Service Institutions (Prevention of Violence & Damage to Property) Act, 2008
Tamil Nadu	Tamil Nadu Medicare Service Persons And Medicare Service Institutions (Prevention Of Violence & Damage Or Loss to Property) Act, 2008
Madhya Pradesh	Chikitsak Tatha Chikitsa Sev Se Sambaddha Vyaktiyon Ki Suraksha Adhiniyam, 2008
Orissa	Orissa Medicare Service Persons & Medicare Service Institutions (Prevention of Violence & Damage to Property) Act, 2008
Haryana	Haryana Medicare Service Personnel & Medicare Service Institutions Act, 2009
Karnataka	Karnataka Prohibition of Violence against Medicare Service Personnel & Damage to Property in Medicare Service Institutions Act, 2009
Maharashtra	Maharashtra Medicare Service Persons & Medicare Service Institutions (Prevention of Violence & Damage or Loss to Property) Act, 2010
Chhattisgarh	Chhattisgarh Medicare Service Persons & Medicare Service Institutions Act, 2010
Assam	Assam Medicare Service Persons & Medicare Service Institutions Act, 2011
Puducherry	Puducherry Medicare Service Persons & Medicare Service Institutions (Prevention of Violence and Damage or loss to Property) Act, 2011
Bihar	Bihar Medical Service Institution & Person Protection Act, 2011
Gujarat	Gujarat Protection of Medicare Service Persons and Medicare Service Institutions (Prevention of Violence & Damage to Property) Act, 2012
Goa	Goa Medicare Service Personnel & Medicare Service Institutions Bill, 2013

A cursory glance over the functioning of the protection of medic are service persons and institutions against the violence and damage to property laws in Indian states reveals fragmented and conflicting enforcement. Right from the Andhra Pradesh to states like Karnataka, Maharashtra, Punjab[37] and Haryana, there is uniformity in cognizability, punishment and compensation.[38] The penology of the incitement, abetment and commission 3 years imprisonment and fine of ₹ 50,000 offense committed alongside the cognizable and non-bailable and triable by the Court of Judicial Magistrate of the First Class.



The criminological pattern of violence against doctors' remains in state of laxity as most of the cases either remains beyond the pale of the cognizance or best a compromise with the convicts.[39] The country requires strict monitoring of violence against doctors in normalcy and emergency. The COVID-19 pandemic has been a momentous occasion to set the health care as well security of medical professionals in perfect harmony. Notwithstanding the fact that the 'health' is in domain of state legislature the success of the central law on doctors' security will not hang in balance in implementation and enforcement. It is well understood in the context of the salutary impact of the *Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act*, 1994 which is central health legislation and applied across Indian states.[40]

3.3 *Epidemic Diseases (Amendment) Ordinance, 2020*: The EDAO, 2020 is a viable legal response to violence against medical workforce during COVID-19 pandemic.[41] It devotes to the security law expressed the goal of the *EDAO, 2020 as* to 'secure medical care administration staff and property, including their living and working premises against viciousness during pandemics.'[42] It added three meanings of *acts of violence, healthcare service personnel and property* under Section 2B of the *EDA*, 1897. The comprehensive portrayal 'acts of violence' covers badgering, terrorizing, harm and injury to a medical care professional in the discharge of obligations inside the clinical premises.[43]

Table-2: Protective provisions of Epidemic Diseases (Amendment) Ordinance, 2020

Definition	Section	Provision
Acts of Violence	Section 1A(a)	Harassment, Intimidation, Actual Harm & Injury
Healthcare Service Personnel	Section 1A(b)	Doctors, Nurses, Paramedics and Community Health Workers
Property	Section 1A(c)	Clinical Establishments, Quarantine Facilitation, Mobile Medical Units & Other Property

The healthcare personnel contains doctors, nurses, paramedical workers, community health workers deputed in the contagion control.[44] The articulation of 'property' incorporates clinical establishments, quarantine and isolation facility, mobile medical units, and health care property instrumental in diagnostics and therapeutic treatment during the pestilence and pandemic.[45] The tempering of the clinical information and reports covered under the brutality and not the property under the *EDAO,* 2020.[46]

Discussion:

The Public Health Act of 1875 and the Public Authorities Protection Act of 1893 are now the current Corona Virus Act of 2020, which served as the foundation for the EDA of 1897. The Indian government continues to endorse lurking behind the colonial epidemic-pandemic laws, unfortunately. The *National Health Bill* of 2009, the *Prevention of Violence Against Doctors, Medical Specialists, and Medical Institutions Bill* of 2018, and the *Health Services Personnel and Clinical Establishments (Prohibition of Violence and Damage to Property)* Bill of 2019 were all proposed health legislation that was not passed.

In reality the Sections 3(2) and 3(3) of the *EDAO,* 2020 offers succor by criminal sanction and enforcement for egregious hurt caused to a healthcare service personnel.

