



Why Medical Schools Fail to Prepare Doctors for Financial Management and Self-Protection

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Abstract – Medical education is also well-known in terms of their ability to produce clinically competent physicians, but in a systematic way, they fail to provide them with the practical competencies they need in relation to the realities of medical practice. This article explores two main gaps of modern medical education, inadequate integration of financial literacy and practice-management education, and insufficient preparation around medical violence and litigation. Through a thorough analysis of the current education systems, evaluation of real world consequences, and comparison of overseas benchmarks, the paper clarifies how these omissions breed the creation of financially precarious doctors who are ill-equipped to handle abusive patients. The study shows that about ten years after graduation, a significant number of doctors feel deep discontent not in the incompetence in clinical practice but in the failure to survive in the economic and ego defense aspects of practice. The article proposes meaningful curricular changes such as mandatory teaching of financial literacy, indemnity insurance, and violence-de-escalation skills, and provides practical models that can be utilized by practicing clinicians to correct these shortcomings independently. These results bring about the conclusion that combining survival skills with scientific education would produce more resilient, happy physicians who could provide high-quality care to patients and maintain financially viable practices. This kind of transformation requires the concerted action of the medical schools, regulatory bodies, professional associations, and individual practitioners.

Keywords: medical school financial preparation, doctor practice management skills, medical violence protection training, physician indemnity insurance India, medical education gaps, healthcare professional burnout, defensive medicine litigation, medical career financial planning.

1. INTRODUCTION

1.1 The Ten-Year Revelation

The transition of a medical student to a practicing physician is one of the stricter professional educational processes. Students get exposed to rigorous learning, various examinations, lack of sleep during residency, and a lot of clinical training. Upon coming out of this crucible, they are there with a certain diagnostic acumen as well as a thorough knowledge of human physiology and pathology as well as the concern about patient welfare. The society uses a lot of resources in nurturing these highly trained clinicians, hoping they will be the pillars of healthcare service delivery. However, towards the end of the tenth year of working independently, there is a worrying tendency. Even the physicians with high academic scores, those who have good diagnoses of complicated cases and the ones who apply advanced treatment protocols, claim that they develop a feeling of incompetence. They argue that they are not ready not to handle the clinical challenges they are facing but the practical realities, which frame such medical decisions. A lack of fulfillment of this kind is created by a kind of inherent disconnection: medical schools teach the science of curing and systematically neglect the survival skills that are required in the modern healthcare practice.



This detachment has taken two especially unhealthy forms. To begin with, doctors find out that they have little financial literacy or practice-management knowledge. Although they are able to detect obscure tropical illnesses, they are ill at organizing consultation accounts that are able to cover overhead expenses. They are also aware of intricate pharmacologic interactions but have problems negotiating with insurers. They know how to engage in advanced surgical procedures, and make basic mistakes in cash-flow management. Financial communication is not a commonplace subject taught in medical education and is implicitly implied to be incompatible with professional ethics. This cultural silence puts physicians in a precarious financial position and makes them unprepared to do business in the reality of the business.

Second, physicians join the field completely unprepared to deal with the threat of medical violence and lawsuits that have been increasing. The vision that is promoted by medical training is that of thankful patients, successful treatment and unquestioning reverence. Learners obtain evidence-based protocols and clinical decision-making practices based on the premise that excellent medicine is bound to produce positive results and patient satisfaction. Practically, patients can get worse despite best treatment, grieving can turn to blame, families can turn violent, lawsuits can ruin lives, physical abuse of health care professionals can escalate dramatically, especially in such countries as India where the phenomenon has become crisis levels.

These gaps in the curriculum are far-reaching. Physician financial incompetence causes expensive mistakes, practice sustainability issues, and intense stress as a cause of burnout. Without this understanding on litigation risks, the practitioners might not have sufficient insurance cover, which might subject them to a lawsuit that would destroy their professions. Poor training on how to behave in case of violence exposes physicians to lack of de-escalation techniques, safety measures, and psychological resources to cope with traumatic experiences with aggressive patients or families.

The current model of medical education is based on a dangerous assumption: clinical competence is the only guarantee of professional success. Schools seem to think that the physicians will automatically understand business management, financial planning, legal protection, and resolution of conflicts. This assumption is always proved wrong; physicians are really good in medicine, however they are not good at the infrastructural requirements needed to offer this medicine in a sustainable and safe way.

Both critical deficiencies have been covered in the article. It examines the reasons medical training continues to feature these gaps despite obvious financial implications, evaluates practical consequences of the situation on doctors and healthcare systems, and suggests specific changes in curriculum. It also provides concrete recommendations to practitioners already working in the field that will need to fill these knowledge gaps on their own, giving specific frameworks, resources, and protection that can be implemented in the shortest time possible. The necessary change is not around the edges but core. Medical training should no longer be based on pure science, but scientific and survival training. Institutions have to realize that medicine is a vocation and a profession, curing and commercial, caring and self-defense. It is only with a combination of these competencies that the profession will be able to end up with physicians who feel truly ready to take up careers in which they have set out.

2. OBJECTIVES

This article has a number of interrelated goals that touch on the root cause of the disconnection between medical education and practice reality. To begin with, it reports and discusses the methodical training lapses in financial management and self-protection, and how such gaps are reflected in physician



experience and career pathways. Second, the paper identifies the actual implications of these gaps, with them being financial losses, legal vulnerability, physical safety risk and psychological effects on physician wellbeing and patient care quality. Third, the article offers a detailed outline of a curriculum reform with particular competences that medical schools are expected to incorporate into the existing programs and suggests the implementation strategies that would not be disruptive to the rigorous medical education. Fourth, it provides very practical advice on how present practitioners can manage such knowledge gaps on their own and provide certain resources, action steps, as well as protective measures that may be taken right now. Lastly, the article aims to trigger a wider debate on the issue of redefining the concept of professional competence in the medical profession, to include not only clinical excellence but also the practical skills required to sustain their career and to keep them safe. This work is expected to bring a systematic change in teaching a new practitioner the appropriate methods of becoming a full-fledged professional after providing evidence, international comparisons, and practical solutions.

3. CURRENT TRENDS

The medical practice environment has experienced a radical change over the past decades medical education has not kept abreast with the changes. The recent examination of current tendencies in budgetary strains and violence on medical personnel highlights the necessity to fill these gaps of studies. These trends indicate that the pressures that physicians are facing are not a few aberrant trends but general trends that require broad-based curricular reforms.

3.1 Financial Complexity in Modern Practice

In a modern medical practice, one finds themselves in some of the most complicated financial ecosystems that are not closely related to simple fee-for-service system of earlier generations. Doctors are now going through different insurance plans, which have different reimbursement rates, coding requirements, and administrative processes. Layered fiscal streams are created by government insurance plans, contract arrangements of private insurers, and direct payments by patients and require advanced management skills.

Corporate medicine has come to power and this has changed the old paradigms of practice. The hospital jobs, the independent practices being acquired by different healthcare companies on a private basis, and large healthcare conglomerates have become powerful players. These organizations offer physicians the respite of not having to worry about financial management but also often come at the cost of professional autonomy and even income. Newly-trained physicians face the challenge of balancing the extreme risk of entrepreneurial ownership with low earning paths of employed jobs.

The cost of healthcare is increasing at an even faster rate than the rest of the inflation, thus limiting the ability of physicians to make money on a variety of fronts. The cost of equipment expenditures is high and the obsolescence is fast. The cost of regulatory compliance provides a very expensive administrative infrastructure. EHR systems require a significant investment in software, hardware and training. Salaries of staffing employees are increased to compete in the narrow labor market. At the same time, insurance reimbursement rates remain unchanged or even fall in real terms, which is what is known as a scissors effect as costs keep going up, and revenues remain at the same level.

Student debt facing young licensed physicians has never been as high as it is currently. Education fees and its related expenses have been on the rise thus making a good number of graduates to have a loan of over 10 to 20 lakhs. This debt has a far-reaching effect on the career decision-making process, which directs



physicians into specialties with better-paying positions or jobs regardless of their own interests or talents. The need to ensure maximum income, during the early years of career, not only clashes with the selfless intentions with which many people were inclined to the sphere of medicine but is also directly opposed to it.

Taxation systems that have an influence on medical practitioners have become more complicated. Professional incorporation, choice of legal structures, maximization of retirement contribution, and tax planning of goods and services all require high levels of fiscal skills. The consequence of errors in these areas can have a huge long term cost repercussion, but medical education provides minimal training preparation.

Telemedicine, online scheduling systems, and digital payment systems have brought new financial arrangements and sources of revenue. The physicians are required to not only understand these technologies clinically, but financially as well, their effect on practice economics, payment processing fee, and acquisition cost of patients. Technological advancement is so swift that it requires a sustained fiscal literacy and not just a onetime fiscal education.

3.2 Rising Medical Violence and Litigation

Interpersonal violence against healthcare professionals is one of the most problematic modern tendencies in the medical field. Cases that previously were thought to be isolated and rare have become recurrent dangers that reconfigure physician patterns of work to a great extent. In some ways, especially in the emergency departments, the verbal aggression, the physical assault, and the property damage are becoming very common and frequent occurrences.

One of the worst scenarios has been the spike in violence towards medical professionals in India. The Guindy knife attack is only the tip of the iceberg. Security tapes at hospitals are a common occurrence as family members are caught beating up doctors due to the death of patients or due to unforeseen complications. Such incidents can be amplified through social media leading to mob violence before they get real facts or conclusions of investigation.

There are several causes of this violence. Impractical patient attitudes, which are partly reinforced by medical shows about the wonders of recovery and fallible practitioners, are bound to create disillusionment when clinical reality turns out to be more convoluted. Lack of effective communication between overworked doctors and nervous families enables miscommunication to grow. Staffing levels are low and overcrowded which creates a sense of disrespect or neglect which eventually leads to resentment that manifests itself when negative results occur.

Stressors on the economy are also a major factor. Healthcare spending is a burden to family income, particularly the poor. Once costly treatments have failed, families feel that they have lost the little resources they have dedicated to it, and this is augmented by the emotional distress that they also experience which may be discharged as direct violence towards the least obvious provider of care – the treating physician. Such reactions are further propagated by the feeling that doctors make money when patients suffer regardless of the outcomes.

The courts of a number of jurisdictions have not done a good job protecting healthcare employees or distinguishing cases of negative outcomes and actual negligence. Such inadequate security has resulted in a situation where violence against physicians is not punished severely by the law and this encourages the potential attackers. At the same time, doctors can be subjected to extreme fines due to the allegation



of misconduct, which creates a highly unequal structure of distributing all unfavorable outcomes to physicians and depriving them of fundamental physical safety.

The legal environment has turned out to be more unfriendly. Medical malpractice lawsuits have been on the increase with often unrealistic expectations of medical competence that have been the basis of the discrimination. Consumer protection legislation, which was initially designed to be used in commercial dealings, is occasionally used in directing medical care in such a way that complex clinical care choices are simplified to service failures. Damage is sometimes awarded on emotional grounds instead of strictly evaluating whether the ordinary care was administered.

