world (including a hospital in New Delhi) representing a wide range of economic circumstances, the overall rate of death decreased to nearly zero and the overall rate of postoperative complications decreased by 36% after the implementation of the WHO checklist.[10] Eleven hospitals in the Netherlands participated in a similar study to examine the effectiveness of a 'comprehensive, multidisciplinary surgical safety checklist, including items such as medication, marking the operative side, and use of postoperative instructions'.[9] This checklist was very similar to the WHO checklist. Compared with the five control hospitals, where there was no change in the number of complications and in-hospital mortality, in the six hospitals where the checklist was used, the total number of complications decreased by over 10% and in-hospital mortality decreased to nearly zero.[9]

Medical/surgical checklists may prove to be especially helpful in developing countries, where resources are limited and procedures are often far from standardized. Interestingly, in the previously mentioned WHO study that implemented the checklist in eight international hospitals, hospitals located in developing countries demonstrated the most significant reduction in complications.[10] WHO has since introduced the Surgical Safety Checklist in several developing countries, where it has been effective.[10] In efforts to further reduce mortality, WHO recently created a checklist for safer childbirth that is currently being piloted in a large healthcare clinic in Karnataka, India.[12] The utility of these checklists is that they are nearly universally applicable; as WHO has shown, one checklist can be used in different operating rooms and for a wide variety of procedures.[12]

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Letter from Chennai

A HAZARDOUS OCCUPATION

Medicine is a hazardous occupation anywhere in India, but in Tamil Nadu it can even be fatal. A doctor in a southern town, who happened to be an anaesthetist at an Employees' State Insurance (ESI) Hospital, had a private clinic (Tamil Nadu's Government Medical Service permits private practice) where she did obstetric work. She was providing antenatal care to a pregnant woman. One day this woman complained of abdominal pain, and the doctor found the foetus dead *in utero*, and suggested a caesarean section to save the life of the mother. Apparently, the mother developed complications during surgery, and the doctor immediately referred her to a private hospital that had better facilities. The patient was declared dead on arrival at that hospital. Her husband was understandably aggrieved and picked up a quarrel with the doctor. It is said that the doctor complained to the local police station and asked for protection, but apparently no action was taken. Sadly, the husband did not stop there. After completing the funeral rites on 31 December 2011, he walked into the clinic and killed the doctor with a sickle. He then surrendered himself to the police, admitting that he killed the doctor. He claimed that she was responsible for the death of his wife and child because of a wrong diagnosis.

Readers might remember that after numerous incidents of violence against doctors in the past, and after a strike by members of the Indian Medical Association (IMA) of Tamil Nadu, the government passed the Tamil Nadu Medicare Service Persons and Medicare Service Institutions (Prevention of Violence and Damage or Loss to Property) Act, 2008. This law has clearly not served its purpose as a preventive measure. Some doctors have been assaulted and their hospitals and clinics have been damaged, but no one had committed a deliberate murder till this incident.

The Tamil Nadu Government Doctors' Association (TNGDA) went on strike; 16 000 doctors are said to have taken part, including 1500 from medical colleges. The next day, they were joined by several members of the state unit of the IMA. A number of demands were presented to the Collectors of various districts: immediate punishment of the perpetrator of the crime, an order that all hospitals should be protected by the police station in the vicinity, and disciplinary action against the police officer who did not take any steps to protect the doctor though a complaint had

been made regarding the incident 2 days earlier. They also called on all Primary Health Centre doctors to stop doing caesarean sections.

Understandably, the case has aroused much comment from the public in the form of letters to the editors of many newspapers. Some of the comments have dealt with the fact that the murdered doctor was an anaesthetist in government service but had undertaken a caesarean section. Clearly, this is not a valid objection. All of us are declared to be Bachelors of Medicine and Surgery, and our training includes obstetrics and gynaecology, in which subjects we pass examinations and undergo practical training as interns. We are as much qualified to practise obstetrics including operations as we are to prescribe medicines and to do general surgical operations. What is needed is that we should have some degree of expertise in the subject, which this doctor had, as she had been practising as an obstetrician.

The profession came under criticism for going on strike. I am in agreement with this view. I agree with Calvin Coolidge, President of the USA, who in 1919 said: *'There is no right to strike against the public safety by anybody, anywhere, any time.'* Despite all statements that emergency services will be provided, people will be inconvenienced, and some may suffer serious harm because of denial of timely treatment. I would be in favour of any kind of demonstration, as for instance the wearing of black arm bands, distribution of pamphlets protesting the lack of adequate protection, and perhaps the list of demands of the TNGDA and the IMA, but strike action is abhorrent.