4.1 ***Security of the Health Care Work Force***: Although Section 4 *EDA*, 1897 has managed the cost of assurance to the officials. The clinical and paramedical powers confronted the assault of individuals regularly falling back on brutality as a counter to heavy hammer lockdowns arranges progressively. The public authority turned to isolate defiance in 188, 269, 270, 271 of the *IPC*, 1860.[47] The endorsing system planned in *Health Services Personnel and Clinical Establishments (Prohibition of Violence and Damage to Property) Bill*, 2019 did not develop to law. The proposed law condemns individuals enjoying to attack specialists and other medical care experts with severe conviction. Since the proposed Bill did not bring to the rule book, the President proclaimed *EDAO,* 2020 in the right sincere. The *EDAO,* 2020 accommodates the twin discipline *viz*; Punishment for commission or abetment of a demonstration of savagery" and 'discipline for egregious hurt caused to a healthcare service personnel.'

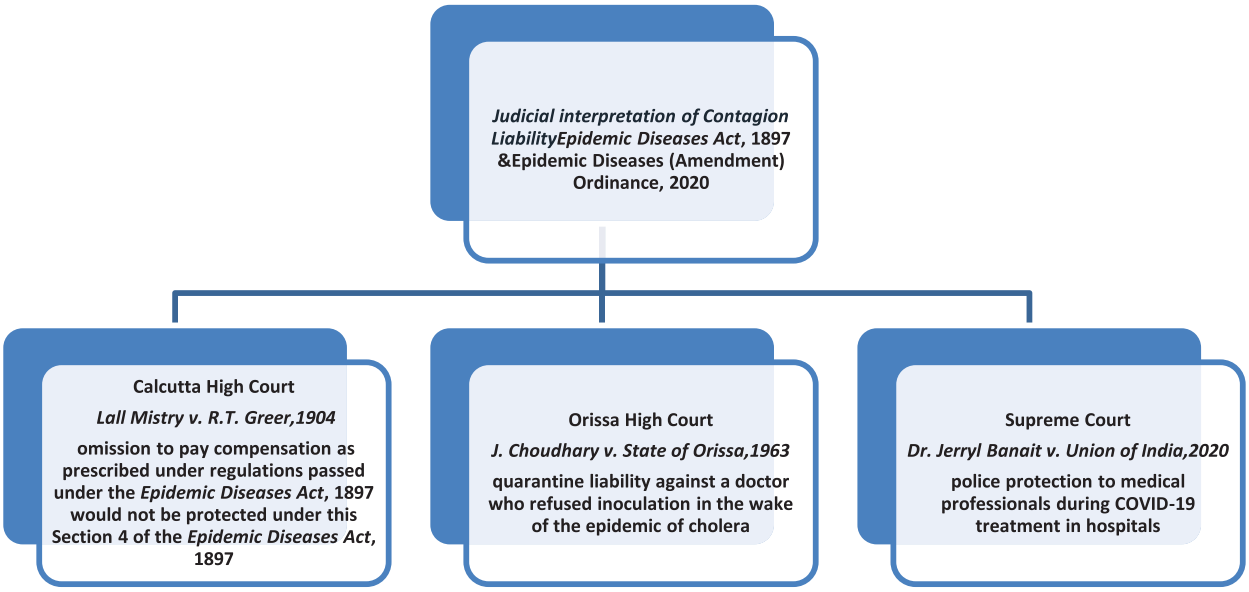
Definition	Section	Provision
Punishment For Hurt	Section 3(2)	Punishment For Commission Or Abetment Of An Act Of Violence
Punishment For Grievous Hurt	Section 3(3)	Punishment For Grievous Hurt Caused To A Healthcare Service Personnel
Imprisonment& Fine	Section 3(C)& 3(D)	Imprisonment of 3-5 years & Fine ₹ 50k to 2 Lac[Sections 3(2)] Imprisonment of 6 months-7 years & Fine ₹ 1 Lac to 5 Lac[Sections 3(2)]

The 'commission and abetment of demonstration of viciousness' made culpable with the detainment of 3 months to 5 years along with a fine of ₹ 50,000 to ₹ 2 Lac. Section 3(3) endorses 'discipline for deplorable hurt caused to a medical care administration staff.' The commission of these offences dependent on the assumption of the fault and mental State of the culprit under Section 3C and culpable with detainment from a half year to 7 years and a fine of ₹ one lac to ₹ five lac. The Supreme Court in *Dr. Jerryl Banait v. Union of India* directed the central and federal Governments for ensuring police protection to medical professionals working engaged in COVID-19 diagnosis and treatment in hospitals besides mandatory supply of the personal protective equipment (PPEs) in the wake of COVID-19 pandemic attack and violence.