The insurance carriers also contribute to the issue because in some cases they refuse to cover the claims that are worth being insured, which means that physicians are involved in expensive lawsuits even when they have insured indemnities. The costs of the defense against claims, although successful in the end, are very costly both financially and emotionally. Most doctors choose settlement to evade expenses of expensive litigation and mental tension, even in situations where they feel that their services were reasonable.

The psychological impact of medical violence and threats of litigations is immense. Medical workers complain of constant fear of possible legal proceedings, intimidation in the workplace, and unwillingness to consider difficult or risky cases. This mode of defence essentially changes clinical decision-making, which is usually against the best of the patient. The problem of chronic stress is also a significant contributor to burnout, now occurring in about half of practicing physicians in the first ten years of practice.

Professional bodies are now pressurizing the need to have greater protection such as the enactment of certain acts to criminalize any kind of violence against medical staff and to provide better legal definitions of medical negligence. These efforts are however facing significant hurdles including the fact that people are still suspicious of physician attitudes and politicians fear being seen as being unresponsive to patient sufferings. The development is slow and evolutionary and the violence and litigation threats are on the rise.

3.3 The Burnout Crisis

Such economic and health safety strains get added to a burnout epidemic threatening the sustainability of healthcare. There are rates of emotional exhaustion, depersonalization of patients, and less sense of personal accomplishment reported by the physicians, which are much higher than those in any other profession. Although the reasons are multifactorial, the pressure of having to overcome new business issues simultaneously with the threat of being a victim of violence or suing is one of the key factors.

Burnout is experienced in affectations of significant concern. Doctors work fewer hours, leave early, or leave clinical practice to an administrative or non-medical position. Specialties such as emergency medicine and obstetrics are facing a recruitment crisis with new graduates being hesitant to embrace the specialties where the violence is very high or the chances of litigation are very high. Underserved and rural areas are in a struggle to find doctors who are ready to practice in remote locations with little support and the possibility of increased risk factors.

The quality of patient care suffers negatively when physicians suffer burnout. Burned-out clinicians spend less time with each patient, make more medical errors, have lower empathy, and prescribe in a less liberal manner in order to avoid possible complications that may lead to litigation. Ironically, this defensive medicine lowers the quality of care and increases the healthcare expenses by unnecessarily testing and performing operations.



Medical schools have started to recognize the crisis of burnout but usually discuss it in the context mainly of individual resilience instead of discussing the institutional predispositions such as the lack of preparation to financial and safety realities. Wellness programs, mindfulness courses, counseling programs have an intrinsic worth but are not able to counter the lack of practical skills that physicians need to succeed in the modern practice settings.

4. THE MONEY TABOO IN MEDICAL EDUCATION

4.1 The Cultural Silence Around Finances

The type of medical education functions on a very specific cultural level where the mentioned talks about money are considered distasteful, even unethical. This taboo continues, based on the historical images of medicine as a professional occupation that is independent of business activity. The Hippocratic school stressed the role of curing more as a moral obligation and charges were considered a necessary but rather unfortunate thing. This philosophical tradition lives on in modern medical education, creating an atmosphere where financial discussions are unseemly or mercenary.

This system of discomfort is reflected in the curriculum. Thousands of instructional hours are devoted to anatomy, physiology, pharmacology, pathology and acquisition of clinical skills in medical schools. Learners are trained to identify minor physical examination results, analyze complicated lab results, and develop advanced care plans. They explore rare genetic pathologies which may never be actually realized in clinical practice. However, the comprehensive curriculum does not teach how to compute the actual cost of delivering a consultation, how to design fees that would help in making the practice sustainable, or how to negotiate with insurance companies that would mainly dictate their future income.

Faculty often emulate discomfort or dismissiveness when financial matters are raised by chance. The rather common phrases like we do not treat money and care about the money, another profession is better, and so on strengthen the message of the idea that the financial interests do not coincide with the professional morals. This attitude is absorbed by students, and they develop the attitude that practicing economics is betrayal of their mission of healing. This ethical system creates a hazardous blind spot where doctors feel guilty of providing the financial survival of themselves.

The implicit curriculum is even more effective in comparison to the explicit teaching. Medical learners can witness how the attending doctors seem uncomfortable about negotiating fees with patients, where patients accept anything insurance companies assure them of, or where physicians have money problems but feel that it is inappropriate to disclose such information. Learners do not see examples of physicians who are able to combine caring to patients with effective business strategies. The subtextual message is therefore that financial prowess and medical brilliance do not go hand in hand, they actually go against one another.

This medical silence creates a deep illusion amongst the medical students. They note that their professors, who work in medical schools or hospital setups, appear to be practicing medicine with no concern of money. Students reason out that clinical competence will be sufficient in ensuring financial stability. They fantasize that once they become doctors, the economic issues will take care of themselves: patients will bear relevant charges, insurance will compensate justly, and practice funds will manage themselves and doctors will deal with medicine.

The illusion is quickly shattered to reality in a very painful way. When medical school graduates move to independent practice, they are thrown into financial complexities with which they are not even prepared.



This abrupt plunge into alien land creates severe tension, expensive errors and in certain instances, even employment ending financial hardships.

4.2 The Rude Awakening of Practice

The money reality hits when the physicians start considering their practice first job or the ability to open their own clinic. They are offered contract opportunities that include remunerations that they are not able to properly appraise. Should they have a flat salary, a model based on productivity or a partnership route? What do non-compete agreements, tail coverage, or benefits really mean? The medical school does not offer any model of how to analyse these questions.

Doctors that start practicing on their own face even a greater learning curve. They are required to obtain funds, negotiate leases, buy machinery, recruit employees, develop accounting systems and come up with schedules of fees. Every decision has high financial consequences, and physicians make these decisions without any form of training and with little informal advice. The excitement that comes with being in the independent practice is soon followed by the fear of financial devastation.

The practical aspects of practice in medicine are much more difficult than most doctors expected. Equipment requires initial purchase and further maintenance, recalibration as well as replacement. Medical supplies must be ordered, controlled, and minimized in terms of waste and made available. The needs of the staff include salaries, benefits, training, and management. Facilities require renting, utilities, insurance, and maintaining. Software, research, and computers and electronic health record systems need subscriptions, updates, and technical support.

Meanwhile, revenue comes across as so much more difficult and unpredictable as physicians are accustomed to. The insurance firms have very complex requirements in their coding systems, and the slightest of mistakes in documentation may lead to the denial of claims. Insurers have wide variations in their reimbursement rates, which makes it difficult to predict the income according to the number of patients received. Certain insurers make the payment on the date, and others postpone the payment taking months, which leads to cash-flow difficulties. Direct patient payments (previously the staple of medical practice) make up a lesser portion of the revenue but present unique issues with regard to fee transparency and fee collection practices.

The competencies needed to deal with this financial complexity are part of a group of competencies that is completely separate to clinical medicine. Physicians need to understand the terms like operating margins, break-even analysis, accounts receivable aging, and working-capital management. They will have to decode profit-and-loss, monitor key performance indicators, and make evidence-based decisions concerning the operations of the practice. These competencies do not have anything to do with the diagnosis of the disease or the treatment of the patient, yet they are important to the sustainability of the practice as well.

It is very expensive to learn by trial and error. Doctors who start underpricing their services will struggle to increase the fees in future without compromising on the retention of patients. Those who enter poor insurance plans get entangled in uncompensated agreements. Physicians that do not adopt sound billing software lose money. Mismanaged cash flow practitioners are forced to encounter a scenario where the payroll or rent payments become unsustainable even though they are technically favorable. Any error has got financial implications that may require years before it can be corrected, or even not.

The financial expenses are aggravated by the emotional impact. Doctors did not go into the profession to run businesses. They end up spending evenings going through accounts receivable reports as opposed to



reading medical journals. They are concerned with paying out payroll instead of attending to patients. Cognitive tension is caused by the mismatch between their training, motivations, and the reality of their daily life. Most physicians complain of feeling that they are not doing something very important in their work, when they are actually competent as a clinician but are put into a situation they have never tackled during their training.

The situation is complicated by the expectations of the patients as well. Most patients, assume that physicians are wealthy and do not want to pay a fee that is considered high. Others would expect free consultation of a considerable discount, and consider payment proposals as uncorporate or unsympathetic. These demands are in conflict with the economic fact that medical practice is run on fairly slim margins and needs a steady stream of revenue to continue to exist. Doctors have to tread a fine line between achieving reasonable compensation and maintaining therapeutic relationships. No medical school offers any guidelines on such hard talks.

Physician burnout is also greatly caused by financial uncertainty. According to doctors, financial issues make them lose sleep, give them problems in their relationships with people, and discourage their working satisfaction. A certain number of physicians will be trapped in to displeasent practice environments due to lack of financial means to change, especially physicians with high student debts. Some other people rely on financial factors as the main criterion when choosing their career options, as opposed to clinical interests and patient needs.

Patient care can be undermined by financial constraints. Stressed physicians can experience the urge to have a larger number of patients per hour, and thus less encounter time. They can wait before they can buy new equipment or employ a sufficient number of staff. Others go to the extent of commissioning unnecessary tests or procedures to make incremental income therefore falling into the grey area of ethics since there is no viable option of survival of the practice. The quality of care that medical training is trying to develop is compromised by poor practice economics preparation.

4.3 Practical Framework for Financial Competence

The solution to these shortcomings is to incorporate financial literacy into medical courses in a systematic manner. It cannot be a throwaway or an elective, but it has to be a competency that should be at the heart of every graduate physician. The framework must also proceed in a logical manner due to the medical education, and sophistication should be developed as the students' progress.

In preclinical years of study, medical schools must begin offering the basic concepts of business in conjunction with the education of the healthcare system. As students are taught the way the health system is structured and provided, they need to know the economics behind these systems. Basic courses ought to include the notions of revenue, costs, profit margins, cash flow, and various structures of practice. The students are supposed to internalize the fact that medical practices are businesses that need to make enough money to cover their expenses and pay the physicians to use their knowledge and expertise and years of trainings.

Development of fee-structure is one of the most important skills that physicians need to master. Medical schools are expected to educate students on how to estimate the actual price of offering different services. This includes direct cost, which can be supplies and staff time, and indirect costs, which include rent, utilities, equipment depreciation and administration overhead. Students are supposed to be taught how to consider the time needed to make contact with patients and to prepare them before the visit, to fill in documentation, and to communicate with them after the visit. They have to study the market rates in the



local area, insurance reimbursement rates and charge people according to their training and experience and to be competitive.

The process of insurance navigation requires much consideration due to its location as a key in practice revenue. Medical education ought to offer practical training in deciphering insurance contracts, and deciding whether to be in certain panels or not and when to negotiate better rates or reject the participation. Learners are supposed to master the fundamentals of coding and billing, the role of proper documentation in facilitating proper reimbursements, how to improve on the appeal of claims denied and how to write off uncollectible balances as opposed to aggressively seeking payment.

Various model practice have various financial connotations that a physician ought to understand prior to making career choices. Solo practice means the greatest freedom of action with all business risks and duties. Group practices offer common costs and collegial support but need to have partnership agreements and decision-making. Hospital work removes business administration though it generally earns less and offers less freedom. These trade-offs should be thoughtfully analyzed by medical schools and not blown out by the first opportunity available in front of the students.

