time from hospital. The medical officer has 24 hours to decide on the request for discharge. If it is felt that the patient cannot be discharged, the medical officer must apply to a medical board which can sanction a further 90 days' stay in hospital.

In my years of psychiatry training and practice between 1998 and 2004 in India, I did not see a single referral going to this "medical board". I am not even sure whether such a board exists. Normally what happens is that patients who want to go home are restrained, sometimes with the help of relatives, and given medication to calm them down, in their "best interests" as deemed by the treating professionals.

There are serious ethical issues here. Patients who may lack capacity can sign a form saying that they are seeking treatment voluntarily. But when they wish to be discharged they are prevented from signing themselves out without a referral to the medical board.

Patients may refuse to come into hospital informally can be admitted against their will on the request of their relatives or a friend. This needs to be supported by two medical certificates in the prescribed form.

This constitutes a minority of admissions for various reasons. Psychiatric hospitals generally prefer patients coming in voluntarily as it avoids the hassle of getting two medical certificates. So patients are forced to sign on a piece of paper they know nothing about, thereby becoming a voluntary admission.

It is ethically questionable how a friend can request admission for psychiatric treatment for somebody else. This psychiatric treatment can include parenteral medication as well as ECT. There is no definition of a "friend" as well in the Act. There is no provision for punishment of these "friends" if they are found abusing this provision of the Act.

There are no legal safeguards in the Act protecting these patients admitted against their will. There is no independent body looking into the admission procedures.

There is no role for a social worker in the Indian situation. This has been substituted by a relative or a friend making the act liable for abuse.

There is no legal provision in the Indian mental health act for treatment against patients's will.

Admission under special circumstances on request of a friend should be taken away completely and replaced by an application made by a trained social worker in mental health and to be supported by two medical practitioners independently. Detailed assessment of mental capacity needs to be done before patients are accepted as voluntary patients.

Audits need to be carried out at psychiatric hospitals across the country to see whether provisions of the existing MHA 1987 are implemented fairly. Stringent punishment should be meted out to those violating the law.

The Indian Psychiatric Society has been debating the act for several years now but nothing has happened in the last 15 years. Medical professionals as well as people in authority need to acknowledge deficiencies in the current act and address them to safeguard the rights of this vulnerable group of patients. The government needs to make sure that the Act is implemented across the country in a uniform fashion. Psychiatrists, human rights activists, social workers and lawyers need to work in partnership and come up with an amended version of the Act as soon as possible.

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Why should doctors go to rural areas?

I often read that doctors are not ready to go to rural areas, and many patients die because the medical officer is not available. Laws are being made to compel doctors to work in rural areas.

Since I became a doctor in 1975, there has been no change in the scenario of primary heath centres, which are fast deteriorating into post offices where cases are registered and transferred to higher centres. No emergency medicine and facilities are available. The medical officers who do stay are busy with their private practices. Committed doctors become frustrated with the government's priorities. I worked as a medical officer for 14 years. At the primary health centre in Birwadi, then in Kolaba district, I studied the scorpion sting in detail and reported my findings. I would spend 50% of my salary on phone calls to Mumbai and Pune for expert advice on people admitted to hospital for scorpion stings. The director of health services forced me to work on the target for family planning cases. Ultimately I got a transfer to Pune where I registered for MD. After completing my MD, in 1982, I got myself transferred to a primary health centre at Poladpur in Raigad. I was warned to leave government service as the majority of officers were corrupt and nobody would protect me for honest service.

Since 1983 I have suffered various ailments for which I have no choice but to go to Mumbai or Pune for treatment. My physician classmate who also worked in a rural posting had an acute myocardial infarction. As the lone physician in the area, he read his own ECG, advised his staff to give him streptokinase and died of reperfusion arrhythmias.

My children do not get a good education in rural areas. What facilities does the government give doctors who do stay in rural areas and do life-saving work? This question remains unanswered

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