This is submitted the success of the legal reform brought spectacular changes in the therapeutic and compensatory medical care during the COVID-19 pandemic. It is evident from the fact that India recorded 3, 42, 85,612 positive cases as of 1st November 2021 and recovery rate of the 98.58% of COVID patients due to meticulous effort of the doctors. On the other hand massive vaccination drive marked 1,97,08,51,580 and touched 524999 as of 26thJune 2022.[48] The Indian government has termed the COVID-19 as epidemic, pandemic and disaster and honed simultaneous strategies and preparedness for its control.[49]

4.2 ***Sociology of Medical Professions & Cult of Violence:*** It will not be out of place to delineate succinctly on the socio-legal framework of the sociology of medicine and medical professions in India. The professional socialization of medical fraternity operates in the social system symptomatic to the decadence of civility among the Indian population. It also encompasses the occupational division of labour in society as professional socialization and social system.[50] It owes to the myriad of declining social mores with trust deficits and commercialization of health sector in India.[51] The victimology of doctors ranges between 8-38% top in the world in violence as substantiated by the World Health Organization report.[52] The safety of medical force is non- negotiable facets of the health governance specially in health emergency and COVID-19 pandemic.[53] Epistemologically, the hospital is communitarian institution based on the concept of total institution which entails that commonality of residence and work in formally administered round of life.[54] The theoretical implication entails communitarian approach in the 'sick role cycle' of the patient.[55] The vitality of cross- cultural comparisons of disease and health impinges on the cross- system comparisons with biases, prejudices, and social beliefs of life.[56] Thus a sociological approach to violence against doctors[57] needs a dispassionate identification in comparative legal perspective in COVID-19 specificities.[58]

4.3 ***Comparative Legal Response:*** In light of the COVID-19 pandemic, numerous nations, for example, China, Ireland, the Philippines, Singapore, Taiwan, United Kingdom and the United States, have appropriately passed well-being enactments.[59] The United Kingdom set out on *Health Protection (Corona virus) Regulations*, 2020 *Corona virus Act*, 2020; *Contingencies Fund Act*, 2020; *Health Protection (Corona virus, Restrictions) (England) Regulations*, 2020 *Coronavirus (Scotland) Act*, 2020.[60] Also, the United States presented a considerable number of



enactment covering *Corona virus Preparedness and Response Supplemental Appropriations Act*, 2020; Families First *Corona virus Response Act*, 2020; *Corona virus Aid, Relief, and Economic Security Act,* 2020 and *Paycheck Protection Program and Health Care Enhancement Act*, 2020.[61] Among Asian nations, China, Singapore, and Taiwan have passed laws on COVID-19 and altered the constitution and momentary resolutions and guidelines.[62] In a similar legitimate change at the worldwide level, it is essential to evaluate the Indian government *EDAO,* 2020 proclaimed by the President under Article 123 of India's Constitution to manage the new circumstances.[63] The health governance linked to the fiscal allocation of India's 'health is wealth' and Health for All' under the constitutional canopy of the Article 47. The policy orientation eventually fosters growth and economic development and downsizing of the propensity of the violence against the medical workforce.

Conclusion:

The clinical experts and personnel are leading of COVID-19 prognosis and merit security and well-being during contagion visits. The MoHFW guaranteed medical care persons security and life coverage for COVID-19 administrations. The proportions of MoHFW works in tandem with the Ministry of Home Affairs' bearings in epidemic control drive. The Supreme Court judgment gave the force to the multi-facet of security to medical services in the COVID-19 pandemic. The Indian legislatures while showing some urgency have switched over from the *EDA*, 1897 by returning to *EDAO*, 2020 during COVID-19 pandemic. There is little rationale for India to take asylum in the vintage form of the contagion laws. The State of Delhi and Maharashtra have passed COVID-19 Regulations, and the central government ought to likewise start enactment on the pandemic control. The State should make a substantial move against people blocking clinical experts in the release of their obligations. There is an earnest need to emerge from pounds and shells of the *EDA*, 1897. The mending dash of a pandemic requires an answer past the criminalization of a pestilence with the novelty of legal backup.

Recommendation:

- The study recommends a medical professional friendly working environment for surgical and therapeutic method of treatment of in Indian hospital.
- It desires harassment free clinical administration of health in epidemic,pandemic and general disease surveillance conditions.
- It recommends a robust legal framework for the health care in during COVID-19 pandemic in India in the given corpus of the public health laws, policies and governance.
- The World Health Organization norm for the doctors and para medical forces should be incorporated through the systemic reform in the health care system in India.

- It demands for the consequential refurbishing of the criminal justice system to protect medical fraternity and health services provider in emergency and normalcy.
- It expects an effective and stringent criminal administrative architecture to fight violence and criminality against medical and professions and institutions.

Contribution of Authors:

- M.Z.M. **Nomani:** Formulation of research design, material and methods and preparation of research methodology.
- Hekmatullah **Mulki:** Formulation of interpretative skills and legal explanations.
- Merwais **Niazy:** Interpretation of statutes, rules and regulations for the manuscript.
- Nasir Ahmad **Nusrati:** Development of comparative law and jurisprudence and precedent.
- Mohd. Yasin **Wani:** Analysis of international and Indian case laws.
- Abdullah **Samdani:** Evaluation of criminological and sociological trends of medical profession.

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