The practice sustainability requires cash-flow management skills. Doctors should be able to understand that profitability and cash flow are different: the timing of cost and income creates some problems and seasonal fluctuations in the number of patients require proper reserves. Students ought to be taught how to make financial projections, the time to borrow money, and the signs of financial distress. This can be introduced at a tender age so that the concepts become a second nature to them.

The physicians need attention on investment and retirement planning due to their unusual financial situations. Later onset of career, significant student debt, and possibly unsteady earnings patterns necessitate careful financial planning. The medical education must seek to cover the fundamentals like tax advantaged retirement accounts, tax implications of several business entities, and the significance of insurance products like disability insurance. The students do not have to be the experts in financial matters but know enough to ask professional advisors the intelligent questions, as well as when the specialist help is needed.

These concepts are solidified with real-world application exercises. Students are to examine contracts of various practice positions, calculate total compensation (along with benefits) and compare opportunities on equal terms. They can develop a simple business plan of opening a clinic, research on what the actual cost of equipment, rent, staff and supplies will be in their local market and estimate the number of patients they would break even with different fee structures. Abstract ideas can be applied in such experiential exercises to practical skills.

Nothing can be as valuable as a guest lecture by practicing physicians who are successful in practice finances. Invite individual practitioners, practice partners, and medical practice administrators to talk about real life issues and solutions. Ask to share the lessons learned and mistakes made. It is quite helpful to hear that it is not abnormal to face financial difficulties, that dealing with them does not mean that the individual does not provide high-quality care to patients, and that the skills in this area can be trained even in cases in which they initially appear strange.

Financial discussions can be incorporated in mentorship programs that involve medical students along with senior physicians. Mentors are able to exchange negotiations, practice set-ups and transition experiences. Such informal discussions can be more effective than formal coursework since they are organized in the framework of permanently existing relationships and clinical discourse.



This is not intended to turn medical students into business gurus but give them enough of financial literacy so that they can make wise decisions, know when to seek expert advice, and the most expensive mistakes to avoid. Doctors who have such a foundation take the practice transition and business decisions with confidence unlike the anxiety and confusion that characterizes their experience at present.

5. THE UNSPOKEN THREAT OF MEDICAL VIOLENCE

5.1 From Compassion to Courtroom

Medical students enter their practice with a lot of idealism. They envision healing the diseased, solacing the pain, and receiving respect and gratitude of their effort. The curriculum upholds such image by projecting the image of medicine as a good profession. Lectures are devoted to the mechanisms of diseases, treatment, and professional ethics. There are case discussions that bring out diagnostic reasoning and therapeutic decision-making. Clinical rotations also expose students to normally cooperative and appreciative patients. This mode of learning paints an imperfect, even harmful image of actual medicine practice. The students are taught good practices as well as evidence-based medicine and they are assuming that good practices always lead to positive results and happy patients. They think that love and commitment will save them the adverse effects. In case of negative results in their limited experience, supervising physicians normally cope with the emotional aftermath and shield students against the uncivilized responses of bereaved or furious families. The real world is much more difficult and even unfriendly. Health care cannot assure good results. Excellent treatment may not benefit patients. There are complications even in cases where the procedures are performed to perfection. The illnesses advance regardless of the best efforts of the doctors. The human body is erratic and medicine is more of an art than a science. Even the most competent doctors will have patients dying, getting hitches, and treatment failures.

The grateful patient to the hostile adversary can change in an incredibly short time. Once the families praised physicians, they start accusing them immediately the results are not satisfactory. Grief turns into blame. The motivation to seek someone to blame is on the most obvious player, the treating physician. Patients or families that appeared to be rational turn into aggressive, threatening, or litigious. This change can be attributed to unrealistic demands of medical capacities. Medical dramas in television depict miraculous patients and doctors who make few mistakes. Patients internalize these images and create unconscious convictions that modern medicine can heal anything. In case the reality comes out less than satisfactory, they infer that failure entails incompetence or negligence as opposed to limits of science. Such situations are aggravated by failures in communication. Doctors who are overworked in facilities with many individuals also do not have a chance to discuss with patients and families extensively. The lay people are confused with medical jargon. Prognosis and possible complications are condensed into very short communications that may not be well comprehended or recalled by the families. In case of complications, families argue that they had never been advised, never given their consent, or deceived on dangers.

Another layer is economic factors. Healthcare expenditure is a burden on the family, particularly in case of sustained treatment or severe illness. Families feel that they have wasted their resources in costly care where nothing has been achieved. This economic cost, coupled with the sorrow over the bad results, makes the emotional condition rather unstable as the anger at doctors is mixed with the anger over the financial expenses. Reactions are also dependent on cultural factors. Some communities treat death or disability as stigma which makes the families to shift responsibility to the healthcare providers. The social media allows personal grievances to go viral, and occasionally it can be a mob-reaction before the truth is known. Even



when there is no context, viral videos of hospital confrontations influence the perception of medicine and physician behavior among the population.

These realities are virtually unprepared in medical education. The debate surrounding informed consent is based on ethical standards and legal expectations and does not consider the practical aspect of insuring actual understanding. Communication training is optional but in most cases focuses on rapport building and information exchange but does not cover handling devastating news or situations with hostility. The possibility of physical violence by the patients or families is practically neglected. Graduates emerge technical competent without having the psychological and practical readiness to handle the emotional side of negative outcomes. They do not have guidelines on why rational individuals turn violent, ways of defusing stressful moments, or ways of cushioning themselves judicially and physically. This loophole exposes new physicians who are the most in need of such skills at the onset of their practice but most inexperienced at exercising them.

5.2 The Indian Context Rising Medical Violence

There is an acute healthcare worker violence crisis in India. What could otherwise be considered as isolated instances of a given crime in other nations has now become a routine of frequent and even violent assaults on doctors and employees. These cases can be verbal, threat-based, property-related and even murder. The issue is so rampant that it essentially is changing the way doctors practice and career choices amongst medical students. Criminal cases involving high profile attract attention. One such example is the Guindy knife attack in which a physician was severely stabbed by a patient or family member. There have been other cases where the doctors were beaten into unconsciousness in hospital corridors, hospital emergency departments were destroyed by violent mobs, and the physicians were kidnapped by family members who insisted on certain treatment or results. On social media, videos of such confrontations are soon distributed, and usually edited to focus on the coldness or lack of ability of the physician, and leave out context that could put the situation in a different perspective.

The rates of violence are high in the emergency departments. The overcrowding, long wait times, resource constraints coupled with the critical patients, nervous families, exude the pressure-cooker atmosphere. The immediate response by families of patients who succumb during the ER is sometimes physical assault on surgeons and nurses. Any death will be viewed as a failure that could have been avoided and someone needs to be accountable to this expectation held by people partly due to the television dramas, which expect the emergency departments to rescue everyone. The same is related to intensive care units. Families like those on call outside units become more and more anxious when loved ones are deteriorating despite all the treatment. The emotional pressure of waiting and a lack of knowledge regarding the severity of a critical illness and treatment restriction may provoke violent reactions in case of death. Doctors in rounds are subjected to aggressive interrogations, claims of poor care, or requests of medically unnecessary procedures.

Outpatient clinics are not an exception. Patients or families who are not pleased with the length of consultation, prescription preferences or perceived lack of interest by the physician occasionally react violently. The social media exacerbates the situation when patients make videos of their encounters with a doctor, manipulate the footage so it can make them seem ignored or indifferent, and upload the videos to provoke angry responses. The targeted harassment or even physical attack can be a result of the viral spread. There are various reasons why India is especially susceptible to medical violence. Healthcare infrastructure, though on the improve side, is highly strained in most regions. Hospitals run by the government have the problem of overcrowding which results in long queues, short consultations and the



perception that doctors are not interested in the individual patients. Better equipped, privatized hospitals impose fees that stress family finances, which causes resentment when they fail.

The doctor–patient ratio in India is way below the optimum levels. Doctors in the state hospitals or the villages usually have hundreds of patients every day, and cannot possibly converse meaningfully with each of them. This production line method, though necessary, causes the patients to feel devalued. The feeling that a doctor never listened to her or explained anything to her sets a ground to accuse her when complications arise. The differences in the level of education among patients cause problems in communication. Doctors who are taught in English–speaking medical schools may find it difficult to describe complicated things in local languages. Technical words do not have direct translations so doctors are compelled to translate them through approximations which are not necessarily meaningful. Patients who have a low health literacy level could misinterpret information about the development of the disease, the available treatment, or the prognosis. These communication failures cause negative expectations that create disappointment and frustrations.

The cultural demands to medical care are not similar to the Western models that define medical education. Extended families anticipate to be involved in medical decisions, and this brings about circumstances that physicians have to deal with family dynamics and at the same time attend to patients. Patient autonomy, which is promoted in training, is inconsistent with family–centred decision–making, which is supposed to occur in practice. Such cultural incompatibilities bring about stress and misinterpretation. Healthcare workers safety in the law is still lacking in most jurisdictions. Although there are states where laws have been passed that directly target the issue of violence against medical professionals, their implementation is not consistent. In some cases, police do not consider physician attacks as crimes but as disputes between the parties. The legal process may take years, which is not much of a deterring factor. The image that there are few consequences of attacking doctors encourages violent actions.

Professional bodies have lobbied to have more intense protection but with little success. The Indian Medical Association has demanded the enactment of far–reaching laws against violence on healthcare personnel, security increase in health centres as well as quick justice on attacks on doctors. These initiatives are however challenged by politics and mistrust on the part of the populace. The media at times represents the violent cases as reasonable retaliation to medical carelessness and creates a negative perception of doctors in the minds of people. The psychological effect on Indian doctors is tremendous. This is because according to the surveys, majority of the doctors have either been the victims or have witnessed violence at their work places. Most of them claim they are always afraid when they are at work particularly in emergency environments. Other physicians change practicing patterns to reduce perceived risk, and avoid high–risk specialties or procedures that they would otherwise take up. The burnout and early clinical practice retirement are significantly due to the chronic stress. These trends are being watched with increasing alacrity by medical students. Awareness of the reality of violence as a prospective aspect of their careers affects the choice of specialty and area of practice. The critical nature of emergency medicine does not mean that it has been able to attract sufficient practitioners, in part because of the risk of high violence. This is rural practice, which is difficult to attract already, compounded by isolation and possibly unfriendly reactions of the community to negative outcomes.

5.3 Financial Vulnerability Litigation Costs

In addition to the physical safety issues is a less–considered aspect of vulnerability, which is financial exposure to litigation. Even the Indian legal framework, which aims at insuring that patients are not subjected to actual negligence, occasionally treats unfavorable medical results as malpractice. The



consumer protection legislation, which was originally meant to be applied in commercial transactions, is increasingly being applied to the medical care, where complex clinical decisions are seen as a failure of services which can make them liable to compensation claims. One malpractice lawsuit can ruin a young doctor. The compensation claims of 20 to 50 lakhs are getting more popular. Such sums constitute several years of earnings to most doctors, particularly those with a short practice experience. Fighting such allegations even in cases when doctors think that they have offered the right treatment would involve spending lakhs of rupees in hiring a lawyer to defend themselves. The legal and possible court costs and judgement/settlement are potentially bankrupting the physicians without proper protection.