Meanwhile, I hope the case will move to its logical conclusion rapidly, and not drag on for decades. To have any deterrent effect against such crimes in future, justice must be delivered while the incident is still fresh in public memory.

THE TAMIL NADU CHIEF MINISTER'S COMPREHENSIVE HEALTH INSURANCE SCHEME

An advertisement in the newspapers invited applications 'from hospitals all over Tamil Nadu to be selected for empanelment as a Network Hospital' under this scheme, and provided the URL of a website providing details. While I am in no position to apply, curiosity drew me to the website. We are informed that 'this is a lofty Insurance Scheme launched by the Tamil Nadu State Government through the United India Insurance Company Ltd (a Public Sector Insurer headquartered at Chennai) to provide free medical and surgical treatment in Government and Private hospitals to the members of any family whose annual family income is less than ₹72 000 (as certified by the Village Administrative Officers). The Scheme provides coverage for meeting all expenses relating to hospitalization of beneficiary as defined in the Scope of the Scheme.' The benefits, we are told, are that 'The scheme seeks to provide cashless hospitalization facility for certain specified ailments/procedures. The scheme provides a coverage up to ₹100 000 per family per year on a floater basis for the ailments and procedures covered under the Annexure "C"'.

'For certain specified ailments and procedures of critical nature, which are listed under Annexure "D" in the Scheme, the overall limit is increased from ₹100 000 to ₹150 000.'

'There are two other covers other than the hospitalization benefits under Annexure "C" & "D" available under the Scheme. They are a) Follow-up Treatment as listed under Annexure "E" & b) Additional Diagnostic procedures listed under Annexure "F".'

The procedure for availing the benefits are as follows: 'Free health camps/screening camps will be conducted by network hospitals as per the directions given by Project Director of Tamil Nadu Health Systems Society. Minimum of one camp per month per empanelled hospital will be held in the districts in each policy year. The persons who need treatment are identified in the Health camps. Such patients can approach the hospital in the network and follow the guidelines below:

A new Health Insurance identity card with biometrics is being issued to all those members who have been holding the smart cards in the earlier scheme. Till such time new cards are issued the public can use the earlier smart (Health) cards.

This card should be shown at the Assistance Counter established at the empanelled hospital.

After due verification of the details and authenticating the identity of the patient by the Liaison Officer, the necessary Pre-authorization request for cashless facility will be submitted by the DMO of the hospital.

The Project Office will approve the request on authentication of the identity and provided the procedure planned is within the Scheme.

Even those patients who have the smart cards, though not identified through the Health Camps can also avail the benefit as above.'

No fewer than 330 hospitals are listed as approved for the scheme, including all the Government Medical College Hospitals in the state, and many of the Headquarters Hospitals. We are informed in the Tamil version, but not in the English version on the website, that 1.34 crore (13.4 million) families will benefit, that 1016 treatment modalities will be provided, with 113 covering follow-up and 23 diagnostic procedures.

This scheme is supposed to be better than the previous Varumun Kappom Thittam of Dr Karunanidhi. I admit I have not gone into the small print of both the schemes. One point touted when the scheme was introduced was that under Dr Jayalalithaa's scheme more work would be done in Government Hospitals, but as long as a large number of private hospitals are also covered people are more likely to go there. I am told that this scheme provides ₹100 000 coverage each year for 4 years, but the old scheme allowed a total payment of ₹100 000 for four years. Second, the income limit for eligibility has been raised. To make sure more of the benefits go to government hospitals, some illnesses will be covered only in the public sector.

And why do you need such a scheme at all? Why not just make facilities available in all the government hospitals, so that all citizens can go there and receive the best of treatment without charge, as used to happen in the good old (really old) days? This complicated procedure of obtaining the certificate from the village authorities, then obtaining clearance for 'cashless facility' will lead to delays, and perhaps will call for speed money.

IS THERE A DOCTOR ON BOARD

I was on a flight from Mumbai to Chennai when I heard this announcement—a request that any doctor on board would please make himself known to the flight crew. I did so immediately, and found that I was the only doctor on that flight. I was first asked to provide proof that I was indeed a doctor. I do not make a habit of carrying my certificate of registration with the Medical Council, or copies of my degree certificates, when I travel, so the best I could do was to fish out a visiting card from my wallet that mentioned my designation. With no one better qualified available, they had to make do with me. I was led to an extremely groggy looking passenger seated on the air hostess's seat in the galley, but threatening to fall off any minute. He admitted to feeling faint, so I put him flat on the floor. There was hardly any room to get myself

alongside him, but I was able to squeeze in without having to sit on him and did a cursory examination. I called for a sphygmomanometer and a stethoscope, and they indeed had one in an emergency kit, which arrived after a few minutes. Fortunately, a few minutes of lying flat did the trick, and he recovered to full consciousness. When I had the necessary tools I recorded a normal blood pressure. It turned out he just had air sickness and had vomited, then felt faint. The emergency kit had a tablet of Avomine that I made him swallow, and in a few minutes he was back to his seat and eating a hearty breakfast.