Malpractice defense is an extraordinarily stressful process whether it is won or lost. Doctors are served notices in court months or years after they have been treating patients and in some cases based on encounters that they hardly recalled. They need to recreate the events based on medical records, find witnesses whose memory has been corrupted by time, and justify decisions made when there is no full information. The litigious method of law practice considers the clinical judgment decisions as possible crimes and the physicians are expected to explain all decisions exhaustively. Consumer courts, which are created due to their speed in resolution compared to the conventional civil litigation, do not always have the medical background necessary to assess clinical care in the right manner. Untrained judges have to determine the standard of care was achieved, and frequently they are guided by expert evidence, which can be inconsistent and subjective. Sometimes, the burden of the proof appears to be inverted where the physicians are supposed to show that they did all the right things instead of the plaintiffs proving that they were actually negligent.

All practicing physicians should have a standard protection under professional indemnity insurance but medical education categorically fails to enlighten students on this important protection. Majority of the physicians learn about indemnity insurance only after they have been in practice and it is usually after a near-miss experience or hearing about a fellow physician who incurred claims without insurance. This ignorance leads to young doctors usually practicing uninsured at a tender age. The indemnity insurance policies usually cover the two or three crores ensuring against the professional negligence claims. These policies include defense expenses in court and other damages or settlement up to policy limits. The cost depends on the specialty, the place of practice, and the amount of coverage but is usually an easily manageable cost when expected and budgeted. It is not that insurance is not available or is prohibitively costly but that the physicians are not aware of the fact that they need insurance until the crisis hits them.

There is no overstatement of the financial effects of practicing without insurance. When a physician has to deal with a 50 lakh claim that is not insured, he or she has to get that money somehow. Majority of young doctors do not have enough savings or assets. It is hard to borrow such amounts without collaterals. The threat may take physicians into settlements that they consider feel unwarranted merely because they are unable to protect themselves. Other doctors with huge uninsured claims have gone into bankruptcy, effectively killing their financial futures and possibly their careers as doctors.

Claims management makes a lot of financial disruption and stress even though there is insurance. Deductibles are usually provided as policies, which have to be paid by physicians before being covered. Raising premiums after claims (even successful ones) has an impact on future financial planning. Other insurers will drop the physicians once they have claimed on several occasions, and the coverage becomes hard to secure. The administrative hassle of documenting, attending depositions, and collaborating with defense attorneys is time consuming that might be utilized attending to patients or generating revenue. In part, this litigation exposure is the basis of the defensive medicine phenomenon. Physicians also request



extra tests and consultations not because they feel these are necessary medically but to provide a documentation trail that can be used to avert any future claims. This practice of defense is very expensive to healthcare, and in many cases, it does not significantly benefit the patients. Ironically, the inability of medical education to equip physicians with the necessary skills to survive a lawsuit is one of the reasons why certain practices that compromise cost-effective, evidence-based medicine are performed.

The psychological influence is the same as the stress caused by violence threats. Doctors note that they always experience anxiety due to lawsuits, particularly following any negative outcome. They recreate clinical experiences in their minds, wondering how they would have made other choices that would have avoided complications. The fear of legal action may make decision making impossible and the physician may fail to act decisively when he or she is called upon to act. Other doctors become cynical towards the patients and they will perceive each patient as a future lawsuit case instead of a future treatment. Specialty choice indicates litigation issues to a great degree. The rates of malpractice are exceptionally high in obstetrics, orthopedic surgery, and neurosurgery partly due to the high-risk nature of these specialties in which negative outcomes are not related to the lack of proper care. There are also cases when talented medical students do not even want to pursue these specialties due to the fear of litigation though they are interested and competent. This poses alarming gaps in the availability of specialists particularly in rural regions where recruitment is already a challenge. The location decisions on practice also include the litigation climate. The physicians who would consider practicing in the rural setting should evaluate risks of litigation and other issues such as professional isolation and lack of resources. This is because even in the urban areas, which also have their own challenges, there is at least access to legal representation and peer support when they are confronted with claims. All these factors complicate the rural recruitment even more and increase the disparities in healthcare access.

5.4 Practical Protection Strategies

Physicians should be equipped with medical education that will equip them with all the dangers of the present medical practice such as violence and litigation. The medical school should be the beginning of this preparation and should proceed through residency and initial years of practice. It is not meant to induce paranoia, but to provide practitioners with a working skills and knowledge base so that they can practice confidently, compassionately and safely. The medical training should include legal literacy. The students should have a fundamental understanding of medical law, e.g., the distinction between adverse outcomes and negligence, the components necessary to establish malpractice, and the legal standards applicable to practice. As well as a requirement in the field of ethics, informed consent should be presented as a legal protection, and the mechanism of how to ensure that the conversations about risks, benefits, and alternatives are properly documented should be taught.

The documentation training should be based on practices that will safeguard against litigation and enhance quality care. Clinical reasoning Why certain tests were requested or not, which and why were the differential diagnoses, why was the treatment chosen. In case of complications, the response should be described in further documentation in a manner that is not defensive and does not distort history. The best legal protection is to have proper contemporaneous documentation.

Communication training should be given much emphasis than it is given. Doctors should be equipped with the ability to convey terrible information in a kind but firm manner without using euphemism which obstructs the truth of the matter. They have to determine how well families are able to listen and know when



they are not getting the explanations and change their strategy in that case. Managing realistic family expectations, not making excessively optimistic predictions or pessimism which are unwarranted should be part of training.

Escalation strategies, de-escalation strategies that need to be taught and practiced on a regular basis. Students should also be aware of the dangerous symptoms of the increasing aggression, both verbal and non-verbal. They require a scheme of how to react to enraged patients or families like how to accept feelings, not to defend oneself, maintain safe distance, and when it is necessary to summon security or police. The professional actor role play allows the students to learn these skills in controlled environments prior to the real life.

Physical safety measures should be looked at systematically. The spaces must also be constructed in a way that is security conscious and include such features as panic buttons within exam rooms, open sight lines to avoid cornering, and special security staff who would be prompt to respond to any danger. Students ought to be taught a simple personal protection: they ought to place themselves near exits when having a difficult conversation, they should neither wear tight-fitting pieces of clothing such as neckties or lanyards, which may get caught, nor should they ignore their conscience when the situation feels unsafe.

This insurance training has to be compulsory to all medical students on the verge of graduation. Schools ought to give comprehensive information on professional indemnity insurance: types of cover, common exclusions, the ways of obtaining the right limits, and the ways of getting the right insurers. Students need to know that insurance is not a luxury but a professional need, and its price needs to be discussed in terms of career financial planning, which is being initiated at the stage of medical school.

It is as essential to understand insurance policies as it is to get a policy. Doctors should understand their notification responsibilities in the event that an incident that could result in claims takes place since immediate notification maintains coverage. They are also supposed to know the policy limits, when they need extra umbrella cover. The awareness of the impact of claims on future insurability and defense costs is valuable information to make a well-informed settlement or defense decision.

The peer support networks should be supported and recognized by the institutions. Hospitals and medical schools should also help with linkages between the experienced physicians and the trainees to discuss hard interactions, experiences of violence, and stresses of litigation. These informal talks must be arranged and put as professional growth. Doctors learn a lot by knowing that others have been through what they have experienced and the ways they overcame them.

Mental health services should be easily accessible and de-stigmatized. Doctors that undergo violence or litigation are usually truly traumatized psychologically. Stoicism culture in the profession may lead to doctors not seeking help. Institutions ought to have confidential counseling services and make it an active practice to take advantage of the counseling. Psychological support should be normalized as a demonstration of professionalism, rather than weakness, and this would significantly contribute to the wellbeing of physicians.



Practice in medical law, violence prevention, and communication skills should be updated regularly as a part of the requirements of continuing education. Legal environment is a dynamic environment in which regulations and court decisions influence practice. The trends in violence change and new prevention efforts are needed. Best communication practices are improved by refreshing every now and then since research provides new findings. Inclusion of such subjects in the continuing education, which is compulsory, is important in making sure that physicians remain up-to-date.

It must be used in the real world prior to graduation. Students are to undergo formal training on de-escalation techniques and maybe certified by the law enforcers. They ought to do the real malpractice case study researching failures and the manner in which the better practices could have been able to avoid claims. Practical skills will be developed by administering mock exercises, which involve bad news delivery or dealing with angry families with constructive feedbacks provided by the experienced physicians and communication specialists. Eventually, it is aiming at the realization of physicians who can practice in a confident and compassionate manner and secure themselves accordingly. Whenever a physician has sufficient knowledge of the law, good communication skills, knows and addresses hazardous circumstances, and is well insured, they are able to concentrate on their core duty which is patient care. The other option where unprepared doctors have to deal with a crisis is not beneficial to anyone.

6. THE SYSTEMIC FAILURE OF MEDICAL EDUCATION

6.1 Science Without Survival Skills

The field of medical education has changed significantly in the last century as it includes new scientific findings, clinical innovations, and technological progress at an exceptionally fast rate. The medical curriculum in modern sense is a marvelous accomplishment in the transmission of knowledge in a systematic manner. Students learn the human anatomy in absolute fineness and recognised the gross anatomy and the cellular and molecular structure. They study physiology and biochemistry and gain an advanced understanding of the working of living systems. Pharmacology discusses drug mechanisms, therapeutic applications and adverse effects. Pathology educates on genetic mutation disease mechanisms up to organ failure.

There is also an improvement in clinical training. Students get to know of sophisticated physical examination methods that are a centuries-old practice. They become able to think in a diagnostic way, combining clinical data with test results in order to diagnose diseases correctly. There is the integration of evidence-based medicine in planning treatment through the application of research to make decisions. Procedural training Procedural training provides practical training in specialties in the field of specialization. The outcome is doctors who are well endowed to tackle complicated medical issues and other advanced procedures. This is the ultimate attainment in medical education or this scientific and clinical excellence. Physicians whose performance has been trained to high standards are of immense benefit to patients. The quality of diagnosis, therapy, and safety of the procedures is much greater than that of the older generations. The medical schools should be appreciated as they have given birth to clinically competent physicians.

Nonetheless, the same system is based on a risky premise that clinical competence can be a direct guarantee of professional success and career contentment. Schools assume that medical practice, insurance, self-insurance, and litigation exposure as well as dealing with violent patients or families will be naturally handled by the doctors, who are capable of diagnosing and treating diseases. Such an



assumption is always mistaken, but the gap is still overlooked in education. Implications on the individual physicians are not the only consequences. Physicians with poor financial management abilities may provide poor care due to the absence of money to purchase equipment or staff. The financial stress pressures them to work with more patients in an hour, which does not give them time to spend on each interaction. The instability of practice causes turnover and a break in continuity of care regarding chronic conditions.

The risk of litigation alters the decision making towards the negative. Defensive medicine pushes unwarranted tests and operations and makes the cost so high and the benefit so low. Instead, physicians refer high-risk patients or procedures and patients have to travel to tertiary centers or do away with necessary treatment. Paperwork drains time which would otherwise be used with patients and care has become a checklist. The physicians who are not ready undergo psychological trauma. Others come to be cynical and they see the encounters as the source of possible conflict. There are those who experience anxiety that influences judgment and warmth. Chronic stress is a cause of burnout that drives able physicians out of practice and leaves communities without providers needed.

There is a problem with the feedback loop. The professors that have acquired knowledge through experience do not know how to teach financial management, legal protection, or violence prevention. The concealed curriculum continues the ignorance since students observe the teachers struggling or evading these issues. The generations are repeating expensive mistakes, each of them understanding some lessons which have to be taught systematically. Medical training is geared towards dealing with individual patients and hence does not prepare physicians to the bigger picture within which care is given. Students consider disease processes and treatment protocols but not the healthcare system, practice economics, and social issues that can affect outcomes. Not only is necessary to clinical excellence, but this is not enough to be a successful and sustainable career.

It is not that schools put too much emphasis on science or clinical medicine. Such topics are the background and should be profoundly covered. The issue lies in the fact that there is an unspoken rule that nothing is more important. The curriculum is packed to the brim, and there is no time to include such non-essential subjects as practice management or self-protection. Graduates are good in medicine yet find it hard to cope with the whole thing.

6.2 International Comparisons

An analysis of the situation in other nations proves that these gaps are not unavoidable, but are indicative of certain curricular decisions that may be altered. Some countries have started incorporating practice reality preparation, which can be used by India to emulate.

American schools are the leaders in business and management studies. Most of them have elective courses on practice management, medical economics and healthcare policy. Others render the topics mandatory to some extent. It includes the content on the fee structure, insurance contracts, employment negotiation, and practice models. Students get to know about the simple financial principles and estimate the career opportunities.

American approach is also focused on the legal aspects. Training on informed consent, documentation and management of risk of malpractices is offered to students. Legal analysts talk about actual cases, and they show how a lack of documentation or even communication results in a lawsuit. This integration demonstrates that the legal protection is not a heavy burden which is compliance but good clinical practice which benefits both the patients and the physicians.



Canadian programs focus on health and robustness. In response to high burnout, mental health support, stress management, and work–life balance are incorporated in Canadian schools. Although this foundation does not directly deal with financial literacy or violence, it facilitates the discourse of non-clinical issues. Other Canadian programs are communication training, particularly on hard conversations.

The business skills are also innate in British training since employment in the NHS is predominant. Healthcare economics, organization of the system, and quality improvement are the subjects of the curriculum. Even in individual practice, it is pertinent to know how to organize economics and allocation of resources to the organization. British training is also focused on professional standards and medicolegal concerns which students are ready to navigate the regulatory sphere.

The communication training in Australian schools is advanced and includes learning how to deal with hard-to-manage patients and de-escalation. Given that there is violence towards healthcare workers globally, Australian schools educate students to identify aggression, be safe, and act in response to aggression. This training is accorded as systematic as clinical skills, based on formal curricula, practiced scenarios, and assessment.

Implementation is different even in these progressive systems. Electives only get to motivate students a good number of graduates do so without exposure. There is a lack of faculty experience and crowded academic schedules do not welcome new material. However, the experiences of other countries have demonstrated that the experience of practical preparation may be introduced without the sacrifice of clinical education.

The system of Indian medical education is behind. It pays little or no attention to the practice management, legal protection, or violence prevention and concentrates mainly on clinical training. The disparity creates itself despite the evidence that Indian doctors are experiencing special challenges. National Medical Commission has also changed education, but practical training is yet to intertwine.

India has a number of things that hinder its development. The strain to generate adequate number of physicians poses an obstacle to the implementation of the content that could lengthen training or cut clinical concentration. Faculty who have been trained according to the traditional model have little knowledge and will doubt the applicability of non-clinical subject matter. The cultural unwillingness to talk about money contributes to business and financial uneasiness.

There are also constraints of resources. Most government organizations also have stretched budgets that prevent the hiring of new employees or development of new curricula. The emphasis remains naturally on clinical infrastructure instead of diversifying into more unconventional directions. The pressures of recruitment encounter by the private schools might not emphasize on practical preparation.

These issues have not been stipulated in regulatory frameworks meaning that institutions determine them on their own. Schools have no responsibility to graduate preparedness since they are not required to be accredited or to cover the licensing exams. Conventional methods are still used even though they have continued to build up poor performance.

6.3 The Cost of Ignorance

The lack of teaching on financial and protective skills produces replicated trends that squander potentiality and erode care. The realization of these expenses underscores the need to seal loopholes. On the personal level, young doctors commit avoidable financial errors at the beginning of their practice. They take contracts without the knowledge, compensation, non-compete, and insurance. This is because they get



joined to panels that have underpriced services and then fail to increase charges. Every failure has a compounding financial effect. Failure to practice is a waste to the society in terms of training. A trained doctor will need considerable amount of both the government and the personal resources. The society misses the opportunity to receive a competent service of doctors who are incompetent because of poor financial management, but not because of incompetence in clinical care. New practice failure is generally recognized as being unnecessarily high.

Unprotected physicians are subject to litigation claims that are expensive. Uninsured young doctors who are exposed to malpractice have to seek help of attorneys they cannot afford and even go bankrupt. The risks would have been prevented by making them aware of indemnity insurance. This is a professional negligence bordering omission. Psychologists are faced with violence. A post-traumatic stress is caused by physical attacks or threats. Others move out of clinical practice to administrative positions; others remain and practice with diminished empathy and increased cynicism, which damages their relationship with patients. Violent psychological wounds are irreversible damage that would have been mitigated through adequate preparation.

The problem is depicted by burnout rates. Research indicates that approximately half of doctors experience burnout ten years down the line. Among the stressors are financial anxiety and fear of violence or litigation. Further preparation would not remove all the problems, but it would offer means to cope with them in a better way. The cycle continues between generations. Untrained practitioners are unable to tutor the youngsters on finance or self-defense. Informal learning happens too late when it has been too expensive to make mistakes. Individual generations are basically born to start afresh without the systematic impartation of knowledge.

The quality of healthcare is negatively affected when doctors have problems with sustainability and safety. The financial stress will reduce the length of appointments because doctors will maximize the volume. The lack of timely equipment and insufficient staffing affect the quality of care. Defensive medicine is fueled by fear of litigation that raises costs and at times removes care. Compromise by unprepared physicians is detrimental to patients. These pressures are found in specialty choice and geographic access. The specialties that are high-risk have fewer practitioners since students are afraid of litigation and violence. Isolation and possible community rejection all add to rural practice making it less appealing. Such recruiting issues pose unsafe loopholes particularly to vulnerable groups.

System financial cost is big. Defensive medicine is cost inflating, pitting unnecessary tests and procedures. Training is wasted in practice failures and early retirements which create shortages that increase the cost of the remaining physicians. Burnout decreases the productivity of the workforce, which increases the recruitment and training expenses. There is loss of professional satisfaction and meaning. Physicians that joined the medical field to treat are busy with business, legal issues and safety. Lack of their motivations being in touch with reality leads to existential discontent that cannot be compensated with clinical success. Most of them believe that they are not meeting some of the requirements of their career, despite clinical success. These are some of the problems that should be addressed. Through practical preparation in curricula, we will safeguard the physicians and enhance patient care, and save the investment in medical education.

7. REIMAGINING MEDICAL EDUCATION

7.1 Core Curriculum Integration



Solving the gaps in medical training cannot be accomplished by a few cosmetic additions and extracurricular trainings. It requires a meaningful change where financial literacy and self-protection skills can be integrated in the mainstream curriculum as seriously as clinical competencies. These issues ought to begin very early, develop gradually, and reach competency that will be demonstrated by the time of graduation.

First year of medical school is the best place to start teaching financial concepts. Learners who are being taught in the area of healthcare systems and healthcare policy must also understand the concept of healthcare economics both at the macro- and micro-levels. They need to query What are the monetary operations of various models of delivery? What is the working of insurance systems? Which business models are used in medicine? The discussions provide background information concerning the role of physicians in the overall economy.

Introduction to the basic concepts of business should be part of the first-year curriculum in combination with elementary science. The students are expected to know the difference between revenue and profit, the difference between fixed costs and variable costs, and be able to read simple financial statements. This is not aimed at transforming medical students into accountants but rather making them financially literate so that they can make informed career choices in the future. Introducing these concepts at an early age familiarizes them as opposed to foreignness when students are required to apply them.

Second-year students, whose transition is into clinical rotation, should be exposed to practical practice management instruction more. They need to know the real cost of operations of different kinds of practices, physician prices their services, and consequences of different insurance panel decisions. Students are to examine actual practice financial statements, determine where revenue comes in, what kinds of costs are involved and what drives profitability. Examples of good and bad processes will be presented in case studies to describe these principles more precisely.

Students are to be given clear training and training practice in negotiating fees with patients during their clinical rotations. Money in the present model is seldom talked about before the student and is often handled totally by the staff members which leaves the students not ready to deal with the necessity of money. Modeling fee conversations and allowing them to be practiced by students should be attended by the physicians. The idea behind this is to make the transparency of fees have a normal feel as opposed to awkwardness.

Students in their third-year are expected to master insurance navigation by using practical activities. They ought to study insurance plan panels in their locality, estimate the rates of reimbursement of the popular procedures, and compare them to the costs of service. They have to train in filling in insurance forms, coding, and writing appeal letters on rejected claims. These are tiresome yet necessary skills which are more convenient to acquire through guidance as opposed to being pressured to do so.

The education in law ought to follow the same. Introductory medical law, including the basic principles and landmarks, is given to first-year students. Informed consent is taught to the second-year students in detail and both the principles of ethics and the legal requirements. The documentation during the clinical years shields the students of law and recommend quality care. They are taught to understand the circumstances when they need to seek legal advice and they also know their rights and obligations.

During the medical education, communication training should be paid much more attention. The students must be taught and trained in how to deliver bad news, how to handle family expectation, how to identify when the aggression is escalating and how to de-escalate the tense situation. Being as essential as



physical examination methods, these skills need to be taught methodically and trained. Professionally-acted role-played, taped, and reviewed allows students to practice these skills in low-stakes settings.

Violence prevention training should be included in the curricula just like infection control, or patient safety. Students need to know how to identify red flags of possible violence, the factors of the process of escalation and de-escalation, and how to leave the dangerous situations without harm. Control of physical safety measures such as the location of panic buttons, security response measures, and personal safety measures ought to be addressed in an orderly manner. This training does not go beyond realizing the reality without instilling paranoia.

The education on insurance should be compulsory. The last-year students are to be provided with the information concerning professional indemnity insurance: how to compare policies, how to select the coverage amount, which insurers are available, and how to take care of continuous coverage. The seriousness of this information should be equal to the licensing conditions, as such information is vital professional security. Schools ought to think of making a mandatory condition of showing evidence of insurance coverage before graduation.

Financial analysis of various practice options should be used during career-planning sessions. Students also think over different specialties and environments and ought to be aware of the financial consequences of such decisions. They should have basic knowledge of the salaries and the differential between the employed and ownership jobs, the direction of the trend, and the sustainable debt loads of each job avenue. Such practical financial points of consideration should guide, rather than predetermine, career choices.