In his classical essay 'In praise of idleness', Bertrand Russell writes: 'Work is of two kinds: first, altering the position of matter at or near the earth's surface relatively to other such matter; second, telling other people to do so.' It has been several decades since I ever did anything myself, as distinct from telling other people to do so, and I shudder to think of what would have happened if this had been a genuine emergency where I did not have a registrar available to carry out my instructions. While my former patient was enjoying himself, I had this unpleasant idea to think about. More was to come. The airhostess brought a large form to me and demanded that I fill it out. It had a proforma with columns for all the measurements and examinations I was taught by *Hutchison's Clinical Methods* when I was a third year student. Details like the state of his pupils, his temperature and respiratory rate, the pulse rate and the blood pressure (these two the only parameters I had actually measured), descriptions of his heart sounds and every individual system were demanded. The woman kindly told me that all I had to do was to sign it and they would fill it up. I have never been happy about signing anything blank, from a cheque to a letter paper, and I refused to do so. Instead, I struck everything off with one bold stroke and wrote what I had actually done. She was most unhappy about this irregular procedure, but there was nothing else she could do. She retained my card, and I wonder whether I will receive a stiff letter from the airline doctor reprimanding me. On the other hand, I could also hope for a letter thanking me for the prompt service rendered, but that may be too ambitious. More than a month has elapsed, and I have received neither communication.

Perhaps the Director General of Civil Aviation should give some thought to this matter, and devise a more practical report form.

THE ONE THAT GOT AWAY UNREVERSED

Of all the actions of the previous government, the ones I would most like to see reversed by this one are Mr Karunanidhi's advice to the police not to 'harass' people breaking the helmet law, and the sanction to the practice of Jallikattu or bull baiting. Alas, it is that season of the year again, and this pernicious custom continues.

Jallikattu goes on, nominally with precautions to avoid torture of animals and injury to humans, but the newspapers report evidence of both in plenty.

M.K. MANI

Letter from Glasgow

'BE PREPARED': PLANNING FOR MAJOR EMERGENCIES

One of the things that I always look out for is news in the UK media about India. Even in this digital age with its myriad of ways of communicating (or as some would say from face-to-face communication to Facebook), it is the news agencies that provide me with different perspectives on my country of birth. I appreciate the positive news from India, whether it is about health, economic, social, cultural, environmental or other advances, but the negative news also lingers and impinges on the mind. This includes train[1] and plane[2] accidents, and natural disasters.[3] Apart from the sorrow felt at the loss of life and suffering, and noting the institutionalized mantra of state and federal officials announcing payments to those affected, I also think of how the emergency services, including health services, coped with the incident. Did they plan for it? Were any preventive actions considered and/or possible? Were the services adequately prepared and did they respond effectively, efficiently and in time? How quickly did the recovery period last before things were back to normal? Did they review the incident to learn lessons for the future? These are some of the questions which come to mind—not just for such incidents in India but elsewhere as well—because it is part of what I do as Director of Public Health in Lanarkshire.

Health protection, encompassing communicable disease control, control of non-communicable environmental hazards and emergency planning, is an integral part of public health. The planning for emergencies affecting the health service is an important aspect of the work of all National Health Service (NHS) Boards in Scotland. In Lanarkshire, which has the responsibility to protect, improve and promote the health of, and provide healthcare to, its 640 000 residents, there is a Major Emergency Plan.[4] The Plan lays out what actions are to be taken if we were faced with a large number of casualties in the emergency departments of our three district general hospitals.

To help the work of NHS Boards and other organizations in emergency planning, there is UK and Scottish[5] guidance. As part of that, a major emergency is defined as 'a situation either arising or threatened which requires the special mobilization and/or redeployment of staff or resources with consequent interruption to routine activities'. In Lanarkshire, the Major Emergency Plan considers major emergencies affecting the NHS that could arise from a variety of causes including road, air or rail crashes, pollution to the environment, fires or explosions, industrial accidents, severe weather and communicable disease outbreaks/pandemics. This list includes just some of the possible scenarios, but a key aspect of any plan is that it must be flexible to respond in a coordinated and proportionate fashion to any challenge, not just the ones envisaged.

The aims of NHS Lanarkshire's Major Emergency Plan are to (i) provide an overall strategic framework to ensure that essential healthcare needs are met effectively when normal services become overloaded, restricted or non-operational due to a major emergency,