The practice areas that need to be demonstrated competently in pre-graduation assessments should be similar to clinical skills exams. The learners may examine a practice opportunity, spot red flags, and determine whether the financial conditions are reasonable. They might be tested on their skills in negotiating fees with fake patients or capturing informed consent discussions in a manner that is appropriate. By making them graduation requirements, they will obtain sufficient attention.

Integration should not necessarily have a significant impact on the length of the medical education process or push critical clinical training aside. Most of these issues can be introduced in the existing classes with slight modifications. Practice economics could be offered in health policy courses. Fee conversations and challenging conversations could be incorporated into the training of clinical skills. Legal and ethical classes might be increased to include practical protection. They are the important things that must not be viewed as optional.

7.2 Faculty Development

Faculty capability is vital in the success of any curricular reform that entails delivering the content. The existing medical faculty, which is trained according to conventional programs, is not always competent in financial management, practice economics, legal protection, or violence prevention. Schools will not be able to just make it compulsory to teach these subjects without the investment in teacher training and strategic hiring.

Business and management gurus should be employed by the medical schools to assist in the teaching of practice management and financial literacy. MBA programs in healthcare offer graduates that are knowledgeable of the business and the healthcare environment. These are professionals who are able to design a curriculum, deliver courses and guide students in career financial planning. Their existence is an indication that schools do not underestimate practical preparation.



The faculty should also include legal professionals that focus on the medical malpractice and healthcare law. They provide real-life experience in how the doctors get into trouble with the law and what the best types of protections are. They go beyond the abstract guidelines in teaching and provide concrete teaching regarding documentation, informed consent and risk management. Professors of law can be used to guide students on when to consult lawyers and how to collaborate with them.

Victims prevention of violence training should involve security professionals who are experienced in healthcare. These specialists know the dynamics of the medical environment and can educate de-escalation skills specific to physician–patient relationships. They can be trained on how to recognize the threat and how to keep themselves safe and this can be applied in medicine with due consideration. Relevant knowledge is brought by specifically experienced policing or security consultants who have worked in hospitals.

To be comfortable including practical topics in rounds and patient care supervision, clinical faculty should develop professionally. Workshops on talking about fees, bad news delivery, dealing with angry families and writing to provide legal protection can assist them in introducing these issues in their natural way. Faculty can also be required to be re-educated in areas that they did not learn in the formal set-up.

The successful physicians who have managed to overcome these issues are priceless teaching tools. Individual professionals who have in the past established sustainable practice, partners in a group who have negotiated complex business relations, physicians who have endured malpractice suits all have wisdom to share. Schools must formulate institutionalized ways such as guest lectures or mentor programs to bring these practitioners into education.

These issues demand varied styles of teaching when compared to the medical education which has been practiced traditionally. Lecture alone is not applicable to financial concepts which require exercises and case studies. Skills in communication involve role-plays and feedbacks instead of observation. It is an advantage of legal education to investigate real cases and not abstract principles. Faculty must be supported in creating such practices and urged to be creative with regard to curriculum.

Faculty development should incorporate the principles of adult learning and hands-on learning. It is to ensure that these subjects are interesting and applicable instead of being theoretical and dull. The faculty that can relate financial literacy to actually relevant career choices or teach students how communication skills can help them avoid violence will have a much greater effect than the faculty explaining the abstract material.

Medical schools should recognize non-clinical teaching efforts by reward systems. The faculty members who establish new strategies on the management of teaching practice or violence prevention should have the same promotion consideration as members of the clinical education. At present, teaching in these areas of soft skills is underestimated in medical schools. This implicit hierarchy has to be altered.

Interdisciplinary cooperation between the medical and business, law, or public safety faculty enhances education among all. The mixed courses or shared duties make students receive different views and make other faculty aware of the context in healthcare. Such partnerships also enable the study of the effectiveness of education, in terms of methods that provide the most positive results.

7.3 Regulatory Changes

Although individual medical schools can and must act to bring about reform, a systematic change needs regulatory mandates that bring accountability into existence. Medical education regulation authorities,



especially the National Medical Commission of India, ought to come up with a definite requirement on financial literacy and self-protection training which is required to be satisfied by every school.

The minimum competencies in the practice management and financial literacy should be stated in the accreditation requirements. It is expected that schools that are pursuing or are retaining accreditation will show that their curriculums encompass intentional teaching on these topics and students attain specific learning outcomes. Such requirements would do away with the prevailing circumstance in which schools can flout these topics without reprisals. Accreditation standards are relevant in that, the school may lose its capacity to conduct its running in case it does not meet the requirements.

National Medical Commission must formulate comprehensive competency frameworks in practical preparation as is the case with the available clinical skills. It should specify the knowledge and skills that a graduate physician should have about practice economics, communication skills, protection of the law as well as indemnity insurance. Defining competencies enables the schools to construct the curriculum in a systematic way instead of adding to it on a case-by-case basis.

The licensing exams would be able to add questions to these areas and hold schools and students accountable. In case the medical licensing exam involves knowledge of basic practice economics, insurance, informed consent, and violence prevention measures, students will consider learning these areas important and schools will make sure that these areas are adequately covered. Even a percentage of exam content in these areas would make a big difference in the perceived importance of these areas.

The test methodology must be based on real practice as opposed to memorization. True competency would be evaluated by scenario-based questions that would require students to analyze practice opportunities, react to angry patients, or make decisions about the time the insurance coverage is sufficient. These questions should be formulated by experts in their fields to make sure that they are testing the pertinent knowledge and skills and not trivia.

Medical education requirements must also continue to provide a mandatory update on legal matters, financial management and prevent violence. Doctors must be obliged to attend a given number of CME hours in these areas on a regular basis say after every three–5 years. This makes sure that the practicing doctors keep abreast in these fields despite their incompetence in training. The CME requirements would partially fill the educational gaps that might have existed in the past and will indicate the significance of such subjects.

The National Medical Commission ought to direct a study on the efficacy of various strategies of educating these practical skills. What are the methods used to create real competency? Which ways should limited time in the curriculum be employed? What are the long-term consequences of physicians who undergo systemic preparation as opposed to non-prepared ones? Factual research is needed in evidence-based reform.

The professional medical associations should collaborate with the regulatory bodies to champion such changes. The roles of shaping policy are in the Indian Medical Association, specialty organizations, as well as the state medical councils. Their lobbying, as the representatives of practicing doctors, who are aware of these needs, has a certain weight. Institutional inertia can be broken through a collective professional voice that can clamor reform.

The changes of the rules need to be introduced through a gradual process so that the schools have time to create new courses and prepare the teachers. It will not be realistic to implement it immediately because



there is a lack of faculty knowledge and curriculum limitations. Goal-driven plans that have specific milestones bring about accountability in the face of practical constraints. Schools can be aware that compliance is going to be demanded sometime and prepare.

Indian regulatory strategies may be informed by global comparisons and cooperation. Education in countries more advanced in incorporating practical preparation is a good way not to reinvent the solutions. Medical educator exchange programs, collaborative curriculum creation or international model adoption with cultural adaptation would hasten the process.

Finally, system reform turns local school efforts into system reform. Most progressive institutions will only change when necessary, although there are progressive institutions that will do so voluntarily in order to fill these gaps. Regulation creates a level playing field whereby every school has to prepare physicians well enough to meet the realities of practice such that once they graduate they are well, well prepared physicians irrespective of what school they graduated to.

8. IMMEDIATE ACTIONS FOR CURRENT PRACTITIONERS

Although the long-term mission of medical education reformation will have an advantage on future doctors, time is of the essence. Practitioners already in place should have a responsibility of sealing any loopholes caused by the unfinished training. There are many tools and measures that are going to enable the doctors to enhance their financial literacy and self-insure, which is good news.

8.1 Financial Education Self-Study

Begin by being frank and estimating what you are well-informed about finances and identifying what you are not. Question to ask Do I know my real operating costs of my practice? Am I able to read my personal financial statements? Am I fairly and competitively priced? Are the insurance panels to which I am joining profitable? It is an uncomfortable check in that demonstrates where to concentrate any learning energy.

Professional associations are important. The Indian Medical Association provides workshops, webinars, and individual consulting practice economics, billing and financial planning. Specialty societies offer aid in the same way. Their programs are framed in a way that doctors can identify with and emphasize the challenges that are affecting them in a particular way.

The past years have enjoyed the boom of healthcare business schools. A significant number of universities have been providing certificates or degrees in healthcare management or medical practice administration. Full-time degrees might not be an option, but most schools offer part-time or online programs that can fit a schedule of a busy clinician. These classes include systematic practice management, healthcare economics, and financial leadership.

The other strong foundation is the books focused on physician financial literacy. Most authors are themselves doctors and are writing useful books on practice management, personal doctor-to-doctor-financial planning books and career long-term planning. These texts have real practice examples between paying down student debt and retirement strategies. Reading during the course of a few hours once a week can provide you with a solid structure that can be relied on in addressing financial problems.

Physicians have a specialised touch by financial advisors. They understand the late-career entrance, big debt burden, risky earnings, and tax-convolutions the doctors are subjected to. They will be able to plan retirement, propose investment stacks, recommend insurance and advise practice finances. Selecting advisors that are fiduciaries will guard you against sales-based advisory.



The learning groups comprising of peers are strong. Through informal study circles with fellow colleagues, the doctors will be able to share the mistakes and successes of their colleagues. Business aspect of medicine is demystified through collective review of financial statements, negotiating prices and insurance and shared troubleshooting. Team work facilitates the learning process.

The flexibility is offered in online courses and certifications. There are numerous sites with practice management modules, healthcare economics and financial planning modules on which professionals can attend. These usually involve exercises, case studies, and tests to solidify learning. Their self-study system allows clinicians to learn at times of change as opposed to set timelines.

Practice-management consultants are able to provide custom strategies. Even though there is an initial cost of contracting a consultant, the savings realized by the efficiency usually supersede the cost. When operations are reviewed, experienced consultants identify inefficiencies, propose pricing adjustments and propose operational changes. Their foreign perspective is able to reveal their blind spots that a professional doctor may miss.

Learning is concentrated in conferences and workshops. These events condense highly intensive, narrow content into a couple of days, providing in-depth subventions on individual subjects. The informal networking of the peers with similar problems is also value added to the formal agenda. According to accounts given by many clinicians, one conference changes their perception about practice management altogether.

Self-directed financial education is the key that is best achieved when it is considered as a priority. Carve out the usual learning time as in clinical CME and begin with free or low-cost materials in books or online courses. Then move to higher education such as consultant work or college studies. Financial literacy is an investment that is rewarded during a career.

8.2 Immediate Protection Measures

In addition to learning, physicians have to take immediate action to protect themselves against violence and lawsuits. The following will lessen risk as you develop more knowledge.

The decisive action that you need to make should be the purchase of professional indemnity insurance in case you are yet to have it covered. Compare different insurers on terms of cover, exclusions and premiums. Do not go with the cheapest plan unless you are sure of what the plan covers. Make sure that coverage is occurrence based or that you understand tail-coverage provisions in case you are using a claims based policy. There should not be gaps in continuous coverage.

Coverage limits matter. The two to three crore ceiling might appear adequate, however, it can be increased depending on specialty, location, and risk exposure. Extra umbrella insurance is frequently required on high-risk procedures. It is important to keep in mind that limits cover defense expenses and even possible judgments or settlements and appropriate coverage can save the career and tranquility of mind.

The enhancement of documentation is critical and urgent. The best thing is to have a full record. With each patient encounter write why you diagnosed this or that, what you considered, why you opted to treat or not, what risks you talked about and what the patient did. Documentation, which is clear and is of the time, is hard to question than those which seem to have been changed with time.

Include templates that capture the following important information: informed consent, medication counselling, follow-up plans. When you experience complications, document your activities without the use



of defensive words and justifications. Use of literature reviews or note consults to demonstrate consideration when making a decision.

The Safety measures that were previously implemented in terms of physical safety are to be reconsidered, in particular, in the emergency departments that can be considered risky areas. Check your surroundings on security loopholes. Are there panic buttons that are accessible? Is it able to respond promptly to security threats? You won't be cornered because of sight lines that are open? Make employees understand and respond to deteriorating situations. Make corrective actions on apparent weaknesses.

The individual risk is reduced by personal safety behaviours. In heated discussions, sit close to the exits. Keep off objects that may be picked, e.g. neckties or lanyards. Never doubt your instincts when a circumstance is unsafe, engage security or delay the interaction. Your wellbeing comes first before accomplishing a specific clinical activity.

The support groups and professional networks offer pragmatic advice and emotional rescue. Meet other community members through associations, online groups or local groups. Sharing, inquiring, and being educated by other people who have faced the same issues is a way to get through it. It is priceless to have peer support when stressing.

Your skills in short communication can be improved with workshops that hone your skills in dealing with challenging interactions. Find classes on how to deliver bad news, how to manage patient expectations or de-escalate conflicts. Even short training provides the methods you can use on a short-term basis. The investment on one day training is often paid back.

Any possible claim or unfriendly originality should be accompanied by legal consultation. Lots of lawyers have cheap or free introductory consultations. Knowing your position in law early gives ability to make protective measures. Wishful thinking that problems will go away is never a good solution; consulting an attorney is normally cheaper than court proceedings.

Continuing education of medicolegal issues, violence prevention and management of practice should become a habit. The change of laws, trends of violence, and best practices in the business changes. Participate in webinars, professional journals and attend appropriate workshops in order to update knowledge.

Complex or high-risk case peer consultation enhances patient care and legal safety. Share difficult situations with peers, record these discussions, and seek official second opinions as required. This participatory style shows hard working and evidences wise decision making.

Violence and litigation crisis response plans are of immense value. Know what you can do in case of an attack: whom to call, places of safety. Similarly, during delivery of legal documents, know your attorney and how your insurance company handles the reporting of the same. With such plans, you can act in calmness compared to acting in reaction with crisis at hand.

9. BROADER IMPLICATIONS FOR HEALTHCARE

9.1 Impact on Patient Care

The willingness of physicians to practice in real life is directly connected with the quality of patient care. The problem of finances and worries about lawsuits or violence disrupt the work of a doctor and his relations with the patients. The identification of these effects demonstrates that bridging the existing gaps in education can benefit doctors and the individuals they are attending to.



Monetary pressure reduces the amount of time a physician has with an individual patient. Doctors are afraid of payroll or overhead thus they are hurried to see as many patients as they can within a given time of day to survive. Shorter appointments imply that they will not spend as much time discussing and patients will feel rushed. The failure to engage doctors in sufficient time per visit destroys a strong therapeutic relationship.

The infrastructure and support of a practice is also undermined due to financial instability. The physicians struggling in purchasing the equipment tend to postpone their purchase, usually using the old equipment that can provide diagnostics of a lower quality. They might employ less personnel, leading to the bottlenecks that will result in patients waiting longer or leaving assistants unable to serve accordingly. It results in an unfriendly working atmosphere in the office when the maintenance is deferred due to financial problems, reducing the level of patient satisfaction and comfort.

Fear of lawsuits alters the practice of care choices in the doctor in most cases to the detriment of the patients. Defensive medicine- requesting tests or procedures primarily to protect against lawsuits, rather than clinical need, is a cost-increasing exercise. Defensive practices are increasing healthcare expenditures annually by billions of dollars and result in health risks, including unnecessary test complications.

Less obvious but equally likely to result in a frozen decision in a crucial situation, fear of a lawsuit may suddenly make a doctor hesitate in his or her decision. The worry will also cause hesitation, further consultations, and delays in information collection. This act of defense stalling can lead to worse results than immediate action which is based on judgment. Patients are harmed where a physician is not able to do what he or she is sure about.

The litigation risk avoidance restricts access to patients with complex conditions or high-risk conditions. Even where the doctors are clinically interested, they tend to refuse to treat patients who they perceive to be a high risk in terms of complications or lawsuits. Complex obstetric patients have difficulties finding willing providers. Surgeries that need complex work could be referred in far tertiary centers, where the patient and even his or her family will have to bear the cost of traveling. This risk selection goes against the principle of care being as a result of clinical need, and not litigation risk.

Physicians who undergo violence or litigation trauma are less emphatic and emotionally available. The coping strategies to chronic stress can cause them to emotionally detach themselves to patients. It is encounters that such doctors treat as work instead of taking care of therapeutic relationships. Patients observe such disengagement and they believe that their doctors do not treat them as people.

The documentation of defensive medicine occupies the time that can be used to provide direct patient care or professional development. Physicians take hours of their time to complete long and voluminous paperwork, which is primarily meant to defend them in legal terms rather than contribute to clinical practice. Such distraction limits time available to educate patients, counsel them and make wise decisions. The ensuing checkbox methodology serves the legal purposes, but undermines treatment.

When physicians are economically stable and not fear of violence and lawsuits, their medication is sure to be better. Economic soundness will allow them to purchase advanced gadgets, recruit enough personnel and spend time with every patient without worrying about revenue. Trust in protection of the law encourages evidence-based care as opposed to defense. The emotional availability that leads to compassionate care is promoted by the feeling of being print on a physical level.



Doctors who are stable emotionally and financially are made available. They are easy to adopt new patients, increase office hours, and enhance access based on urgent needs. They make time to educate and engage in preventive care with patients, increasing long-term outcomes. They also handle complicated cases which others would shun because they are assured of the resources and protection.

The quality of communication also increases significantly when physicians are no longer afraid of being beaten or sued. Safe physicians have open and honest discussions on the challenging issues, present bad news decently, and communicate inherent doubts. They are able to confess the weaknesses and mistakes without being afraid of legal actions. This real-life conversation enhances treatment relationships and increases patient satisfaction, despite poor outcomes.

Practice longevity has a major impact on the quality of care. Burned-out physicians leave early and leave the community without experienced doctors. Patients who have been involved in trusting relationships are deprived of continuity when their doctors go. The years of institutional knowledge and clinical wisdom are lost when the doctors fail to maintain their careers because of insufficient training on the real world practice.

9.2 Healthcare System Sustainability

The modern medical education framework tends to equip doctors with insufficient skills when it comes to handling financial and safety issues, which has led to a set of unsustainable trends that jeopardize the healthcare delivery. These systemic implications can be used to explain why the training of physicians should not only focus on the individual.

Malpractices amongst young doctors are a waste of the massive investment that the society puts in training medical professionals. It costs the government a lot through the funding of medical schools, subsidization of physician training in teaching hospitals, and other support mechanisms to educate a physician. In cases where physicians are unsuccessful in practice in the first five years due to inadequate money management as opposed to incompetence in clinical practice, such an investment is partially squandered. The doctor can still practice, but frequently he or she no longer deals directly with patients, whether in administrative or non-medical positions, which leaves the practitioner workforce already strained badly in need by society.

The medical practice is financially unstable which is a contributing factor to the current healthcare workforce shortages. Physicians who observe the high failure rates in the practice of young physicians may have a completely different career path. Some of them seek working jobs in major healthcare systems instead of independent practice, which diminishes the range of models of practices. Although some physicians prefer employment, the removal of independent practice opportunities due to financial unsustainability is a literal loss to the patient who may want such environment.

Attack on healthcare employees causes acute difficulties in recruiting specialists in high demand and low-income regions. The intellectual appeal and significance of emergency medicine notwithstanding, it has a hard time recruiting sufficient practitioners, in part due to the fact that the emergency departments are the most violent. The remote country practice is even less attractive when it is supported by isolation and possible hostile reaction of the communities towards the negative outcomes. Such staffing shortfalls leave unsafe gaps in the coverage of health care where people do not access the services they need.

The epidemic of burnout in physicians lowers the productivity and sustainability of healthcare workforce. Physicians who are burned out reduce their working hours, retire at a young age, or even move to non-clinical positions. The workforce of the effective healthcare is not reducing due to a decrease in the number



of physicians who are licensed to practice, but rather due to a reduction in the number of physicians who work less or abandon direct care of the patient. This adds to the already existing physician shortages and needs new physicians in even greater numbers in order to sustain the current healthcare capacity.

Defensive medicine contributes a lot to the increase in healthcare expenses without commensurate quality enhancements. Unwarranted testing and processes that are requested primarily to protect oneself against lawsuits are a waste of resources that can be used to carry out other productive healthcare services. The hospitals develop additional capacity to meet defensive medicine test and procedures requirements. Insurance companies raise the premiums to cover such inflated costs rendering healthcare unfriendly to the patients and employers. Defensive medicine cascades of effects compromised the efficiency of the healthcare system.

This is because the quality of leadership in healthcare becomes compromised as qualified clinicians move out of practice because of lack of proper preparation and support. The medical systems require physician leaders that are familiar with clinical medicine and health care operations. In cases where great doctors burn out, or unsuccessful in the practice, they usually move into leadership positions without proper preparation and interest. Meanwhile, doctors that could have made great leaders are not seeking leadership opportunities as they are concerned with clinical survival.

Healthcare delivery model innovation needs to involve physicians who are ready to experiment and make levelheaded risks. Physicians are however risk-averse not innovative due to financial and legal vulnerability. Physicians who fear practice survival or lawsuits use old methods instead of experimenting with new patterns of care delivery. This conservatism, though acceptable, is a drag on healthcare innovation and it does not allow the creation of possibly better practice methods.

The trend in the health care delivery system towards large corporate systems, which are partially caused by the impossibility of individual physicians to maintain individual practice, creates challenges to healthcare quality and access. Large systems have economies of scale and resources that individual practitioners cannot compete with, but they also make the care less personalized and sometimes more concerned with financial output than quality of care. A system of healthcare that accommodates a variety of practice models that are viable independent practices will probably offer greater service to the patients than one that is all about corporate healthcare.

These systemic problems are manifested in geographic distribution of physicians. The underserved areas, not only the rural areas but also the urban poor neighborhoods, experience a shortage of physicians which is complicated by the lack of interest in the economics and safety of practicing medicine. These communities are usually not able to sustain the number of patients required in order to have a financially viable practice. They could experience increased complex unreimbursed care. The prevalence of violence towards healthcare workers might be higher. Together, these aspects render the recruitment almost impossible, continuing to create inequalities in healthcare access.

The generational effect is worrying to the sustainability of the healthcare systems. As medical students see their mentors hamper with their finances and violence, they start questioning the medical careers. Applications to medical school are also still high around the world, though there is a growing trend of such applicants to have either a privileged background or a family with the means of helping them in the protracted training. The low-income students who may present more physician related to underserved groups are unable to sustain the lost income and expenses. This population change influences the kind of physicians to be and the kind of communities they end up working in.



When the medical profession can only seem to be interested in protecting their financial well-being instead of the patients, it undermines their trust in the medical profession. On the one hand, doctors must have the financial security and the ability to defend themselves legally; on the other, defensive medicine or rejecting high-risk patients gives the impression of the physician being more concerned with the self-interest of patients than the patients themselves. This image, although unjustified, hurts the social contract between medicine and society that gives physicians freedom in exchange of considering the patient first.

9.3 Professional Satisfaction and Longevity

Proper preparation to the reality of practice is a strongly influential factor in career satisfaction of physicians, but this has often been overlooked when discussing wellbeing. These relationships are useful to understand that educational reform is not just a technical modification of the curriculum – it is a basic investment in the length and the satisfaction of career. When a doctor understands the economics of practice and feels safe, he or she looks at the profession with optimism, rather than with constant nervousness. Such a way of thinking has a significant influence on routine. Doctors who are not afraid to report to supervisors have the ability to dedicate their mental capacity to clinical issues and relationships with patients instead of constantly worrying about remaining in practice or being legally exposed. The difference between the state of professional satisfaction among professionals who feel prepared and those who feel overwhelmed by non-clinical burdens is hard to be overestimated.

Financial literacy enables the physicians to make career decisions on their own freewill, rather than on out of desperation. Physicians who are aware of the financial consequences related to various models of practices are able to choose environments that fit their interests and values. The negotiators of employment contracts do this based on knowledge of practice economics. This power to decide informedly, autonomously essentially increase long-term satisfaction. Career satisfaction is also highly linked to a feeling of control in professional life. Doctors who are ready to face the realities of practice have a sense that they are able to handle the challenges as opposed to being victimized by unforeseen events. Systematic frameworks are prepared to be used by the prepared doctors to handle financial or legal issues. This agency safeguards against helplessness that is the root cause of burnout.

Work-life balance can be achieved when the physicians are efficient in practice. Financial literacy will allow proper pricing and productivity planning that will produce sufficient income without too many hours. Knowledge of practice economics enables physicians to select the workload depending on their preferences of the lifestyle rather than the actual financial panic. Better work-life integration is directly supported by the scheduling control that is associated with financial competence. When physicians are not desperate or competitive, relationships with colleagues are enhanced. Physicians who are struggling financially might consider the colleagues as competitors over scarce resources or patients. The ones who are afraid of litigation might be reluctant to consult and share cases. As a contrast, physicians that are financially stable and have no doubts about their legal positions can work together more easily, exchanging knowledge and providing mutual assistance. These peer relationships significantly increase job satisfaction.

When practicing medicine according to personal values and not necessarily financial gains, the meaning and purpose are improved. Doctors who are required to attend too many patients to earn a living cannot give the comprehensive care they went into the medical field to offer. Clinical interests are put at risk by those who refuse to treat some patients or procedures as a result of litigation claims. Physicians will find their work meaningful when they practice in accordance with values due to financial security and legal protection. Involvement in continuing medical education and professional development is a stark contrast



between the prepared and unprepared doctors. People who are always worried about staying in practice or are at risk of being sued do not have much mental energy to learn new strategies or become more knowledgeable. On the other hand, safe doctors have made an investment in continuous education, which makes the practice thought-provoking. Maintaining interest and burning out are minimized with continual learning.

The sense of being good at everything related to the professional life, and not only clinical medicine, is a powerful psychological influence. Doctors are accustomed to being professionals in their areas. Professional identity is threatened when they believe that they cannot manage finances or are exposed to unknown dangers. The growth of practice management and self-protective competence recovers the feeling of mastery that constitutes the component of physician self-concept. The next logical outcome of these factors of satisfaction is career longevity. Doctors who can make a living, enjoy their work, fulfill their intellectual needs, and live in accordance with their principles continue to work long after physicians who develop chronic stress. The long length of career is beneficial to individual physicians and health facilities in need of senior practitioners. When the physicians serve a 30–40 years period rather than a 10–15-year one, the ROI on medical education increases dramatically.

The mentorship and leadership come more naturally out of satisfied doctors. Individuals who have overcome career hurdles and are content in their profession find it easy to counsel junior colleagues, transferring the wisdom in them. They take on leadership positions, push improvements in policies, and can help improve medicine through other means than direct care with patients. This larger involvement enhances the whole healthcare fraternity. The personal life and relationship impacts are inexplicable. Physicians who are professionally successful and content are better partners, parents, and members of society. Professional struggle that is chronic is detrimental to personal relationships, physical health and life satisfaction in general. Improved career satisfaction as a result of improved preparation and assistance has far-reaching benefits even beyond the workplace to every other facet of life.

10. CONCLUSION

Albeit medical schools equip clinicians in a great way, they never equip the doctors on the practical aspect of practice. The loopholes are primarily found in financial literacy, practice management, and medical violence and litigation prophylaxis. Consequently, some clinicians are excellent diagnosticians and curers, but they struggle with the business aspect of the field and feel continuously vulnerable to ill-will patient responses. These issues have actual and multifaceted outcomes. The physicians repeatedly make expensive financial mistakes, practice without adequate accountability and liability protection, and face violence lacking the de-escalation and security training. The outcome is high burnout rates, premature career exit and subsequent discontent even in capable clinicians. In the case of health systems, it has resulted in wasted educational expenditures, defensive medicine that is increasing costs, and exacerbating physician shortages. The patients get less quality care due to doctors being busy trying to make money to live and fear of being attacked or sued.

This article demonstrates that these problems are not inevitable and unsolvable. The comparison of other medical education systems with international systems has shown that practical training to current practice has begun to be embedded in other medical education systems. The research on physician experience identifies the precise knowledge and skills that are important. Institutionalized structures are welcome to provide orderly learning about financial literacy, practice management, legal protection and violence prevention instead of learning, which is expensive, based on trial and error. There should be an all-inclusive



reply. The schools should incorporate financial and protection skills within the essential curricular programs, and they should be rated equally to the clinical skills. The capacity to deliver these subjects should be developed through the faculty development and specific recruitment. These subjects should be mandatory in the curricula and examinations conducted by regulators. Professional organizations should be the champions of these changes and offer means to practicing physicians who are required to bridge knowledge gaps.

Doctors who are already in practice have to act individually. And resources are available, including the workshops conducted by professional associations, professional financial counseling, and violence-prevention training. Practitioners must acknowledge their weaknesses and take decisive action. Anyone who does not have professional indemnity insurance needs to purchase one as soon as possible. Other than insurance, physicians ought to enhance financial literacy, documentation, communication, and safety measures. The required change does not only lie in the refinements of curricula it entails the re-assessment of professional competence. Medicine entails healing practice and business processes. The practice of compassionate care exists within complex financial structures and even well-wishers in the work of the clinician face aggressive reactions which require self-defense. The disregard of such facts results in failure of education to its students, no matter how sophisticated the clinical training they go through.

The focus will be to create physicians who are indeed prepared to be in the careers they will follow self-assured rather than nervous, capable of working through decades without burnout or losing interest. This is possible by imparting not only medical knowledge but the actual survival skills of modern practice. It is only at this point where the education has taken this wider purpose that doctors will feel that they have been prepared in their training. The stakes are high. Medical care in the world is faced with a problem of physician shortages, burnout crisis, and health care sustainability. It is becoming difficult to access quality care by patients. Attack on clinicians is also increasing. These interrelated issues will not be eliminated without addressing their causes such as the inadequate training in non-clinical aspects of practice.

The era of gradual modifications is gone. There should be a paradigm shift in medical education that recognizes current realities in practice. This will not be an automatic change, and will have to be an advocacy and action response by schools, regulators, professional bodies, and individual physicians. All of the stakeholders contribute to the formation of education that will prepare physicians to be successful in the profession to the full extent. To the students who are currently in training, this article must confirm the fears they already have regarding their practice preparation. They are right in their intuition of important issues that are not addressed. They are supposed to support the change in curriculum in their institutions. They ought to find electives and informal learning. They ought to associate with clinical practitioners who will be happy to impart practical wisdom. They ought to be proactive so as to equip themselves with the aspects of the practice that their formal education does not cover.

This article diagnoses and prescribes problematic issues to practicing clinicians. Their practice and legal practice vulnerability or violence are not specific failures, but anticipated outcomes of insufficient preparation. Funds to cover these gaps are available. An active promotion of financial literacy, obtaining appropriate insurance, self-protection skills are an individual and career duty. To teachers, this article is a challenge to make you expand your perspective of teaching responsibilities and professional competence. Generation of clinically good doctors is precious and actual, but not enough. The profession requires physicians prepared in all areas of practice and not only clinical practice. Seize the opportunity to be the first to adopt new pedagogical practices that combine practical training and clinical training.



To policymakers and regulators, the article demonstrated that there is an urgent need to require comprehensive physician preparation. Demand and supply will not stimulate the necessary changes in education without facilitation. Accountability brought about by the regulatory mandates ensures that every school equips physicians with the current realities of the practice. These requirements have more influence on education than any other aspect. The vision is quite obvious Medical education must bring out clinicians who are scientifically advanced yet practical trained clinicians. They can move into sustainable business models with relative confidence to practice evidence-based medicine, protect themselves appropriately and provide caring care, and have decades with fulfilling careers with no burnout. To do this it is necessary to note that medicine is not only healing science but also survival skills. Both should be presented by education, which is an equal dedication and rigor.

The change begins with frank discussion. The veil of money in medical education should be done away with, and open talks on practice economics and career financial planning should take its place. The positive attitude of the grateful patients and all-good outcomes should be replaced with the realistic approach towards the multi-level emotional interactions and the occurrence of violence that characterizes modern practice. Such discussions are uncomfortable as they are questioning established notions regarding medicine, but the cost of improvement is suffering. The profession is on a crossroad. One is to continue with existing practices, which will continue the struggle, burnout, and early retirement of physicians with the hope that people will somehow cope despite their lack of proper training. The alternative route would be the holistic preparedness where physicians are provided with all the competencies that will make them have successful, long, and rewarding careers. The decision is obvious in simple terms, and it is hard to choose the more advantageous option due to the culture of inertia and opposition in organizations.

This paper provides data, discussion, models, and practical ideas to steer the required change. The issue is evident, the solution is evident, and the future will be good in case the correct measures are implemented. All that is left is the desire and readiness to do something, the bravery to break the tradition, and the dedication to provide future physicians with the maximum preparation they require. The time for action is now. Profession needs to change, and the change should begin with the understanding that it is not sufficient to teach medical science anymore. Education should incorporate science and survival skills in order to equip clinicians to be successful rather than merely practicing medicine.

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